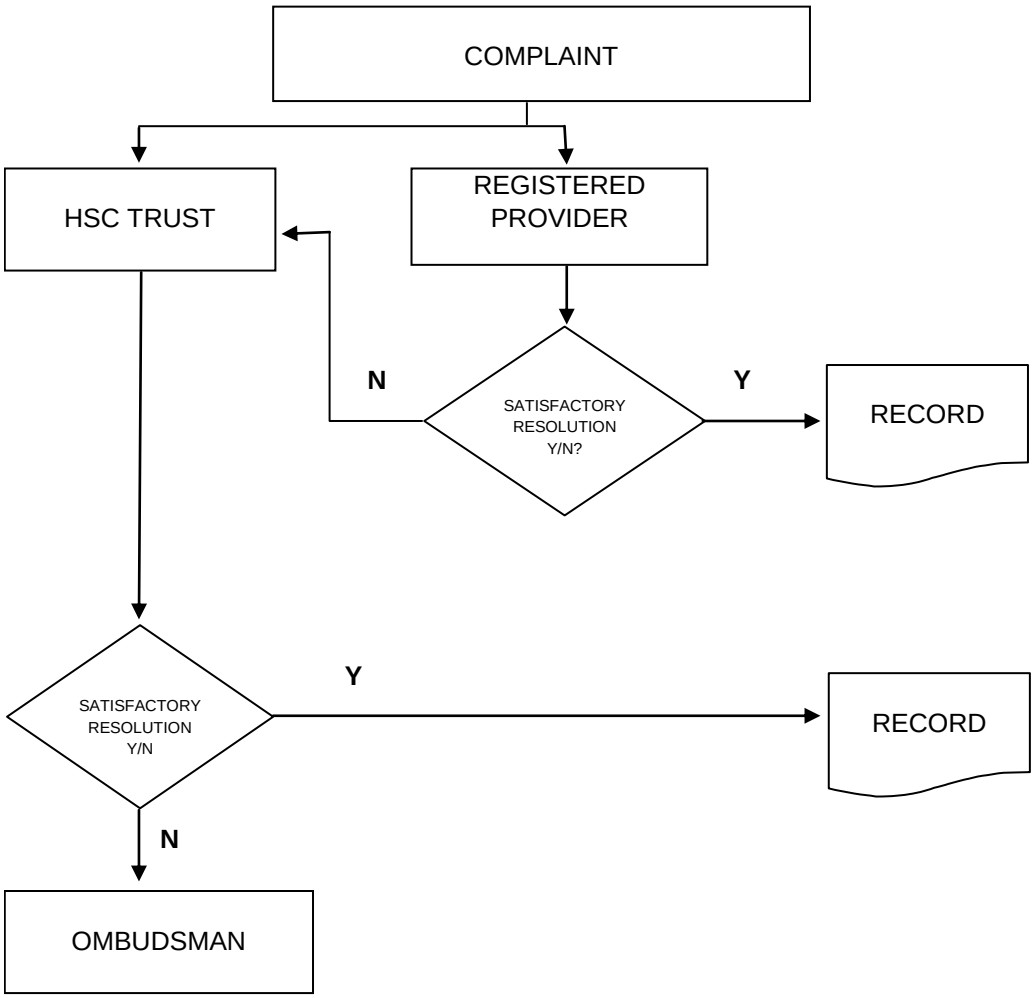
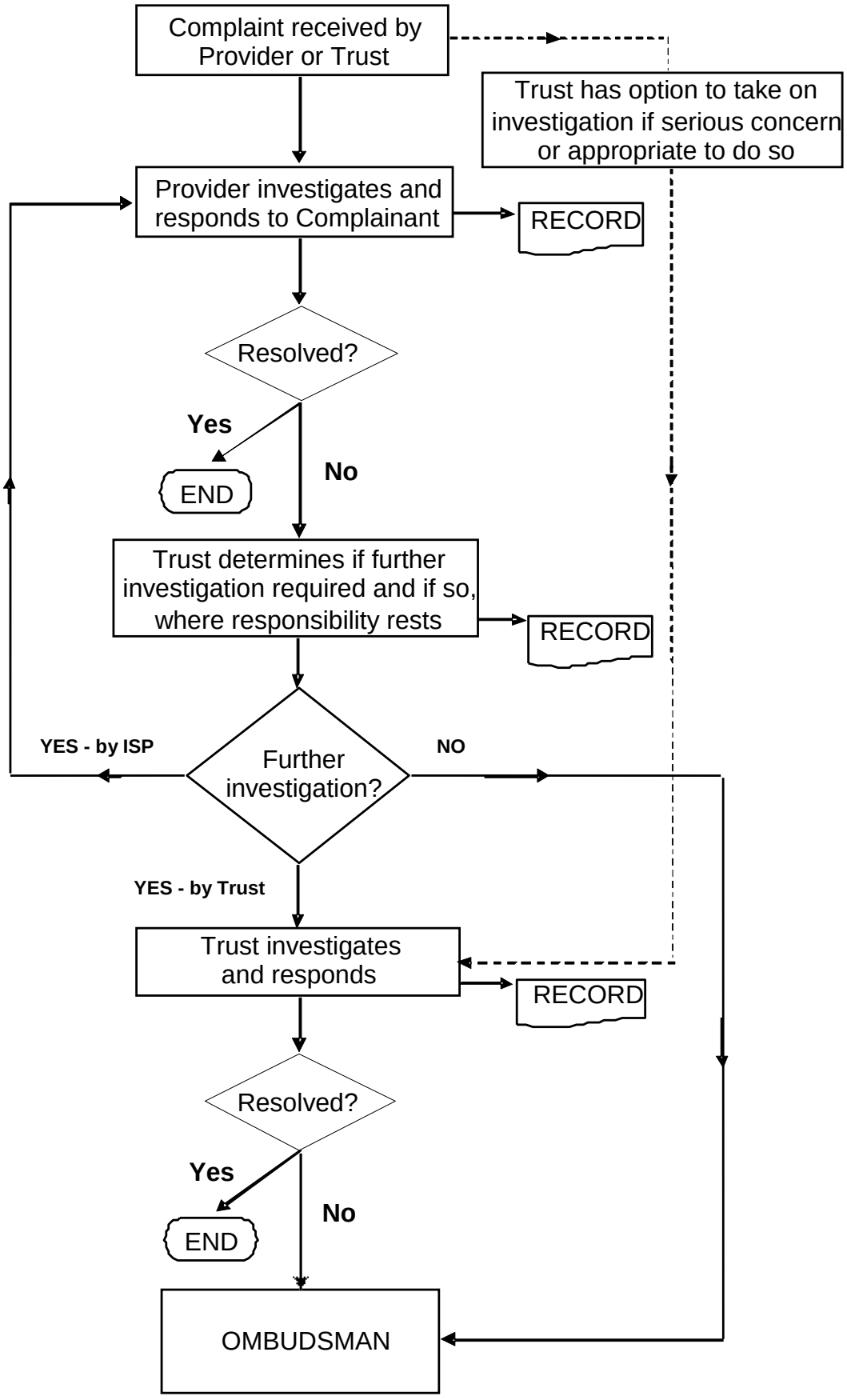
REGULATED ESTABLISHMENTS & AGENCIES FLOWCHART
(Services commissioned by HSC)



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 HSC Board)
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.

The HSC Board

4.5 The HSC Board must 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 HSC Board must provide the Department with quarterly complaints statistics in relation to all FPS and, where appropriate, out-of-hours services.

4.7 The HSC Board must 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 HSC Board acted as "honest broker". Copies should be sent to the PCC, the RQIA, the Ombudsman and the DOH. Reports must not breach patient/ client confidentiality.

HSC Trusts

4.8 All HSC Trusts including the Northern Ireland Ambulance Service (NIAS) must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide their Management Boards and the HSC Board 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 HSC Board, PCC, RQIA, the Ombudsman and the DoH. Reports must not breach patient/ client confidentiality.

Quarterly reports

4.11 The management boards of the HSC Board and 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 The HSC Board's quarterly reports to their management board should include a breakdown of complaints received in relation to **all** Family Practitioner Services and, where appropriate, out-of-hours services.

4.13 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

4.14 Family Practitioner Services must provide the HSC Board with anonymised copies of all written complaints received and responses provided by the Practice within 3 working days of the response being issued.

4.15 Arrangements should be in place to ensure that the complainant is aware and agrees to his/her complaint being forwarded to the HSC Board.

4.16 The HSC Board must record and monitor the outcome of all FPS complaints lodged with them.

Other HSC organisations

4.17 All other HSC organisations must publish an annual report on complaints handling. Copies should be sent to the PCC, HSC Board and the DoH. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

4.18 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.

Department of Health (DoH)

4.19 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.

Learning

4.20 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[22].

4.21 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.

4.22 The HSC Board must 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.

[22] 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

HSC Board

5.1 The HSC Board 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 HSC Board must maintain an oversight of all FPS and HSC Trust complaints received and, where appropriate, out-of-hours services. The HSC Board must be prepared to investigate any patterns or trends of concern or clusters of complaints against individual clinicians/ professionals.

5.3 The HSC Board must have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The HSC Board 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; and
- promoting the provision of advice and information to the public about the design, commissioning and delivery of health and social care services.

5.7 If a person feels unable to deal with a complaint alone, the staff of the PCC can offer a wide range of 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: www.patientclientcouncil@hscni.net or Freephone 0800 917 0222

WHO CAN HELP ME RAISE MY COMPLAINT?

You can get practical help to raise your complaint from the Patient and Client Council (PCC).

You can contact a PCC Officer at:

Phone: 0800 917 0222
Email: complaints.pcc@hscni.net

For more information, visit PCC's website:
www.patientclientcouncil.hscni.net

The PCC Complaints Support Service is there to:

- Give you information on how to complain and who to complain to
- Help you write letters of complaint
- Make telephone calls for you about your complaint
- Go with you to meetings about your complaint and make sure your concerns are responded to
- Work with health and social care organisations to improve services as a result of your complaint

WHAT CAN I DO IF I AM NOT SATISFIED WITH THE TRUST'S RESPONSE?

If you are not happy with the trust's response to your complaint, you can contact the Northern Ireland Public Service Ombudsman (NIPSO) at:

Phone: 0800 343 424
Email: nipso@nipso.org.uk
For more information, visit NIPSO's website:
www.nipso.org.uk

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;
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) 2009;
- Amendment Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009);
- 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).

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: 020 7713 5155 www.gcc-uk.org	**Nursing and Midwifery Council (NMC)** Nurses, midwives and specialist community public health nurses Phone: 020 76377181 www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: 020 71676000 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: 02890 326927 www.psni.org.uk
General Optical Council (GOC) Opticians Phone: 020 7580 3898 www.optical.org **General Osteopathic Council (GOsC)** Osteopaths Phone: 020 7357 6655 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: 020 73898030 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: 028 95362600 www.niscc.info

ANNEX 4: HSC PRISON HEALTHCARE

1. From 1 April 2008 responsibility for HSC prison healthcare was transferred to the DOH. From that date the DOH delegated responsibility for commissioning those health and social services to the Eastern Health and Social Services Board (EHSSB). From 1 April 2009 this responsibility transferred to the HSC Board. 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 or treatment or about 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[23] 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.

[23] 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: (028) 9023 3821
Freephone: (0800) 34 24 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:

   9th Floor, Riverside Tower
   Lanyon Place
   Belfast
   BT1 3BT
   Tel: 028 90 517500

   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/HSC Board 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/HSC Board; 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/HSC Board. In FPS complaints it may be suggested by the HSC Board.

FPS arrangements

6. The Practitioner/Practice/Pharmacy Manager (respondent) should approach the HSC Board Complaints Manager for advice.

7. Where a request for a conciliator is received the HSC Board Complaints Manager will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that conciliation would aid resolution then the HSC Board Complaints Manager will advise the FPS Practice/Practitioner. In some cases the HSC Board 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 HSC Board Complaints Manager (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 HSC Board (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 HSC Board of the outcome.

11. Using conciliation does not affect the right of a complainant to pursue their complaint further through the HSC organisation or HSC Board (for FPS) if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

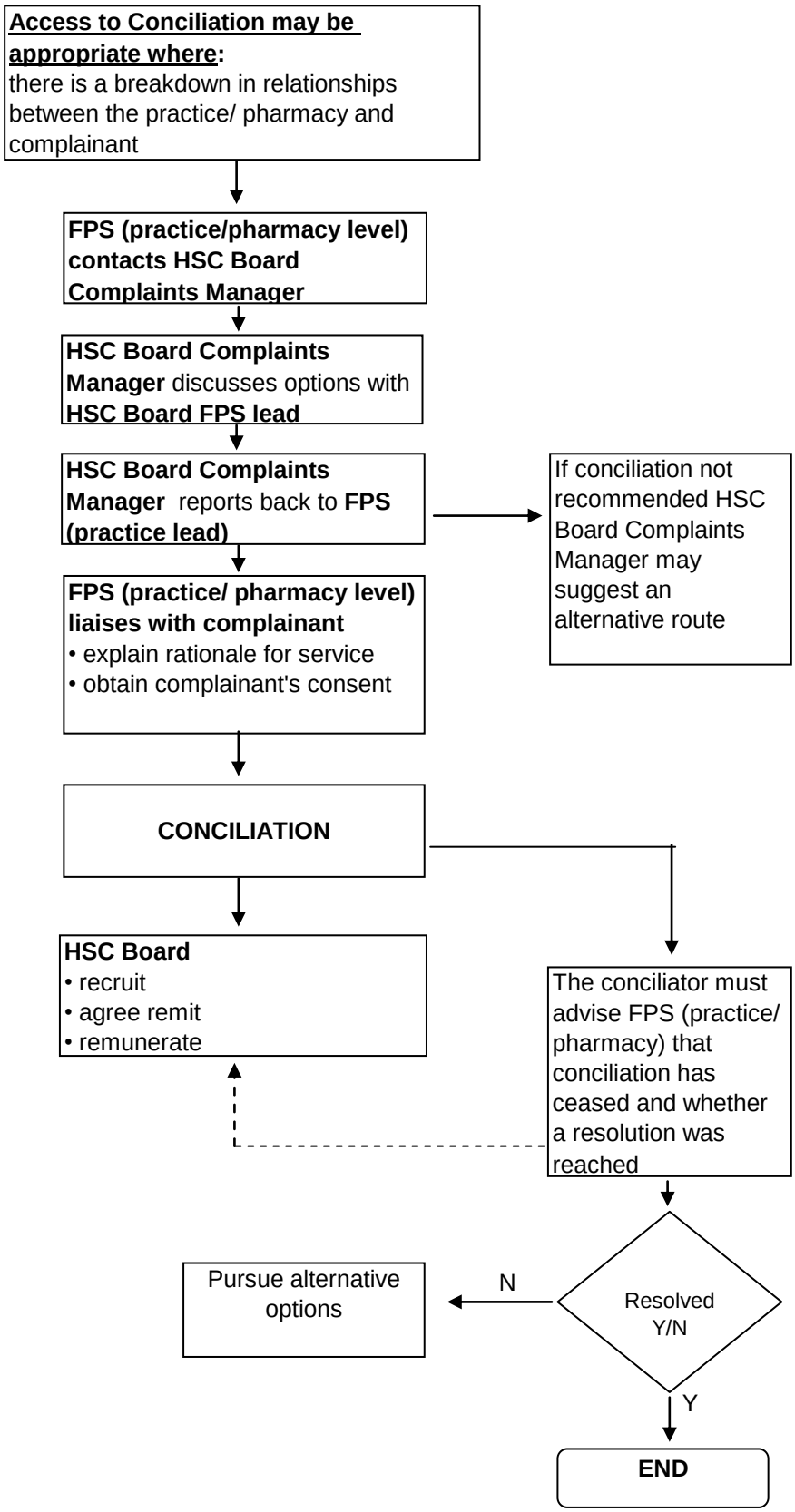
Appointment of conciliators

12. The HSC organisation or HSC Board (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 HSC Board will monitor the effectiveness and usage of conciliation arrangements within HSC Trusts and FPS.

Conciliation – FPS Access



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 HSC Board. 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 HSC Board Complaints Manager for advice.

3. Where a request for an Independent Expert is received the HSC Board Complaints Manager **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 HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board may consider an alternative to an Independent Expert.

Agreement and consent

4. The FPS Practice/Practitioner/HSC organisation/HSC Board 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 HSC Board Complaints Manager (on behalf of FPS) will make the necessary arrangements.

5. The HSC organisation or HSC Board 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/HSC Board 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/HSCB (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 HSC Board (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 HSC Board (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

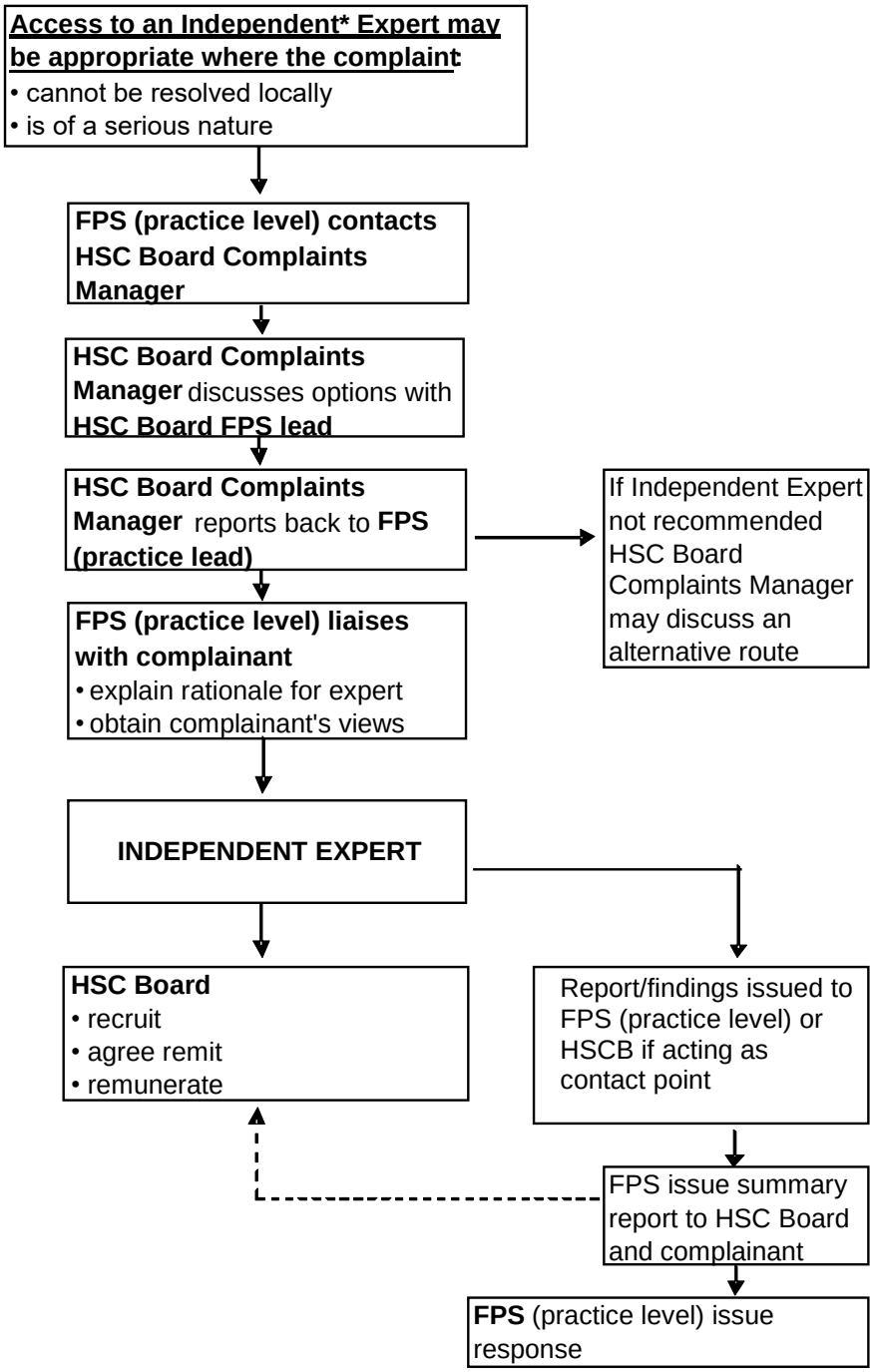
Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

Monitoring

11. The HSC Board 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 HSC Board Complaints Manager for advice.

6. Where a request for a lay person is received the HSC Board Complaints Manager **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 HSC Board Complaints Manager will advise the FPS practice. In some cases the HSC Board **may** consider an alternative to a lay person.

Agreement and consent

7. The FPS Practice/ Practitioner/ HSC Organisation/HSC Board 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/HSC Board Complaints Manager (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/HSC Board 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/HSC Board. The full report will be made available by the Practice/ Practitioner/HSC Organisation/HSC Board (for FPS only) and to the complainant.

10. The letter of response to the complainant is the responsibility of the Practice/Practitioner/HSC Organisation/HSC Board.

Appointment of lay persons

11. The HSC organisation or HSC Board (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 HSC Board 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 HSC Board Complaints Manager in supporting and advising FPS on the handling of complaints. The complainant or the Practice/Practitioner can ask the HSC Board to act in this role at any point in the complaints process. It is expected that the HSC Board will not carry out the investigation but it is also expected that the HSC Board 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 HSC Board 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 HSC Board. Where the complainant contacts the HSC Board the Complaints Manager will explain the options available to resolve the complaint:

- that the complaint can be copied to the relevant practice/pharmacy for investigation, resolution and response; or
- that the HSC Board 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 HSC Board's involvement.

5. Where the HSC Board Complaints Manager has been asked to act as honest broker he/she 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[24]; 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 HSC Board Complaints Manager, 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 HSC Board 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 HSC Board Complaints Manager for further advice and support.

[24] 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[25]'.

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.

[25] '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*[26] 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.

[26] 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[27] 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.

[27] 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[28] (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[29].

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[30].

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 Board and HSC Trusts should familiarise themselves with these requirements.

[28] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[29] Adoption Order (NI) 1987: http://www.legislation.gov.uk/nisi/1987/2203/contents
[30] Representations Procedure (Children) Regulations (NI) 1996: http://www.legislation.gov.uk/nisr/1996/451/contents/made

CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

↓

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

↓

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[31]	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 HSC Board's role in FPS complaints
HSC Board	Health and Social Care Board
HSC Organisation	an organisation which commissions or provides health and social care services and for the purpose of this guidance includes the HSC Board, 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

[31] Formally the Department for Health, Social Services and Public Safety (DHSSPS)

	Northern Ireland Blood Transfusion Service
NIBTS	Northern Ireland Public Services Ombudsman (NIPSO, known as 'the Ombudsman')
NIPSO	refers to immediate necessary treatment provided by FPS 6.00 pm to 8.00 am Monday – Friday, weekends and local holidays
Out of-Hours services	
	Patient and Client Council
PCC	a small-scale experiment or set of observations undertaken to decide how and whether to launch a full-scale project (refers to personal
Pilot Scheme	dental services provided by an HSC Trust in this case)
	is a complaints procedure established by the pilot scheme
Pilot Scheme Complaints Procedure	is an FPS complaints procedure established within the terms of the relevant regulations
Practice based complaints procedure	person carrying on or managing the establishment or agency
Registered Provider	Regulation, Quality and Improvement Authority which is the organisation responsible for regulating, inspecting and monitoring the standard and
RQIA	quality of health and social care services provision by independent and statutory bodies in Northern Ireland
	for example, residential care homes, nursing homes, children's homes, nursing agencies, independent clinics/hospitals, etc. registered with
Registered Establishments and Agencies	
	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)

HEALTH AND SOCIAL CARE BOARD

POLICY FOR THE MANAGEMENT OF COMPLAINTS

November 2020

1. Introduction

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

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

What the Policy Covers

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

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

What the Policy does not cover

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

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

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

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

Confidentiality

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

2. Standards for Complaints Handling

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

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

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

3. Standards and Guidelines for Resolution and Learning

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

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

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

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

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

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

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

4. Definitions

4.1 Complaint:

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

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

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

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

4.2 Complainant:

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

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

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

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

4.3 Consent

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

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

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

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

the decision has been taken.

5. Complaints concerning commissioning decisions by the HSC Board

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

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

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

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

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

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

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

6.2 The primary objective of local resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint, as quickly as is sensible in the circumstances. The

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

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

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

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

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

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

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

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

7.2 Lay Persons

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

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

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

7.3 Conciliation

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

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

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

7.4 Independent Experts

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

any attempts at earlier enhanced local resolution.

An independent expert may be considered beneficial where the complaint:

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

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

8. Receipt of Complaints

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

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

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

8.4 Complaints addressed directly to the HSC Board Chairman or Chief Executive, such as those from Members of Parliament, Members of the Legislative Assembly, District Councillors etc, will

be dealt with as in 8.3 above.

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

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

FPS Complaints received by the Board

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

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

Board Complaints received by the HSC Board

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

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

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

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

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

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

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

9. Northern Ireland Public Services Ombudsman

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

10. Complaints Monitoring

10.1 Under the HSC Complaints Procedure the complaints handling role and responsibilities of the HSC Board are to monitor complaints

processes, outcomes and service improvement; and dissemination of learning. The use of this information will also inform commissioning processes and purchasing decisions.

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

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

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

10.5 Monitoring information will be: -

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

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

(ii) **Family Practitioner Services**

The HSC Complaints Procedure requires Family

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

(Iii) **Health and Social Care Trusts**

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

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

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

11. Role of the Patient and Client Council

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

12. Equality

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

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

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

This Policy will be reviewed in December 2021

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY
TERMS OF REFERENCE
QUALITY SAFETY AND EXPERIENCE GROUP (QSE)

1.0 Introduction

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

The purpose of the Quality, Safety and Experience Group is to identify themes, patterns and areas of concern emerging from all existing sources; and agree the actions to be taken to address these in order to improve the safety and quality of services commissioned. A diagrammatic overview of the Quality, Safety Experience Internal co-ordination arrangements for the PHA/HSCB is attached in appendix 1.

2.0 Objectives of the QSE Group

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

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

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

3.0 Working Arrangements between Existing Groups/Information Flow to QSE

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

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

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

4.0 Membership of the QSE

Joint Chairs: **Director of Nursing, Midwifery and Allied Health Professionals;**

Director of Public Health/Medical Director;

Director of Performance and Corporate Services;

Director of Social Care;

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

Representative for General Medical Services/Safety and Quality;

Head of Pharmacy and Medicines Management;

Assistant Director of Nursing and Allied Health Professionals;

Assistant Director of Public Health Medicine (Safety and Quality)

Clinical Director, Safety Forum;

Governance Manager;

Head of Nursing, Quality and Patient Safety;

Pharmacy Lead – Medicines Governance and Public Health;

Complaints/Litigation Manager;

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

Head of Optometry (co-opt as required);

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

In Attendance:

Deputy Complaints Manager

Assistant Governance Manager

Senior Nurse (Safety, Quality and Patient Experience)

5.0 Frequency of Meetings

Meetings of the Group will be monthly

6.0 Administrative Support to the QSE Group

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

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

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

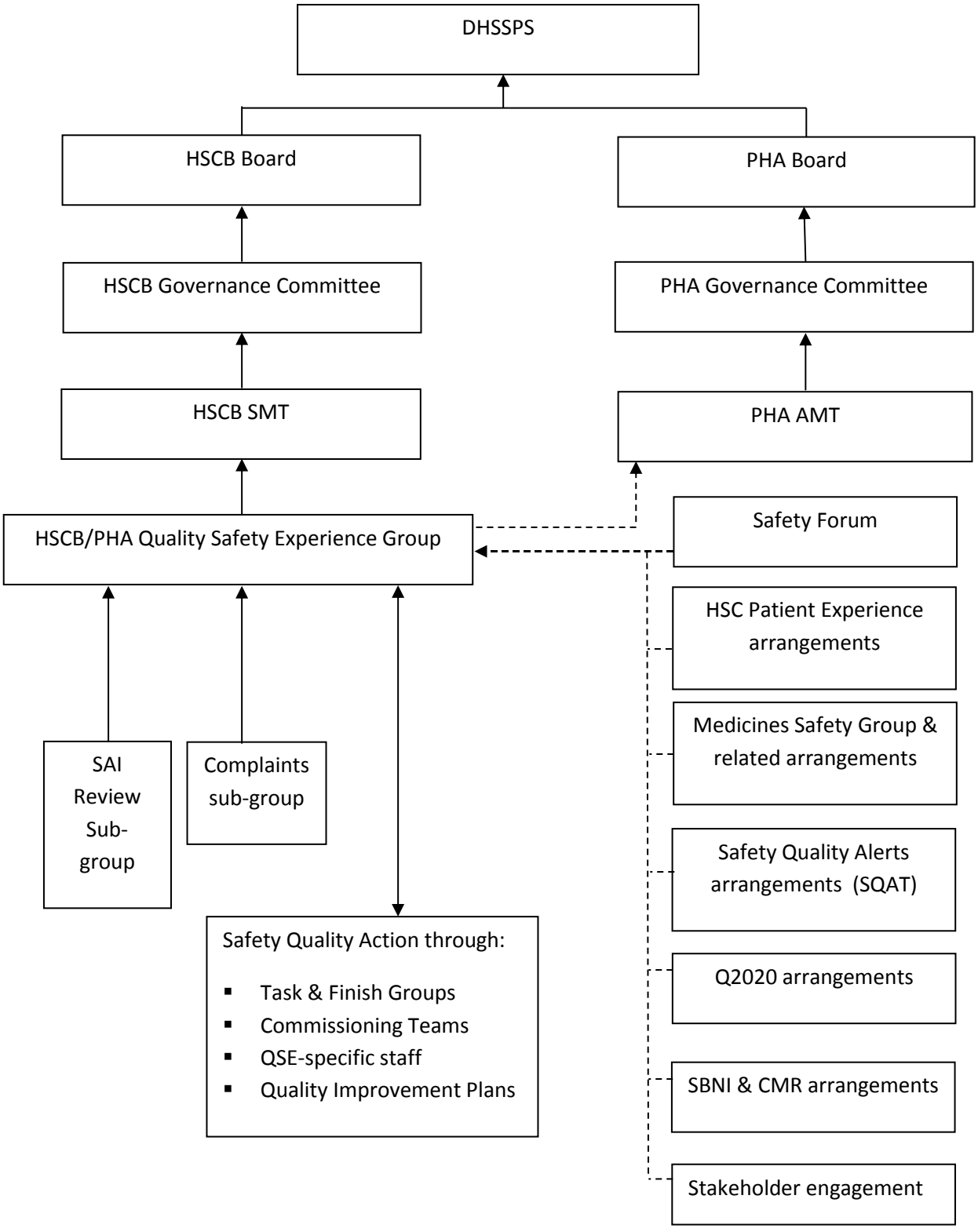
6.4 Agenda items and papers should be forwarded to Personal Information redacted by the USI

7.0 Review of Terms of Reference

These Terms of Reference will be reviewed in 12 months.

Appendix 1

Diagrammatic Overview of Quality Safety Experience Internal Coordination Arrangements – HSCB/PHA



Reviewed 3 September 2015

To be used for the submission of issues to Chief Executive/SMT

FROM: Corporate Services

DATE: **19 October 2021**

TO: HSCB SMT

ISSUE:	HSC Complaints Report January - March 2021
TIMING:	Routine
PRESENTATIONAL ISSUES	N/A
FOI IMPLICATIONS	N/A
FINANCIAL IMPLICATIONS	None
LEGISLATION/POLICY IMPLICATIONS	Legislative/Policy requirement for quarterly report to SMT
EQUALITY/HUMAN RIGHTS/RURAL NEEDS IMPLICATIONS	None
RECOMMENDATION:	To note the attached HSC Complaints Report January - March 2021 and to be considered by GAC at next meeting.

Submission may include the following areas as a guide.

Introduction/Background

HSC complaints activity January - March 2021; providing examples of complaints, trends and themes which have been highlighted at the Regional Complaints Sub-Group and discussed at the Quality Safety and Experience Group. The Report also details actions that have been taken or recommended.

Issue HSC Complaints Reports January - March 2021

Considerations N/A

Options N/A

Risks N/A

Recommendation (Should be a direct lift from first page)

To note the attached HSC Complaints Report January - March 2021 and to be considered by GAC at next meeting.

Name of Director – Lisa McWilliams, Strategic Director of Performance Management and Corporate Services

Ext no. Personal Information

Copied to: N/A

(Any additional material referenced should be included as Appendices eg letters
Draft responses, papers)

Thematic Review – Palliative Care

Mealtimes Matter – Poster

QUARTER 4 COMPLAINTS REPORT JANUARY - MARCH 2021

Index **Page**

1.0 Summary Position

The findings of Sir Robert Francis', Mid Staffordshire Inquiry levied criticism at the level of complaints information considered by Management Boards of health organisations. Therefore rather than receive statistical information only, the HSCB quarterly reports are formatted to provide narrative examples of HSC Trust and FPS complaints where learning, concerns, patterns or trends have been identified. These are contained within **Annex 1** of this report. This paper will also be considered at Governance and Audit Committee.

This report provides detail of complaints activity across the HSC for the period January – March 2021 to include, identification of learning, trends and themes which have been considered at the Regional Complaints Sub-Group (RCSG) meetings within the reporting period. The report also highlights how complaints information acquired through the monitoring process informs key areas of ongoing work.

1.1 **Of significance**, the number of complaints received and closed by HSC Trusts during this period has increased in comparison to the previous quarter. It is noted that HSC Trusts closed 955 in Q4 compared to 812 complaints in Q3 20/21which had been impacted by staff sickness and redeployment of staff to deal with the COVID-19 response.

1.2 In respect of the HSCB, seven complaints were received during this period compared to four in the previous quarter (Q3 20/21).

1.3 Local resolution returns from Family Practitioner Services have seen an increase on the previous quarter; 31 returns compared to 26 during the previous quarter (Q3 20/21); and 25 requests for the HSCB to act as Honest Broker compared to 21 in the previous quarter (Q3 20/21).

2.0 Summary of HSCB Complaints Monitoring Process

2.1 <u>HSC Trusts</u>

The HSCB receives an anonymised summary of each issue of complaint, along with an outline of the response issued in respect of closed complaints

from each HSC Trust. This information is received two months retrospectively. HSCB continues to work with HSC Trusts in relation to the quality of the information provided within the summary reports and to ensure that this maintained.

2.2 Family Practitioner Services (FPS)

In respect of Family Practitioner Services, the HSCB receives an anonymised copy of each written complaint together with the response issued by the Practice/pharmacy within three working days of the response being issued.

2.3 Monitoring Mechanism

Complaints staff share information with relevant professionals within the HSCB/PHA who provide input into the Regional Complaints Sub-Group (RCSG). These professionals determine whether any further information or clarification is required from the HSC Trust and confirm whether they are content with the actions that have been taken. They also consider whether there is any regional learning and/or make recommendation(s) to the Quality Safety and Experience Group (QSE) on suggested courses of action as a result of an individual complaint or pattern/trend. The QSE Group is currently under review.

In addition, these staff also feed relevant information from complaints into existing professional/commissioning and regional groups of which they are members.

The sharing of complaints information to regional groups in this manner has in recent years informed the development of the Regional Dementia Strategy; the ongoing development of the Advance Care Planning Policy; the Falls Strategy and as a result of a continuing pattern of complaints regarding the discharge arrangements for, in particular, vulnerable patients, a review of complaints of this nature is ongoing with a view to informing the Regional Discharge Group in the development of a Safe Discharge policy. Similarly, a review of complaints was undertaken in relation to ‘Mealtimes Matters’, an always event, to help inform improvement work in this regard. Unfortunately, this piece of work has been temporarily paused due to staff availability/redeployment.

3.0 Complaints Activity – January - March 2021

3.1 HSC Trust Complaints

The number of complaints received and closed by HSC Trusts during this period has increased in comparison to the previous quarter. It is noted that HSC Trusts closed 955 in Q4 compared to 812 complaints in Q3 20/21which had been impacted by staff sickness and redeployment of staff to deal with the COVID-19 response. Each of the HSC Trusts provides the HSCB with information in respect of closed complaints.

HSC Trust Complaints by Subject – January – March (Q4 20/21)

The top ten issues of complaint received by HSC Trusts are outlined in the table below.

Top Ten Issues of Complaint Received by HSC Trusts Between 1 January 2021 – 31 March 2021							
Subject	**BHSCT**	**NHSCT**	**SET**	**SHSCT**	**WHSCT**	**NIAS**	**Total**
Communication/Information	118	16	78	67	24	1	**304**
Quality of Treatment & Care	67	16	114	46	48	10	**301**
Staff Attitude/Behaviour	60	9	53	49	23	7	**201**
Waiting List, Delay/Cancellation Outpatient Appointments	46	2	14	9	4	0	**75**
Clinical Diagnosis	18	8	13	15	12	0	**66**
Quantity of Treatment &Care	32	3	0	10	5	0	**50**
Patient Expenses /Finances	14	2	5	5	0	0	**26**
Planned Assessment of Need	0	2	0	24	0	0	**26**
Waiting List, Delay/Cancellation Planned Admission to Hospital	23	0	0	0	2	0	**25**
Infection control	13	4	0	0	6	0	**23**
Total	**391**	**62**	**277**	**225**	**124**	**18**	**1097**

There continues to be a trend of a significant number of complaints regarding staff attitude and communication/information. As previously advised, HSC Trusts have adapted virtual zoom training sessions to target specific problem areas in this regard and have noted improvements in those areas following these sessions. In addition Trusts have considered one to one reviews; issued learning letters and memos and held learning days. However, due to

COVID restrictions the learning days had been put on hold. Communication replaces Treatment and Care as the top subject of complaint.

The HSCB will keep this position under review via the monitoring meetings with HSC Trusts.

For the period January – March 2021 (Q4 20/21) the complaints reviewed by professionals, broken down by area of concern, across the six HSC Trusts are:

Closed Complaints Received from HSC Trusts, (January - March 2021)							
Area of Concern	**BHSCT**	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**	**NIAS**	**Total**
Patient Experience	148	57	72	56	79	31	**443**
Palliative Care/ Death/Dying	8	6	7	12	12	1	**46**
Allied Health	8	1	2	11	7	0	**29**
Maternity/Gynaecology	30	9	12	17	7	0	**75**
Emergency Department	27	10	11	26	24	0	**98**
Social Care & Children	58	72	44	32	28	0	**234**
Prison Healthcare	-	-	13	-	-	-	**13**
GP OOHs (Trusts)	2	-	0	0	-	-	**2**
Sepsis	0	1	0	0	0	0	**1**
Stroke	0	1	0	0	1	-	**2**
Neurology	10	1	1	0	0	-	**12**
Total	**291**	**158**	**162**	**154**	**158**	**32**	**955**

HSC Trust Learning

According to information received from the HSC Trusts, learning/action was identified/taken in respect of 264 complaints in the period compared with 309 in Q3 2021; to include new/ revised processes, shared learning within departments/individuals and discussions at safety briefings and Mortality and Morbidity (M&M) meetings. It should be noted that where professionals reviewing this information feel regional learning is merited, such complaints will be discussed at the Quality Safety and Experience Group (QSE) to decide what further action is required as outlined at point 2.3.

3.2 Family Practitioner Service (FPS) Complaints

The HSCB receives anonymised copies of approximately 150 written complaints and responses (local resolution returns) from FPS Practices each

year, primarily from General Medical Practitioners and General Dental Practitioners.

In addition, the HSCB acts as an intermediary, or 'honest broker', in approximately 60 – 80 complaints per year (predominantly General Medical and Dental Practitioner complaints). The role of an intermediary requires a level of mediation on the part of the HSCB's complaints staff in an attempt to successfully resolve complaints at Practice-level where possible.

It should be noted that in line with the Board's monitoring role, complaints concerning clinical/professional/regulatory issues (including 'honest broker') are shared with respective professional staff in the Directorate of Integrated Care. Where issues are identified, appropriate action is taken by professionals and fed back to the complaints team be noted and recorded. During this period one complaint required further action and this is highlighted below at Annex point 1.

3.2.1 Local Resolution FPS Complaints

During this period the HSCB received 31 local resolution returns from GP Practices. This is a slight increase on the previous quarter when 24 returns were received. One return was received from a Dental Practice, and there were no returns received from Pharmacies.

Subject	GP	Dental	Total
Treatment & Care	12	1	13
Staff Attitude & Behaviour & Communication	10	0	10
Appointments	2	0	2
Medications	2	0	2
Registration	1	0	1
Other	2	0	2
Personal Records	1	0	1
Total	**30**	**1**	**31**

3.2.2 Honest Broker Complaints and Timescales

During this period the HSCB was requested to act as an honest broker in 25 complaints. This is a slight increase on the previous quarter when 21 requests for honest broker complaints were made.

Subject	GP	DENTAL	Total
Treatment & Care	7	1	8
Staff Attitude & Behaviour & Communication	6		6
Registration	5		5
Other	2		2
Removal	1		1
Failure to follow agreed procedures	1		1
Personal Records	2		2
Total	**24**	**1**	**25**

Honest Broker Timescales

Six honest broker complaints were carried over from the previous quarter. During this period 19 complaints were responded to. 14 were responded to within the 20 working day timescale; five were responded to outside of this timescale.

Two complaints were responded to within between 34 and 35 working days - awaiting consent and clarification from the complainants added to the timescales. Three complaints were considerably over the timescale, 43, 60 and 61 working days and delays were as a result of the pressures on Practices as a result of the pandemic.

Twelve complaints remained ongoing at the end of the reporting period.

3.3 HSCB Complaints

Within this period seven complaints were received relating to HSCB processes and ECR applications. This compares to four HSCB complaints received in the previous Quarter (Q3 20/21). Three complaints also carried over from the previous quarter . Four HSCB complaints were closed during this period and six remain ongoing.

During this period four complaints relating to HSCB were closed. Two complaints were responded to within 27 and 30 working days - delays occurred due to awaiting approval on responses. Two were responded to significantly outside the timescale (55 and 71 working days); one required liaison with another organisation and the other was delayed due to the availability of key staff. Complainants were kept updated throughout the process. Six complaints regarding HSCB will carry over into the next reporting period.

HSCB Learning

In respect of the four complaints closed during this period, each investigation found that while due process had been followed, an apology had been issued.

3.4 OOHs Complaints

During this period the HSCB received six complaints regarding the GP Out of Hours Service from Trusts and Mutual Providers. This compares to seven complaints in the previous quarter (Q3 20/21).

Category of Complaint	BHSCT	DUC	SEHSCT	SHSCT	WUC
Treatment & Care	0	4	0	0	0
Staff Attitude and behaviour	1	0	0	0	0
Communication	1	0	0	0	0
Total	**2**	**4**	**0**	**0**	**0**

Relevant professionals review complaints regarding the Out of Hours service and no concerns were identified during this period.

4. Other Issues

4.1 Informing key areas of work

4.1.1 Complaints concerning Discharge Update – As previously advised the RCSG agreed that a review of complaints regarding discharge arrangements

across the HSC Trusts over a 12 month period should be undertaken. This review was undertaken and a paper was subsequently discussed at a Safety Briefing meeting on 18 June 2021. It was agreed that in order to provide a complete picture, data should also be reviewed concerning SAIs, AIs and Patient Experience. In the interim the paper will be shared with the Regional Discharge Group in the knowledge that further information will follow to ensure there will not be a delay in sharing the rich information from complaints.

4.1.2 DNR/DNAR Thematic Review – Professionals have carried out a thematic review of complaints concerning palliative care. A further review of complaints was undertaken to support that which had already informed the DNAR/Palliative care work.

The Advance Care and Planning Lead, who is advancing the Advanced Care Planning Policy in NI, has taken note of the themes arising from this review ie communication, documentation, attitude and decision making and will ensure that all of these issues are covered and examined by this new policy. (Attached)

4.1.3 **'**Mealtimes Matter' This is an 'Always Event' that is a key priority for Trusts, and led by NHSCT(attached). At the request of the Patient Safety, Quality and Experience Lead, a review of complaints was undertaken for the period October 2019 - March 2021to identify key themes to inform this improvement work on Mealtimes. This work is currently paused due to staff availability.

4.2 COVID-19 Complaints Update – The Q3 complaints report indicated that an update would be provided in relation to themes that had been identified specifically relating to the impact of COVID-19, ie complaints regarding palliative care/care of the dying/access to loved ones when dying; visiting arrangements; and waiting times associated with delayed treatment/care. A review of complaints regarding COVID -19 specific issues has demonstrated that during the period October to December 2020 (Q3 20/21) 86 COVID-19 related complaints were received and 105 during the period January to March (Q4 20/21). This represents a 22% increase in complaints concerning these particular issues. The largest number of complaints relate to the impact on

waiting times, reduction or suspension of services and visiting restrictions. We will continue to monitor complaints concerning these issues.

SMT are asked to note this report and its contents for consideration at the Governance and Audit Committee. Further information is available on any of the example complaints detailed, should this be required.

Liz Fitzpatrick (Mrs)
Complaints/Litigation Lead HSC Board

Annexe 1

Examples of FPS and HSC Trust Complaints where learning has been identified/there has been further professional consideration or action/patterns or trends have been identified.

FPS Complaints

1. **A complaint was raised on behalf of a Syrian refugee who has limited English. Their advocate was concerned that the Practice implied that they do not use Interpreting Services for telephone appointments, rather the Practice requests patients bring a friend/relative to their appointment or speak to the GP on their behalf. The patient had an appointment with a GP but did not understand the advice provided, due to lack of interpreting service**.

   Practice Response: - The Practice explained that whilst it would be ideal to have an interpreter available for all telephone and face to face appointments, regrettably more often than not, they are unable to get an interpreter from the Big Word (interpretation and translation technology). Either their call to the Big Word is unanswered or they do not have the appropriate language available. Where the Practice identifies a need for an interpreter staff always highlight this to the GP and also take details to ensure they have a contingency plan where possible. Often this means relying on friends or relatives which is not ideal.

   RCSG Action: As a result of this complaint, the HSCB made contact with the Big Word, highlighting the issues of complaint being received. Correspondence was also re-issued to FPS Practices to remind them of their responsibilities regarding the provision of interpreting services and details on how to access both face to face and telephone appointments.

   Action taken: The Big Word advised HSCB that the difficulties experienced were as a result of the Global pandemic. Restrictions were put in place in respect of face to face bookings which impacted greatly on their conference call service. They have now implemented 3-way calls via their automated system and in addition have commenced a recruitment campaign to recruit linguists to cover the volumes at peak times.

Additional information - The NI Public Services Ombudsman has the power to conduct investigations on her own initiative under section 8 of the Public Services Ombudsman Act (Northern Ireland) 2016 which can be conducted where the Ombudsman has a reasonable suspicion of systemic maladministration (service failure) or systemic injustice (sustained as a result of the exercise of professional judgement).

The Own Initiative team are currently conducting preliminary research on behalf of the Ombudsman into a range of areas of potential concern. This includes potential concerns in GPs use of interpretation/translation services in Northern Ireland and HSCB is co-operating with this office.

HSC Trust Complaints

2. A patient raised concerns that their baby's heart defect was not detected at their scan.

Trust response: The Trust apologised and explained that detection rates for cardiac abnormalities nationally are approximately 50%. The images were reviewed again and there was no indication of a cardiac abnormality. The private scan was done 9 days later, which can make a difference to the size of structures within the heart, equipment may differ and the foetal position may become optimal for scanning within this period. The Trust stated that the cardiac imaging was not carried out using the pre-set cardiac settings on the scanner and that this had been discussed with the Sonographer and learning shared. The consultant reviewed the patient with the foetal anomaly scan that had been performed at the Trust and their private scan. Noting the presence of mild bilateral renal pelvic dilatation, they discussed the implications of this finding, including a risk of underlying chromosomal problem of 1-2% and a referral was made to paediatric cardiology.

RCSG Action: Professionals requested additional correspondence in relation to this complaint and noted the Trust had explained learning had been identified. It advised that the diagnostic quality of the saved cardiac imaging was not good. The pre-set cardiac setting had not been used. It is imperative, especially when scanning the heart that the image quality is optimised with appropriate manipulation of all scanner settings. Professionals noted this learning had been shared with the Anomaly Scan Improvement Group/all

Obstetric Sonographers in all of the 5 Trusts and were content the learning had been shared appropriately.

3. **A Complainant raised concerns about their treatment and care after presenting to the ED several times with a headache; no scan was carried out. They had to be blue-lighted to the RVH with an aneurysm and have been left permanently damaged and unable to work.**

   Trust Response: The Trust convened a meeting with the complainant to discuss their attendances at ED and the treatment provided. The Trust advised that it was sorry to learn staff within ED had been dismissive and had insisted the complainant had had a migraine. The Trust reassured the complainant that investigations were normal and did not indicate a scan was necessary until their fourth attendance when their symptoms had worsened and an aneurysm was diagnosed. It apologised for their experience and for the impact this had had. The Trust advised that learning had been identified in terms of taking more care with patients who presented with severe and sudden onset of headache, especially when they present frequently over a short time period of time.

   RCSG Action: Correspondence was requested and shared with relevant professionals, who are liaising with Trust Governance colleagues to seek clarification as to whether this requires to be considered for SAI. This continues to be followed up.

4. **A patient presented at ED on the advice of the Out of Hours Service as they could not rule out a stroke. In ED the examining Doctor was dismissive and suggested referral to Occupational Therapy for assessment. The patient was discharged and re-attended the following day where a CT brain scan was taken which showed a large mass on their brain.**

   Trust Response: The Trust advised that investigations ie bloods, urine and ECG were normal and the complainant was discharged with advice to follow up with their GP. The Trust advised it was sorry to learn of their diagnosis. It advised that a Senior Consultant in Emergency Medicine had undertaken a review of their care and discussed the complainant's case with the Doctor involved. On reflection, the Doctor agreed a CT brain scan should have been

requested to rule out the presence of a subdural haematoma in the first instance. Apologies were given for any distress caused.

RCSG Action: Correspondence relating to the complaint was requested and shared with relevant professionals, who are liaising with Trust Governance colleagues to seek clarification as to whether this requires to be considered for SAI. This continues to be followed up.

5. Escalation of Complaints to SAIs

A Service User attended ED with severe leg pain. The patient was examined and appropriate tests were carried out. They were discharged with follow up by their GP for onward referral to neurology. The patient returned to ED as the leg pain became unbearable. Following examination they underwent surgery to remove a clot. The patient's condition deteriorated and required an above knee amputation.

Learning: This was discussed and considered by the relevant SAI group; new Regional Learning was identified. Governance colleagues advised that a Learning Matters Article will be completed on Acute Limb Ischaemia. This will be shared in a future report.

Department of Health Advance Care Planning Policy for Northern Ireland (for adults)

DNACPR

Thematic Review of DNACPR Issues

February 2021

CONTENTS

1.0 Executive Summary

1.1 Introduction

Advance Care Planning is one of the key priority areas for the Palliative Care in Partnership Programme since 2016. During COVID – 19 the issues relating to Advance Care Planning and in particular Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) have gained a greater emphasis, urgency, and priority.

In response, the Department of Health has tasked a small project team to develop a Regional Advance Care Planning Policy (Adults) for NI. They are also tasked with drafting a comprehensive suite of supporting documentation and with implementing a comprehensive training and education plan.

The high level plan has been approved by the Minister of Health. The Regional Clinical Ethics Forum and the Palliative Care in Partnership members have provided commentary on the scheme of work, inclusive of methodology for the various stages of the development of this Policy.

To ensure rigour from the outset, a thematic analysis was undertaken on a number of key data sources which related to either advance care planning broadly, or DNACPR specifically. These sources included the following six recently published reports;

- Age NI, 'Lived Experience: Voices of older people on the COVID-19 Pandemic 2020',
- Amnesty International, 'As if expendable. The UK Governments failure to protect older people in Care Homes during the Covid-19 pandemic'.
- The CQC interim report from its review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 pandemic,
- The National Audit of Care at the End of Life (NACEL), Second round of the audit report Northern Ireland (2019/20),
- The Patient Client Council: Exploring the experiences and perspectives of clinically extremely vulnerable people during COVID 19 shielding December 2020.
- NI Assembly Committee for Health, Inquiry Report on the Impact of COVID-19 in Care Homes (February 2021)

The thematic analysis also included Health and Social Care data; "Regional Complaints" received from across all the Health and Social care Trusts in Northern Ireland between April 2018 and June 2020

which related to ACP or DNACPR. A search of “Serious Adverse Incidents” reported similarly, will be completed when the data is made available to the Project Team.

This paper presents the findings from this initial thematic analysis and is intended as a live document that will be developed further as the work progresses, to include new relevant information as it emerges.

1.2 Thematic analysis overarching themes

Following this initial analysis, a number of overarching themes are evident.

- There should be No blanket approach to DNACPR (Human Rights issue)
  (In both Amnesty UK and CQC interim Report)
- Public misunderstanding of DNACPR
- HSC professionals misunderstanding/poor knowledge of DNACPR process (including no review of status)
- No/Poor/insensitive Communication re DNACPR
- CQC finds that a combination of increasing pressures and rapidly developing guidance may have contributed to inappropriate advance care decisions

2.0 Evidence

What follows is a synopsis of key findings from the six abovementioned reports.

2.1 Age NI – "Lived Experience: Voices of older people on the COVID-19 Pandemic 2020"

Using feedback from older people who accessed their support services during COVID-19 or through hearing older people views during the weekly consultative forum, Age NI compiled this publication, which reflects key concerns and experiences through four key themes:

1. Support, health and care

2. Communication and connection

3. Loneliness and isolation

4. Grief and loss.

Figure I – Extracts from the Age NI report

"Older people around the world bear the brunt of the impact of the COVID-19 pandemic. In Northern Ireland, as elsewhere, statistics paint a stark picture:

• People aged over 65 make up 90% of all the deaths attributed to COVID-19

• People who were living in care homes account for over 50% of related deaths"

Our thematic analysis focused on issues pertaining to DNACPR

- *These are without doubt challenging times, but it is crucial that we continue to protect people's fundamental human rights. The role and timing of advanced (sic) care planning has taken on particular significance.*
- *Advanced (sic) care planning Families were distressed and concerned when advanced (sic) care planning and DNA CPR (Do not attempt cardiopulmonary resuscitation) forms were raised during the early stages of the pandemic.*
- *Action point: Start the conversation and follow best practice in advanced (sic) care planning.*

Key messages / Recommendations

- Older people must not be discriminated against particularly, on the basis of age or condition when it comes to treatment options and choices.
- Older people need to be kept at the heart of compassionate, best practice, care.

Other than that outlined in figure I, there was no further detail provided in the report regarding DNACPR, however Age NI will participate in the Stakeholder engagements.

2.2 Amnesty International: As if expendable. The UK Governments failure to protect older people in Care Homes during the Covid-19 pandemic

This report focuses on the number of COVID-19 related deaths of people over the age of 65 in England, between March and June 2020 (40% of the total of all those who died). Of these, 76% lived in care homes. The report makes the case that the UK government, national agencies, and local-level bodies have taken decisions and adopted policies during the COVID-19 pandemic that have directly violated the human rights of older residents of care homes in England—notably their right to life, their right to health, and their right to non-discrimination.

Figure II - Extracts from Amnesty International Report

"Throughout the pandemic, concerns about the inappropriate use of Do Not Attempt Resuscitation (DNAR) forms have been repeatedly raised."

"Concerns about blanket imposition of DNAR were reported across the country, pointing to flaws with how decisions were taken and policies communicated to those who are supposed to implement them—CCGs, GPs, and care homes. Care home managers reported to Amnesty International and to media cases of local GP surgeries or Clinical Commissioning Groups (CCGs) requesting them to insert DNAR forms into the files of residents as a blanket approach."

The guidance also included instructions related to hospital admission, asking GPs to ensure "patients who do not already have a 'do not convey to hospital' decision are prioritised and have one in place".

"Discussions on advanced (sic) care planning should be warm and natural conversations. This is not how they should be done. One care home with 26 residents had 16 residents sign DNARs in a 24-hour period. It was distressing for staff and residents … Care homes felt like they were being turned into hospices, and being asked to prepare to manage deaths instead of managing life."

"Following investigations by a senior local figure and news coverage of the story, the CCG responded that while "agreeing advance care plans is a routine and important part of how GPs and care homes support their patients and residents, we recognise there may have been undue alarm caused by the interpretation of this particular guidance." (129 A local official told Amnesty International that the CCG sent a follow-up letter apologising and clarifying guidance shortly after the news coverage).

"indicate that pressure was being exerted from the acute sector to free up hospital beds with little concern for the consequences on the health and lives of those in other settings, including care homes, or for equal treatment in access to care. Discussing how the CCG guidance came to be issued, a senior local figure told Amnesty International that it was clear from conversations he had with senior figures in the local health system that they were under "an enormous amount of pressure from upwards" and

that they were given instructions orally which were not sent in writing or would be worded differently when sent in writing. This would explain why so many CCGs and GPs asked care homes to put DNAR instructions on their residents in a blanket approach even though there is no written record of any such government policy".

"The concern about blanket DNAR instructions was widespread and serious enough, right from the outset of the pandemic, to prompt warnings by the UK's main medical and social care bodies at the beginning of April 2020. In a joint statement issued on 1 April, the British Medical Association (BMA), the Royal College of General Practice (RCGP), the Care Quality Commission (CQC), and the Care Provider Alliance (CPA) warned that: "It is unacceptable for advance care plans, with or without DNAR form completion to be applied to groups of people of any description. These decisions must continue to be made on an individual basis according to need."

"blanket DNACPR" decisions, or decisions taken about resuscitation status by others (GPs, hospital staff or clinical commissioning groups) without discussion with residents, families or care home staff, or that they disagreed with some of the decisions on legal, professional or ethical grounds".

Human Rights violations

"The UK is a state party to international and regional human rights treaties which require it to protect and guarantee fundamental human rights relevant to the concerns addressed in this report, including, notably, the right to life, the right to highest attainable standard of physical and mental health, the right to non-discrimination—including on the grounds of age, disability or health status—the right not to be subjected to inhuman or degrading treatment, and the right to private and family life.206 The UK's obligations under international human rights law requires that it respect, protect and fulfil the human rights of individuals within its jurisdiction. Most of these rights have been enshrined in UK law by the Human Rights Act, which incorporates into domestic law the rights set out in the European Convention on Human Rights (ECHR)"

"Decisions by some CCGs and GPs to direct care homes to put blanket DNAR on all residents and the government's failure to ensure compliance by CCGs, GPs and care homes with standard DNAR procedures violated the right to life, the right to health and the right to non-discrimination of care home residents, who were subjected to such practices as members of a specific category—older persons with and without disabilities living in assisted facilities".

The Report also noted with regard to issues of *"PPE, testing, etc the suspension of inspections by the CQC meant that there was little meaningful protection against such practices"* i.e. the application of blanket DNACPR decisions or decisions taken about resuscitation status that did not involve the person or those closest to them.

Key messages / Recommendations including an Enquiry re DNACPR:

- The extent to which there was inappropriate use of DNARs by health and care professionals, including the incorrect interpretation of them to mean that a person should not be sent to hospital.
- Call for an urgent and thorough review of all DNACPR forms that have been added to care home residents' file since the beginning of the pandemic to ensure they have been completed with the full knowledge, consideration and consent of the resident and/or their family or legal guardian where they do not have mental capacity according to the terms set out in the Mental Capacity Act.
- Call to ensure all staff working in the home understand when and how DNARs/DNACPRs apply and that they do not in themselves indicate that a patient does not want to be taken to hospital or does not want to receive (non-CPR) medical treatment.

2.3 The Care Quality Commission (CQC) interim report from its review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 pandemic. (Dec 3rd 2020)

The CQC is the independent regulator of all health and social care services in England. Prompted by concerns about the blanket application of DNACPR decisions during the early stages of the COVID -19 pandemic, it conducted a special review. The review looked at all key sectors, including care homes, primary care and hospitals, and explored the implementation of best practice DNACPR guidance.

Figure III Extracts from the CQC report

"Early findings are that at the beginning of the pandemic, a combination of unprecedented pressure on care providers and other issues may have led to decisions concerning DNACPR being incorrectly conflated with other clinical assessments around critical care".

Recommendations/Outcome

"DNACPR decisions and advance care plans should only ever take place with clear involvement of the individual, or an appropriate representative, and a clear understanding of what they would like to happen".

CQC is now undertaking a more in-depth review in fieldwork, to establish current practice and identify "what local systems need to do so they can protect against possible future errors."

2.4 National Audit of Care at the End of Life (NACEL) Second Round of the Audit (2019/20) Report Northern Ireland.

NACEL is an annual audit managed by the NHS Benchmarking Network, supported by the Co-Clinical Leads, the NACEL Steering Group.

The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the "*Five priorities for care"* set out in "*One Chance To Get It Right"* and "*NICE Quality Standards 13 and 144"*.

The *Five priorities for care* reflect the Northern Ireland Department of Health circular "HSS (MD) 21/2014 *Advice To Health And Social Care Professionals For The Care Of The Dying Person In The Final Days And Hours Of Life – Phasing Out Of The Liverpool Care Pathway In Northern Ireland By 31 October 2014". The circular sets* out five principles that should underpin high quality care in the final days and hours of life. These principles reflected the good practice outlined in the Department's "*Living Matters; Dying Matters (LMDM), Palliative and End of Life Care Strategy for adults"*, published in 2010.

The NI audit, undertaken during 2019/20, comprised:

- An **Organisational Level Audit** covering hospital/submission level questions;
- A **Case Note Review** which reviewed consecutive deaths in the first two weeks of April 2019 and the first two weeks of May 2019 (acute providers) or deaths in April and May 2019 community providers.

Key messages / Recommendations

NACEL shines a spotlight on the last admission to hospital prior to death and highlights whether hospital staff in Northern Ireland are delivering against the quality standards and statements which are universally accepted as good practice.

Figure IV Extracts from the NACEL report

"Advance care planning is an important part of individualised care planning. Analysis from round two indicates that in Northern Ireland, there is limited advance care planning occurring."

"An important element of individualised care planning is understanding the wishes and preferences of dying people, and those important to them. Advanced care planning is one element of this. Given that on average, the dying person was in hospital up to three and a half days before dying in Northern Ireland, it is documented in 5% of cases only that the dying person had participated in end of life care planning during the final admission. It was documented that 3% of dying people had participated in advance care planning prior to their last admission. This is in relation to all deaths."

"Further, analysis indicated that participation in advance care planning was limited, even though Northern Ireland have guidance available, across all care settings, to facilitate this process. Given that the median time from recognition of death to dying was almost three and a half days in Northern Ireland, there may well have been missed opportunities for patients to participate in advance care planning."

Similarly, the audit found limited evidence of discussions regarding DNACPR with the person or with their family/caregivers. The report goes on to make the following recommendation;

"Ensure that every opportunity is taken to give dying people the option to participate in advance care planning, to reflect their choices and wishes at the end of their life. This should include documenting in the patient's care records, the preferred place to die (if known), and facilitating this wherever possible."

2.5 PCC: Exploring the experiences and perspectives of clinically extremely vulnerable people during COVID 19 shielding December 2020

Shielding advice was issued to an estimated 80,000 people in Northern Ireland, significantly changing their lives and those living with them. In May 2020, the Patient and Client Council (PCC) sought to engage with these groups, in partnership with the Department of Health (DoH). The rationale was to ensure that the voices of those impacted by shielding informed decision making and messaging around changes to the restrictions introduced in March 2020.

Respondents who indicated that they were using palliative care support were asked a series of follow-on questions:

Q11. Have you (the person shielding) discussed your future wishes/preferences for care (known as Advance Care Planning) with your GP or another health or social care professional?

Q12. If 'yes', did you have this discussion before you began shielding?

Q13. If 'no', would you like the opportunity to discuss your future wishes/preferences for care?

Q14. What would be the best, most appropriate way to have this discussion in your circumstances?

Key Findings:

despite their serious health conditions, only 24% of the 209 respondents who reported receiving palliative care support indicated that they had discussed Advance Care Planning (ACP) with a health professional. A large majority of respondents (72%) indicated that they had not discussed ACP with a health professional.

Of those who had discussed ACP with a health or social care professional, the majority (68%) had done so prior to the start of shielding.

Of those who had *not* discussed ACP with a health or social care professional, 41% reported that they would like the opportunity to discuss these issues.

However, several respondents reported that being asked about ACP by a health or social care professional during a pandemic would make them feel as though their lives were less valued than those of other ill or well persons.

Among those open to having a conversation about ACP, shielding appeared to influence how they would like to be approached. Around half of these respondents reported that they would prefer to have such discussions over the phone or by email, with some specifically attributing this to their need to shield. It is of interest that a small number of respondents, while open to discussing ACP, felt it was too early for them to be having such discussions.

DNACPR did not feature in this report

2.6 DNACPR Related Complaints to HSCTs April 2018 - June 2020

A trawl of all complaints to HSC Trusts across the Region pertaining to DNACPR related issues, between April 2018 and June 2020 was undertaken and two clear themes were identified; Issues in relation to communication and public and professional lack of understanding regarding DNACPR decision making. The issue of no review of DNACPR was also raised. What follows are the recorded complaints cited under each respective themes;

Communication:

"DNR placed on the patient's file but not discussed with the patient or his family; family not kept informed of the patient's condition";

"Family felt pressured into agreeing with DNR; no solution given to help with diagnosis; family provided with conflicting information; incorrect information provided to family; incorrect information on patient's records; staff did not tell the family the patient was in his final hours of life";

"*Patient was discharged from hospital with a DNR which family were not told or consulted about".*

"A gentleman raised concerns regarding lack of communication following a meeting regarding a DNR placed on his mother's records"

"Family only spoken to directly by Dr/Consultant once by telephone to discuss DNAR. Daughter lives in England and was not given enough information over telephone".

Complaint regarding the confusion over a DNR order being placed on a patient with a rare syndrome while in Acute hospital. Also feel that DNR was not discussed in an appropriate manner.
"Service user with late stage dementia was admitted to the Emergency Department. On transfer to the ward it was noticed that a DNAR was on his records. His NOK was informed that staff in the Emergency Department had made this decision. NOK feels this should have been discussed with him".
"Doctor in A&E issued a DNR form in the patients file without consulting family in respect to it. Wants an immediate explanation of this and why it was done".
"No Review of DNACPR"

Public and professional lack of understanding regarding DNACPR decision making

"Family state as she was extremely unwell, decisions were made at A&E to put a DNAR in place. Family disagree with this decision which was later removed. Family want to know how and on what basis this decision was made".
To be reinforced with both medical and nursing staff the importance of patients and their next of kin being fully involved in discussions and decisions taken in relation to DNR
"Patient was upset by comments made by a doctor about resuscitation. Comments from consultant which stated that it was clinically correct for the doctor to discuss resuscitation with the patient, even though it caused him distress".
Complaint letter regarding a deceased gentleman's consultant. This consult is accused of authorising a DNR. The family were not consulted regarding this.
*query regarding DNAR practice; attitude of doctor. (*No detail available in data)

2.7 NI Assembly Committee for Health, Inquiry Report on the Impact of COVID-19 in Care Homes

The Health Committee decided in July 2020, based on evidence it had taken in the spring in relation to the particular impact of COVID-19 on care homes, to conduct a short inquiry, in order to produce recommendations to help mitigate and manage the impact of a potential second surge of the virus in care homes. The report on the Inquiry was published in February 2021 and makes specific recommendations pertaining to ACP.

Figure V: Extract from the NI Assembly Report NIA 59/17-22

Advance Care Planning is another issue that was brought to the Committee's attention in recent months and the Committee acknowledges the sensitivity of such conversations and the importance of this matter being dealt with on an individual basis, supported by the appropriate professional and taking account of the unique needs, preferences and changing circumstances of the individual, ideally well in advance of a crisis.

The Committee also notes that ACP goes well beyond circumstances where resuscitation is appropriate and covers a wide range of care and treatment preferences, in a variety of circumstances.
The Committee notes the pressure felt by some care home staff to lead these important conversations for which they felt further training and medical input was required.

Recommendation 34: Advance Care Planning should be discussed with each care home resident, on an individual basis, ideally ahead of any crisis; it should be led by the clinician who knows the individual best, with the input of other relevant professionals; and reviewed as necessary.

Recommendation 35: The Department of Health should clearly outline and communicate the rights of older people and families regarding end-of-life planning and this should reference the approach to treatment and care planning recommended under NICE guideline NG163.

Recommendation 36: Steps should be taken to ensure that relevant professionals have access to appropriate training in advance care planning.

3.0 Conclusion

The findings from this thematic analysis identifies five key themes; There should be No blanket approach to DNACPR (Human Rights issue); Public misunderstanding of DNACPR; HSC professionals misunderstanding/poor knowledge of DNACPR (including no review of status) and No/Poor/insensitive Communication re DNACPR. Taking cognisance of these issues during the development of a regional ACP Policy for adults in Northern Ireland, is vital and provides a degree of rigour to the work. Some of the findings from this thematic analysis also provide a useful steer for the focus of any public messaging from the Department of Health, Public Health Agency and the Project team regarding advance care planning and DNACPR.

4.0 References

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The Patient Client Council (2020), Exploring the Experiences and Perspectives of Clinically Extremely Vulnerable People during COVID-19, Shielding December 2020
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Mealtime Matters

Antrim Hospital - Our pledge - putting patients first at mealtimes

The mealtime co-ordinator will ensure that all patients receive timely assistance with their meal when required

1. Menu order

Nursing staff must:

- Take menu order using electronic tablet.
- Assist patients / carers with choice and consider patient meal preferences / allergens.
- Ensure right meals are ordered for the right patients; consider need for texture, speech and language needs and special diets including food allergeries.
- Consider the need for snacks for patients with reduced appetite.
- Ensure menus are uploaded to Catering office by 10am each morning.

2. Before mealtime

Nursing staff must ensure:

- A Registered Nurse leads and co-ordinates the mealtime service for patients in their bay or the entire ward.
- Food texture and dietary recommendations are clearly identified.
- Plate method is displayed above bed to identify patients' needs.
- Patients are in a comfortable upright position. Bed tables are cleared and positioned correctly.
- Patients are offered/assisted to visit bathroom.
- Patients hands are washed.
- Provision of adapted plates or cutlery and protective napkin where required.
- That patients requiring mealtime assistance are identified at handover and safety briefings.
- Encourage carers of patients with dementia to visit and assist their relative at mealtimes.

The registered nurse in charge of a bay/ward liaises with and guides Mealtime Companions in relation to specific mealtime care of patients

Staff with catering responsibilities:

- Remove and store snacks until required.
- Ensure food trolley is immediately plugged in once delivered from the kitchen at lunch and dinner times.
- To alert nursing staff / mealtime co-ordinator that meals will be served in five minutes.
- Ensure the food temperatures are checked and recorded in line with Food Safety requirements.

The staff member responsible for the service of beverages:

Must in advance liaise with the registered nurse in charge of a bay / ward to ensure support is provided to patients who require their drinks to be thickened. Check signage for patients not eating or drinking.

3. During mealtime

Staff with catering responsibilities:

- Proceed to the ward service area and take direction from the mealtime co-ordinator.
- Serve food in correct portion size as ordered.
- Present food attractively as per the standard plate model.
- Ensure that seasoning and accompanying sauces are served.

Nursing staff must ensure:

- Patients are not interrupted during mealtime unless it is clinically necessary.
- All available nursing staff and auxiliary staff will assist with mealtimes.
- Staff hands are washed prior to service delivery.
- Staff focus on assisting one patient at a time with feeding.
- The right meal is served to the right patient and corresponds with speech and language/dietetic recommendations.
- Alternatives are offered to patients who refuse their meal.

4. After mealtime

Staff with catering responsibilities:

- Before clearing away, check with the meal co-ordinator if anyone would like more to eat.
- Check meal service has gone well with the meal co-ordinator.
- Report any problems to the Supervisor/Manager.

Nursing staff must ensure:

- Mealtime co-ordinator must scan the ward to ensure all patients have eaten and received assistance.
- Ensure patients are satisfied with their meal and communicate any issues to the Manager/Supervisors.
- Record patient intake of food/fluid where appropriate.
- In the event of a patient missing their meal or being admitted after mealtimes the out of hours catering service can be utilised.

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REFORM AND MODERNISATION PROGRAMME

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COMPASSION OPENNESS RESPECT EXCELLENCE
C O R E

HSC Northern Health and Social Care Trust

August 2018

To be used for the submission of issues to Chief Executive/SMT

FROM: Corporate Services

DATE: **19 October 2021**

TO: HSCB SMT

ISSUE:	12th Annual Complaints Report 2020/21
TIMING:	Routine
PRESENTATIONAL ISSUES	N/A
FOI IMPLICATIONS	N/A
FINANCIAL IMPLICATIONS	None
LEGISLATION/POLICY IMPLICATIONS	Legislative/Policy requirement for quarterly report to SMT
EQUALITY/HUMAN RIGHTS/RURAL NEEDS IMPLICATIONS	None
RECOMMENDATION:	To note the attached 12th Annual Complaints Report 2020/21 and to be considered by GAC at next meeting.

Submission may include the following areas as a guide.

Introduction/Background

The 12th Annual Complaints Report of the HSC Board provides a review of events during the year 2020/21, and an overview of complaints activity throughout this period.

Issue 12th Annual Complaints Report 2020/21

Considerations N/A

Options N/A

Risks N/A

Recommendation (Should be a direct lift from first page)

To note the attached 12th Annual Complaints Report 2020/21 and to be considered by GAC at the next meeting.

Name of Director – Lisa McWilliams, Strategic Director of Performance and Corporate Services

Ext no. Personal Information

Copied to: N/A

(Any additional material referenced should be included as Appendices eg letters
Draft responses, papers)

Special 'Complaints' Edition Learning Matters

Thematic Review Analysis– DNAR/CPR

Mealtimes Matter – Poster

Reminder of Best Practice Guidance – SQ-SAI-2020-060

Letter to SHSCT - SQ-SAI-2020-060

Health and Social Care Board

THE 12th ANNUAL COMPLAINTS REPORT

OF THE

HEALTH AND SOCIAL CARE BOARD

April 2020 – March 2021

Index

1.0 Summary Position

This is the 12th Annual Complaints Report of the HSC Board and provides an overview of complaints activity during 2020/2021.

COVID-19 remains a dominant feature in everyday life and continues to cause significant impact on the delivery of Health and Social Care services, which remain under considerable pressure. The number of complaints returns received by the HSC Board concerning FPS Practices has continued to reduce, consistent with the position in recent years. The number of occasions that the HSC Board has acted in the role of 'honest broker' is on a parallel with the previous year. However, there has been a significant decrease in the number of complaints regarding Health and Social Care Trusts in the period.

Position at a glance

- This year has shown a significant decrease in the number of issues of complaint received by the Health and Social Care Trusts (HSC Trusts) with 5,005 issues being received compared with 6,105 in the previous year (2019/20).

- Nonetheless, the top three categories of complaint remain quality of treatment and care, communication/information and staff attitude/behaviour.

- In response to the continued pattern/trend of complaints regarding staff attitude/behaviour and communication a number of HSC Trusts have initiated and concentrated complaints training on specific programmes of care or areas of work where there are high level of complaints received of this nature.

- In relation to Family Practitioner Services (FPS) there continues to be a downward trend in the number of complaints and responses being received by the HSC Board from FPS Practices. In 2020/21 105 local resolution returns were received by the HSC Board. This compares with 140 the previous year.

- In terms of complaints where the HSC Board acted as an 'honest broker' there has been a consistent level with 69 complaints being received in 2020/21 compared with 70 in 2019/20. There has also

been an improvement in the number of such complaints being responded to within the 20 working day timescale.

- Throughout the course of 2020/21 HSC Board complaints staff both directly and through daily contacts with colleagues in FPS Practices have noticed an increase in dissatisfaction from patients experiencing difficulty in getting through the telephony systems, accessing the triage mechanisms, and booking appointments in GP Practices. There has also been an increase in difficulties with service users gaining registration with NHS dental practices. These expressions of dissatisfaction may not always progress to formal complaints being made, but electronic or telephone replies are being given.

- There was a significant reduction in the number of complaints received by the HSC Board in 2020/21 (16) compared with 29 in 2019/20 and 18 in 2018/19. Unfortunately, only four of these complaints were responded to within 20 working days due to a number of reasons ranging from the involvement of other HSC organisations and the scheduling of meetings regarding the complaints.

- The HSC Board carried over 4 complaints from the previous year (2018/19); received a total of 85 complaints during 2019/20 (both HSC Board and honest broker complaints); responded to 52 of these complaints within 20 working days and has carried over 18 ongoing complaints into 2020/2021.

- During 2020/21 HSC Trusts received 14,683 compliments - a compliment is described as ‘an expression of praise, commendation or admiration’. Of note, the three top categories of compliments remain consistent with the three top categories of complaint.

- A special ‘complaints’ edition of the HSC Board/Public Health Agency ‘Learning Matters’ newsletter was published outlining examples where regional learning had been identified.

- The HSC Board Regional Complaints sub-Group (RCsG) undertook a review of complaints regarding discharge arrangements across the HSC Trusts over a 12 month period and shared this with the Regional Discharge Group.

- The outstanding recommendations from the Audit of Complaints Management undertaken in 2019 have been followed up and only one recommendation remains incomplete.

- During the period the HSC Board/HSC Trust Monitoring Group met on 2 occasions. Discussions included the impact of COVID on HSC Trusts' ability to respond to complaints within timescale, and the pattern and nature of COVID related complaints which began to emerge as the year progressed.

2.0 HSCB Monitoring Process for HSC Complaints

The RCsG is a sub-group of Quality Safety and Experience Group (QSE). It reviews complaints information received from HSC Trusts and FPS Practices and also any complaints received by the HSC Board and the Public Health Agency (PHA). Membership comprises representatives from the HSC Board, the PHA and the Patient and Client Council (PCC). The HSC Board's complaints staff share specific categories of complaint to designated professionals in the HSC Board and PHA for review and consideration at RCsG meetings. These include complaints concerning Emergency Departments, maternity and gynaecology, social services, Out of Hours services, allied health professions, and issues associated with patient and client experience. Complaints relating to FPS are reviewed by the HSC Board's respective professional advisers and a summary of all FPS complaints are circulated on a quarterly basis to this Directorate.

A standing item on the QSE agenda requires the RCsG to provide regular updates on complaints issues and/or developments. A quarterly report advising of any key issues or trends arising from complaints and any learning identified from individual complaints is also submitted. During the year the meetings of the QSE have been significantly impacted by pressures associated with COVID and the governance arrangements around safety and quality are currently under review. Areas of concern or patterns from the RCsG may be reported through to the weekly 'Safety brief' jointly led by the Director of Strategic Performance, HSC Board and the Director of Nursing and Allied Health Professionals, PHA.

2.1 HSC Trusts -

In keeping with the requirements of the HSC Complaints Procedure, the HSC Board receives information from all of the HSC Trusts for monitoring purposes. This information is categorised into specific areas of complaint and shared with designated professionals within the HSC Board and PHA, who sit as members of the RCsG. This monitoring process ensures that complaints information is routinely linked into existing work streams/professional groups, for example: -

- Food and Nutrition (Mealtime work)
- Falls
- Development of Pathways for Bereavement from Stillbirths, Miscarriages and Neonatal Deaths
- Development of Pathways for End of Life Care/Palliative Care
- Maternity Commissioning Group
- Patient Experience Working Group (10,000 more voices)
- Regional Discharge Group

The monitoring also highlights specific complaints concerning sepsis and stroke (typical and atypical presentation).

Quarterly reports from the RCsG are shared with the HSC Board's SMT, and with the HSC Board's Governance Committee on a twice yearly basis.

2.2 Family Practitioner Services (FPS) -

There are in excess of 1500 FPS Practices across Northern Ireland. Under the HSC Complaints Procedure all of these are required to forward to the HSC Board anonymised copies of any letters or statements of complaint together with the respective responses, within three working days of the response having been issued.

From day to day contact with FPS Practices, it is apparent that the process of resolving complaints *'on the spot'* is continuing to flourish across FPS, with Practice staff successfully addressing issues/queries and concerns from patients and families without the need for formal submission of a complaint. This is to be welcomed and the HSC Board would encourage Practices to seek to resolve complaints in this way and effectively de-escalate the situation and reach resolution, provided the complainant is content with this approach. This is in line with the ethos of local resolution within the HSC Complaints

Procedure in seeking to resolve complaints as close to their source as possible.

However, the HSC Board also strives to remind FPS Practices of their obligations in terms of the HSC Complaints Procedure, in relation to the requirement to share complaints and responses with the HSC Board. The e-learning package had been updated and re-launched on a new platform last year and all FPS Practices reminded of these requirements.

While many Practices are content to deal with complaints directly, there is an increasing number of Practices contacting the HSC Board complaints staff for 'support and advice' in relation to resolving complaints at local level.

As in previous years, during 2020/21 treatment and care again accounted for the majority of all complaints handled under local resolution. In line with other years, complaints concerning staff attitude/behaviour and communication were the next highest categories.

3.0 Complaints Activity

3.1 The Year in Detail

3.2 Review of Complaints regarding HSC Trusts

During the period 5,005 issues of complaint were received by the six HSC Trusts. This represents a significant decrease from 6,105 issues received in 2019/20 and similar numbers received in recent years: 6,049 issues received in 2018/19; 6,189 received in 2016/17; and 6,181 received in 2015/16.

While the figures should be viewed in the context of the considerable volume of interactions between service users and health and social care professionals on a daily basis, the pandemic has obviously impacted on the volume of complaints being received. This may have resulted from 'lockdowns' and general reluctance to enter hospitals particularly when levels of COVID-19 were high, and possibly understanding, and to some extent sympathy, for the pressure Health and Social Care staff were working under.

Number of complaints issues received per HSC Trusts in 2019/20 and 2020/21 and percentage responded to within 20 working days

Trust	**2019/20**	**% in 20 working days**	**2020/21**	**% in 20 working days**
Belfast	1,646	49.7%	1,610	53.0%
Northern	672	77.5%	614	70.2%
South Eastern	769	43.2%	1,228	29.0%
Southern	701	50.4%	857	49.0%
Western	489	26.2%	545	46.0%
NI Ambulance	93	6.5%	151	23.2%
Total	**6,105**	**49.4%**	**5, 005**	**49.4%**

In terms of programme of care, the top six were: -

2019/20		**2020/21**	
1. Acute Services	(58.6%)	**1.** Acute Services	(53.8%)
2. Mental Health	(7.8%)	**2.** Family & Child Care	(10.5%)
3. Family & Child Care	(7.5%)	**3.** Elderly Services	(8.3%)
4. Elderly Services	(7.0%)	**4**. Maternity/Child Health	(7.9%)
5. Maternity/Child Health	(6.0%)	**5.** Mental Health	(7.4%)
6. Primary Health & Adult Community	(1.9%)	**6**. Learning Disability	(1.6%)

Composite HSC Trusts complaints by Programme of Care during 2019/20 and 2020/21 were:

Programme of Care	**2019/20**	**2020/2021**
Acute	3,576	2,695
Maternal & Child Health	367	394
Family & Child Care	458	524
Elderly Services	426	413
Mental Health	474	368

Learning Disability	113	82
Sensory Impairment & Physical Disability	40	28
Health Promotion & Disease Prevention	24	12
Primary Health & Adult Community	113	51
None (No POC assigned)	474	376
Prison Healthcare*	40	62
Total Complaint Issues	**6,105**	**5,005**

***South Eastern HSC Trust only**

HSC Trusts complaints by Subject during 2020/21

Subject	Belfast	Northern	South Eastern	Southern	Western	NIAS	Total
Access to Premises	9	4	13	4	2	1	**33**
Aids/Appliances/Adaptations	16	5	3	6	6	0	**34**
Clinical Diagnosis	59	36	69	34	35	1	**234**
Communication/Information	370	74	294	217	78	1	**1034**
Complaints Handling	1	0	6	0	1	0	**8**
Confidentiality	20	7	16	8	13	0	**64**
Consent to Treatment/Care	2	0	2	2	1	0	**7**
Children Order complaints	0	0	0	0	5	0	**5**
Contracted Regulated Domiciliary Services	0	5	5	0	0	0	**10**
Contracted Regulated Residential Nursing	0	16	3	0	0	0	**19**
Contracted Independent Hospital Services	0	0	0	0	0	0	**0**
Other Contracted Services	1	2	0	0	0	0	**3**
Delay/Cancellation for Inpatients	1	1	2	10	2	0	**16**
Delayed Admission from A&E	1	0	3	4	5	0	**13**
Discharge/Transfer Arrangements	48	15	26	18	16	0	**123**
Discrimination	3	2	6	5	1	0	**17**
Environmental	18	6	7	10	1	0	**42**
Hotel/Support/Security Services	6	9	6	10	3	0	**34**
Infection Control	22	5	10	10	1	3	**51**
Mortuary and Post Mortem	0	0	1	0	0	0	**1**
Policy/Commercial Decisions	16	19	16	11	7	0	**69**
Privacy/Dignity	3	3	25	3	6	1	**40**
Professional Assessment of Need	13	17	11	82	7	0	**130**
Property/Expenses/Finance	50	11	12	14	12	1	**100**
Records/Record Keeping	20	7	42	7	3	0	**79**
Staff Attitude/Behaviour	208	102	199	161	95	45	**810**

Transport, Late of Non-arrival/Journey Time	1	0	1	1	1	56	**60**
Transport, Suitability of Vehicle/Equipment	0	0	0		0	0	**0**
Quality of Treatment & Care	292	217	359	157	164	35	**1224**
Quantity of Treatment & Care	107	9	17	34	26	0	**193**
Waiting List, Delay/Cancellation Community Based Appts	10	7	22	3	12	0	**54**
Waiting List, Delay/Cancellation Outpatient Appts	164	22	18	12	3	0	**219**
Waiting List, Delay/Cancellation Planned Admission to Hospital	107	5	9	9	14	0	**144**
Waiting Times, A&E Departments	7	2	8	2	2	0	**21**
Waiting Times, Community Services	10	1	4	6	2	0	**23**
Waiting Times, Outpatient Departments	14	5	9	8	2	0	**38**
Other	11	0	4	9	21	8	**53**
Total	**1,610**	**614**	**1,228**	**857**	**545**	**151**	**5,005**

The three most common 'subject of complaint' issues continue to be quality of treatment and care (1,224); communication/information (1,034); and staff attitude/behaviour (810).

3.3 Review of Family Practitioner Services (FPS) Complaints

3.3.1 Complaints handled under Local Resolution

Subject	GP	Dental	Pharmacy	Ophthalmic	Total
Treatment & Care	**35**	**5**	**0**	**0**	**40**
Appointments	**11**	**0**	**0**	**0**	**11**
Prescriptions	**9**	**0**	**0**	**0**	**9**
Communication/Information	**16**	**0**	**0**	**0**	**16**
Staff Attitude	**13**	**0**	**0**	**0**	**13**
Confidentiality	**1**	**0**	**0**	**0**	**1**
Personal Records	**1**	**0**	**0**	**0**	**1**
Warnings	**2**	**0**	**0**	**0**	**2**

Medication	**4**	**0**	**0**	**0**	**4**
Removals	**0**	**0**	**0**	**0**	**0**
Registration	**1**	**0**	**0**	**0**	**1**
Failure to Follow procedures	**0**	**0**	**0**	**0**	**0**
Other	**6**	**0**	**1**	**0**	**7**
Total	**99**	**5**	**1**	**0**	**105**

The downward trend in the number of complaints and responses being received by the HSC Board from FPS Practices has continued in recent years. Previously the HSC Board would have received between 170 – 200 returns from FPS Practices. During 2019/20, 140 returns were received and this has decreased again to 105 during 2020/21. A reminder was recently issued to all FPS Practices of their obligation to forward complaints/responses to the HSC Board.

3.3.2 'Honest broker' complaints

Subject	**GP**	**Dental**	**Pharmacy**	**Ophthalmic**	**Total**
Treatment & Care	**23**	**8**	**0**	**0**	**31**
Appointments	**0**	**0**	**0**	**0**	**0**
Prescriptions	**2**	**0**	**0**	**0**	**2**
Communication/Information	**5**	**2**	**0**	**0**	**7**
Staff Attitude	**6**	**0**	**0**	**0**	**6**
Confidentiality	**0**	**0**	**0**	**0**	**0**
Failure to follow Procedures	**1**	**0**	**0**	**0**	**1**
Registration	**7**	**0**	**0**	**0**	**8**
Medication	**0**	**0**	**1**	**0**	**1**
Removals	**4**	**0**	**0**	**0**	**4**
Warnings	**2**	**0**	**0**	**0**	**2**
Personal Records	**2**	**0**	**0**	**0**	**2**
Other	**4**	**2**	**0**	**0**	**6**
Total	**56**	**12**	**1**	**0**	**69**

On occasions where complainants do not wish to approach the FPS Practice directly, the HSC Board's complaints staff can act as an 'honest broker' between both parties. This intermediary role may arise due to a patient's or relative's concern about the impartiality of the FPS Practice to investigate the complaint, or because of a breakdown

in the relationship between the patient and the practitioner. However, for the HSC Board's complaints staff to act in this role, with the aim of assisting local resolution and/or in helping restore relationships (where possible), or reaching a position of understanding, both parties must be in agreement to this occurring.

Not all complaints can be resolved by an exchange of written communication and on occasions this can involve meetings with the complainant to discuss the issues involved, the response subsequently received and what further action can/should be taken; as well as meeting separately with the Practice being complained about, or facilitating joint meetings of both parties.

While the HSC Board may become involved as an 'honest broker' the responsibility for investigation of the complaint lies with the Practice. In this regard, there is an option for the Practice to respond directly to the complainant, or via the HSC Board.

In the period 2020/21 the HSC Board acted as an 'honest broker' in 69 complaints concerning FPS Practices compared to 70 in 2019/20, which is very much in line with numbers received in previous years.

Of the 69 'honest broker' complaints received, 45 were responded to within 20 working days. This is substantial improvement as in previous years only about 50% of the complaints were responded to within the timescale: - 29 out of the 70 in 2019/20, 67 out of the 115 in 2018/19 and 17 out of 43 in 2016/17. The role of 'honest broker' demands continued contact and liaison between the relevant parties and this ensures that timely and accurate updates are provided.

FPS Practices themselves can request the services of the HSC Board to act in this role and while the complainant must also be in agreement, these instances may often involve complex complaints.

3.3.3 Complaints concerning the HSC Board

The HSC Board received 16 complaints in 2020/21 a significant decrease from that received in 2019/20 (29) and 2018/19 (25). This number of complaints would be more in line with those received in previous years, 9 in 2017/18, 12 in 2016/17 and 8 in 2015/16.

In relation to the 16 complaints received in 2020/21 the vast majority of these (6) related to decisions taken by the HSC Board in respect of

Extra-Contractual Referrals and also reimbursement in respect of Cross Border treatment. Other concerns raised related to the HSC Board's complaints handling, the governance review of Muckamore Abbey Hospital, pharmacy opening hours and suspension of the Minor Ailment Scheme.

In terms of response times for HSC Board complaints – 4 of the 16 complaints were responded to within 20 working days. It is disappointing that only a quarter of the complaints were responded to within timescale. In regard to those not meeting the timescale reasons for delays were due to the involvement of another organisation (BSO); the scheduling of mutually agreeable date for a meeting with the complainant; delays in HSC Board staff reviewing a draft response; and reviewing the HSC Board's decision not to appoint an independent expert on a dental complaint.

3.4 Independent Lay Persons

The involvement of an independent Lay Person is one of the potential options available within the HSC Complaints Procedure to resolve complaints at local resolution. This year neither the HSC Board nor any of the HSC Trusts involved an Independent Lay Person in any of their complaints.

3.5 Independent Experts

Similarly, obtaining an independent medical opinion/professional is a further option available under the HSC Complaints Procedure as a means of seeking to resolve complaints under local resolution.

During the period 2020/21 the HSC Board did not seek independent expert opinions in any complaints.

In 2020/21 the HSC Trusts involved independent experts' opinions as follows: -

HSC Trust	**Number of Opinions**
Belfast	4
Northern	1
South Eastern	0
Southern	0
Western	0
NI Ambulance Service	0
Total	**5**

4. Other Issues

4.1 Learning Matters Newsletter
During the year a special 'Complaints' edition of Learning Matters was published outlining complaints where regional learning had been identified (Annex 4). Feedback from the HSC Trusts at the HSC Board Monitoring meeting indicated that this special 'Complaints' edition had been very well received by staff in the HSC Trusts. (see attached)

4.2 Advance Care Planning Policy Engagement
Palliative Care complaints are reviewed by professionals and Do Not Attempt Resuscitation Cardio-Pulmonary Resuscitation (DNAR CPR) is a long standing theme within complaints. The Regional Advance Care Planning Lead continues to update RCsG in respect of any developments in this regard (see attached).

4.3 Complaints concerning Discharge
As professionals continued to note the volume and nature of complaints relating to safe discharge arrangements - discharge and transfer of patients are within the top ten issues of complaints received by HSC Trusts, the RCsG agreed that a review of complaints regarding discharge arrangements across the HSC Trusts over a 12 month period should be undertaken. The purpose being to share the findings in the first instance with the Regional Discharge Group, chaired by the Director of Social Care and the Director of Nursing and highlighting potential to inform Policy and a Standard Framework around safe discharge. This review was undertaken and a paper was subsequently discussed at a Safety Brief meeting in June 2021.

It was agreed that in order to provide a complete picture, data should also be reviewed concerning SAIs, AIs and Patient Experience. In the interim the paper will be shared with the Regional Discharge Group in the knowledge that further information will follow. This will ensure there is no delay in sharing the rich information from complaints.

4.4 Revalidation - is a legal requirement for all doctors who are registered with the General Medical Council (GMC). Failure to revalidate results in placing a doctor's licence to practice at risk

and therefore they are unable to work. The Assistant Director of Integrated Care/Head of General Medical Services is the Responsible Officer for making the revalidation recommendation for all GPs in Northern Ireland. This process involves establishing if there are any complaints or concerns regarding each GP both at Practice and OOH level etc. The Complaints Team provides information to colleagues in the Directorates of Integrated Care Services to inform this process throughout the year.

4.5 COVID-19 Complaints - Discussion at the HSC Board Monitoring meeting with HSC Trusts confirmed that HSC Trusts continued with existing processes to grade and escalate complaints of concern during the COVID-19 pandemic. It was noted that specific themes of complaint were beginning to emerge, specifically relating to the impact of COVID-19, ie complaints regarding palliative care/care of the dying/access to loved ones when dying; visiting arrangements; and waiting times associated with delayed treatment/care. As time has progressed this has also included the impact on vulnerable people who are unable to give a history when unaccompanied to HSC facilities. During the period October to December 2020 (Q3 20/21) 86 COVID-19 related complaints were received and 105 during the period January to March (Q4 20/21). This represented a 22% increase in complaints concerning these particular issues. The largest number of complaints related to the impact on waiting times, reduction or suspension of services and visiting restrictions.

4.6 **‘**Mealtimes Matter’ - This is an ‘Always Event’ and a key priority for HSC Trusts, led by the Northern HSC Trust (Attached). At the request of the Patient Safety, Quality and Experience Lead, a review of complaints was undertaken for the period October 2019 - March 2021 to identify key themes to inform this improvement work on Mealtimes.

5.0 NI Public Services Ombudsman

The NI Public Services Ombudsman 2020/21 Annual Report has yet to be published.

Further information on the NI Public Services Ombudsman can be found on the website: - nipso@nipso.org.uk

Annex (1)

Examples of Complaints with Learning/Change to Policy or Procedure

Example 1 - FPS Complaint

A complaint reviewed related to an error in patient's medication when they received their medibox. The patient's consultant had increased the dosage from 25 mgs to 50 mgs. Having become unwell, the patient contacted their GP and checked the medication, and it was established that while the label was correct the medication was not.

Practice Response: - The Pharmacy explained how the error had occurred and apologised for the distress caused. It advised that it was cooperating with Pharmaceutical Society of NI and HSC Board Integrated Care professionals in relation to this adverse incident and confirmed that an incident report was submitted to the Directorate of integrated Care.

This confirmed that the incident was due to human error and the pharmacy advised that there had been learning arising from the complaint. The pharmacy identified the contributory factors and implemented a number of changes to improve patient safety and prevent reoccurrence.

The following contributory factors were identified:

- Additional pressures caused by Coronavirus. The workload in the pharmacy has increased substantially due to the pandemic.

- The blister pack concerned had significant polypharmacy with 11 tablets in the morning which made the error less apparent.

- Non-adherence to Standard Operating Procedures (SOP) was not a contributory factor. However, additional information has been added to the SOP to prevent this reoccurring again.

Additional actions have been taken to reduce the risk of re-occurrence of the incident:

- A new step added to the standard operating procedures as an extra safety measure. A coloured note is attached to the front of a patient's file to highlight any changes to medication (including dose changes).

- Learning to be careful when dealing with half tablets and recent dose changes with blister packs with considerable polypharmacy.

- The proprietor has increased the size of the dispensary and improved the lighting and the dispensary space. This improved working area should reduce the risk of dispensing errors.

The Integrated Care Team confirmed that it will not be taking any further action. It had shared a copy of Learning from Adverse Incidents: Adherence to Requests for Dispensing in Instalments & Communication of Instalment Dispensing Medication Changes and a copy of a newsletter on clinical checks with the Pharmacy; an electronic link was also shared Medicines Safety Matters Community Pharmacy Vol 3 Issue 1. The Team confirmed that the incident has been recorded for sharing learning with other pharmacies.

Example 2 - HSC Trust Complaint:

A lady raised concerns that her husband should have been with her when she was told their daughter would be born sleeping (he was not allowed in due to covid-19 restrictions). She also believes that the belt to monitor her daughter's heart rate should have been put on when she first went into labour. She and her husband were not informed that the hospital could have provided a coffin for their daughter; this information was relayed to her husband by the undertaker when he called to make funeral arrangements. The lady also raised concerns in respect of the information provided to parents in relation to post mortem arrangements.

HSC Trust Response:- The Trust offered its sincere and deepest condolences and apologised unreservedly for how this devastating news was relayed to the mother. It acknowledged that the restrictions in place as a result of Covid-19 meant she was alone when she was told her baby had passed away. The Trust explained that medical staff have a duty of care to be open and transparent and to withhold the news could have caused more anxiety whilst waiting on her husband to come in. The Doctor apologised that they did not communicate clearly enough

and for the distress this had caused.

In respect of monitoring her daughter's heart rate, the Trust explained that NICE guidelines do not indicate a cardiotocography for low risk women. It confirmed that staff had auscultated her baby's heartbeat and no heart rate abnormalities where detected.

The Trust apologised for the confusion in relation to information provided by staff regarding funeral arrangements; staff were not aware that coffins were available at the hospital, they have met with the Trust mortician and are now familiar with processes. The Trust apologised for any further distress this may have caused.

Additional RCSG Action:- A redacted copy of the correspondence relating to this complaint was requested and shared with relevant professionals. On review professionals have sought clarification from a Public Health Specialist, to identify any regional learning in relation to the pathology service with Alder Hey, Liverpool, and communication with families. They have confirmed that they have a planned for the review of the PM pathway in May and this feedback will be taken on board.

Example 3 – HSC Trust Complaint:

A family raised concerns that their relative had fallen from a sling which was not properly attached to a hoist; the family provided CCTV footage to the Trust which was distressing to watch as it involved a very vulnerable elderly person who is a dementia patient; is immobile and relies on full professional support and care from the Trust's care workers. The operation of the Hoist caused concern to the relatives as there appeared to be no support to the patient while the equipment was being operated. The relatives were also unhappy with the behaviour of the staff - the care plan book was 'propped' against their relative's legs and set on their stomach. The family were informed that there was no fault with the sling or hoist rather the issue had been human error.

HSC Trust Response: The Trust apologised and noted that the carers had also apologised in person to the complainant on the day of the incident. It advised that the incident was escalated to the locality manager, who arranged for a supervisor to visit the service user's home the following morning to check on them, examine the hoist and make sure there was no obvious fault with the equipment; they reported that

the hoist was working correctly. This was also confirmed by Trust Estates staff.

The Trust acknowledged it had reviewed the CCTV footage which also confirmed the hoist was working correctly. The Trust acknowledged that the CCTV footage from the incident was distressing to watch and the performance of the staff concerned was not as the Trust would have expected. The sling had not been correctly connected to the hoist. The Trust indicated that its investigation had found that this unfortunate incident was as a result of human error. The Trust was disappointed to hear that the care plan had been set on the elderly patient's stomach and rested against their legs which is not acceptable practice and apologised for this. The Trust advised that all Domiciliary Care workers (DCWs) have been reminded of the policy in relation to recording and safe storage of records during visits.

Assurances were given that the DCWs were managed appropriately and in accordance with the Trust Policies and Procedures.

RCSG Action: Additional correspondence relating to the complaint was requested and shared with relevant professionals. On review, professionals agreed that a letter should be issued to the Trust for the attention of the Interim Director of Older People and Primary Care enclosing a reminder of best practice guidance letter (attached) and a request that the Trust undertake the following actions to prevent and mitigate the risks of this incident occurring again:

1. Share the Reminder of Best Practice letter with all relevant staff and discuss it at safety briefings/team meetings to highlight/raise awareness of the risk of death / serious harm if a person falls from a hoist.

2. Ensure current guidance as detailed in the letter is being followed.

3. Ensure all Domiciliary Care Worker staff are aware of the importance of not using manual handling equipment unless trained to do so.

Example 4 – HSC Trust Complaint:

A patient raised concerns that their baby's heart defect was not detected at their scan.

HSC Trust response: The Trust apologised and explained that detection rates for cardiac abnormalities nationally are approximately 50%. The images were reviewed again and there was no indication of a cardiac abnormality. The private scan was done nine days later, which can make a difference to the size of structures within the heart, equipment may differ and the foetal position may become optimal for scanning within this period. The Trust stated that the cardiac imaging was not carried out using the pre-set cardiac settings on the scanner and that this had been discussed with the Sonographer and learning shared. The consultant reviewed the patient with the foetal anomaly scan that had been performed at the Trust and their private scan. Noting the presence of mild bilateral renal pelvic dilatation, they discussed the implications of this finding, including a risk of underlying chromosomal problem of 1-2% and a referral was made to paediatric cardiology.

RCSG Action: Professionals requested additional correspondence in relation to this complaint and noted the Trust had explained learning had been identified. It advised that the diagnostic quality of the saved cardiac imaging was not good. The pre-set cardiac setting had not been used. It is imperative, especially when scanning the heart that the image quality is optimised with appropriate manipulation of all scanner settings. Professionals noted this learning had been shared with the Anomaly Scan Improvement Group/all Obstetric Sonographers in all of the five HSC Trusts and were content the learning had been shared appropriately.

Annex (2)

COVID related Complaints October – December 2020 (Q3 2021) and January – March 2021 (Q4 20/21)

October – December 2020

Subject	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Waiting times associated with delayed treatment/care	24	1	6	0	0	31
Reduced/ Stopped Service	2	6	2	5	9	24
Visiting Restrictions inc palliative care patients	3	4	1	4	7	19
Communication with families	3	3	2	1	2	11
Treatment and Care	0	1	0	0	0	1
Total	32	14	11	10	18	86

January – March 2021

Subject	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Waiting times associated with delayed treatment/care	21	1	5	2	9	38
Reduced/ Stopped Service	14	3	2	1	4	24
Visiting Restrictions inc palliative care patients	6	3	2	3	2	16
Communication with families	0	4	1	2	7	14
Treatment and Care	1	4	0	1	4	10
Adherence to Guidance	0	2	0	1	0	3
Total	42	17	10	10	26	105

Complaints Contact Points:

HSC Board
Tel: 028 95 363893
Email: complaints.hscb@hscni.net

Belfast Health and Social Care Trust
Tel**:** 028 95 048000
Email: complaints@belfasttrust@hscni.net

Northern Health and Social Care Trust
Tel**:** 028 94 424655
Email: userfeedback@northerntrust.hscni.net

South Eastern Health and Social Care Trust
Tel: 028 90 561427
Email: complaints@setrust.hscni.net

Southern Health and Social Care Trust
Tel: 028 38 614150
Email: complaints@southerntrust.hscni.net

Western Health and Social Care Trust
Tel: 028 71 611226
Email: complaints@westerntrust.hscni.net

Northern Ireland Ambulance Service Trust
Tel**:** 028 90 400 999
Email: complaints@nias.hscni.net

Patient and Client Council
Freephone: 0800 917 0222
Complaints.PCC@hscni.net

NI Public Services Ombudsman
Freephone: 0800 34 34 24
nipso@nipso.org.uk

LEARNING MATTERS

Welcome to Learning Matters Special 'Complaints' Edition 16 March 2021

HSC Health and Social Care

QUALITY 2020

Introduction

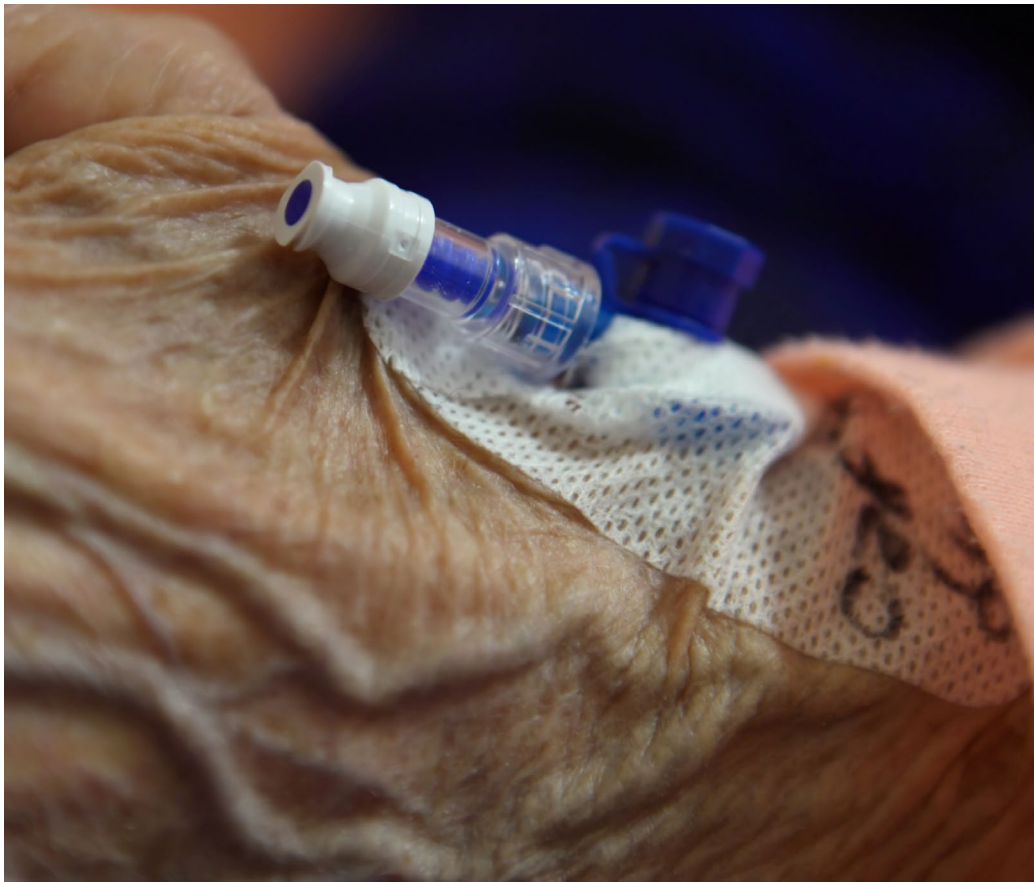
Welcome to this special 'complaints' edition of Learning Matters. All cases presented in this edition have been dealt with through the various Trusts complaints departments. Following resolution of all complaints within Trusts they are forwarded to the Health and Social Care Board (HSCB) complaints department to be reviewed by HSCB and Public Health Agency (PHA) professionals, who ascertain if there is any regional learning from cases or if there are recurring themes, patterns or trends in relation to complaints; that are important to highlight and learn from, so that improvements can be made in relation to patient safety, quality of care and the patient experience.

IN THIS EDITION

Safe Discharge: Remember to check the peripheral intravenous (IV) cannula has been removed

Across the HSC there have been an increasing number of complaints generated, i.e. at least 7 in the past 18 months, in relation to patients being discharged from the hospital setting with a peripheral intravenous cannula still in place because the healthcare professional has omitted to check it has been safely removed prior to discharge. Although none of these complaints resulted in any patient coming to harm, it is however a patient safety issue and should not happen if robust, safe person-centred discharge is undertaken.

A common finding following analysis of these complaints is that this type of incident occurs most frequently following discharge from the Emergency Department (ED).

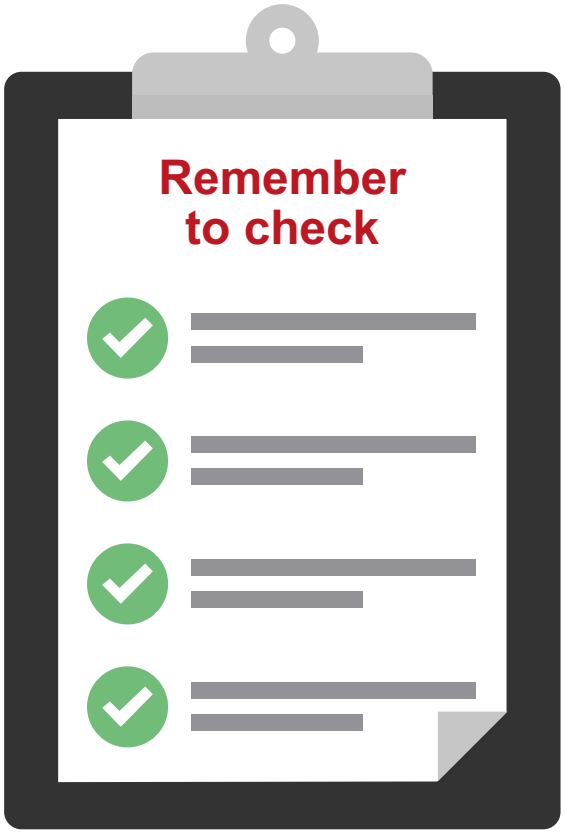


LEARNING MATTERS

Welcome to Learning Matters
Special 'Complaints' Edition 16 March 2021

HSC Health and Social Care

QUALITY 2020



KEY LEARNING

HSC Trusts should have robust processes in place for safe patient discharge, including documentation that details the IV cannula check has been undertaken to ensure it is removed if one is in place.

There are several strategies to avoid accidental discharge with IV cannula in situ including:

- A **clear and simple discharge checklist** that includes a check for cannulas.
- Regular reminders at team meetings/safety briefings for staff to always check for IV cannula in situ and complete the necessary documentation, when the patient is being discharged.
- As part of the insertion procedure healthcare staff should always **inform the patient** (and family members) that it ***must*** be removed on discharge and advise them to flag with a staff member if this has not occurred.
- Regardless of setting, a peripheral IV cannula observation chart must **always** be completed on insertion, as this will also be another prompt for removal on discharge.
- In the ED or primary care setting, beware of the patient that enthusiastically re-dresses themselves prior to discharge, as it is very easy for long sleeved shirts etc. to obscure that visual cue of the cannula still in situ.

The date, time and reason for removal of cannula should always be documented in the patient's nursing and/or medical notes.

LEARNING MATTERS

Welcome to
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HSC Health and Social Care

QUALITY 2020

Importance of considering flexor sheath infection in any patient presenting with signs of soft tissue infection in the fingers/hand

A patient presented to the Emergency Department with a red, swollen, tender finger and feeling unwell. The patient had a history of a thorn foreign body in the left middle finger, which they had attempted to remove. On presentation the patient looked pale and was complaining of feeling shivery and nauseated.

The patient was triaged appropriately and bloods were taken which did not indicate any significant systemic infection. The assessing doctor did consider the possibility of flexor sheath involvement but felt there was no evidence of this at the time of assessment. The doctor administered a single dose of intravenous antibiotics and discharged the patient with a course of oral antibiotics and safety net advice to seek further medical review should their symptoms worsen.

The patient's pain did not improve and the swelling in the hand worsened, so they had to urgently re-attend hospital for emergency surgery, due to an **infection of the flexor tendon sheath** of the finger.

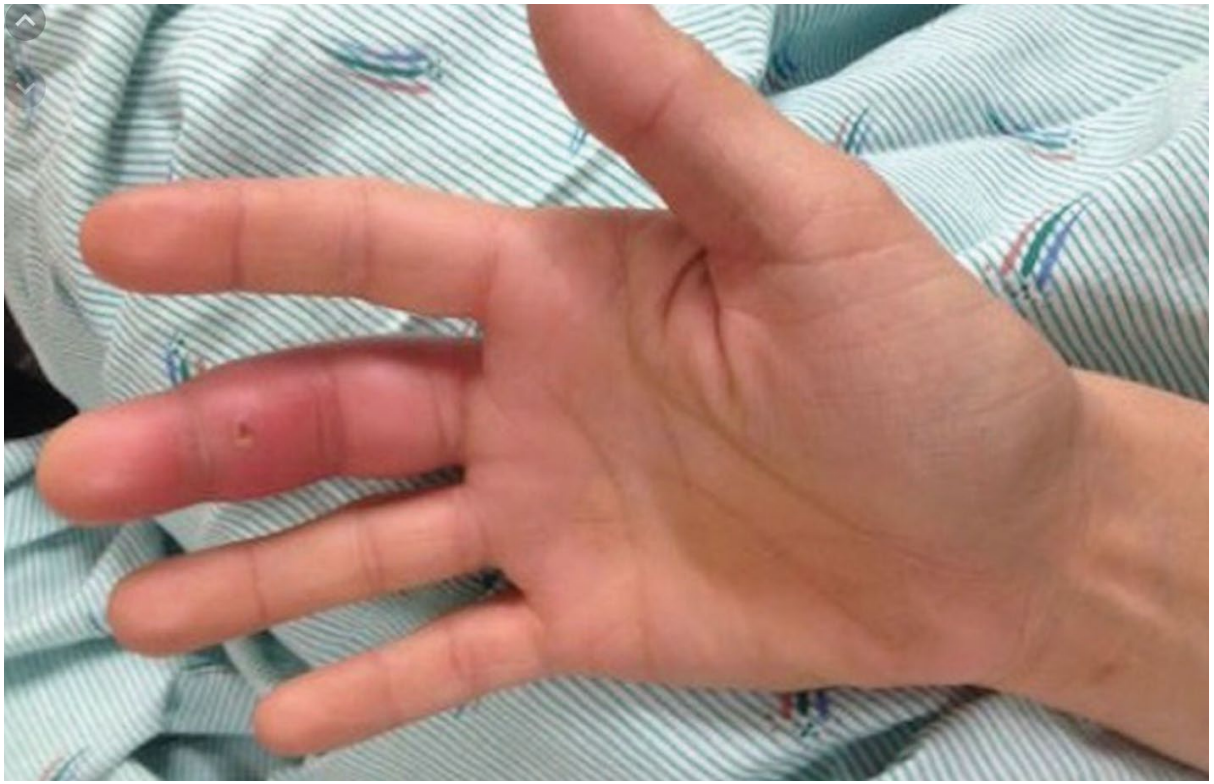

Figure 1. Flexor sheath infection of the right middle finger from a patient with a drill puncture wound.
From: Chan E, Robertson BF, Johnson SM. Kanavel signs of flexor sheath infection: a cautionary tale. Br J Gen Pract 2019; https://bjgp.org/content/69/683/315

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KEY LEARNING

Flexor tendon sheath infection or pyogenic flexor tenosynovitis is an aggressive, closed-space bacterial infection that can lead to significant morbidity if not effectively managed. The purpose of presenting this case is to raise awareness amongst all staff of the importance of thorough history taking, examination and documentation in relation to this important diagnosis.

- Pyogenic flexor tenosynovitis accounts for 2.5-9 % of all hand infections.
- Treatment typically consists of intravenous (IV) antibiotics and surgical drainage of the sheath with open or closed irrigation.
- Despite advances in antibiotic therapy, pyogenic flexor tenosynovitis remains a clinical challenge that requires prompt diagnosis and management.
- Patients present with one or more positive Kanavel's cardinal signs:
  1. Exquisite pain on passive extension of finger
  2. Exquisite tenderness along course of tendon sheath
  3. Fusiform swelling of entire digit
  4. Digit with semi-flexed posture
- Treatment is usually IV antibiotics if the injury is less than 48 hours old. If this is unsuccessful within 12-24 hours then surgical intervention is recommended.
- If the patient presents after 48 hours, then surgical intervention is recommended.
- Healthcare professionals should be aware of the importance of considering the diagnosis of a flexor tendon sheath infection when patients present with a history of injury to the finger, a deep cut, or penetrating trauma, ensuring that they are referred to Plastics at the earliest opportunity.

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HSC Health and Social Care

QUALITY 2020

Headache: Assessment in the Emergency Department (ED)

A patient attended their GP with a history of increasing headaches, vertigo and tiredness, causing disturbed sleep particularly due to nocturnal headaches with vomiting. Following eye assessment by the GP, the patient was advised to attend the ED immediately with a GP letter of referral suggesting a CT brain scan was required.

At the ED the patient was assessed by medical staff. All clinical observations were within normal limits. The doctor noted that the patient had a moderately severe unilateral throbbing headache with nausea and vomiting; that there was a known history of migraine headaches and that this episode had woken the patient from their sleep. Clinical examination revealed the patient was alert, orientated and coherent, with a Glasgow Coma Score (GCS) of 15/15. There were no cranial nerve deficits, no motor or sensory deficits and pupils were equal and reactive to light. There is **no documentation** that a fundoscopy examination was undertaken.

The doctor did consider a "space occupying lesion" such as a Meningioma in their assessment, but did not consider that it was likely enough to require an emergency brain CT scan on the night of attendance, nor did they ask the patient to return the next day for this investigation. The patient was subsequently diagnosed with migraine headache and on discharge from the ED was provided information regarding adequate hydration, analgesics, and safety net advice to return if symptoms worsened.

One week later, following review by the optician and complaining of worsening vision, the patient was urgently referred to the regional centre with raised intracranial pressure. A CT brain scan showed grade 1 parasagittal meningioma attached to superior sagittal sinus which required urgent surgery.

KEY LEARNING

Headache is a common presentation to the ED and assessment can be complicated. Headaches waking patients from sleep, as in this case, is suggestive of a more serious cause.

The purpose of presenting this case is to raise awareness amongst all staff of the importance of being alert to features suggestive of a serious cause of headache and the importance of seeking advice from **senior colleagues** at the earliest opportunity. Senior advice was **not** sought in this case.

As per NICE guidance - assessment for a person attending with headache should include:

- A detailed history, being alert for features suggestive of a serious cause of headache including: progressive or persistent headache, headache with vomiting
- Check: Vital signs including fundoscopy

NICE guidelines available here

Also applicable to the learning from this case is The Royal College of Emergency Medicine Consultant Sign-Off (June 2016) which states: *'there are many other presentations that carry important risk (e.g. headache), and individual departments may wish to add these and other conditions locally when staffing allows.'* Full detail of the Consultant Sign-Off is available here to read for context and completeness in relation to how it may relate to this complaint.

LEARNING MATTERS

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HSC Health and Social Care

QUALITY 2020

Recognising Ovarian Torsion

A young girl presented to the Emergency Department (ED) with sudden onset abdominal pain and associated vomiting. A history of recurrent abdominal pain was noted. Examination was normal and she was discharged with a diagnosis of non-specific abdominal pain and advised to return if any further concern.

The patient re-presented to the ED the next day with worsening symptoms of abdominal pain. The pain was now associated with anorexia and radiation to the right thigh. Examination revealed a soft abdomen with mild right iliac fossa tenderness and bowels were moving normally.

Vital signs and blood results were normal. Urinalysis was positive for leucocytes, but there were no features of urinary tract infection (UTI). The patient was diagnosed with constipation and discharged. The patient's mother was asked to attend the GP to consider referral to Paediatrics if the issue continued.

The patient re-presented to the ED later the same day with worsening of abdominal pain, making this the third ED attendance in 48 hours. The patient was examined by the ED Consultant. Abdominal examination was unremarkable, however she was admitted to hospital, as this was the third attendance with the same presenting complaint.

The following morning she was reviewed by surgeons who considered taking her to theatre to rule out atypical presentation of appendicitis, however an ultrasound scan of abdomen and pelvis, ordered by ED the evening before was performed, which confirmed the diagnosis of **ovarian torsion.**

KEY LEARNING

Ovarian torsion is rare in children but accounts for 3% of all cases, in the child who presents with acute abdominal pain. Importantly it requires immediate surgical intervention. The presence of vomiting, short duration of abdominal pain, and elevated CRP level has a predictive value for the diagnosis of ovarian torsion in children (Bolli et al., 2017).

Re-attendance to the ED with an ongoing issue should prompt review by a senior ED doctor. The Royal College of Emergency Medicine (RCEM) recommend consultant sign-off for patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. RCEM standard is available here.

Important to note:

- Blood markers should **not** be solely relied upon as an indicator of significant pathology or as criterion for admission. Normal inflammatory markers can be falsely reassuring.
- Ultrasound abdomen is the first line imaging modality for suspected appendicitis in paediatric patients, but as demonstrated in this case is useful for detecting other pathology.

References
Bolli, P., Schädelin, S., Holland-Cunz, S. and Zimmermann, P. (2017). Ovarian torsion in children. *Medicine,* 96(43), p.e8299.

www.rcem.ac.uk. (n.d.). *RCEM Standards - Consultant Sign-off.* [online] Available at: https://www.rcem.ac.uk/RCEM/Quality-Policy/Clinical_Standards_Guidance/RCEM_Standards.aspx?WebsiteKey=b3d6bb2a-abba-44ed-b758-467776a958cd&hkey=0c1979a4-cd10-4592-babd-9a76d8000d2f&RCEM_Clinical_Standards=2 [Accessed 26 Feb. 2021].

LEARNING MATTERS

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HSC Health and Social Care

QUALITY 2020

DURING 2019/20:
- HSCTs received 6105 complaints.

The top three categories of complaints were in relation to:
1. Treatment and care (1399 complaints)
2. Staff attitude and behaviour (1021 complaints)
3. Communication (948 complaints)

'Focus on' Professionalism

A family member of a child attending a chemotherapy appointment raised a complaint with the respective Trust, after witnessing staff 'laughing and joking' inappropriately and 'being on mobile phones'. A further complaint was made by the family member in relation to a staff member they had encountered who was 'rude'.

We should be aware of our surroundings at all times, while working in health and social care, particularly when interacting with work colleagues or patients and be sensitive to others who may witness or overhear our conversations. It is important to consider how interactions or behaviours which may hold no ill-intention, such as joking with colleagues or looking at your phone, is perceived from the point of view of a service user or their family members.

Complaints relating to poor patient experience concerning staff professionalism; namely attitudes and behaviour are not uncommon within the NI health service. This is clearly evident from the complaints information below, where **1021** complaints were received by HSC Trusts in 19/20, that related to **staff attitude and behaviour.** It is therefore **essential** this pattern and trend is highlighted and most importantly improved for those who use our services, often at a very vulnerable and uncertain time in their life.

KEY LEARNING

Professionalism is integral to delivering high quality, safe and effective person centred care across the HSC system in N. Ireland. Being an inspiring role model and working in the best interests of people in our care, regardless of what position we hold and where we deliver care, is what really brings practice and behaviour together in harmony.

In N. Ireland the four Health and Social Care Values provide clarity for all HSC staff, including prospective staff, on the values we should live every day, and the behaviours expected of us, regardless of the HSC organisation we work for. These values and behaviours will send a clear message to patients, service users, families, and carers about the care and support they should expect, and how this should be delivered.

LEARNING MATTERS

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Health and Social Care

QUALITY 2020

For all **nursing staff** the following key information is applicable to learning from this complaint and others of similar nature: Enabling professionalism in nursing and midwifery practice is available at the link below:
Enabling professionalism in nursing and midwifery practice.

NMC Code available at the link below:
Nursing and Midwifery Council (2018).

For all **medical staff** the following key information is applicable to learning from this complaint and others of similar nature: The General Medical Council (GMC) **'Good medical practice'** guidance which is available at the link below:
Good medical practice - GMC (gmc-uk.org)

For all **AHP staff** the following key information is applicable to learning from this complaint and others of similar nature: The Health and Care Professions Council (HCPC) **Standards of conduct, performance and ethics** available at the link below:
HCPC Standards.

All pharmacists are expected to abide by the Pharmaceutical Society NI Code
https://www.psni.org.uk/psni/about/code-of-ethics-and-standards/

Another useful resource for all Health and Social Care staff in relation to learning from complaints on attitudes and behaviour is the link below to the Cleveland Clinic video on Empathy:
Cleveland Clinic Empathy - Cleveland Clinic Annual Report 2012

In summary, health and social care staff should be aware of the large volume of complaints generated across the HSC in relation to professionalism concerning staff attitudes and behaviours. HSC staff must act at all times in a polite and courteous manner and with the highest of professional standards and behaviours as set out in guidance by their professional regulatory body.

Contact Us
If you have any comments/feedback or questions on the articles in the newsletter please get in contact by email at learningmatters@hscni.net

Learning Matters is available on:
https://www.publichealth.hscni.net/publications/learning-matters-newsletters

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Anne-Marie Phillips
Denise Boulter

Health and Social Care Board
Anne Kane
Matthew Dolan
Sally Kelly
Liz Fitzpatrick

Mealtime Matters

Antrim Hospital - Our pledge - putting patients first at mealtimes

The mealtime co-ordinator will ensure that all patients receive timely assistance with their meal when required

1. Menu order

Nursing staff must:

- Take menu order using electronic tablet.
- Assist patients / carers with choice and consider patient meal preferences / allergens.
- Ensure right meals are ordered for the right patients; consider need for texture, speech and language needs and special diets including food allergeries.
- Consider the need for snacks for patients with reduced appetite.
- Ensure menus are uploaded to Catering office by 10am each morning.

2. Before mealtime

Nursing staff must ensure:

- A Registered Nurse leads and co-ordinates the mealtime service for patients in their bay or the entire ward.
- Food texture and dietary recommendations are clearly identified.
- Plate method is displayed above bed to identify patients' needs.
- Patients are in a comfortable upright position. Bed tables are cleared and positioned correctly.
- Patients are offered/assisted to visit bathroom.
- Patients hands are washed.
- Provision of adapted plates or cutlery and protective napkin where required.
- That patients requiring mealtime assistance are identified at handover and safety briefings.
- Encourage carers of patients with dementia to visit and assist their relative at mealtimes.

The registered nurse in charge of a bay/ward liaises with and guides Mealtime Companions in relation to specific mealtime care of patients

Staff with catering responsibilities:

- Remove and store snacks until required.
- Ensure food trolley is immediately plugged in once delivered from the kitchen at lunch and dinner times.
- To alert nursing staff / mealtime co-ordinator that meals will be served in five minutes.
- Ensure the food temperatures are checked and recorded in line with Food Safety requirements.

The staff member responsible for the service of beverages:

Must in advance liaise with the registered nurse in charge of a bay / ward to ensure support is provided to patients who require their drinks to be thickened. Check signage for patients not eating or drinking.

3. During mealtime

Staff with catering responsibilities:

- Proceed to the ward service area and take direction from the mealtime co-ordinator.
- Serve food in correct portion size as ordered.
- Present food attractively as per the standard plate model.
- Ensure that seasoning and accompanying sauces are served.

Nursing staff must ensure:

- Patients are not interrupted during mealtime unless it is clinically necessary.
- All available nursing staff and auxiliary staff will assist with mealtimes.
- Staff hands are washed prior to service delivery.
- Staff focus on assisting one patient at a time with feeding.
- The right meal is served to the right patient and corresponds with speech and language/dietetic recommendations.
- Alternatives are offered to patients who refuse their meal.

4. After mealtime

Staff with catering responsibilities:

- Before clearing away, check with the meal co-ordinator if anyone would like more to eat.
- Check meal service has gone well with the meal co-ordinator.
- Report any problems to the Supervisor/Manager.

Nursing staff must ensure:

- Mealtime co-ordinator must scan the ward to ensure all patients have eaten and received assistance.
- Ensure patients are satisfied with their meal and communicate any issues to the Manager/Supervisors.
- Record patient intake of food/fluid where appropriate.
- In the event of a patient missing their meal or being admitted after mealtimes the out of hours catering service can be utilised.

ramp
REFORM AND MODERNISATION PROGRAMME

iQi innovation Quality improvement

COMPASSION C OPENNESS O RESPECT R EXCELLENCE E

HSC Northern Health and Social Care Trust

August 2018

Department of Health Advance Care Planning Policy for Northern Ireland (for adults)

DNACPR

Thematic Review of DNACPR Issues

February 2021

CONTENTS

1.0 Executive Summary

1.1 Introduction

Advance Care Planning is one of the key priority areas for the Palliative Care in Partnership Programme since 2016. During COVID – 19 the issues relating to Advance Care Planning and in particular Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) have gained a greater emphasis, urgency, and priority.

In response, the Department of Health has tasked a small project team to develop a Regional Advance Care Planning Policy (Adults) for NI. They are also tasked with drafting a comprehensive suite of supporting documentation and with implementing a comprehensive training and education plan.

The high level plan has been approved by the Minister of Health. The Regional Clinical Ethics Forum and the Palliative Care in Partnership members have provided commentary on the scheme of work, inclusive of methodology for the various stages of the development of this Policy.

To ensure rigour from the outset, a thematic analysis was undertaken on a number of key data sources which related to either advance care planning broadly, or DNACPR specifically. These sources included the following six recently published reports;

- Age NI, 'Lived Experience: Voices of older people on the COVID-19 Pandemic 2020',
- Amnesty International, 'As if expendable. The UK Governments failure to protect older people in Care Homes during the Covid-19 pandemic'.
- The CQC interim report from its review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 pandemic,
- The National Audit of Care at the End of Life (NACEL), Second round of the audit report Northern Ireland (2019/20),
- The Patient Client Council: Exploring the experiences and perspectives of clinically extremely vulnerable people during COVID 19 shielding December 2020.
- NI Assembly Committee for Health, Inquiry Report on the Impact of COVID-19 in Care Homes (February 2021)

The thematic analysis also included Health and Social Care data; "Regional Complaints" received from across all the Health and Social care Trusts in Northern Ireland between April 2018 and June 2020

which related to ACP or DNACPR. A search of “Serious Adverse Incidents” reported similarly, will be completed when the data is made available to the Project Team.

This paper presents the findings from this initial thematic analysis and is intended as a live document that will be developed further as the work progresses, to include new relevant information as it emerges.

1.2 Thematic analysis overarching themes

Following this initial analysis, a number of overarching themes are evident.

- There should be No blanket approach to DNACPR (Human Rights issue)
  (In both Amnesty UK and CQC interim Report)
- Public misunderstanding of DNACPR
- HSC professionals misunderstanding/poor knowledge of DNACPR process (including no review of status)
- No/Poor/insensitive Communication re DNACPR
- CQC finds that a combination of increasing pressures and rapidly developing guidance may have contributed to inappropriate advance care decisions

2.0 Evidence

What follows is a synopsis of key findings from the six abovementioned reports.

2.1 Age NI – "Lived Experience: Voices of older people on the COVID-19 Pandemic 2020"

Using feedback from older people who accessed their support services during COVID-19 or through hearing older people views during the weekly consultative forum, Age NI compiled this publication, which reflects key concerns and experiences through four key themes:

1. Support, health and care

2. Communication and connection

3. Loneliness and isolation

4. Grief and loss.

Figure I – Extracts from the Age NI report

"Older people around the world bear the brunt of the impact of the COVID-19 pandemic. In Northern Ireland, as elsewhere, statistics paint a stark picture:

• People aged over 65 make up 90% of all the deaths attributed to COVID-19

• People who were living in care homes account for over 50% of related deaths"

Our thematic analysis focused on issues pertaining to DNACPR

- *These are without doubt challenging times, but it is crucial that we continue to protect people's fundamental human rights. The role and timing of advanced (sic) care planning has taken on particular significance.*
- *Advanced (sic) care planning Families were distressed and concerned when advanced (sic) care planning and DNA CPR (Do not attempt cardiopulmonary resuscitation) forms were raised during the early stages of the pandemic.*
- *Action point: Start the conversation and follow best practice in advanced (sic) care planning.*

Key messages / Recommendations

- Older people must not be discriminated against particularly, on the basis of age or condition when it comes to treatment options and choices.
- Older people need to be kept at the heart of compassionate, best practice, care.

Other than that outlined in figure I, there was no further detail provided in the report regarding DNACPR, however Age NI will participate in the Stakeholder engagements.

2.2 Amnesty International: As if expendable. The UK Governments failure to protect older people in Care Homes during the Covid-19 pandemic

This report focuses on the number of COVID-19 related deaths of people over the age of 65 in England, between March and June 2020 (40% of the total of all those who died). Of these, 76% lived in care homes. The report makes the case that the UK government, national agencies, and local-level bodies have taken decisions and adopted policies during the COVID-19 pandemic that have directly violated the human rights of older residents of care homes in England—notably their right to life, their right to health, and their right to non-discrimination.

Figure II - Extracts from Amnesty International Report

"Throughout the pandemic, concerns about the inappropriate use of Do Not Attempt Resuscitation (DNAR) forms have been repeatedly raised."

"Concerns about blanket imposition of DNAR were reported across the country, pointing to flaws with how decisions were taken and policies communicated to those who are supposed to implement them—CCGs, GPs, and care homes. Care home managers reported to Amnesty International and to media cases of local GP surgeries or Clinical Commissioning Groups (CCGs) requesting them to insert DNAR forms into the files of residents as a blanket approach."

The guidance also included instructions related to hospital admission, asking GPs to ensure "patients who do not already have a 'do not convey to hospital' decision are prioritised and have one in place".

"Discussions on advanced (sic) care planning should be warm and natural conversations. This is not how they should be done. One care home with 26 residents had 16 residents sign DNARs in a 24-hour period. It was distressing for staff and residents … Care homes felt like they were being turned into hospices, and being asked to prepare to manage deaths instead of managing life."

"Following investigations by a senior local figure and news coverage of the story, the CCG responded that while "agreeing advance care plans is a routine and important part of how GPs and care homes support their patients and residents, we recognise there may have been undue alarm caused by the interpretation of this particular guidance." (129 A local official told Amnesty International that the CCG sent a follow-up letter apologising and clarifying guidance shortly after the news coverage).

"indicate that pressure was being exerted from the acute sector to free up hospital beds with little concern for the consequences on the health and lives of those in other settings, including care homes, or for equal treatment in access to care. Discussing how the CCG guidance came to be issued, a senior local figure told Amnesty International that it was clear from conversations he had with senior figures in the local health system that they were under "an enormous amount of pressure from upwards" and

that they were given instructions orally which were not sent in writing or would be worded differently when sent in writing. This would explain why so many CCGs and GPs asked care homes to put DNAR instructions on their residents in a blanket approach even though there is no written record of any such government policy".

"The concern about blanket DNAR instructions was widespread and serious enough, right from the outset of the pandemic, to prompt warnings by the UK's main medical and social care bodies at the beginning of April 2020. In a joint statement issued on 1 April, the British Medical Association (BMA), the Royal College of General Practice (RCGP), the Care Quality Commission (CQC), and the Care Provider Alliance (CPA) warned that: "It is unacceptable for advance care plans, with or without DNAR form completion to be applied to groups of people of any description. These decisions must continue to be made on an individual basis according to need."

"blanket DNACPR" decisions, or decisions taken about resuscitation status by others (GPs, hospital staff or clinical commissioning groups) without discussion with residents, families or care home staff, or that they disagreed with some of the decisions on legal, professional or ethical grounds".

Human Rights violations

"The UK is a state party to international and regional human rights treaties which require it to protect and guarantee fundamental human rights relevant to the concerns addressed in this report, including, notably, the right to life, the right to highest attainable standard of physical and mental health, the right to non-discrimination—including on the grounds of age, disability or health status—the right not to be subjected to inhuman or degrading treatment, and the right to private and family life.206 The UK's obligations under international human rights law requires that it respect, protect and fulfil the human rights of individuals within its jurisdiction. Most of these rights have been enshrined in UK law by the Human Rights Act, which incorporates into domestic law the rights set out in the European Convention on Human Rights (ECHR)"

"Decisions by some CCGs and GPs to direct care homes to put blanket DNAR on all residents and the government's failure to ensure compliance by CCGs, GPs and care homes with standard DNAR procedures violated the right to life, the right to health and the right to non-discrimination of care home residents, who were subjected to such practices as members of a specific category—older persons with and without disabilities living in assisted facilities".

The Report also noted with regard to issues of *"PPE, testing, etc the suspension of inspections by the CQC meant that there was little meaningful protection against such practices"* i.e. the application of blanket DNACPR decisions or decisions taken about resuscitation status that did not involve the person or those closest to them.

Key messages / Recommendations including an Enquiry re DNACPR:

- The extent to which there was inappropriate use of DNARs by health and care professionals, including the incorrect interpretation of them to mean that a person should not be sent to hospital.
- Call for an urgent and thorough review of all DNACPR forms that have been added to care home residents' file since the beginning of the pandemic to ensure they have been completed with the full knowledge, consideration and consent of the resident and/or their family or legal guardian where they do not have mental capacity according to the terms set out in the Mental Capacity Act.
- Call to ensure all staff working in the home understand when and how DNARs/DNACPRs apply and that they do not in themselves indicate that a patient does not want to be taken to hospital or does not want to receive (non-CPR) medical treatment.

2.3 The Care Quality Commission (CQC) interim report from its review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 pandemic. (Dec 3rd 2020)

The CQC is the independent regulator of all health and social care services in England. Prompted by concerns about the blanket application of DNACPR decisions during the early stages of the COVID -19 pandemic, it conducted a special review. The review looked at all key sectors, including care homes, primary care and hospitals, and explored the implementation of best practice DNACPR guidance.

Figure III Extracts from the CQC report

"Early findings are that at the beginning of the pandemic, a combination of unprecedented pressure on care providers and other issues may have led to decisions concerning DNACPR being incorrectly conflated with other clinical assessments around critical care".

Recommendations/Outcome

"DNACPR decisions and advance care plans should only ever take place with clear involvement of the individual, or an appropriate representative, and a clear understanding of what they would like to happen".

CQC is now undertaking a more in-depth review in fieldwork, to establish current practice and identify "what local systems need to do so they can protect against possible future errors."

2.4 National Audit of Care at the End of Life (NACEL) Second Round of the Audit (2019/20) Report Northern Ireland.

NACEL is an annual audit managed by the NHS Benchmarking Network, supported by the Co-Clinical Leads, the NACEL Steering Group.

The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the "*Five priorities for care"* set out in "*One Chance To Get It Right"* and "*NICE Quality Standards 13 and 144"*.

The *Five priorities for care* reflect the Northern Ireland Department of Health circular "HSS (MD) 21/2014 *Advice To Health And Social Care Professionals For The Care Of The Dying Person In The Final Days And Hours Of Life – Phasing Out Of The Liverpool Care Pathway In Northern Ireland By 31 October 2014". The circular sets* out five principles that should underpin high quality care in the final days and hours of life. These principles reflected the good practice outlined in the Department's "*Living Matters; Dying Matters (LMDM), Palliative and End of Life Care Strategy for adults"*, published in 2010.

The NI audit, undertaken during 2019/20, comprised:

- An **Organisational Level Audit** covering hospital/submission level questions;
- A **Case Note Review** which reviewed consecutive deaths in the first two weeks of April 2019 and the first two weeks of May 2019 (acute providers) or deaths in April and May 2019 community providers.

Key messages / Recommendations

NACEL shines a spotlight on the last admission to hospital prior to death and highlights whether hospital staff in Northern Ireland are delivering against the quality standards and statements which are universally accepted as good practice.

Figure IV Extracts from the NACEL report

"Advance care planning is an important part of individualised care planning. Analysis from round two indicates that in Northern Ireland, there is limited advance care planning occurring."

"An important element of individualised care planning is understanding the wishes and preferences of dying people, and those important to them. Advanced care planning is one element of this. Given that on average, the dying person was in hospital up to three and a half days before dying in Northern Ireland, it is documented in 5% of cases only that the dying person had participated in end of life care planning during the final admission. It was documented that 3% of dying people had participated in advance care planning prior to their last admission. This is in relation to all deaths."

"Further, analysis indicated that participation in advance care planning was limited, even though Northern Ireland have guidance available, across all care settings, to facilitate this process. Given that the median time from recognition of death to dying was almost three and a half days in Northern Ireland, there may well have been missed opportunities for patients to participate in advance care planning."

Similarly, the audit found limited evidence of discussions regarding DNACPR with the person or with their family/caregivers. The report goes on to make the following recommendation;

"Ensure that every opportunity is taken to give dying people the option to participate in advance care planning, to reflect their choices and wishes at the end of their life. This should include documenting in the patient's care records, the preferred place to die (if known), and facilitating this wherever possible."

2.5 PCC: Exploring the experiences and perspectives of clinically extremely vulnerable people during COVID 19 shielding December 2020

Shielding advice was issued to an estimated 80,000 people in Northern Ireland, significantly changing their lives and those living with them. In May 2020, the Patient and Client Council (PCC) sought to engage with these groups, in partnership with the Department of Health (DoH). The rationale was to ensure that the voices of those impacted by shielding informed decision making and messaging around changes to the restrictions introduced in March 2020.

Respondents who indicated that they were using palliative care support were asked a series of follow-on questions:

Q11. Have you (the person shielding) discussed your future wishes/preferences for care (known as Advance Care Planning) with your GP or another health or social care professional?

Q12. If 'yes', did you have this discussion before you began shielding?

Q13. If 'no', would you like the opportunity to discuss your future wishes/preferences for care?

Q14. What would be the best, most appropriate way to have this discussion in your circumstances?

Key Findings:

despite their serious health conditions, only 24% of the 209 respondents who reported receiving palliative care support indicated that they had discussed Advance Care Planning (ACP) with a health professional. A large majority of respondents (72%) indicated that they had not discussed ACP with a health professional.

Of those who had discussed ACP with a health or social care professional, the majority (68%) had done so prior to the start of shielding.

Of those who had *not* discussed ACP with a health or social care professional, 41% reported that they would like the opportunity to discuss these issues.

However, several respondents reported that being asked about ACP by a health or social care professional during a pandemic would make them feel as though their lives were less valued than those of other ill or well persons.

Among those open to having a conversation about ACP, shielding appeared to influence how they would like to be approached. Around half of these respondents reported that they would prefer to have such discussions over the phone or by email, with some specifically attributing this to their need to shield. It is of interest that a small number of respondents, while open to discussing ACP, felt it was too early for them to be having such discussions.

DNACPR did not feature in this report

2.6 DNACPR Related Complaints to HSCTs April 2018 - June 2020

A trawl of all complaints to HSC Trusts across the Region pertaining to DNACPR related issues, between April 2018 and June 2020 was undertaken and two clear themes were identified; Issues in relation to communication and public and professional lack of understanding regarding DNACPR decision making. The issue of no review of DNACPR was also raised. What follows are the recorded complaints cited under each respective themes;

Communication:

"DNR placed on the patient's file but not discussed with the patient or his family; family not kept informed of the patient's condition";

"Family felt pressured into agreeing with DNR; no solution given to help with diagnosis; family provided with conflicting information; incorrect information provided to family; incorrect information on patient's records; staff did not tell the family the patient was in his final hours of life";

"*Patient was discharged from hospital with a DNR which family were not told or consulted about".*

"A gentleman raised concerns regarding lack of communication following a meeting regarding a DNR placed on his mother's records"

"Family only spoken to directly by Dr/Consultant once by telephone to discuss DNAR. Daughter lives in England and was not given enough information over telephone".

Complaint regarding the confusion over a DNR order being placed on a patient with a rare syndrome while in Acute hospital. Also feel that DNR was not discussed in an appropriate manner.
"Service user with late stage dementia was admitted to the Emergency Department. On transfer to the ward it was noticed that a DNAR was on his records. His NOK was informed that staff in the Emergency Department had made this decision. NOK feels this should have been discussed with him".
"Doctor in A&E issued a DNR form in the patients file without consulting family in respect to it. Wants an immediate explanation of this and why it was done".
"No Review of DNACPR"

Public and professional lack of understanding regarding DNACPR decision making

"Family state as she was extremely unwell, decisions were made at A&E to put a DNAR in place. Family disagree with this decision which was later removed. Family want to know how and on what basis this decision was made".
To be reinforced with both medical and nursing staff the importance of patients and their next of kin being fully involved in discussions and decisions taken in relation to DNR
"Patient was upset by comments made by a doctor about resuscitation. Comments from consultant which stated that it was clinically correct for the doctor to discuss resuscitation with the patient, even though it caused him distress".
Complaint letter regarding a deceased gentleman's consultant. This consult is accused of authorising a DNR. The family were not consulted regarding this.
*query regarding DNAR practice; attitude of doctor. (*No detail available in data)

2.7 NI Assembly Committee for Health, Inquiry Report on the Impact of COVID-19 in Care Homes

The Health Committee decided in July 2020, based on evidence it had taken in the spring in relation to the particular impact of COVID-19 on care homes, to conduct a short inquiry, in order to produce recommendations to help mitigate and manage the impact of a potential second surge of the virus in care homes. The report on the Inquiry was published in February 2021 and makes specific recommendations pertaining to ACP.

Figure V: Extract from the NI Assembly Report NIA 59/17-22

Advance Care Planning is another issue that was brought to the Committee's attention in recent months and the Committee acknowledges the sensitivity of such conversations and the importance of this matter being dealt with on an individual basis, supported by the appropriate professional and taking account of the unique needs, preferences and changing circumstances of the individual, ideally well in advance of a crisis.

The Committee also notes that ACP goes well beyond circumstances where resuscitation is appropriate and covers a wide range of care and treatment preferences, in a variety of circumstances.
The Committee notes the pressure felt by some care home staff to lead these important conversations for which they felt further training and medical input was required.

Recommendation 34: Advance Care Planning should be discussed with each care home resident, on an individual basis, ideally ahead of any crisis; it should be led by the clinician who knows the individual best, with the input of other relevant professionals; and reviewed as necessary.

Recommendation 35: The Department of Health should clearly outline and communicate the rights of older people and families regarding end-of-life planning and this should reference the approach to treatment and care planning recommended under NICE guideline NG163.

Recommendation 36: Steps should be taken to ensure that relevant professionals have access to appropriate training in advance care planning.

3.0 Conclusion

The findings from this thematic analysis identifies five key themes; There should be No blanket approach to DNACPR (Human Rights issue); Public misunderstanding of DNACPR; HSC professionals misunderstanding/poor knowledge of DNACPR (including no review of status) and No/Poor/insensitive Communication re DNACPR. Taking cognisance of these issues during the development of a regional ACP Policy for adults in Northern Ireland, is vital and provides a degree of rigour to the work. Some of the findings from this thematic analysis also provide a useful steer for the focus of any public messaging from the Department of Health, Public Health Agency and the Project team regarding advance care planning and DNACPR.

4.0 References

Age NI, (2020) Lived Experience: Voices of Older People on the COVID-19 Pandemic 2020
https://www.ageuk.org.uk/globalassets/age-ni/documents/policy/lived-experiences-brochure-final.pdf

Amnesty International, (2020) As If Expendable: The UK Governments failure to protect older people in Care Homes during the COVID-19 Pandemic
https://www.amnesty.org.uk/files/2020-10/Care%20Homes%20Report.pdf?kd5Z8eWzj8Q6ryzHkcaUnxfCtqe5Ddg6

The Care Quality Commission (CQC), (Dec 3rd 2020), Interim report from the review into the application of do not attempt cardiopulmonary resuscitation (DNACPR) decisions during the COVID-19 Pandemic
https://www.cqc.org.uk/sites/default/files/20201204%20DNACPR%20Interim%20Report%20-%20FINAL.pdf

National Audit of Care at the End of Life (NACEL) Second round of the Audit report Northern Ireland (2019/20)
https://s3.eu-west-2.amazonaws.com/nhsbn-static/NACEL/2020/NACEL_Northern_Ireland_Round_2_Summary_Report_FINAL.pdf

NI Assembly Committee for Health, (February 2021) Inquiry Report on the Impact of COVID-19 in Care Homes Report: NIA 59/17-22
http://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/health/reports/covid-19-and-its-impact-on-care-homes/report-and-images/health-committee-inquiry-report-on-impact-of-covid-19-in-care-homes.pdf

The Patient Client Council (2020), Exploring the Experiences and Perspectives of Clinically Extremely Vulnerable People during COVID-19, Shielding December 2020
https://patientclientcouncil.hscni.net/download/19/reports/2722/pcc-covid-19-shielding-survey-report-final-dec-20-2.pdf

Health and Social Care Board

Public Health Agency

SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	RISK OF DEATH OR SERIOUS HARM BY FALLING FROM A HOIST
HSCB reference number	SQR-SL-2020-060 (All PoCs)
Programme of care	All programmes of care

LEARNING SOURCE			
SAI/Early Alert/Adverse incident		Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify) Risk identified following observation of a member of staff on a ward using hoisting equipment incorrectly.			

SUMMARY OF EVENT

A member of staff reported observing another member of ward staff attach a loop sling to a hoist with a clip hanger bar. Such practice could lead to serious harm or death of a service user.

REQUIREMENTS UNDER CURRENT GUIDANCE

PLEASE ENSURE THAT ALL STAFF INVOLVED IN THE ASSESSMENT AND HOISTING OF PATIENTS / CLIENTS ARE MADE AWARE OF THE FOLLOWING:

If you are using a hoist and sling from 2 different manufacturers then a hoist / sling compatibility risk assessment should be completed to ensure that it is safe to use the two items together.

If you are using a sling with loop attachments, the loop attachments should never be attached to a clip hanger bar.

If you are using a sling with clip attachments, the clip attachment should never be attached to a loop hanger bar.

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Attaching the sling to the incorrect hanger bar e.g. Attaching a sling with loop attachments to a clip hanger bar will result in a fall from a hoist and possible fatal outcome for a patient / client.

A loop sling has been designed to be used with a loop hanger bar

A clip sling has been designed to be used with a clip hanger bar

Lifting equipment, used in the context of work, is subject to the requirements of the **Lifting Operations and Lifting Equipment Regulations (Northern Ireland) 1999 or LOLER** as the regulations are commonly known. See link below.

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http://www.legislation.gov.uk/nisr/1999/304/contents/made

Lifting equipment must be fit for purpose, appropriate for the task, suitably marked and, in many cases, subject to statutory periodic 'thorough examination' by a competent person.

Periodic thorough examinations during the life of the equipment are required for lifting equipment exposed to conditions which cause deterioration likely to result in dangerous situations. Typically equipment used for lifting people must be examined every 6 months. Other lifting equipment should be examined every 12 months.

It should be noted that the provision of some handling aids may bring about other risks such as those caused by unsuitable equipment or untrained staff.

Before using work equipment check the maximum user weight and safe working load. You will need to have an idea of the patient / client weight and ensure that they don't exceed the weight bearing capacity of the equipment.

Do not use equipment unless trained to do so. Visually inspect the equipment to ensure that it is in good working order and suitable for the task. Follow the manufacturer's instructions for use.

Recommended checklist before using a hoist:

- You have been trained and feel confident to use the equipment.
- The person's care plan should detail that a hoist is to be used. The size and type of sling should be recorded and the leg / shoulder loop configuration stated if a loop system is used.
- If you are using a hoist and sling from 2 different manufacturers then a hoist / sling compatibility risk assessment should be completed to ensure that it is safe to use the two items together.
- The hoist should be in good working order – it should go up and down. For a mobile hoist, the legs open and close, and it moves back and forward (wheels are free running).
- You should know how to operate the emergency lowering system.
- The sling should be clean and undamaged and the label readable.
- The sling is the right size and type for the person and task.
- The safe working load (SWL) of the hoist and sling are suitable for the patient's weight and needs.
- You have explained to the person what you are going to do and have consent and cooperation to proceed.
- You know how to seek further advice and the person's needs are reviewed.

References / Evidence Base:

Health & Safety Executive Guidance on the:

The Lifting Operations and Lifting Equipment Regulations (Northern Ireland) 1999
http://www.legislation.gov.uk/nisr/1999/304/contents/made

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The Provision and Use of Work Equipment Regulations (Northern Ireland) 1999
http://www.legislation.gov.uk/nisr/1999/305/part/II/made

The Guide to the Handling of People 6th Edition. Backcare in collaboration with National Back Exchange 2011.

ACTION REQUIRED

HSC Trusts should:

1. Share this Reminder of Best Practice letter with all relevant staff.
2. Ensure current guidance as detailed above is being followed.
3. Ensure staff are aware of the importance of not using manual handling equipment unless trained to do so.
4. Confirm by 20 May 2020 to Alerts.HSCB@hscni.net that actions 1, 2 and 3 have been completed.

RQIA should:

1. Should share this Reminder of Best Practice letter with all relevant staff in care homes, domiciliary services and the independent sector.

Date issued	19 February 2020		
Signed:	Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information redacted by the USI
Issued by	Marie Roulston Director of Social Care & Childrens Directorate	***PP*** Dr A Mairs Acting Director of Public Health	Mr Rodney Morton Director of Nursing, Midwifery and Allied Health Professionals

Health and Social Care Board

Public Health Agency

RE: SQR-SL-2020-060 (All PoCs) - Risk of death or serious harm by falling from a hoist – Distribution list

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs	✓		CEX		✓
First point of contact		✓	Acting 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 Safety Forum		✓
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					
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		✓

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: Brian Beattie,
Director of Older People &
Primary Care Services

Our Ref: SQR-SAI-2020-060 (All PoCs)

19 July 2021

Dear Brian,

Risk of Death or Serious Harm by Falling from a Hoist – SQR-SL-2020-060 (All PoCs)

You will be aware of the above safety and quality reminder of best practice letter that the HSCB/PHA issued in February 2020, entitled '*Risk of Death or Serious Harm by Falling from a Hoist'*. This regional learning was issued following a staff member observing another member of staff attaching a loop sling to a hoist with a clip hanger bar. This practice had the potential to cause serious harm or death of a service user.

Despite the detailed assurance from the Southern Trust stating the required actions had been completed, I am writing to you as a complaint relating to the Trust has recently came to the attention of the HSCB/PHA (Personal Information redacted by USI.

The complaint relates to an incident which occurred in a client's own home on Personal informati on [redacted], where they fell from a sling which was not correctly attached to the hoist. I trust you appreciate this is extremely concerning in light of the assurance the Trust provided in response to the above letter.

I am now reissuing the attached reminder of best practice guidance letter and request that the Trust undertake the following actions to prevent and mitigate the risks of this incident occurring again:

1. Share this Reminder of Best Practice letter with all relevant staff and discuss it at safety briefings/team meetings to highlight/raise awareness of the risk of death / serious harm if a person falls from a hoist.
2. Ensure current guidance as detailed in the letter is being followed.
3. Ensure all domiciliary staff are aware of the importance of not using manual handling equipment unless trained to do so.

Health and Social Care Board

Public Health Agency

I am happy to discuss if you feel this would be helpful.

Yours sincerely

Signed:	Personal Information redacted by the USI
Issued by	Anne-Marie Phillips Patient Safety, Quality & Experience Nurse Lead, PHA

Enc.

Copy to:

Nicole O'Neill, Complaints Manager, SHSCT
Governance Lead for SQAs, SHSCT
David Petticrew, Programme Manager, Social Care, HSCB
Mrs Liz Fitzpatrick, Complaints Manager, HSCB

Joint Safety and Quality Oversight Group

Terms of Reference

1.0 Introduction

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

The vision of the *'Joint Safety and Quality Oversight Group'* is to reduce silo working by using information and intelligence from across the organisations in order to facilitate the triangulation of learning and influence improvement of HSC commissioned services.

The group is a strategic influencing and advisory group to the respective represented areas. It is not an operational group responsible for daily identification of learning. These learning processes are managed through different mechanisms within the respective organisations.

2.0 Purpose and Functions of the *'Joint Safety and Quality Oversight Group'*

Members of the *'Joint Safety and Quality Oversight Group'* will undertake to:

- Triangulate learning from a wide range of sources available to the group to identify:
  - Themes, patterns and trends
  - Areas of good practice
  - Areas of concern

- Identify and prioritise key areas of safety and quality improvement for inclusion within the groups' annual work-plan that will require co-production and relevant stakeholder engagement.

- Utilise the information to influence and inform ongoing or new initiatives within relevant areas to improve the safety, quality and experience of commissioned services.

- Streamline and further enhance current arrangements within the HSCB and PHA in relation to Safety, Quality and Patient Experience; taking into consideration new structures working with SPPG.

- Provide an assurance to the PHA/HSCB Joint Safety and Quality Directors Forum that the *'Joint Improving Quality Oversight Group'* has an overview of information sources available to triangulate learning and use this information to influence improvements.

- Put in place mechanisms to measure improvements.

3.0 Accountability of the Group

The *'Joint Safety and Quality Oversight Group'* is accountable to the Joint *Safety and Quality* Directors Forum.

4.0 Membership of the Joint Safety and Quality Oversight Group

Chair Jointly Chaired by:

Assistant Director of Nursing, Quality & Safety (PHA)
Governance Lead (HSCB)

Assistant Governance Manager (Co-chair)

Members
Medical lead (PHA)
HSCQI (PHA)
Safety, Quality & Experience Nurse Lead (PHA)
Patient Client Experience (PHA)
Complaints Manager (HSCB)
Integrated Care - Governance Representative (HSCB)
Deputy Governance Lead (HSCB)
Social Care Governance (HSCB)
Allied Health Professional – Governance Representative (PHA)
PMSI – Governance Representative (HSCB)
Commissioning – Governance Representative (HSCB)
Communication rep – HSCB/PHA To be agreed

5.0 Frequency of Meeting

The group will meet bi-monthly.

6.0 Revision of Terms of Reference

The Terms of Reference will be reviewed in 12 months or earlier as required.

TERMS OF REFERENCE

ACUTE SAI REVIEW TEAM

Purpose of Group:

To ensure collective, multidisciplinary decision making on the management of Acute SAI reports and the identification of regional learning.

Designated Review Officers (DROs) will ensure that the process of investigation is carried out in line with the relevant guidance 'Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)'

Specific Objectives:

- Collective, multidisciplinary decision making on the potential identification of regional learning and the process by which that learning should be progressed in a timely manner for example Newsletter Articles or Learning Letters.
- To identify recurring themes and/or contributory factors to SAIs and if appropriate propose topics for thematic reviews.
- Collective, multidisciplinary decision making on the:
    - Review of SAIs /Early Alerts/Never Events/Interface Incidents
    - Appropriate closure of Acute SAIs;
    - Appropriate Level of SAI Review (if requested by DRO)
    - TOR and membership of level 2 & 3 reviews
    - Requirement for additional information / further action from HSC organisations.
- To escalate areas of concern as appropriate

Meeting:

The group will meet twice a month, mainly at HSCB, Linenhall Street, Belfast Teleconferencing facilities will be available for the meetings and the numbers and codes circulated prior to the meeting.

DROs unable to attend meetings will forward an update / proposed action on the SAIs listed for which they are DRO to the Chair or a nominated DRO on their behalf.

Chairing Arrangements:

Chaired by the Assistant Director of Service Development, Safety and Quality, PHA or nominated deputy.

Membership:

Acute DROs from Public Health Directorate
Acute DROs from Nursing / AHP Directorate
Assistant Governance Manager, HSCB

Attendance:
Northern Ireland Medicines Governance Team Leader for secondary care (for items of mutual interest relating to medication issues)

Governance Support:

The group will be supported by staff from the Governance Team HSCB.

Accountability

The Acute SAI Review Team is accountable to the Regional SAI Review Group

Quorum

The Acute SAI Review Team shall be quorate by the attendance of three members of the Group, from a minimum of two professions.

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

Revision of Terms of Reference

The Terms of Reference will be reviewed in one year (June 2019) or earlier as required.

June 2018

Jim Livingstone
Director of Safety, Quality and Standards

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

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Early Alert system

Circular Reference: HSC (SQSD) 10/2010

Date of Issue: **28 May 2010**

For action by:
- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NIBTS
- Chief Executive, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:
- Chief Executive, Patient and Client Council
- Director of Public Health, PHA
- Director of Performance Management and Service Improvement, HSC Board
- Directors of Social Care and Children in HSC Board and HSC Trusts
- Directors of Nursing and AHP in PHA and HSC Trusts
- Director of Integrated Care in HSC Board
- Medical Directors in HSC Trusts
- Chair, Regional Area Child Protection Committee
- Chair, Regional Adult Protection Forum
- Chief Executive, Regulation & Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The Circular provides guidance on the operation of an Early Alert System, designed to ensure that the Department is made aware in a timely fashion of significant events occurring within HSC organisations.

Enquiries:
Any enquiries about the content of this Circular should be addressed initially to:
Safety & Quality Unit
DHSSPS
Room D1
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: Personal Information redacted by the USI
E-mail: Personal Information redacted by the USI

Related documents

HSC (SQSD) 22/2009: Phase 1 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

HSC (SQSD) 08/2010: Phase 2 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

Superseded documents

Status of Contents:

Action

Implementation:

From 1 June 2010

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

Dear Colleague

ESTABLISHMENT OF AN EARLY ALERT SYSTEM

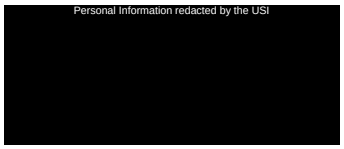
In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department, and the implementation of the Regional Adverse Incident and Learning (RAIL) system (Circular HSC (SQSD) 22/2009).

Circular HSC (SQSD) 08/2010, which issued on 30 April 2010, advised of the transfer of responsibility for managing SAIs from the Department to the HSC Board and Public Health Agency with effect from 1st May 2010, and the revised reporting arrangements which will be in place until the new RAIL system is fully implemented.

The purpose of this circular is to provide specific guidance on the arrangements which should be followed with effect from 1st June to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

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

Yours sincerely



Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Introduction of an Early Alert System

Purpose of the Early Alert System

1.1 The Early Alert System will provide a channel which will enable Chief Executives and their senior staff (Director level or higher) in Health and Social Care (HSC) organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

It is important to note that this reporting system is intended to complement, not replace, existing channels of communication, both formal and informal.

1.2 While it is likely that some of the notifications reported as Early Alerts will also require to be managed as adverse incidents by HSC organisations**, many adverse incidents will NOT need to be reported through this channel.**

Criteria for using the Early Alert System

1.3 The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. ***Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;***

2. ***The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;***

3. ***The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;***

4. ***The media have inquired about the event;***

5. ***The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless;***
    - ***i. there has been an event which has caused harm to a patient or client and which has given rise to a Coroner's investigation; or***
    - ***ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received, or***
    - ***iii. the Coroner's inquest is likely to attract media interest.***

6. ***The following should always be notified:***
    i. ***the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;***
    ii. ***the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;***
    iii. ***allegations that a child accommodated in a children's home has committed a serious offence; and***
    iv. ***any serious complaint about a children's home or persons working there.***

7. ***There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.***

1.4 Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

1.5 It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

1.6 It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice speaks in person to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

1.7 The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within 24 hours of notification of the event, to the Department at earlyalert@dhsspsni.gov.uk and the HSC Board at earlyalert@hscni.net

ANNEX A

Initial call made to _____ **(DHSSPS) on** _____ **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - please confirm report has been forwarded to Chair of Regional CPC.***

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……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact _____

Contact details: Telephone (work or home) ……

Mobile (work or home) ……..

Email address (work or home) …….

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

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FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: ….....

Detail of follow-up action (if applicable) ……

From the Chief Medical Officer
Dr Michael McBride

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

Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Your Ref:
Our Ref: DH1/12/83057
Date: 6 October 2014

BY EMAIL

Chief Executives, HSC Trusts
Chief Executive, HSC Board
Chief Executive, Public Health Agency
Chief Executive, NIBTS
Chief Executive, Business Services Organisation

Dear Colleagues

HSC (SQSD) 7/2014 – PROPER USE OF THE EARLY ALERT SYSTEM - REMINDER

Recent events have highlighted the importance of ensuring proper adherence to the requirements of the Early Alert System. The system is designed to ensure that the Department receives prompt and timely details of events which fulfil criteria which are set out in TAB A by way of reminder. Some of these events (but not all) may become serious adverse incidents and may be notified separately to the HSCB. This does not negate the need for them to be reports as Early Alerts.

Trusts were originally advised of the system on 28 May 2010, when Circular HSC (SQSD) 10/2010] was issued. It can be accessed at: http://www.dhsspsni.gov.uk/hsc_sqsd_10-10.PDF. However, there would seem to be a number of issues around the proper use of the system and speed of reporting. On some occasions events have not been reported at all or not reported immediately and, on a number of occasions, HSC bodies have not followed up their initial telephone notification of an Early Alert to the Department by forwarding a completed pro-forma (attached at Annex A of the 2010 circular) providing further details of the incident to **earlyalert@dhsspsni.gov.uk** within 24 hours of the initial telephone notification.

You are reminded that it is not sufficient to share details via a telephone conversation with a senior official. If an event fulfils the Early Alert criteria, you must notify the Department formally using the proforma as part of the Early Alert system within 24 hours.

The Early Alert System preserves the governance arrangements which are associated with reporting incidents. It ensures that consideration is given as to who should have sight of the detail of event/issues thus providing Department staff and their colleagues with the opportunity to brief Minister or to contribute to that briefing where they are not the lead official.

The importance of the Early Alert System was also emphasised in November 2013 at the public hearings of the Inquiry into Hyponatraemia-Related Deaths. Several witnesses gave evidence of the time when the system was not in place and those arrangements have already been heavily criticised. The Early Alert System was designed to improve upon that situation.

I remind you that it is the responsibility of the reporting HSC organisation to ensure that someone of Director level or higher level reports to a senior member of staff in the Department (Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) and that in ALL cases the initial contact is followed up in the written pro forma within 24 hours.

You are asked to:

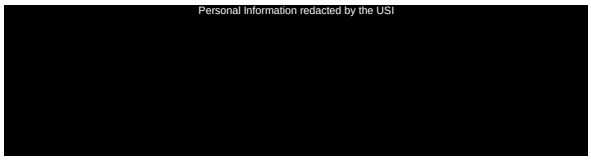
- Note the purpose, criteria and operational arrangements outlined within the Early Alert System

- Communicate this letter and the originating circular [HSC (SQSD 10/2010] to all relevant staff within your organisation.

- Ensure full compliance with the guidance.

Thank you for your assistance in this matter.

Yours sincerely



DR MICHAEL MCBRIDE

cc Catherine Daly
Sean Holland
Julie Thompson
Charlotte McArdle
Mark Timoney
Simon Reid
Ronan Henry
Hazel Whinning
Brian Godfrey
Fergal Bradley
Conrad Kirkwood

ANNEX A

Initial call made to _____ **(DHSSPS) on** _____ **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: **If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - please confirm report has been forwarded to Chair of Regional CPC.*

……

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact _____

Contact details: Telephone (work or home) ……

Mobile (work or home) ……..

Email address (work or home) …….

Forward proforma to the Department at: earlyalert@dhsspsni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: …….. Office: ……..

Forwarded for consideration and appropriate action to: …… Date: ….....

Detail of follow-up action (if applicable) ……

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

Reference: HSC (SQSD) 64/16

Date of Issue: 28 November 2016

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive PHA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents: N/A

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue the guidance and Early Alert notification to advise staff of the procedures to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

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

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

    i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
    ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
    iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
    iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

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

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Yours sincerely

Personal Information redacted by the USI

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Dir of Performance Management & Service Improvement, HSCB
Dir of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts

Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Prof. Sam Porter, Head of Nursing & Midwifery, QUB
Prof. Pascal McKeown, Head of Medical School, QUB
Prof. Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

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Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) ……

Mobile (work or home) …… Telephone (work or home) ……

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: …… Office: ……

Forwarded for consideration and appropriate action to: …… Date: ……

Detail of follow-up action (if applicable) ……

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

Reference: HSC (SQSD) 5/19

Date of Issue: 27th February 2019

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB and PHA for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System

HSC (SQSD) 07/14: Proper use of the Early Alert System

Superseded documents**:**

HSC (SQSD) 64/16: Early Alert System

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

For Information:
Distribution as listed at the end of this Circular.

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue revised guidance for the procedure to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

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

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principle of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

    i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
    ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
    iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
    iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

To assist HSC organisations in making contact with Departmental staff, **Annex A** attached provides the contact details of a range of senior Departmental staff together with an indication of their respective areas of responsibility. **The senior officers are not listed in order of contact. Should a senior officer with responsibility for an area associated with an event not be available, please proceed to contact any senior officer on the list.**

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at **Annex B**, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net.

It is the responsibility of the reporting HSC organisation to comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), Professional Regulatory Bodies, the Coroner etc.) **including compliance with GDPR requirements for information contained in the Early Alert pro forma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the pro forma should relate only to the key issue and it should not contain any personal data.**

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

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

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Yours sincerely

Personal Information redacted by the USI

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Director of Performance Management & Service Improvement, HSCB
Director of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts
Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Professor Donna Fitzimmons, Head of Nursing & Midwifery, QUB
Professor Pascal McKeown, Head of Medical School, QUB
Professor Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Neil Kennedy, Acting Director of Centre for Medical Education, QUB
Professor Sonja McIlfatrick, Head of School of Nursing, UU
Professor Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

ANNEX A
EARLY ALERT SYSTEM: DEPARTMENTAL OFFICER CONTACT LIST
FEBRUARY 2019

HEALTHCARE POLICY GROUP

Deputy Secretary
Jackie Johnston Personal Information redacted by the USI

Primary Care/ Out of Hours Services
Mark Lee Personal Information redacted by the USI

Secondary Care
Kiera Lloyd Personal Information redacted by the USI

Workforce Policy/Human Resources
Andrew Dawson Personal Information redacted by the USI

RESOURCES AND PERFORMANCE MANAGEMENT GROUP

Deputy Secretary
Deborah McNeilly Personal Information redacted by the USI

Capital Development
Brigitte Worth Personal Information redacted by the USI

Information Breaches/ Data Protection
La'Verne Montgomery Personal Information redacted by the USI

Finance Director
Neelia Lloyd Personal Information redacted by the USI

SOCIAL SERVICES POLICY GROUP

Chief Social Services Officer
Sean Holland Personal Information redacted by the USI

Child Protection/ Looked After Children (LAC's)
Eilis McDaniel Personal Information redacted by the USI

Mental Health/ Learning Disability/ Elderly & Community Care
Jerome Dawson Personal Information redacted by the USI

Social Services
Jackie McIlroy Personal Information redacted by the USI

CHIEF MEDICAL OFFICER GROUP

Chief Medical Officer
Dr Michael McBride Personal Information redacted by the USI

Deputy Chief Medical Officers
Dr Paddy Woods Personal Information redacted by the USI

Population Health
Liz Redmond Personal Information redacted by the USI

Chief Dental Officer
Simon Reid Personal Information redacted by the USI

Acting Chief Pharmaceutical Officer
Cathy Harrison Personal Information redacted by the USI

Senior Medical Officers
Dr Carol Beattie Personal Information redacted by the USI
Dr Naresh Chada Personal Information redacted by the USI
Dr Gillian Armstrong Personal Information redacted by the USI Healthcare-Associated Infections (HCAIs) (both confirmed and unconfirmed)

CHIEF NURSING OFFICER

Chief Nursing Officer
Charlotte McArdle Personal Information redacted by the USI

Deputy Chief Nursing Officer
Rodney Morton Personal Information redacted by the USI

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

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Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) ……

Mobile (work or home) …… Telephone (work or home) ……

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: …… Office: ……

Forwarded for consideration and appropriate action to: …… Date: ……

Detail of follow-up action (if applicable) ……

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

Reference: HSC (SQSD) 5/19

Date of Issue: 12 November 2020

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive, PHA
Chief Executive NIAS
Chief Executive RQIA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents**:**

HSC (SQSD) 64/16: Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-64-16.pdf

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This updated circular advises on the use of the Early Alert System with respect to COVID 19 incidents/outbreaks and also serves as a reminder to the operation of the Early Alert system. COVID 19 incidents/outbreaks that are being managed as part of a normal operational response (usual business) should not be routinely reported through the Early Alert system. Such outbreaks/incidents should continue to be reported to Health Protection Team in the PHA as notifiable disease and HSC organisations should continue to provide regular updates to HSCB through established SITREP arrangements.

Action

Chief Executives of HSCB and PHA should:

- Disseminate this circular to all relevant HSCB and PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant staff and all relevant independent sector providers.

Chief Executive of NIMDTA should:

- Disseminate this circular to all relevant staff and doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The Early Alert protocol is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events, which may require the attention of the Minister, Chief Professional Officers and/or policy leads. The purpose of this circular is to clarify arrangements with respect to COVID 19 incidents/outbreaks and re-issue updated guidance for the procedure to be followed if an Early Alert is appropriate.

This updated circular will also serve as a reminder to HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department. The protocol, criteria and operational arrangements for the Early Alert system are provided at **Annex A**, an updated summary of departmental contact numbers is provided at **Annex B**, amendments to these guidance documents, last issued 27 February 2019, are highlighted in yellow for your attention.

During this current surge of COVID-19 incidents/outbreaks have become more prevalent across all HSC organisations, and the handling and management of many of these has become embedded in usual operational business arrangements across HSC organisations. Healthcare outbreaks that are being actively managed as part of an organisation's normal operational response should not be routinely reported

through the Early Alert System. These incidents/outbreaks in health and social care settings should instead continue to be reported to the Health Protection Team within the PHA through established processes for notifiable diseases. Such incidents/outbreaks will subsequently be notified to the Department via daily SITREPs collated by HSCB and via daily update reports shared by PHA's Health Protection service with the Chief Medical Officer's office.

It is important to note that certain COVID-19 incidents/outbreaks, including where there is a serious impact on service delivery, that are not being handled through normal operational response may fall within some of the criteria listed below in **Annex A** and therefore they may warrant an Early Alert. HSC organisations should assess events as they occur/emerge and should they determine that one or more of the criteria listed in Annexe A is met they should report through the Early Alert system as appropriate.

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

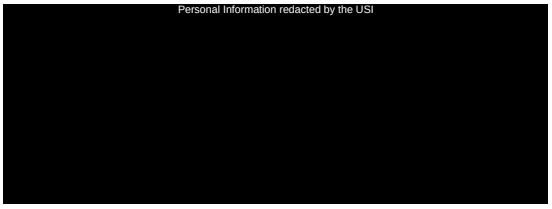
Enquiries:

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

Mr David Wilson
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ

Personal Information redacted by the USI

Yours sincerely



Dr Lourda Geoghegan
Deputy Chief Medical Officer

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Director of Performance Management & Service Improvement, HSCB
Director of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts
Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Professor Donna Fitzimmons, Head of Nursing & Midwifery, QUB
Professor Pascal McKeown, Head of Medical School, QUB
Professor Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Neil Kennedy, Acting Director of Centre for Medical Education, QUB
Professor Sonja McIlfatrick, Head of School of Nursing, UU
Professor Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

ANNEX A

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads and/or require urgent action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principle of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
ii. *the death of, or significant harm to, a Looked After Child, a child on the Child Protection Register or a young person in receipt of leaving and after care services*
iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents) regarding the event, and also an equivalent senior executive in the HSC Board and the Public Health Agency, as appropriate, and any other relevant bodies.

To assist HSC organisations in making contact with Departmental staff, **Annex B** attached provides the contact details of a range of senior Departmental staff together with an indication of their respective areas of responsibility. **The senior officers are not listed in order of contact. Should a senior officer with responsibility for an area associated with an event not be available, please proceed to contact any senior officer on the list.**

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the updated pro forma attached at **Annex C** and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net.

It is important that, when completing the proforma, the information about the person making the notification to the Department, the person who received the information within the Department and the date on which the information is exchanged, is accurate (for recording purposes).

It is the responsibility of the reporting HSC organisation to comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), the Safeguarding Board for Northern Ireland, Professional Regulatory Bodies, the Coroner etc.) **including compliance with GDPR requirements for information contained in the Early Alert proforma and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches. The information contained in the proforma should relate only to the key issue and it should not contain any personal data.**

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial/personnel changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

ANNEX B

EARLY ALERT SYSTEM: DEPARTMENTAL OFFICER CONTACT LIST NOVEMBER 2020

HEALTHCARE POLICY GROUP

Deputy Secretary
Jackie Johnston Personal Information redacted by the USI

Primary Care/Out of Hours Services
Chris Matthews Personal Information redacted by the USI

Secondary Care
Ryan Wilson Personal Information redacted by the USI

Workforce Policy/Human Resources
Preeta Miller Personal Information redacted by the USI

RESOURCES AND PERFORMANCE MANAGEMENT GROUP

Deputy Secretary
Deborah McNeilly Personal Information redacted by the USI

Infrastructure Investment
Andrew Dawson Personal Information redacted by the USI

Information Breaches/Data Protection
La'Verne Montgomery Personal Information redacted by the USI

Finance Director
Brigitte Worth Personal Information redacted by the USI

SOCIAL SERVICES POLICY GROUP

Chief Social Services Officer
Sean Holland Personal Information redacted by the USI

Child Protection/Looked After Children (LAC's)
Eilis McDaniel Personal Information redacted by the USI

Mental Health Learning Disability/Elderly & Community Care
Mark Lee Personal Information redacted by the USI

Social Services
Jackie McIlroy Personal Information redacted by the USI

CHIEF MEDICAL OFFICER GROUP

Chief Medical Officer
Dr Michael McBride Personal Information redacted by the USI

Deputy Chief Medical Officers
Dr Naresh Chada Personal Information redacted by the USI
Dr Lourda Geoghegan Personal Information redacted by the USI

Population Health Director
Liz Redmond Personal Information redacted by the USI

Chief Dental Officer
Simon Reid Personal Information redacted by the USI

Chief Pharmaceutical Officer
Cathy Harrison Personal Information redacted by the USI

Senior Medical Officer
Dr Carol Beattie Personal Information redacted by the USI

CHIEF NURSING OFFICER

Chief Nursing Officer
Charlotte McArdle Personal Information redacted by the USI

Deputy Chief Nursing Officer
Heather Finlay Personal Information redacted by the USI

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria under which event is being notified (mark as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children/young people in care or receiving after care support***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: *If this relates to a child please specify DOB, legal status, placement detail*

** If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of the Safeguarding Board for Northern Ireland (SBNI).*

……

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) ……

Mobile (work or home) …… Telephone (work or home) ……

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: …… Office: ……

Forwarded for consideration and appropriate action to: …… Date: ……

Detail of follow-up action (if applicable) ……

Health and Social Care Board

Public Health Agency

HSCB/PHA Procedure for the Management of Early Alerts

1.0 Background

Circular HSC (SQSD) 10/2010 issued by DHSSPS provided guidance on the introduction of an Early Alert System. The system provides a channel which enables Chief Executives and senior staff in HSC organisations to notify the Department, HSCB and PHA in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads and/or require urgent action by the Department.

2.0 Purpose

The purpose of this procedure is to provide guidance to staff working within the HSCB and PHA on internal processes for the effective management of Early Alerts in conjunction with the procedure for the Reporting and Follow up of Serious Adverse Incidents.

3.0 Notifying Early Alerts

3.1 How to Report

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation communicates verbally (within 48 hours of the event in question) with a senior member of staff in the Department regarding the event, and with a senior officer in the HSC Board, and the PHA, as appropriate, and any other relevant body.

In the case of Family Practitioner Services (FPS) , it is the responsibility of the reporting FPS practice to ensure that a senior person from the practice speaks in person to the Director of Integrated Care (or deputy) in the HSC Board regarding the event, who will in turn communicate with the Department and report the early alert.

Following the above verbal communication, the reporting organisation must arrange for the content of the initial contact to be recorded on the relevant pro forma (appendix 1) and forwarded within 24 hours of notification of the event, to the Department at earlyalert@dhsspsni.gov.uk and the HSC Board at earlyalert@hscni.net

3.2 Criteria for reporting Early Alerts

Appendix 2 lists the criteria for reporting early alerts.

4.0 Process

The process within the HSCB and PHA for managing early alerts will be carried out in conjunction with the Procedure for the Management and Follow up of SAIs. For that reason, there are two possible approaches to be taken:

i. Outside of the SAI process – when a SAI for the same incident has **not** been received

ii. When a SAI for the same incident has been received

4.1 Process when SAI is not received

4.1.1 Early alert is verbally communicated to HSCB and PHA senior staff. Member of staff receiving call will inform (where relevant) other senior staff and professionals within the HSCB/PHA.

4.1.2 Early alert proforma received into mailbox earlyalert@hscni.net and logged onto Datix system by Governance Dept.

4.1.3 Governance Dept will identify a lead officer based on the same basis for allocating SAIs, and issue to the lead officer, copied to Directors and other relevant HSCB/PHA staff (as per appendix 3).

4.1.4 Lead officer will liaise with other relevant professionals within the HSCB/PHA and contact the reporting organisation if appropriate, to determine whether further

action is required or if early alert can be closed. This may include:

- establish more details of the incident
- check if DHSSPS has been advised
- consider if organisation has taken reasonable steps based on information available
- consider whether regional action is required
- consider if relevant regulatory body has been informed

This may also include advising the reporting organisation via the Governance Dept that a SAI notification is necessary and liaison will continue until SAI notification is received (see point 4.2.2)

If early alert can be closed go to point 4.1.6

4.1.5 If further action is required, the Lead officer will liaise with reporting organisation and continue to liaise with all other relevant HSCB/PHA professionals.

4.1.6 When a lead officer is content that appropriate action has been taken in response to the early alert he/she will contact Governance Dept to advise rational for closure.

4.1.7 Governance Dept will close early alert on Datix.

4.2 Process when SAI is received

4.2.1 See points 4.1.1 & 4.1.2

4.2.2 If a SAI has already been received, the Governance Dept will circulate the early alert to lead officers, directors and other relevant HSCB/PHA staff (as per appendix 3) advising a SAI has been received and the early alert is being circulated for information purposes only. The early alert will be closed on Datix at this stage – noting that it is being actioned through the SAI process.

4.2.3 If a SAI is received following receipt of a early alert the SAI procedure will be implemented and the early alert will be automatically closed on Datix by the Governance Dept.

Appendix 4 highlights the above steps by way of a flowchart

5.0 Early Alert Reporting

The Governance Dept will prepare and submit to SMT, regular reports detailing the action taken in response to each early alert received.

Appendix 1 – Early Alert Proforma

Initial call made to: [ ] **(DHSSPS) on (DATE)** [ ]

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name [ ] Organisation [ ]

Position [ ] Telephone [ ]

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify BOD, legal status, placement address if in RRC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

[ ]

A

Name of appropriate contact [ ]

Contact details: Telephone (work or home)

Mobile (work or home) .....

Email address (work or home)

Forward proforma to the Department at:earlyalert@dhsspsni.gov.uk and the HSCB Board at: earlyalert@hscni.net

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: .....Date: .....

Detail of follow-up action (if applicable) .....

Appendix 2

Criteria for Reporting Early Alerts

1. Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;

2. The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;

3. The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;

4. The media have inquired about the event;

5. The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless;
   i. there has been an event which has caused harm to a patient or client and which has given rise to a Coroner's investigation; or
   ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received, or
   iii. the Coroner's inquest is likely to attract media interest.

6. The following should always be notified:
   i. the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;
   ii. the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;
   iii. allegations that a child accommodated in a children's home has committed a serious offence; and
   iv. any serious complaint about a children's home or persons working there.

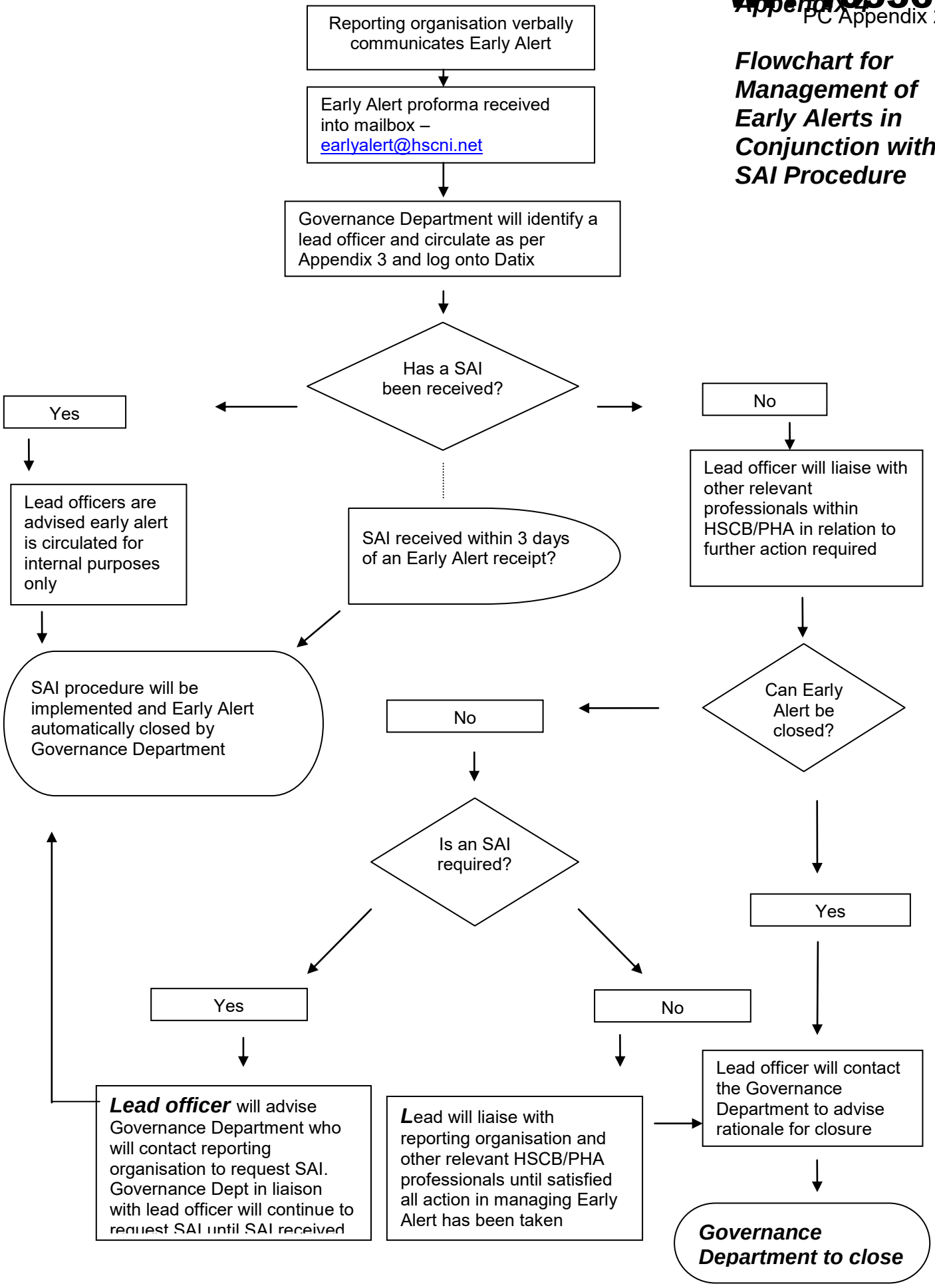
7. There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

NAMES OF LEAD OFFICERS NAMES OF RELEVANT DIRECTOR AND SENIOR STAFF TO RECEIVE COPY OF EARLY ALERT		
PROGRAMME OF CARE	**LEADS**	**COPIED TO**
Acute Services & **Specialist Areas**	**Lead Officer North** Dr Heather Reid **Lead Officer South** Dr Diane Corrigan **Lead Officer East** Dr Paul Darragh **Lead Officer West** Dr Caroline Mason	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Family & Childcare **(Child Protection)**	**Regional Lead HSCB** Mr Tony Rodgers **Regional Lead Nurse PHA** Ms Deidre Webb	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Mental Health / Learning Disability	**Regional Lead SW HSCB** Mr Aiden Murray **Regional Lead Dr PHA** Dr Gerry Waldron **Regional Lead Nurse** Mrs Molly Kane	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Maternity/Child Health/Acute Paediatrics	**Regional Lead Dr PHA** Dr Fiona Kennedy **Regional Lead Nurse** Ms Denise Boulter **Regional Lead SW HSCB** Mr Tony Rodgers	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff

Elderly	**Regional Lead SW HSCB** Mr Kevin Keenan **Regional Lead Dr PHA** Dr Paul Darragh **Regional Lead Nurse PHA** Ms Siobhan McIntyre	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Physical and Sensory Disability	**Regional Lead SW HSCB** Mr Kevin Keenan **Regional Lead Dr PHA** Mr Paul Darragh **Regional Lead Nurse PHA** Mrs Molly Kane	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Independent Service Providers (Acute)	**Regional Lead Dr PHA** Dr Paul Darragh **Regional Lead Nurse PHA** Ms Rose McHugh	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Prison Health	**Regional Lead SW HSCB** Mr Aiden Murray **Regional Lead PHA** Dr Paul Darragh **Regional Lead Nurse PHA** Mrs Molly Kane	Cx & Directors HSCB Cx & Directors PHA Head of Corporate Services Head of Communications Senior Governance Staff
Corporate Business	Mr Michael Bloomfield Mrs Mary Hinds	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff

INTEGRATED CARE		
PROGRAMME OF CARE	**LEADS**	**COPIED TO**
GMS	Dr Katherine MacLurg	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff
Pharmacy	Ms Brenda Bradley	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff
Optometry	Ms Margaret McMullan	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff
Dentistry	Ms Judi McGaffin	Cx & Directors HSCB Cx & Directors PHA Head of Communications Senior Governance Staff

Flowchart for Management of Early Alerts in Conjunction with SAI Procedure



Health and Social Care Board

Public Health Agency

HSCB/PHA Protocol for the reporting and follow up of the DoH Early Alert System

February 2017

Contents

1.0 Background

In June 2010, the process for Early Alerts was introduced by the Department of Health (DoH). Circular HSC (SQSD) 64/16 issued 28 November 2016 (Addendum 1), provided updated guidance on the operation of the Early Alert System. This system is designed to ensure that the Department (and thus the Minister) receive prompt and timely details of events (*these may include potential serious adverse incidents*) which may require urgent attention or possible action by the Department.

The Early Alert System provides a channel which enables Chief Executives and their senior staff (*Director level or higher*) in HSC organisations to notify the Department, in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by the Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the DoH.

Organisations are also required to alert the HSCB of all Early Alert notifications to DoH.

2.0 Purpose

The purpose of this protocol is to provide guidance to staff working within the HSCB and PHA on the internal processes for the effective management of Early Alerts where:

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a) The Early Alert has occurred in HSCB or PHA and is required to be reported to DoH (refer to 3.0);

and/or

b) The HSCB has received a copy of the Early Alert from a reporting organisation in line with the above circular and it will be managed in conjunction with the Procedure for the Reporting and Follow up of Serious Adverse Incidents (refer to 4.0).

3.0 Notifying DoH of Early Alerts that occur within HSCB/PHA

3.1 When an event has occurred within the HSCB/PHA that meets the criteria for reporting an Early Alert to the DoH (see Appendix 2), it is the responsibility of a senior person from the organisation (*at Director level or higher*) to communicate verbally (within 48 hours of the event in question) with a senior member of staff in the DoH[1], all other appropriate senior executives in the HSCB/PHA, and any other relevant bodies regarding the event.

[1]*For example: the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary.*

3.2 In the case of Family Practitioner Services (FPS), it is the responsibility of the reporting FPS practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSCB regarding the event, who will in turn communicate with the DoH and report the Early Alert as per 3.1.1.

3.3 Following the above verbal communication, and in **all** cases, the HSCB/PHA must arrange for the content of the initial contact to be recorded on the relevant pro-forma (Appendix 1) and forwarded within **24 hours** of notification of the event, to the DoH at earlyalert@health-ni.gov.uk. This pro-forma will also be forwarded to the HSCB at earlyalert@hscni.net.

4.0 Process for Follow Up of Early Alerts that have been Notified to HSCB

As detailed above, all Early Alerts notified to DoH are also forwarded to the HSCB. The following steps therefore outline the HSCB/PHA internal process for the management of these, which is in conjunction with the Procedure for the Management and Follow up of SAIs.

4.1 Early Alert proforma received into mailbox earlyalert@hscni.net and logged onto Datix system by Governance Department.

4.2 Governance Department will identify a Lead Officer based on the process for allocating SAIs, and issue to the Lead Officer via email to review as outlined in 4.3 below. Directors and other relevant HSCB/PHA staff are copied into the email (*Refer to SAI DRO Allocation Listing held by HSCB Governance Department*).

Note: If a SAI has already been received, the Governance Department will circulate the Early Alert as per above for information purposes only and close the Early Alert on Datix noting that it is being actioned through the SAI process.

4.3 Lead Officer will review the Early Alert and liaise with other relevant professionals within the HSCB/PHA to determine:

a) If further/immediate action is required (refer to 4.3.1);
b) If, in their professional opinion, a SAI should be submitted (refer to 4.3.2); or
c) If no further action is required by HSCB/PHA and the Early Alert can be closed on Datix (refer to 4.3.3).

The Lead Officer in reviewing the Early Alert may wish to contact the reporting organisation if appropriate to:

- Establish more details of the incident;
- Check if DoH has been advised;
- Consider if organisation has taken reasonable steps based on information available;

- Consider whether regional action is required;
- Consider if relevant regulatory body has been informed.

Note: All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance Department and Governance Departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the Early Alert, is recorded on the HSCB DATIX risk management system.

4.3.1 Where further/immediate action is required the Lead officer will liaise with the reporting organisation via the Governance Department to request further information or immediate actions.

4.3.2 If the Lead Officer in their professional opinion decides a SAI should be submitted, the HSCB Governance Department will notify the reporting organisation that a SAI notification is necessary. Liaison between the HSCB and Reporting Organisation Governance Departments will continue until SAI notification is received and the Early Alert can be closed (see point 4.3.4)

4.3.3 Where the Lead Officer determines that appropriate action has been taken, or no further action is required i.e. no SAI notification to be submitted the Lead Officer will contact the Governance Department to advise rational for closure.

4.3.4 Governance Department will close Early Alert on Datix.

Note: There may be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert, which has already been reported. The Governance Department will forward any updates received to the identified Lead Officer.

A flowchart in Appendix 3 outlines the key stages within the above process.

5.0 Early Alert Reporting

The Governance Department will prepare and submit to SMT, regular reports detailing the action taken in response to each Early Alert received.

Initial call made to: _____ **(DOH) on** _____ **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name		Organisation	
Position		Telephone	

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated***: *If this relates to a child please specify BOD, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact _____

Contact details:

Email address (work or home)……..

Mobile (work or home) ……Telephone (work or home) ……..

Forward proforma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

---

FOR COMPLETION BY DoH:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable)…….....

Criteria for Reporting Early Alerts

1. Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;

2. The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;

3. The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;

4. The event may attract media attention;

5. The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless;

    i. *there has been an event which has caused harm to a patient or client and which has given rise to a Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received, or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. The following should always be notified:

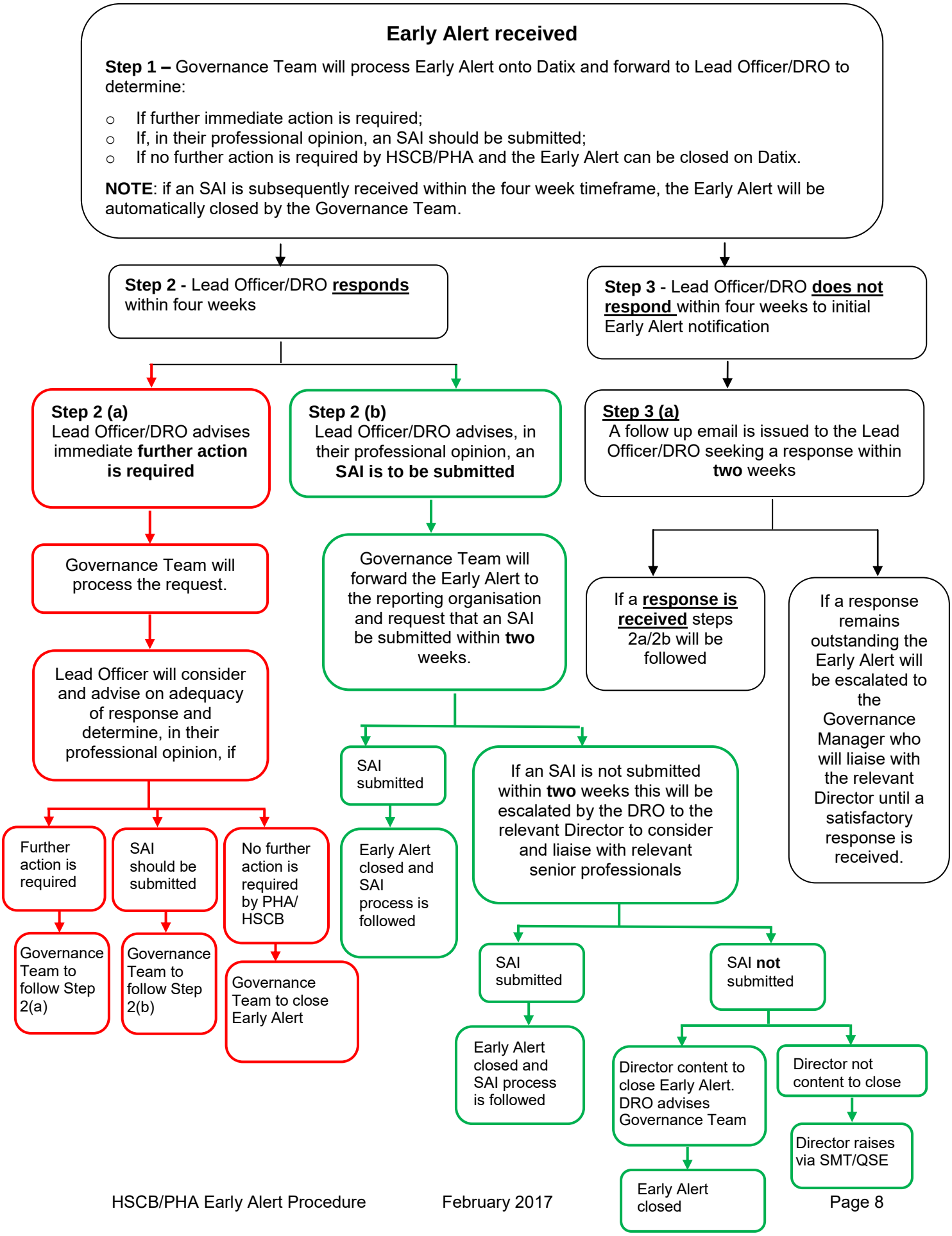
    i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
    ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
    iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
    iv. *any serious complaint about a children's home or persons working there.*

7. There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.

Family Practitioner Services should notify the HSCB about events within the services they provide that meet one or more of these criteria. The HSCB will notify the DoH.

APPENDIX 3

HSCB/PHA Early Alerts PROCESS FLOWCHART – KEY STAGES



ADDENDUM 1

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

Reference: HSC (SQSD) 64/16

Date of Issue: 28 November 2016

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive PHA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents: N/A

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue the guidance and Early Alert notification to advise staff of the procedures to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

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

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

    i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
    ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
    iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
    iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net

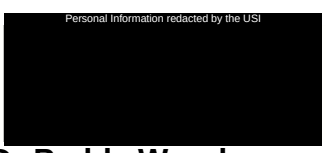
There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

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

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: Personal Information redacted by the USI
Personal Information redacted by the USI

Yours sincerely



Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Dir of Performance Management & Service Improvement, HSCB
Dir of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts
Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Prof. Sam Porter, Head of Nursing & Midwifery, QUB
Prof. Pascal McKeown, Head of Medical School, QUB
Prof. Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

……

……

……

……

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) ……

Mobile (work or home) …… Telephone (work or home) ……

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: …… Office: ……

Forwarded for consideration and appropriate action to: …… Date: ……

Detail of follow-up action (if applicable) ……

HSCB/PHA Protocol for Implementation of Safety Alerts

27 June 2012

Introduction

1. This protocol describes the process which the Health and Social Care Board (HSCB) and Public Health Agency (PHA) will use with Health and Social Care (HSC) Trusts, and primary care providers to implement Safety Alerts and equivalent correspondence issued by the Department of Health Social Services and Public Safety (DHSSPS). It will apply to relevant correspondence issued since 1 April 2012. It is summarised in Appendix 1.

Context

2. Safety Alerts come from a variety of sources to the HSCB, PHA, Trusts and primary care providers. The volume of alerts is challenging for providers and commissioners to manage; some alerts relate to substantive safety issues that require a high level of assurance, while others relate to risk which can be managed within existing risk management and clinical governance arrangements; staff resource capacity and clinical quality measurement systems in providers and commissioners are limited; and for some actions, it is more efficient to have one regional process, rather than each provider taking action individually.

3. This protocol was designed in that context.

Scope

4. This protocol covers Safety Alerts and equivalent correspondence as outlined below.

Category 1

5. Category 1 Safety Alerts include
   - Safety Quality & Standards (SQS) guidance and letters
   - SQS Learning Letters, SAI learning letters
   - NPSA alerts, or equivalent; these may come through SABS
   - Safety or quality-related professional letters from DHSSPS.

Category 2

6. Category 2 Safety Alerts include
   - MHRA notices
   - SABS (Safety Alert Broadcast System) notifications
   - Drug alerts and recalls
   - Medical staff alerts
   - Nursing staff alerts.

Dissemination of Alerts

7. DHSSPS issues Safety Alerts and equivalent correspondence to HSC organisations; some of these require an assurance template to be completed and returned to the HSCB.

HSCB Central Coordinating Office

8. From 1 April 2012, Safety Alerts and equivalent correspondence will be logged by a central coordinating office (CCO) managed by HSCB Corporate Services under the Head of Corporate Services. The Medical Director/DPH will send relevant correspondence to the CCO for logging. The central coordinating office (CCO) will maintain a system to track receipt, follow-up arrangements, progress on implementation and other key information. The CCO will also provide regular summary reports for the HSCB/PHA Safety Quality Alerts Team, SMT, LCG Chairs, HSCB Governance Committee, Board and others as required.

9. A Programme Manager will oversee the process and amongst other duties, will maintain an up-to-date log, prepare for and support team meetings, and prepare an annual summary. They will be supported by a Database Officer who will enter information in the database and produce reports. A lead public health doctor and nurse will act as the first points of contact for the Programme Manager on professional and other issues relevant to the overall process. The CCO will liaise closely with the Administrative support to the Safety and Quality Alerts Team.

HSCB/PHA Safety Quality Alerts Team

10. HSCB and PHA will manage arrangements for the implementation and assurance of Category 1 Safety Alerts through the Safety Quality Alerts Team (SQAT).

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

Regional Alerts Group

12. To ensure input from Trusts and other key groups with a role in safety and quality the Team will work closely with named professional and governance points of contact in each Trust. Trust points of contact will be at Associate Medical Director or Medical Director level. Trust points of contact, the chair of the Trust Collaborative Group, and the HSCB/PHA Safety Alerts Team, will form a Regional Alerts Group (RAG).

13. The Regional Group will provide a forum to
    a. Obtain clinical input to determine the nature and timescale of any regional action
    b. Agree which organisation should lead on a task for the region, with input from relevant others

14. The Regional Group may meet in person and/or work virtually. The Regional Group will be in place for as long as Trusts support it and take an active role in taking forward actions for the region.

Interface with other Safety/Quality-related organisations

15. The HSCB/PHA Team and/or the Regional Safety Quality Alerts Group will seek input from training bodies, GAIN, Business Support Organisation, Health Estates, RQIA and others as required to ensure coordinated action.

Process for Determining Appropriate Arrangements

16. Category 1 Alerts will be reviewed by the professional leads on the Safety Quality Alerts Team to make an initial determination on
    a. Whether or not regional action is required to assist Trusts or primary care, and
    b. The nature of the assurance required regarding implementation.

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

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

19. To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, the Regional Group may set up a Task and Finish Group. Work done for the region would be led by one organisation and then agreed by all relevant parties; this will assist all Trusts in meeting their responsibilities while making efficient use of staff time.

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

Criteria for Regional Action and Assurance Levels

21. To assist the assurance process and without cutting across existing systems, the Team will determine the detail of the method of assuring implementation of an Alert, including those with a requirement by DHSSPS for completion of an assurance template. The method of assurance will be proportionate to the assessed level of risk associated with the issue covered by the Alert and will work on a principle of using existing systems of assurance as much as possible. Options for assurance methods include
    a. Level 1 – material risks which cannot be managed within normal Trust governance and safety arrangements e.g. SAI systems
    b. Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA
    c. Level 3 – completion of an audit specified by HSCB/PHA.

22. The following criteria will be used to assess whether or not regional action is required to assist implementation, and to determine the level of assurance required
    a. The risk to an individual patient is high (impact)
    b. The number of patients who may be exposed to the risk is high (likelihood)
    c. Aspects of implementation are complex and outwith the control of Trusts or relevant organisations (complexity)
    d. A regional approach is achievable (deliverability & stakeholder agreement)
    e. Regional action will not introduce undue delay (timeliness)

f. The Alert relates to an issue with a high public/political profile (public confidence)
g. Other reasons (professional judgment).

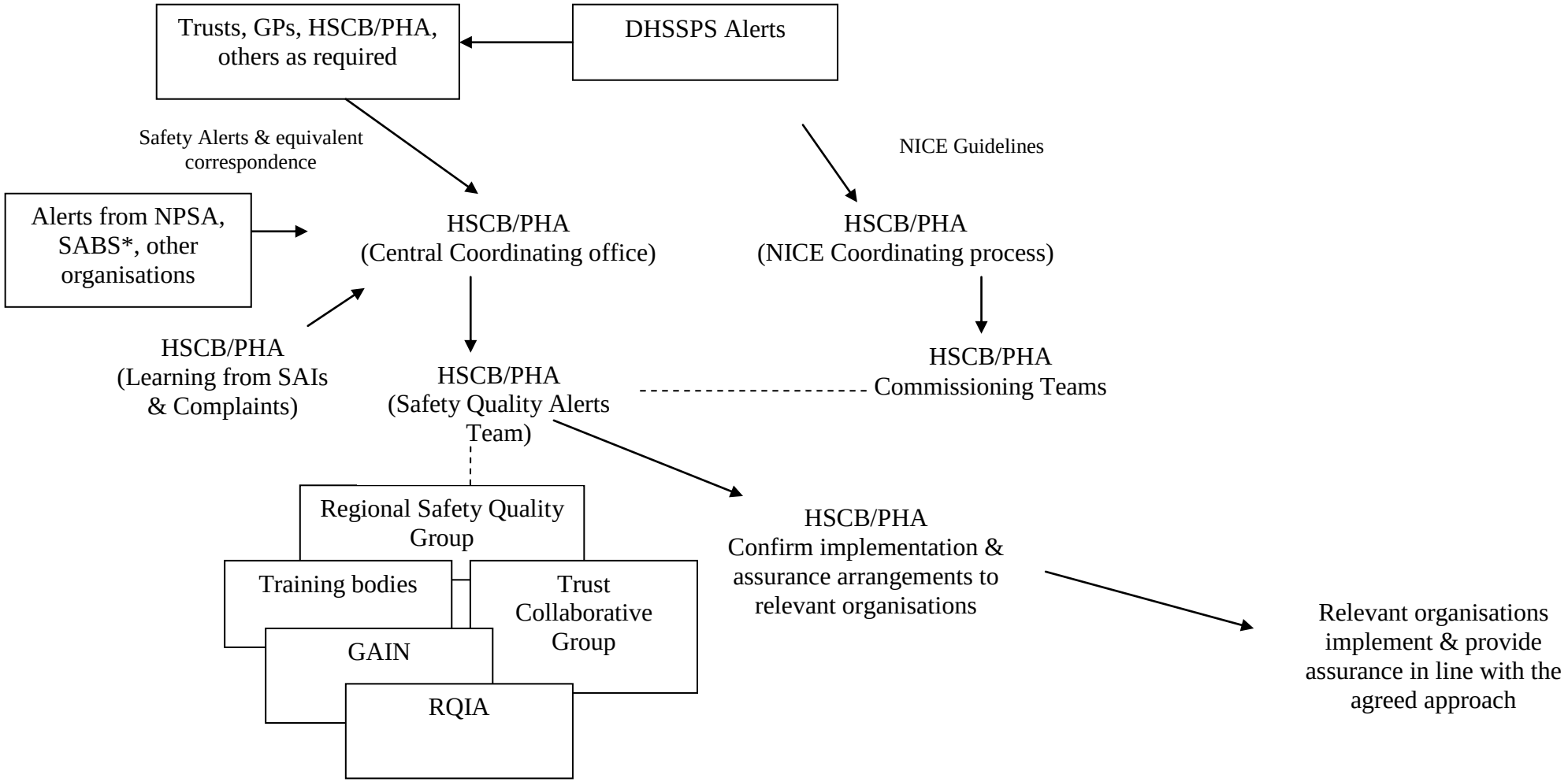
23. In making its decisions, the Team will take account of
- Other Alerts relating to the clinical area in question
- Common themes within a range of Alerts
- Learning from SAIs
- Existing safety quality initiatives for example, through the Safety Forum, the Trusts' Collaborative Group, and the Medicines Safety Subgroup
- Other relevant initiatives, for example, by GAIN, RQIA, NIMDTA, NIPEC, undergraduate training bodies for health and social care staff.

Informing Trust and Primary Care of the Outcome

24. On completion of the processes outlined above, the HSCB will inform Trusts, primary care and other relevant providers or stakeholders of the next steps or requirements. Communication with Trusts will typically be from the HSCB/PHA Medical Director to the Trust Chief Executive's office, copied to the Trust Medical Director.

25. This protocol will be tested and refined in light of experience.

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



** All SABs notifications will be reviewed by a PHA Consultant and those requiring action will be discussed at the Safety and Quality Alerts Team*

Membership **Appendix 2**

HSCB/PHA Safety Quality Alerts Team

- Medical Director/DPH, PHA (Chair)
- Assistant Director Nursing, Safety & Quality & Patient Experience
- Assistant Director Service Development & Screening
- General Practice, HSCB
- Pharmacy, HSCB
- Commissioning, HSCB
- Public Health, PHA
- Nursing, PHA
- Central Coordinating Office, HSCB
- Safety Forum, PHA
- As necessary, social care and AHP input

SAQ Team Roles

- Lead Public Health Doctor – Jackie McCall
- Lead Nurse – Mary McElory
- Lead Pharmacist – Brenda Bradley
- Lead GP – Zara Mayne
- Programme Manager – Elaine Hamilton
- Admin Support – Christine Thompson

Regional Alerts Group

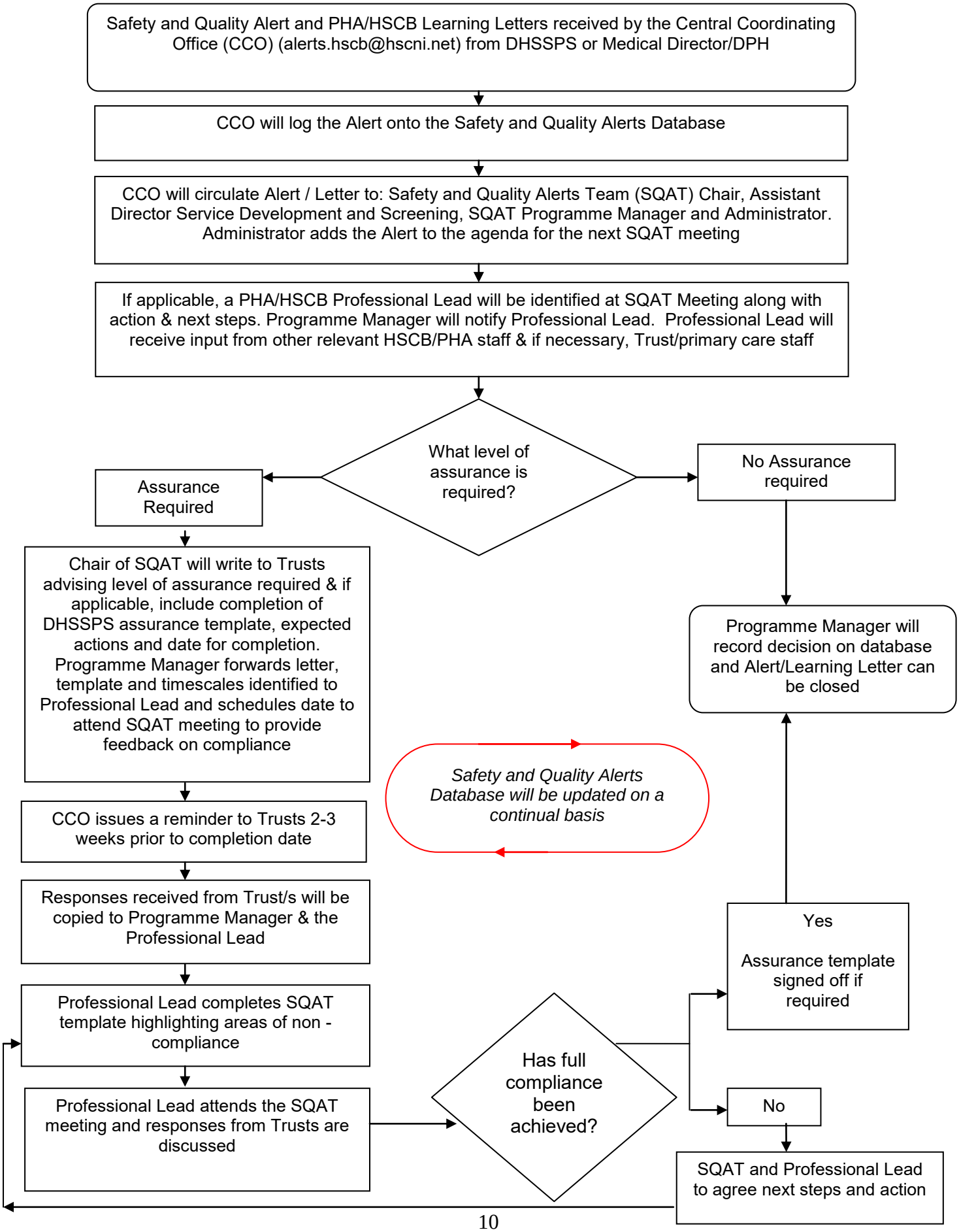
- HSCB/PHA Safety Quality Alerts Team
- Named leads in each of the HSC Trusts & NIAS
- Chair of the Trust Collaborative Group
- Trust points of contact
  - Belfast – Dr. Julian Johnston and June Champion
  - South East – Dr. David Hill and Linda Kelly
  - Southern – Dr. John Simpson and Debbie Burns/Caroline Beattie
  - Northern – Dr Jim Carson and Hazel Baird
  - Western – TBC

Link as required with

- Named PCP Clinical lead in each of the LCG areas
- Trust Leads for medical education
- NIMDTA
- NIPEC
- Undergraduate training bodies
- GAIN
- RQIA
- BSO Procurement
- Health Estates, DHSSPS

Appendix 3

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



HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: 23 August 2013

Introduction

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

Context

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

3. This protocol was designed in that context.

Scope of Safety Quality Alerts (SQAs)

4. This protocol covers SQAs and equivalent correspondence as outlined below. It applies to health and social care-related SQAs though the vast majority relate to health care. Specific arrangements for the independent sector and for SQAs that relate mainly to primary care are described later. A separate process is in place for NICE guidance. Appendix 1 gives a

schematic overview of the interfaces between this process and the process for NICE guidance.

Category 1

5. Category 1 SQAs include
   - DHSSPS Safety Quality & Standards (SQS) guidance and letters
   - Learning Letters arising from serious adverse incidents (SAIs)
   - National Patient Safety Agency (NPSA) alerts, or equivalent
   - Safety or quality-related professional letters from DHSSPS
   - RQIA Reports and other independent reviews.

Category 2

6. Category 2 Safety Alerts include
   - Medicines and Healthcare products Regulatory Agency (MHRA) notices
   - Safety Alert Broadcast System (SABS) notifications
   - Drug alerts and recalls
   - Professional alerts regarding individual practitioners.

Dissemination of Safety Quality Alerts (SQAs) issued by DHSSPS

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

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

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

HSCB Central Coordinating Office

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

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

HSCB/PHA Safety Quality Alerts Team

12. HSCB and PHA will manage arrangements for the implementation and assurance of Category 1 SQAs through the Safety Quality Alerts Team (SQAT). Serious Adverse Incidents and Complaints are managed through their respective teams and lead Directors (Director of Nursing and Allied Health Professionals, and the Director of Social Services, respectively).

13. The SQA Team will include HSCB & PHA representatives from professional groups, and Corporate Services (Appendix 3). It will be sponsored, and chaired as necessary, by the Medical Director/Director of Public Health. It will report through the Senior Management Team of HSCB to the HSCB Governance Committee and Board at the frequency outlined in the HSCB safety quality reporting framework. To ensure timely

processing of Alerts, the Team will meet every 2 weeks. HSCB/PHA will put arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

Trust Input

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

Interface with other Safety/Quality-related organisations

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

Process for Determining Appropriate Arrangements

16. Category 1 Alerts will be reviewed by the Safety Quality Alerts Team to make an initial determination on
    a. Whether or not regional action is required to assist Trusts or primary care with implementation, and
    b. The nature of the assurance required regarding implementation.

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

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

examples of regional action that could help to ensure standardised good quality care within the NI context, taking account of resources and service configuration.

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

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

Criteria for Regional Action and Assurance Levels

21. To assist the assurance process and without cutting across existing systems, the Team will determine the detail of the method of assuring implementation of an Alert. The method of assurance will be proportionate to the assessed level of risk associated with the issue covered by the Alert and will work on a principle of using existing systems of assurance as much as possible. Options for assurance methods include
    a. Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements
    b. Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA
    c. Level 3 – completion of an audit specified by HSCB/PHA.

22. The following criteria will be used to assess whether or not regional action is required to assist implementation, and to determine the level of assurance required
    a. The risk to an individual patient, client, staff member or member of the public, is high (impact)

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

23. In making its decisions, the Team will take account of
- Other Alerts relating to the service area in question
- Common themes within a range of Alerts
- Learning from Serious Adverse Incidents and Complaints
- Existing safety and quality initiatives in health and social care.

Informing Trusts and Primary Care of the Outcome

24. On completion of the processes outlined above, if regional action or assurance is required, the Chair of the Safety Quality Alerts Team will inform Trusts, primary care, and other relevant providers or stakeholders of the next steps or requirements. Communication will be to the Trust Chief Executive's office, copied to the Trust Governance Lead.

Alerts Relating Solely to Primary Care Providers

25. Some Alerts relate solely to primary care providers. The Directorate of Integrated Care has arrangements in place to disseminate, monitor and assure implementation of those Alerts. Those arrangements will continue, and the Director of Integrated Care will report separately on those Alerts to the HSCB Senior Management Team, Governance Committee and Board.

Alerts Relating to Independent Sector Providers

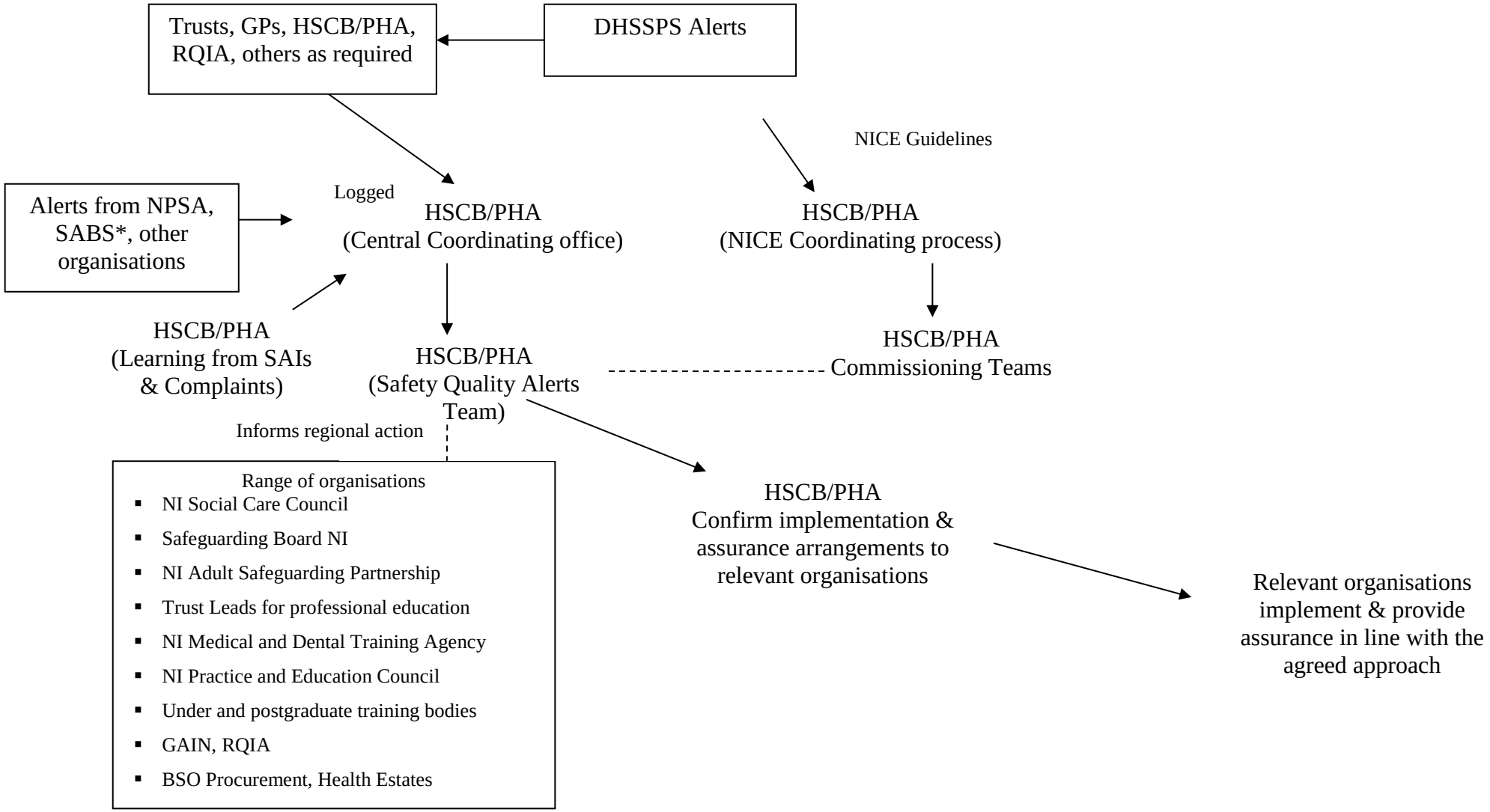
26. Independent providers are already required to respond to many of the types of Alerts covered by this protocol. In addition, DHSSPS or

HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers. DHSSPS also agree the annual work programme of RQIA which may include reviews of governance systems in independent providers, and/or assurance on implementation of specific SQAs.

Review of this protocol

27. This protocol will be refined on an ongoing basis and not less than annually.

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



Template Distribution List **Appendix 2**

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

Membership **Appendix 3**

HSCB/PHA Safety Quality Alerts Team

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- Assistant Director Nursing, Safety & Quality & Patient Experience
- Assistant Director Service Development & Screening
- General Practice, HSCB
- Pharmacy, HSCB
- Public Health, PHA
- Nursing, PHA
- Central Coordinating Office, HSCB
- Safety Forum, PHA
- Social care and AHP input for Alerts relevant to those professions

SAQ Team Roles

- Lead Social Worker – through Fionnuala McAndrew
- Lead AHP – through Michelle Tennyson
- Lead Public Health Doctor – Jackie McCall
- Lead Nurse – Mary McElroy
- Lead Pharmacist – Brenda Bradley
- Lead GP – Zara Mayne
- Programme Manager – Elaine Hamilton
- Admin Support – Christine Thompson

Trust Governance Lead Contacts

- Belfast – Dr Julian Johnston and June Champion
- South East – Dr David Hill and Linda Kelly
- Southern – Dr John Simpson and Debbie Burns/Caroline Beattie
- Northern – Dr Jim Carson and Suzanne Pullins
- Western – Dr Alan McKinney

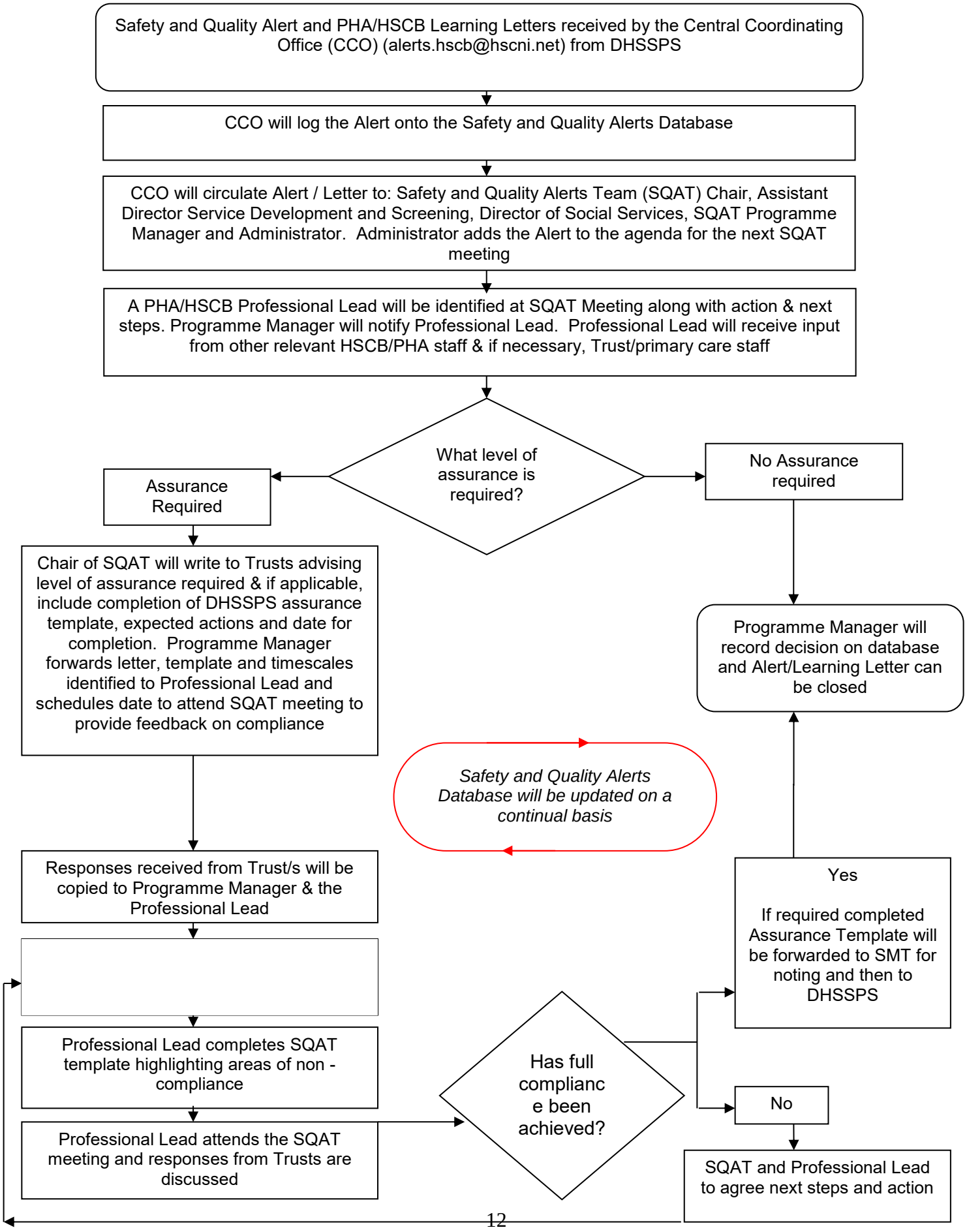
Link as required with

- NI Social Care Council
- Safeguarding Board NI

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

Appendix 4

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



HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: 28 May 2015

1.0 Introduction

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

2.0 Context

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

This protocol was designed in that context.

3.0 Scope of Safety Quality Alerts (SQAs)

This protocol covers SQAs and equivalent correspondence as outlined below. It applies to health and social care-related SQAs though the vast majority relate to health care. Specific arrangements for the independent sector and for SQAs that relate mainly to primary care are described later.

Category 1 SQAs include:

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

Category 2 SQAs include:

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

A separate process is in place for the following:

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

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

If an SQA from DHSSPS includes an assurance template or other form of assurance loop, DHSSPS will send the SQA in Draft form to the lead Director in PHA/HSCB for the SQA process (the Medical Director/DPH), copied to the HSCB lead Director for the HSCB/PHA Coordinating Office (the Director of Performance and Corporate

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

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

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

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

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

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

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

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

6.0 HSCB Central Coordinating Office

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

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

7.0 HSCB/PHA Safety Quality Alerts Team

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

The SQA Team will include HSCB & PHA representatives from professional groups, and Corporate Services (Appendix 3). It will be sponsored, and chaired as necessary, by the Medical Director/Director

of Public Health. It will report through the Senior Management Team of HSCB to the HSCB Governance Committee and Board at the frequency outlined in the HSCB safety quality reporting framework. To ensure timely processing of Alerts, the Team will meet every 2 weeks. HSCB/PHA will put arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

8.0 Trust Input

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

9.0 Interface with other Safety/Quality-related organisations

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

10.0 Process for Determining Appropriate Arrangements

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

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

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

If regional action is required, the proposed actions will be discussed where necessary with Trusts and/other relevant organisations to agree the precise task. It is important to note that any regional actions do not

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

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

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

11.0 Criteria for Regional Action and Assurance Levels

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

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;

- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

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

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

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

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

12.0 Informing Trusts and Primary Care of the Outcome

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

to the Trust Chief Executive's office, copied to the Trust Governance Lead.

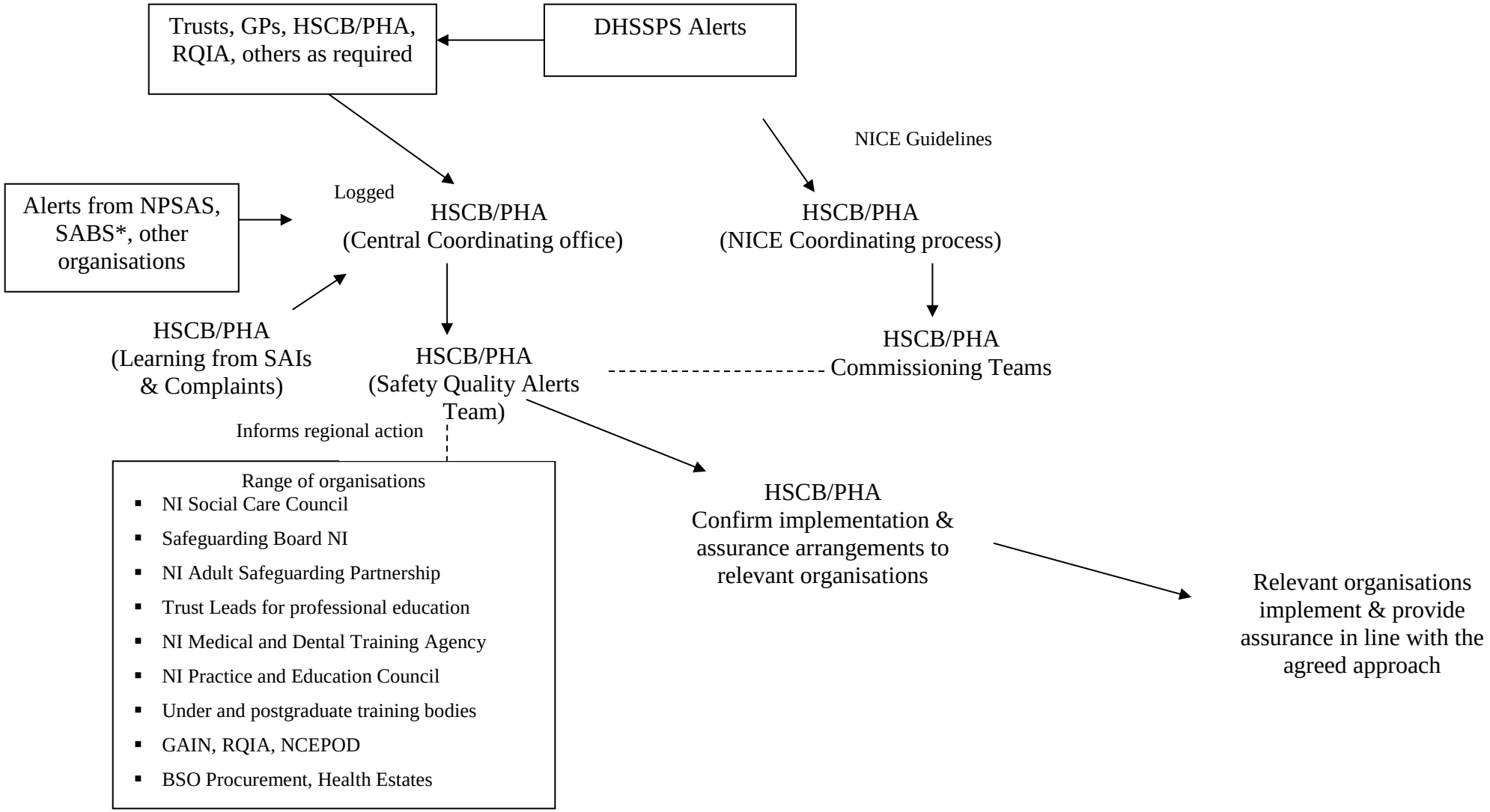
13.0 Alerts Relating to Independent Sector Providers

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

14.0 Review of this protocol

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

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



Template Distribution List

Appendix 2

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

Membership **Appendix 3**

HSCB/PHA Safety Quality Alerts Team

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

SQA Team Roles

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

Trust Governance Lead Contacts

- Belfast – Dr Cathy Jack and Claire Cairns/Christine Murphy
- South East – Dr Charlie Martyn and Irene Low/Liz Campbell
- Southern – Dr John Simpson and Margaret Marshall/Dawn Mackin
- Northern – Dr Ken Lowry and Suzanne Pullins/Ruth McDonald
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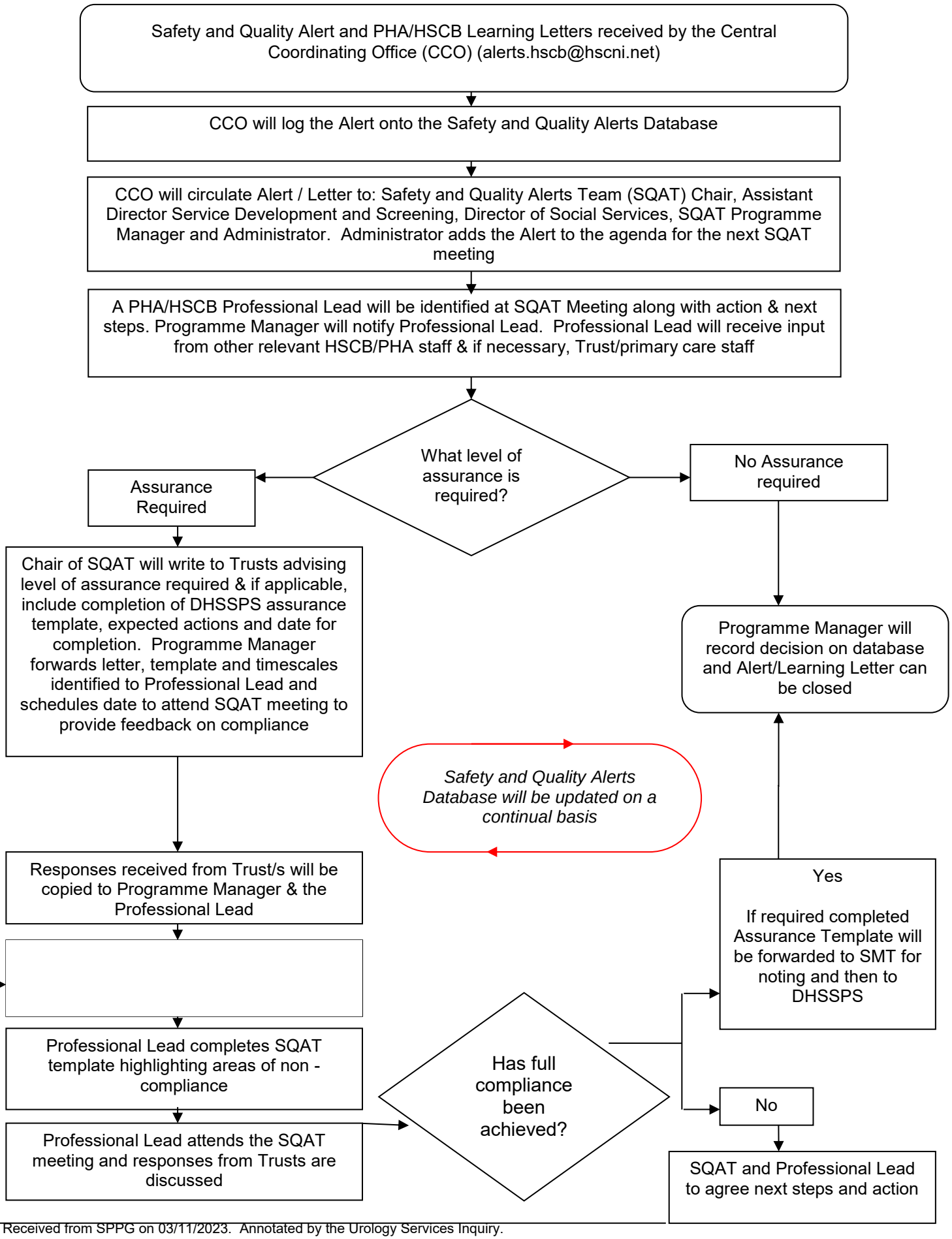
Link as required with

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

Appendix 4

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



Health and Social Care Board

Public Health Agency

Health and Social Care Board / Public Health Agency

Protocol for Implementation of Safety and Quality Alerts

Reference SQAT-01.08.16	**Responsible Officer** Director of Corporate Services	**Review Frequency** Annual
Approved by SQAT	**Approval Date:** 1 August 2016	**Next review due** July 2017
Superseded documents (if applicable) HSCB/PHA Protocol for Implementation of SQAs (April 2012) HSCB/PHA Protocol for Implementation of SQAs (August 2013) HSCB/PHA Protocol for Implementation of SQAs (May 2015)		

I N D E X

HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: July 2016

1.0 Introduction

Safety and Quality Alerts (SQAs) may arise from a variety of sources, including Serious Adverse Incidents (SAIs), reviews by the Regulation and Quality Improvement Authority (RQIA), safeguarding reports, legislative changes, medicines regulators, equipment or device failures, national safety systems, and independent reviews.

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

2.0 What are Safety Quality Alerts (SQAs)

This protocol covers SQAs and equivalent correspondence as outlined below. It applies to health and social care-related SQAs though the vast majority relate to health care. Specific arrangements for the independent sector and for SQAs that relate mainly to primary care are described later.

Category 1 SQAs include:

- Department of Health (DoH) Safety Quality & Standards (SQS) guidance and letters/circulars and Patient Safety Alerts (PSAs);
- Learning Letters or Reminder of Good Practice Letters arising from serious adverse incidents (SAIs) / Complaints;
- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and equivalent robust other national enquiries/audits;
- Guidelines and Audit Implementation Network (GAIN) Reports.

Category 2 SQAs include:

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

A separate process is in place for the following:

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

3.0 Application of Protocol

3.1 Who does this procedure apply to?

This protocol applies to the process for ensuring that care is safe and that adverse events and harm are minimised, involves identifying risks, managing those risks by responding appropriately, disseminating information effectively, and applying the learning from safety or quality related adverse events. The protocol applies to the following HSC organisations:

HSC organisations (HSC)

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

4.0 Management Arrangements for SQAs

4.1 Role of HSCB/PHA Safety Quality Alerts Team

The HSCB and PHA will manage arrangements for the implementation and assurance of all Category 1 SQAs and some Category 2 SQAs (as required) through the Safety Quality Alerts Team (SQAT). Serious Adverse Incidents and Complaints are managed through their respective teams and reports to the Quality, Safety and Experience Group (QSE).

The SQA Team will include HSCB and PHA representatives from professional groups, and Corporate Services (Appendix 3). It will be sponsored, and chaired as necessary, by the Medical Director/Director of Public Health (DPH).

It will report through the Senior Management Team of HSCB to the HSCB Governance Committee and Board at the frequency outlined in the HSCB safety quality reporting framework.

To ensure timely co-ordination and implementation of regional safety and quality alerts, the Team will meet every 2 weeks. HSCB/PHA will put arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

A Programme Manager will oversee the process, maintain an up-to-date log, prepare for and support SQA Team meetings. Appendix 4 gives a schematic overview of the HSCB/PHA Process for the Management of Safety and Quality Alerts.

4.2 Role of the HSCB Alerts Office

SQAs where Trusts or the independent sector have a primary role in implementation will be logged by the Alerts office managed by the Governance Team within HSCB Corporate Services.

All correspondence in relation to alerts will be channelled through the HSCB Alerts mailbox at Alerts.HSCB@hscni.net. The Alerts Office will maintain a system to track progress on implementation.

4.3 Trust Input

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

4.4 Interface with other Safety/Quality-related organisations

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

4.5 Alerts Relating to Independent Sector Providers

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

4.6 Process for Sharing Regional Learning from NI with ROI and GB

A process for sharing regional learning from Northern Ireland with the Republic of Ireland and Great Britain is currently being considered. This protocol will be updated to detail the process once agreed.

5.0 Process

5.1 Process prior to dissemination of SQAs

The Department of Health (DoH) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to assure patient and client safety and best practice. The following describes the process prior to finalisation and dissemination of SQAs.

The DoH, HSCB and PHA share certain SQAs between organisations for comment prior to dissemination to the HSC. These include:

- All Patient Safety Alerts (PSAs);
- Safety and Quality Alerts where assurance is required;
- Learning Letters.

For SQAs developed by the DoH these will be sent to the HSCB Alerts mailbox at Alerts.HSCB@hscni.net for issue to relevant health and social care professionals within HSCB and PHA, to seek comment prior to issue by the DoH to the HSC.

For SQAs developed by the PHA / HSCB these will be sent to the DoH Safety, Quality and Standards mailbox at qualityandsafety@health-ni.gov.uk for issue to relevant Policy Leads for review to ensure compatibility with DoH policy prior to issue by the HSCB/PHA.

At this stage the level of assurance may be also considered as outlined in section 5.3.

This approach is intended to ensure that the actions required of organisations are clear through a single communication.

5.2 Dissemination of SQAs

5.2.1 Dissemination of SQAs issued by DoH

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

5.2.2 Dissemination of Learning Letters/Reminder of Good Practice Letters issued by PHA/HSCB

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

A Learning letter/reminder of good Practice Letter will then be issued via the HSCB Alerts Office to the Chief Executive's office of relevant organisations, Governance Leads in Trusts and other relevant using the standard distribution list. (see Appendix 2)

5.3 Process Following Dissemination of SQAs

5.3.1 Process for Determining Assurances

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

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

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

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

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

5.3.2 Criteria for Identifying Regional Action and Assurance Levels

The PHA/HSCB SQA Team will determine the detail of the method of assuring implementation of an Alert. This will be proportionate to the assessed level of risk associated with the issue covered by the Alert. It will work on the principle of using existing systems of assurance as much as possible. Options for assurance methods include:

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;

- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

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

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

In making its decisions, the HSCB/PHA SQA Team will take account of:

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

5.3.3 Informing of Regional Action/Assurances Required

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

be to the Trust Chief Executive's office, copied to the Trust Governance Lead.

5.3.4 Reviewing Compliance of SQAs

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

In addition bi-annual progress reports to Governance Committee will be prepared by the SQA Team for the following:

- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports and equivalent robust other national enquiries/audits;

These reports will detail the progress on implementation of report recommendations and provide the necessary appropriate assurance mechanism that all HSCB/PHA actions contained within reports are implemented.

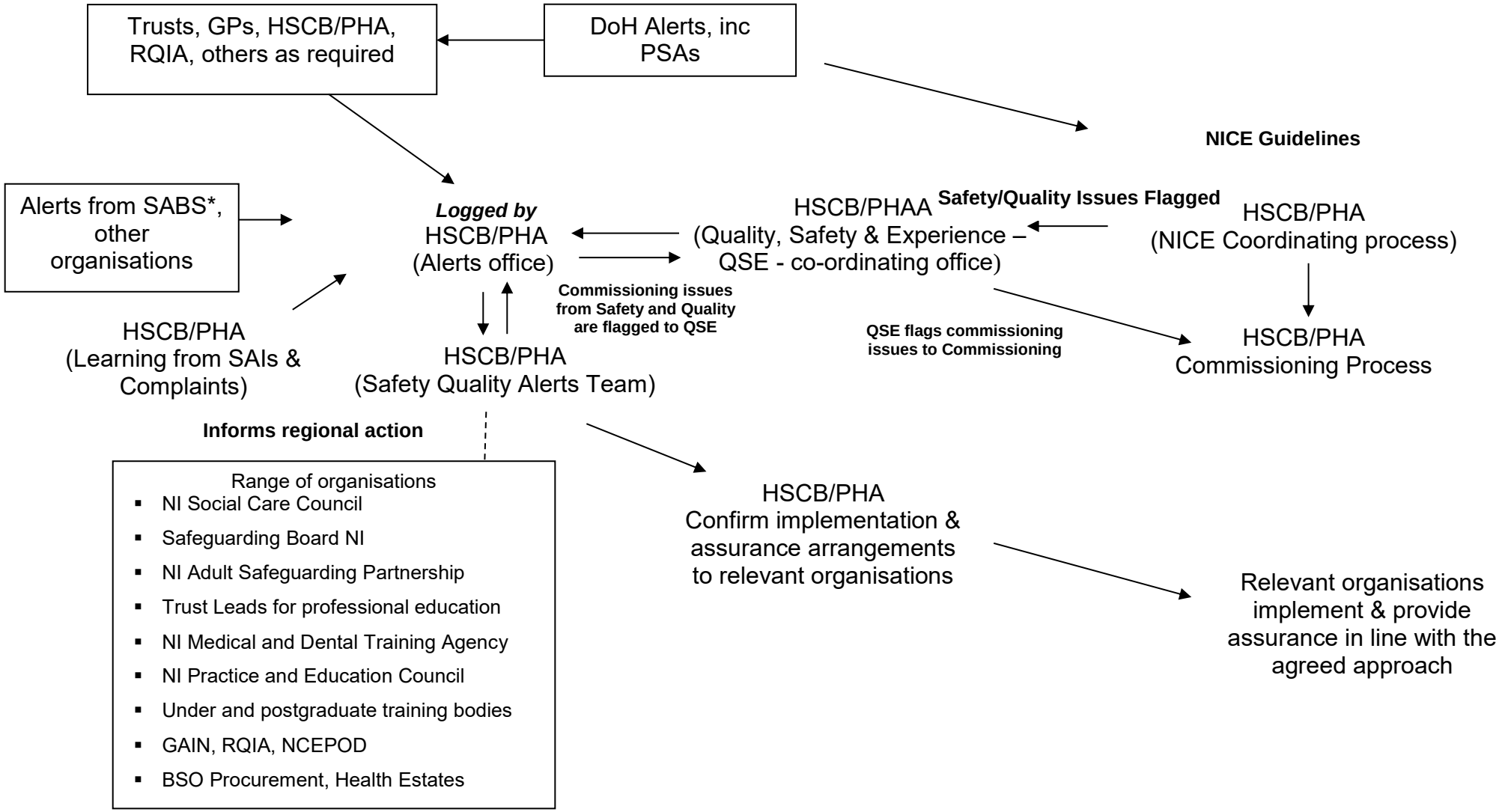
6.0 Reporting of SQAs

An annual report will also be prepared for the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board, DoH, Trusts and others as required.

7.0 Review of this protocol

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

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



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QUB			Community Pharmacists		
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Head of School of Health Sciences (AHP Lead)			Safety, Quality & Standards Office		
Clinical Education Centre			**NI Social Care Council**		
NIPEC			**Safeguarding Board NI**		
GAIN Office			**NICE Implementation Facilitator**		
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Membership **Appendix 3**

HSCB/PHA Safety Quality Alerts Team

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

SQA Team Roles

- Chair – Dr Carolyn Harper
- Lead Performance & Corporate Services – Michael Bloomfield
- Lead Nurse – Lynne Charlton / Mary McElroy
- Lead Service Development & Screening – Dr Brid Farrell
- Lead Pharmacist – Matthew Dolan
- Lead Public Health Doctor – Dr Jackie McCall
- Lead Safety Forum – Dr Gavin Lavery
- Lead AHP – through Michelle Tennyson
- Lead GP – Dr Margaret O'Brien
- Lead Social Worker – through Fionnuala McAndrew
- Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Mareth Campbell

Trust Governance Lead Contacts

- Belfast – Dr Cathy Jack and Claire Cairns/Christine Murphy
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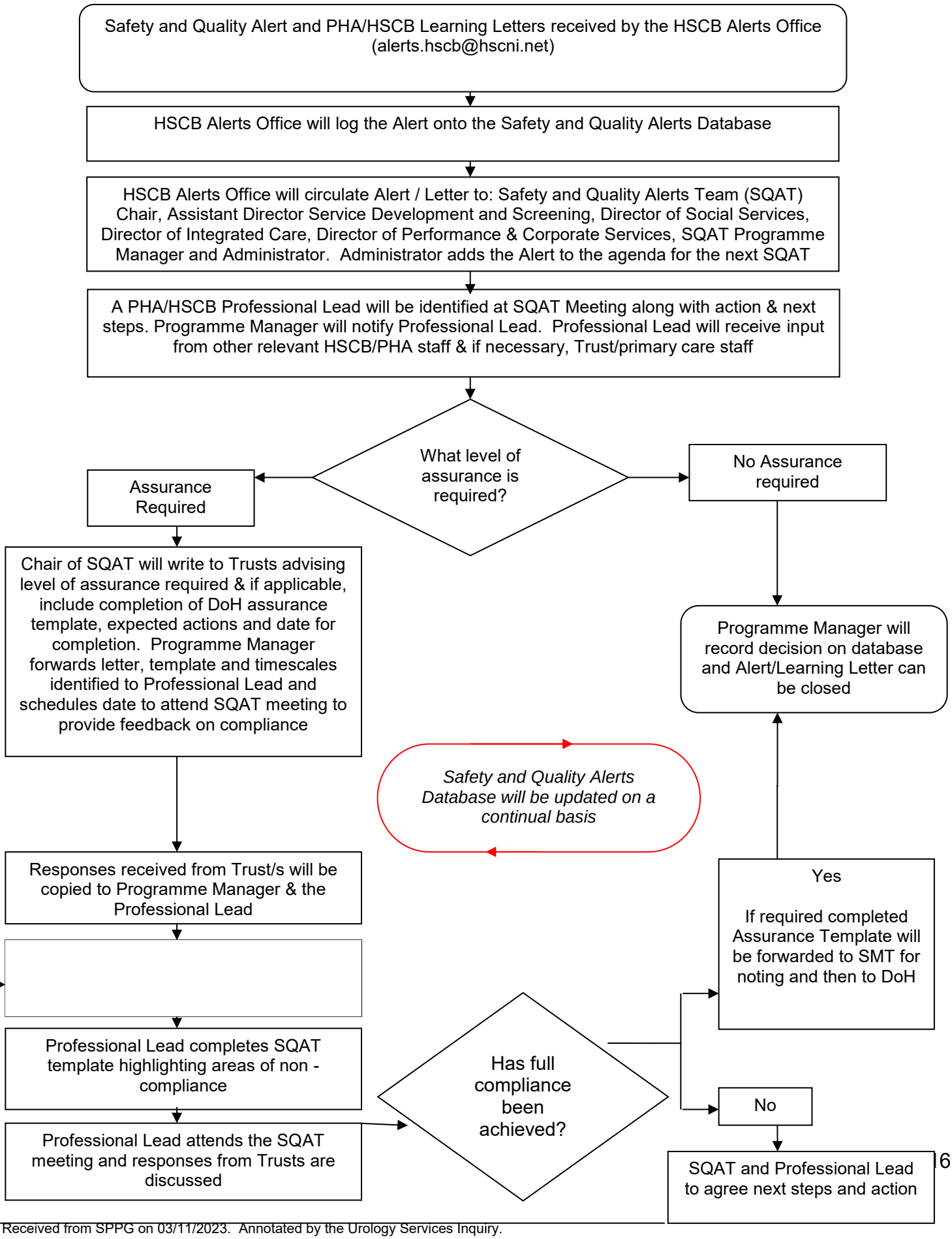
- Western – Dr Dermot Hughes and Therese Brown/Teresa Murray

Link as required with

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

Appendix 4

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



HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

SAFETY AND QUALITY ALERTS TEAM (SQAT)

1.0 Introduction

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

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

2.0 Accountability of the Group

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

3.0 Objectives of the SQA Team

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

4.0 Membership of the Group

Core membership of the SQA Team will consist of the following officers, or their nominated representative, from the HSCB and the PHA: (see annex 2 which details the current membership as at March 2017)

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

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

5.0 Quorum

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

6.0 Administration

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

7.0 Relationship/Links with Other Groups

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

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

- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board
- Medicines Safety Sub-Group (MSSG)
- PHA/HSCB SAI Professional Groups

8.0 Frequency of Meetings

Meetings of the Team will be fortnightly.

9.0 Review of Terms of Reference

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

Annex 1

Health and Social Care Board

Public Health Agency

Health and Social Care Board / Public Health Agency

Protocol for Implementation of Safety and Quality Alerts

Reference SQAT-06.03.17	**Responsible Officer** Director of Corporate Services	**Review Frequency** Annual
Approved by SQAT	**Approval Date:** 6 March 2017	**Next review due** March 2018
Superseded documents (if applicable) HSCB/PHA Protocol for Implementation of SQAs (April 2012) HSCB/PHA Protocol for Implementation of SQAs (August 2013) HSCB/PHA Protocol for Implementation of SQAs (May 2015) HSCB/PHA Protocol for Implementation of SQAs (July 2016)		

I N D E X

HSCB/PHA Protocol for Implementation of Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: March 2017

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Safety and Quality Alerts (SQAs) may arise from a variety of sources, including Serious Adverse Incidents (SAIs), reviews by the Regulation and Quality Improvement Authority (RQIA), safeguarding reports, legislative changes, medicines regulators, equipment or device failures, national safety systems, and independent reviews.

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

2.0 What are Safety Quality Alerts (SQAs)

This protocol covers SQAs and equivalent correspondence as outlined below. It applies to health and social care-related SQAs though the vast majority relate to health care. Specific arrangements for the independent sector and for SQAs that relate mainly to primary care are described later.

Category 1 SQAs include:

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- Learning Letters or Reminder of Good Practice Letters arising from serious adverse incidents (SAIs) / Complaints;
- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and equivalent robust other national enquiries/audits;
- Guidelines and Audit Implementation Network (GAIN) Reports.

Category 2 SQAs include:

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

A separate process is in place for the following:

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

3.0 Application of Protocol

3.1 Who does this procedure apply to?

This protocol applies to the process for ensuring that care is safe and that adverse events and harm are minimised, involves identifying risks, managing those risks by responding appropriately, disseminating information effectively, and applying the learning from safety or quality related adverse events. The protocol applies to the following HSC organisations:

HSC organisations (HSC)

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

4.0 Management Arrangements for SQAs

4.1 Role of HSCB/PHA Safety Quality Alerts Team

The HSCB and PHA will manage arrangements for the implementation and assurance of all Category 1 SQAs and some Category 2 SQAs (as required) through the Safety Quality Alerts Team (SQAT). Serious Adverse Incidents and Complaints are managed through their respective teams and reports to the Quality, Safety and Experience Group (QSE).

The SQA Team will include HSCB and PHA representatives from professional groups, and Corporate Services (Appendix 3). It will be sponsored, and chaired as necessary, by the Medical Director/Director of Public Health (DPH).

It will report through the Senior Management Team of HSCB to the HSCB Governance Committee and Board at the frequency outlined in the HSCB safety quality reporting framework.

To ensure timely co-ordination and implementation of regional safety and quality alerts, the Team will meet every 2 weeks. HSCB/PHA will put arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

A Programme Manager will oversee the process, maintain an up-to-date log, prepare for and support SQA Team meetings. Appendix 4 gives a schematic overview of the HSCB/PHA Process for the Management of Safety and Quality Alerts.

4.2 Role of the HSCB Alerts Office

SQAs where Trusts or the independent sector have a primary role in implementation will be logged by the Alerts office managed by the Governance Team within HSCB Corporate Services.

All correspondence in relation to alerts will be channelled through the HSCB Alerts mailbox at Alerts.HSCB@hscni.net. The Alerts Office will maintain a system to track progress on implementation.

4.3 Trust Input

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

4.4 Interface with other Safety/Quality-related organisations

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

4.5 Alerts Relating to Independent Sector Providers

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

4.6 Process for Sharing Regional Learning from NI with ROI and GB

A process for sharing regional learning from Northern Ireland with the Republic of Ireland and Great Britain is currently being considered. This protocol will be updated to detail the process once agreed.

5.0 Process

5.1 Process prior to dissemination of SQAs

The Department of Health (DoH) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to assure patient and client safety and best practice. The following describes the process prior to finalisation and dissemination of SQAs.

The DoH, HSCB and PHA share certain SQAs between organisations for comment prior to dissemination to the HSC. These include:

- All Patient Safety Alerts (PSAs);
- Safety and Quality Alerts where assurance is required;
- Learning Letters.

For SQAs developed by the DoH these will be sent to the HSCB Alerts mailbox at Alerts.HSCB@hscni.net for issue to relevant health and social care professionals within HSCB and PHA, to seek comment prior to issue by the DoH to the HSC.

For SQAs developed by the PHA / HSCB these will be sent to the DoH Safety, Quality and Standards mailbox at qualityandsafety@health-ni.gov.uk for issue to relevant Policy Leads for review to ensure compatibility with DoH policy prior to issue by the HSCB/PHA.

At this stage the level of assurance may be also considered as outlined in section 5.3.

This approach is intended to ensure that the actions required of organisations are clear through a single communication.

5.2 Dissemination of SQAs

5.2.1 Dissemination of SQAs issued by DoH

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

5.2.2 Dissemination of Learning Letters/Reminder of Good Practice Letters issued by PHA/HSCB

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

A Learning letter/reminder of good Practice Letter will then be issued via the HSCB Alerts Office to the Chief Executive's office of relevant organisations, Governance Leads in Trusts and other relevant using the standard distribution list. (see Appendix 2)

5.3 Process Following Dissemination of SQAs

5.3.1 Process for Determining Assurances

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

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

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

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

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

5.3.2 Criteria for Identifying Regional Action and Assurance Levels

The PHA/HSCB SQA Team will determine the detail of the method of assuring implementation of an Alert. This will be proportionate to the assessed level of risk associated with the issue covered by the Alert. It will work on the principle of using existing systems of assurance as much as possible. Options for assurance methods include:

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;

- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

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

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

In making its decisions, the HSCB/PHA SQA Team will take account of:

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

5.3.3 Informing of Regional Action/Assurances Required

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

be to the Trust Chief Executive's office, copied to the Trust Governance Lead.

5.3.4 Reviewing Compliance of SQAs

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

In addition bi-annual progress reports to Governance Committee will be prepared by the SQA Team for the following:

- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports and equivalent robust other national enquiries/audits;

These reports will detail the progress on implementation of report recommendations and provide the necessary appropriate assurance mechanism that all HSCB/PHA actions contained within reports are implemented.

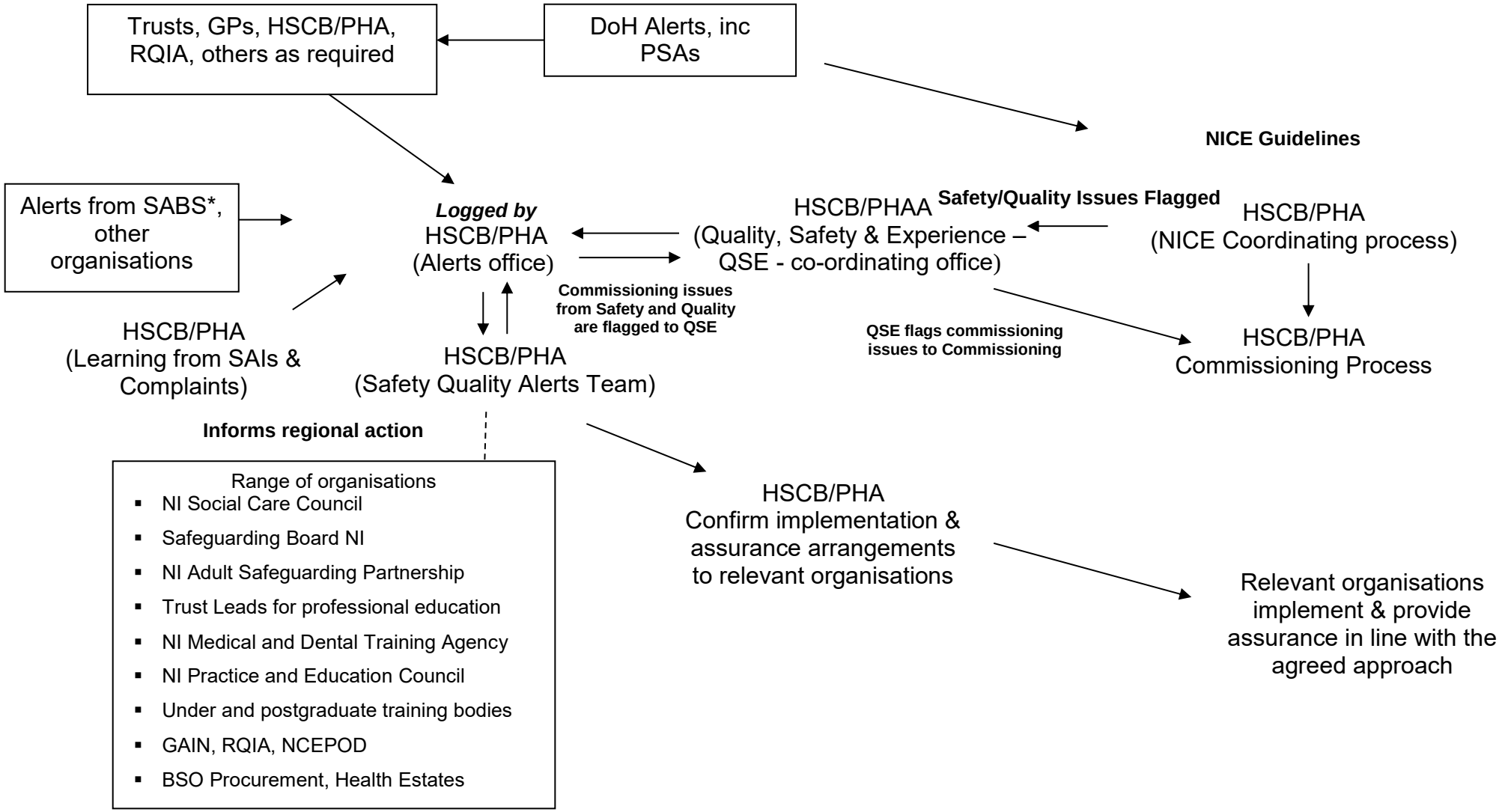
6.0 Reporting of SQAs

An annual report will also be prepared for the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board, DoH, Trusts and others as required.

7.0 Review of this protocol

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

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



Template Distribution List

Appendix 2

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

Membership **Appendix 3**

HSCB/PHA Safety Quality Alerts Team

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

SQA Team Roles

- Chair – Dr Carolyn Harper
- Lead Performance & Corporate Services – Michael Bloomfield
- Lead Nurse – Lynne Charlton / Mary McElroy
- Lead Service Development & Screening – Dr Brid Farrell
- Lead Pharmacist – Matthew Dolan
- Lead Public Health Doctor – Dr Jackie McCall
- Lead Safety Forum – Dr Gavin Lavery
- Lead AHP – through Michelle Tennyson
- Lead GP – Dr Margaret O'Brien
- Lead Social Worker – through Fionnuala McAndrew
- Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Elaine Hyde

Trust Governance Lead Contacts

- Belfast – Dr Cathy Jack and Claire Cairns/Christine Murphy
- South East – Dr Charlie Martyn and Irene Low/Liz Campbell
- Southern – Dr Richard Wright and Margaret Marshall/ /Caroline Beattie Nicole Evans
- Northern – Mr Seamus O'Reilly and Sinead O'Kane /Ruth McDonald

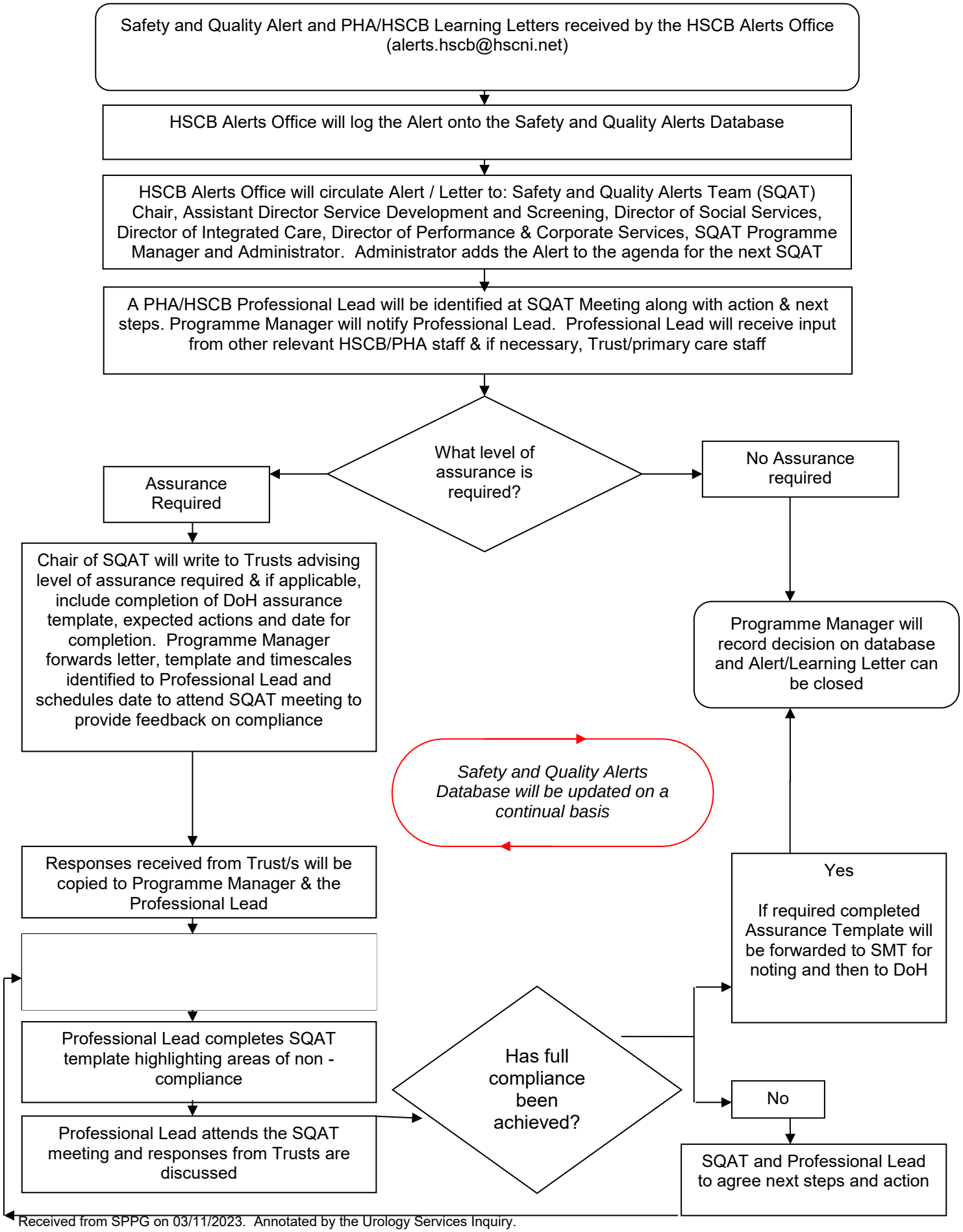
- Western – Dr Dermot Hughes and Therese Brown/Teresa Murray

Link as required with

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

Appendix 4

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



Health and Social Care Board

Public Health Agency

Health and Social Care Board / Public Health Agency

Regional Procedure for Safety and Quality Alerts

Reference SQAT-09.07.18	**Responsible Officer/s** • Head of Corporate Services, HSCB • Director of Nursing, Midwifery and Allied Health Professionals, PHA	**Review Frequency** Annual
Approved by **HSCB SMT**	**Approval Date:** 10 July 2018	**Next review due** June 2019
Superseded documents (if applicable) HSCB/PHA Protocol for Implementation of SQAs (April 2012) HSCB/PHA Protocol for Implementation of SQAs (August 2013) HSCB/PHA Protocol for Implementation of SQAs (May 2015) HSCB/PHA Protocol for Implementation of SQAs (July 2016) HSCB/PHA Protocol for Implementation of SQAs (March 2017)		

Version 1.0

I N D E X

HSCB/PHA Regional Procedure for Safety and Quality Alerts

Date commenced: 1 April 2012

Last updated: June 2018

1.0 Introduction

The Department of Health (DoH), Health and Social Care Board (HSCB), Public Health Agency (PHA) and other organisations issue a variety of correspondence collectively referred to as Safety and Quality Alerts (SQAs).

SQAs focus on the dissemination of regional learning for the health and social care system within Northern Ireland and are issued to service providers to support improvement in practice.

The learning identified in SQAs may arise from information provided from a variety of sources for example, Serious Adverse Incidents (SAIs), Adverse Incidents (AIs), Complaints, reviews by the Regulation and Quality Improvement Authority (RQIA), legislative changes, medicines regulators, equipment or device failures, national safety systems, independent reviews and Learning Notifications.

There are already procedures in place for the management, reporting and identification of learning from a range of sources including:

- SAIs
- Complaints
- Post Fall Reviews, and
- Early Alerts.

Appendix 1 provides an overview of these established processes and links to the relevant procedures.

This revised procedure enables any HSC organisation who may have identified learning from another source, other than those identified above, and wish it to be considered for a Safety Quality Alert.

The learning may originate from one of the following sources and which the referring organisation consider significant and would benefit other Providers.

- Improved practice;
- Learning from:
    - An Adverse Incident or incident trends;
    - Mortality and Morbidly Review;
    - Patient, Client Experience;
    - Coroner's Inquests;
    - Audit or other reviews;
- Any other concern.

This new addition to the Safety Quality Alerts process is referred to as a **'Learning Notification'**.

2.0 What are Safety Quality Alerts?

Safety and Quality Alerts are the regional process which the Health and Social Care Board (HSCB) and Public Health Agency (PHA) oversee the identification, co-ordination, dissemination and implementation of learning.

Safety Quality Alerts (SQAs) are subdivided into a number of categories detailed below:

Category 1 SQAs include:

- Department of Health (DoH) Safety Quality & Standards (SQS) guidance and letters/circulars and Patient Safety Alerts (PSAs);

- Learning Letters (including other professional related letters) or Reminder of Good Practice Letters arising from established processes as outlined in Appendix 1;
- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and equivalent robust other national enquiries/audits;
- Learning notifications.

Category 2 SQAs include:

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

A separate process is in place for:

- NICE guidance.
- Drug alerts and recalls;
- Professional In-Confidence alerts regarding individual practitioners.

However in conjunction with the NICE co-ordinating process and where there are specific safety concerns in relation to commissioning issues, these will be considered by the SQA Team and referred where relevant to QSE. (***Refer to appendix 1 – Overview of processes that link into the arrangements for the issuing of HSCB/PHA SQAs***)

3.0 Application of Procedure

3.1 Who does this procedure apply to?

The procedure applies to the following HSC organisations:

HSC organisations (HSC)

- Health and Social Care Board *(including the Directorate of Integrated Care on behalf of Primary Care providers i.e. GPs, Community Pharmacists, Dentists and Opticians)*
- Public Health Agency