To: SPPG
Copies to: Directors of Finance,
Directors of Social Services of SPPG
and Trusts

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

Circular HSC (CHU) 1/2023

13 March 2023

Charges for Residential Accommodation 2023/24

1. Summary

This circular advises that:

i. Capital limits will remain at their current level (i.e. lower capital limit £14,250 and upper capital limit £23,250);

ii. Savings credit disregards will remain at their current level (i.e. up to £5.75 per week for individuals and up to £8.60 per week for couples); and

iii. The Personal Expenses Allowance (PEA) will increase to £30.44 from 10th April 2023.

Annex A provides further detail.

2. Action

i. HSC Trusts are asked to note the content of this Circular which takes effect from **Monday 10th April 2023**.

3. Enquiries

Any enquiries relating to this letter should be directed to:

Email: Geraldine.Traynor@health-ni.gov.uk

Debbie Murray

Debbie Murray
Care Homes Unit

Annex A

Capital Limits

1. The decision not to increase capital limits has been taken in the context of the continuing significant financial challenges facing the HSC and the ongoing work on the Reform of Adult Social Care. Capital limits in the financial assessment for residential accommodation will remain at their current level (i.e. £14,250 (lower) and £23,250 (upper)).

Pension Credit – savings credit disregard

2. The Assessment of Resources Regulations, as amended in October 2003, introduced a new savings disregard in response to the introduction of Pension Credit. The savings disregard will remain unchanged at £5.75 for individuals and £8.60 for couples; this continues to apply not only to people in receipt of savings credit but also to those with incomes above the savings credit threshold.

Personal Expenses Allowance (PEA)

3. The new PEA prescribed amount, from 10th April 2023 is £30.44 per week. It applies to everyone receiving means-tested support from HSC Trusts for residential or nursing home care. SPPG and Trusts are reminded that the PEA is a small weekly allowance that is disregarded so that residents may use it to spend each week as they wish on personal items and other direct expenses. Pressure of any kind to the contrary is not acceptable, as residents should not be required to spend their PEA in particular ways.

Benefit and Pension Rates

4. The Department for Work and Pensions has published the new Benefit and Pension Rates for 2023 to 2024. This information can be accessed directly at

the following link: https://www.gov.uk/government/publications/benefit-and-pension-rates-2023-to-2024

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP093/14

Title:	**Procedure for Investigating an Incident (excluding SAIs)**		
Author(s)	[redacted], Senior Manager Corporate Governance [redacted], Admin & Datix Manager		
Ownership:	Medical Directorate		
Approval by:	Policy Committee Executive Team	**Approval date:**	11th January 2018 24th January 2018
Operational Date:	January 2018	**Next Review:**	January 2023
Version No.	V4	**Supercedes**	V3
Links to other policies/ procedures	**Adverse Incident Reporting and Management Policy** Procedure for Reporting and Managing Adverse Incidents Procedure for Reporting and Managing Serious Adverse Incidents Procedure for Grading an Incident The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements Guidance on Writing a Statement following an Incident Policy for Sharing Learning Being Open Policy Whistleblowing Policy		

Date	Version	Author	Comments
24th April 2013	1	[redacted]	Final version
December 2013	2	[redacted]	Revised version
June 2014	3	[redacted]	Revised version
29th November 2017	4	[redacted]	Interim update pending regional policy / procedures

1.0 INTRODUCTION

This procedure applies to ALL incidents which are considered *not* to meet Serious Adverse Incident (SAI) criteria. Please see SAI procedure for further guidance on SAIs.

All incidents should be subject to some level of review or investigation. The severity and / or risk grade of the incident will determine the level of review or investigation required.

For the purposes of this procedure the term 'investigation' will be used throughout to mean either informal review or formal investigation.

This procedure outlines the process of adverse incident (excluding SAIs) investigation including determining what level and type of investigation to adopt, a guide through the investigation process itself, subsequent action planning, sharing of lessons learned and audit to assure appropriate compliance with lessons learned.

2.0 PURPOSE

The purpose of this procedure is to enable a robust and systematic approach to the investigation of adverse incidents that will be consistently applied across the Trust.

3.0 SCOPE

This procedure applies to all staff in the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency, contractors and volunteers.

1.0 INTRODUCTION TO INVESTIGATING AN INCIDENT

Many people feel that errors are random occurrences that are unpredictable and beyond control. It is true that chance will play a part in causing some incidents but a large majority of incidents are caused by systemic failures that follow a recurrent pattern. Moreover, if the cause of the incident can be identified, preventative changes can take place and true learning encouraged and shared.

The definition of an adverse incident is as follows:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation"[1].

It is the responsibility of all staff who are involved in, witness to, or become aware of an adverse incident to ensure that this is reported and to complete a Trust Incident Report form.

The Belfast Health and Social Care Trust is committed to staff and service user safety and cooperation with statutory agencies with regard to the response to/and investigation of all incidents up to and including suspicious / unexpected death and serious untoward harm.

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

2.0 LEVEL OF INVESTIGATION REQUIRED

The grading of an incident by severity and risk will determine the requirements for investigating that incident. All incidents will therefore be graded according to severity (actual harm/impact) and risk. (See Procedure for Grading an Incident for further guidance.)

An immediate assessment of the incident grade should be undertaken to allow staff to progress appropriately, if in doubt staff should always grade the incident at the higher level. The incident severity and/or risk grade may require to be amended after further investigation.

Depending on the grade of incident an appropriate level of investigation should be carried out. All levels of investigation require some degree of evidence gathering, making sense of data, analysing problems, identifying cause(s), drawing up conclusions, identifying learning and actions to prevent reoccurrence.

A hot debrief should be considered. This is a review carried out as soon as possible after the incident. This is to identify any immediate learning that could influence future events as well as supporting staff involved.

Investigations should be carried out in accordance with the grading as follows:

2.1 Green – Insignificant or Minor Severity / Low Risk

Who investigates?
The investigation will be commissioned by the incident form approver. It should be investigated locally in the ward/facility in which the event occurred by the incident approver and/or their staff.

Methodology
The outcome of the investigation should be recorded on the investigation and learning section of the incident form. This should include any causes identified, further action taken or planned and any learning. Where no learning or actions are identified, this should be explained as it may be necessary to justify the reasoning behind the decisions at a later date. The investigation should normally be completed no later than 7 working days after the event.

If the investigation identifies any factual inaccuracies with the original incident details, these should be updated accordingly.

Once the investigation is complete and the incident record updated, the approving manager should code the approval status of the incident on Datixweb as 'Approved, investigation complete'. This is not dependent on actions being outstanding.

Actions & Learning
The incident approver is responsible for ensuring all actions are completed and any learning shared as appropriate (see Policy for Sharing Learning for further guidance). Any actions which are not within the local team's control or remain uncompleted should be communicated to a more senior manager for consideration.

2.2 Yellow – Moderate Severity / Medium Risk

Who investigates?
The Service Manager or Assistant Service Manager is accountable for ensuring that all investigations are carried out appropriately. The incident can be investigated and reviewed locally in the ward/facility in which the event occurred by the incident approver and their staff, however where the incident crosses professional and/or managerial boundaries, team membership should reflect this.

Methodology
As a first step consider use of Significant Event Audit (SEA) methodology which is an appropriate technique for this level of investigation. The investigation details should be recorded on the SEA template (Appendix 1) which should be attached to the incident record. A note that the template has been attached should be added to the investigation and learning section of the incident form.

If SEA methodology is deemed not appropriate, the outcome of the investigation should be recorded on the investigation and learning section of the incident form. This should include any causes identified, further action taken or planned and any learning. Where no learning or actions are identified, this should be explained as it may be necessary to justify the reasoning behind the decisions at a later date. The investigation should normally be completed no later than 4 weeks after the event.

If the investigation identifies any factual inaccuracies with the original incident details, these should be updated accordingly.

Once the investigation is complete and the incident record updated, the approving manager should code the approval status of the incident on Datixweb as 'Approved, investigation complete'. This is not dependent on actions being outstanding.

Actions & Learning
The Service Manager or Assistant Service Manager are responsible for ensuring all actions are completed and any learning shared as appropriate (see Policy for Sharing Learning for further guidance). Any actions which remain uncompleted should be communicated to a more senior manager for consideration.

2.3 Amber – Major Severity / High Risk (and not an SAI)

Who investigates?
The Co-Director is accountable for ensuring that all investigations are carried out appropriately. The incident should be investigated and reviewed locally by more than one person and the team should include someone independent from the specialty. Where the incident crosses professional and/or managerial boundaries, team membership should reflect this. More guidance on team membership is available in the Significant Event Audit (SEA) guidance.

Methodology
As a first step consider use of Significant Event Audit (SEA) methodology which is an appropriate technique for this level of investigation. The investigation details should be recorded on the SEA template (Appendix 1) which should be attached to the incident record. A note to this effect should be added to the investigation and learning section of the incident form.

If during the SEA process, it is felt that further analysis is required, the process should transfer to Root Cause Analysis (RCA) methodology. A summary of the results of the investigation should be recorded on the investigation and learning section of the incident form. This should include any causes identified, further action taken or planned and any learning. The investigation report should also be attached to the incident record. Where no learning or actions are identified, this should be explained as it may be necessary to justify the reasoning behind the decisions at a later date. The investigation should normally be completed no later than 12 weeks after the event.
If the investigation identifies any factual inaccuracies with the original incident details, these should be updated accordingly.

Once the investigation is complete and the incident record updated, the approving manager should code the approval status of the incident on Datixweb as 'Approved, investigation complete'. This is not dependent on actions being outstanding.

Actions & Learning
The Co-Director is responsible for ensuring all actions are completed and any learning shared as appropriate (see Policy for Sharing Learning for further guidance).

2.4 Red – Catastrophic Severity or Extreme Risk (and not an SAI)

Who investigates
The Co-Director or Director is accountable for ensuring that all investigations are carried out appropriately. The incident should be investigated and reviewed locally by more than one person and the team should include someone independent from the specialty. Where the incident crosses professional and/or managerial boundaries, team membership should reflect this. More guidance on team membership is available in the Significant Event Audit (SEA) guidance and RCA guidance.

Methodology
Depending on the nature of the incident it may be subject to specific formal Trust investigation process e.g. Case Management Review (CMR), Morbidity & Mortality (M&M) meeting or Cardiac Arrest review. If this is not the case the incident should be subject to SEA or RCA methodology as per Amber section.

A summary of the results of the investigation should be recorded on the investigation and learning section of the incident form. This should include any causes identified, further action taken or planned and any learning. The investigation report should also be attached to the incident record. Where no learning or actions are identified, this should be explained as it may be necessary to justify the reasoning behind the decisions at a later date. The investigation should normally be completed no later than 12 weeks after the event.

If the investigation identifies any factual inaccuracies with the original incident details, these should be updated accordingly.

Once the investigation is complete and the incident record updated, the approving manager should code the approval status of the incident on Datixweb as 'Approved, investigation complete'. This is not dependent on actions being outstanding.

Actions & Learning

The Co-Director or Director are responsible for ensuring all actions are completed and any learning shared as appropriate (see Policy for Sharing Learning for further guidance). This should include any actions or learning identified as a result of other formal Trust investigation processes e.g. M&M, Cardiac Arrest review.

2.5 Summary Table: Level of Investigation

Severity / Risk Grade	Insig. / Minor	Moderate	Major	Catastrophic
	Low	Medium	High	Extreme
Investigation Commissioner	Incident form approver	Service Manager / Asst Service Manager	Co-Director	Director / Co-Director
Investigation duration (guide)	No more than 7 working days	No more than 4 weeks	No more than 12 weeks	No more than 12 weeks
Form	Incident Form	Incident Form (Consider use of SEA template)	SEA template / RCA template (and attach to Datixweb incident record)	SEA template / RCA template (and attach to Datixweb incident record)
Actions	Local implementation / record on incident form.	Local implementation / record on incident form.	Formally monitored.	Formally monitored.
Learning	Record on incident form / shared locally. Patient / Service User / Family informed as appropriate	Record on Datixweb incident form / shared locally. Patient / Service User / Family informed as appropriate	Record on incident form. Shared locally within Directorate. If learning applicable beyond Directorate, Co-Director to share through appropriate Assurance sub-committee. Patient / Service User / Family informed as appropriate	Record on incident form. Shared locally within Directorate. If learning applicable beyond Directorate, Co-Director to share through appropriate Assurance sub-committee. Patient / Service User / Family informed as appropriate

2.6 Incidents involving Non-HSC Organisations

Where incidents are of a serious nature and may include required involvement from other organisations, the Memorandum of Understanding Investigating patient or client safety incidents (Unexpected Death & Serious Untoward Harm) should be used to ensure appropriate investigation on the part of the Trust. This document will guide on which organisation leads and the roles of each in the investigation. Certain investigations or aspects of them may be for others to take forward and therefore the scope of the Trust investigation may be affected.

2.7 Potential Disciplinary / Performance Issues

Incident investigation is designed principally to identify and draw out learning in order that this can be shared, however where an incident involves potential disciplinary or performance issues it is important to follow Human Resources policy and procedures at an early stage. The NPSA Incident Decision Tree can be helpful in identifying these issues early in the investigation process.

3.0 HOW TO INVESTIGATE

The investigation should focus on five key areas:

- **WHAT** - this is detail / specifics in relation to incident / investigation, the actual event and its impact and consequences if any
- **WHERE** - the location / site / area of the incident/ significant in that it may be important in securing evidence / making the scene safe for others and protecting any evidence that may contribute to the investigation
- **WHEN** - the timings / event / notification / resolution from the time of the actual event to the reporting and remedial action, the arrival of assistance and / or other persons involved.
- **WHO** - all persons involved in the incident / investigation, injured parties / witnesses and any others person who have a material contribution to make in terms of the investigation process (remembering that the person(s) affected may also be witnesses)
- **WHY** - findings of the investigation / cause identification / learning to be shared

Of the five areas the WHY is the last to be considered as this will reduce likelihood of jumping to an initial conclusion without due consideration of the facts and causes.

The following sections (3.1 to 3.6) outline the requirements for investigating an incident. The level of detail required should be proportionate to the grading and complexity of the incident.

3.1 Record keeping

Appropriate documentation, including written submissions of witness from staff (see Guidelines on Writing a Statement following an Incident) is required to be recorded and retained in line with good record keeping guidance.

A thorough record of all the investigation activity should be recorded in the appropriate field in Datixweb or added as an attachment to the incident record. Investigators should be aware that the investigation documentation will be covered by the Data Protection Act and will potentially be disclosed to persons outside of the organisation, including the subject of any report.

Once complete, the investigation file should be referenced and filed locally, together with a copy of the final report and completed action plan in accordance with the Trust's Records Retention Schedule. A copy of the final report and action plan, where available, should be attached to the Datixweb record.

3.2 Communicating with and involving patients / service users / families / carers

Staff should follow the Being Open Policy in relation to communicating with patients / service users/ families / carers.

It is important that teams involved in investigations of any incidents where harm occurred, ensure sensitivity to the needs of the patients/service user/relatives/carers involved and agree communication arrangements, where appropriate.
The accountable person should ensure the appropriate level of involvement of patient / service user / family / carer throughout the investigation including discussion / sharing of the final report with the patient / service user / family / carer. The level of involvement clearly depends on the nature of the incident and the patient/service users/relatives/carers wishes to be involved.

3.3 Securing evidence & gathering information

Investigators may find it helpful to consider information from a range of sources including:

- The people involved in or witnessing the event
- The place or environment in which the event took place
- The equipment or objects involved in the event
- The paper work related to the event (e.g. policies, procedures, clinical records, incident reports, risk assessments, maintenance records, clinical audits, training records)
- The widely held beliefs about the normal work processes, team relationships and adequacy of leadership in the workplace.

This list is not exhaustive.

Where required the immediate area should be secured and access be limited until such time as to allow an opportunity to access the scene and record any relevant observations (this may include taking photographs of the scene or measurements).

All material evidence, including written documentation (or copies of), relating to the incident should be gathered and secured as soon as possible after the event. This is particularly important in relation to the timely seizing of CCTV where available, as such evidence may be on a time limited system.

3.3.1 Time Period to be Investigated

From the initial assessment, decide on the time period (start and end dates) that needs to be investigated. This is essential as it determines the information and evidence required. You may therefore need to consider the lead up to and aftermath, as well as the incident itself.
Describe what happened with facts, not opinions, using tools such as a chronology narrative and/or tabular timeline. Avoid the use of abbreviations and medical terms as this may form part of the investigation report which may be read by service users / families/ carers etc. Investigators are encouraged not to pre-judge which events are significant / insignificant in advance of compiling a timeline.

3.3.2 Obtaining Personal Accounts of the Incident

Witnesses to the event and those involved in the incident should be given the opportunity to provide a personal account as to what has occurred.
The PEACE model can be utilised for structured discussion with staff to obtain accounts, if considered appropriate (Appendix 2).
This structured discussion should be carried out in a supportive way, to ascertain the following:

- the role of the witness or those involved in the event and the extent of their involvement.
- The patient and/or relatives/carers account of the incident should be obtained if appropriate.
- the chronology and details of the incident time period
- what problems, action(s), inaction(s) resulted in the incident
- what records, guidelines, equipment were involved
- any other contributory factors e.g. where custom and practice may have deviated from policy and procedure.

3.3.3 Witness statements

Once statements have been received, the lead investigator may wish to speak to staff in person to help clarify part of a statement or account. Any written evidence may become "disclosed" in the event of subsequent legal action and care should be taken in its formulation to include only relevant facts of what actually happened, not what people thought happened. There should be no opinion on who is at fault or any speculation on causes. Forms should be fully completed and all information requested completed.

For further details on Witness Statements please see Guidelines on Writing a Statement following an Incident.

3.3.4 Equipment
For some incidents site visit(s) and liaison with manufacturers and/or suppliers, contractors and/or other agencies/individuals involved may be needed. Any piece of equipment involved in the incident should be removed and preserved as evidence where possible. For further information see Medical Devices Procedures and Guidelines.

3.3.5 Environment – The place in which the incident occurred
Investigators should visit the actual area, if relevant, where the incident took place, preferably before any changes are made and note the layout. A sketch of the area and its layout may be useful particularly if annotated with the location of persons involved in the incident, and other witnesses to the incident. Photographic evidence of the environment can be invaluable.

3.3.6 Evidence storage
Any non-clinical evidence gathered should be attached to the Datixweb incident record e.g. documents, photographs, emails, letters, faxes etc., in order to maintain a complete record of the investigation. If attaching clinical evidence to the Datixweb incident record, the Data Protection Policy must be adhered to. Alternatively this evidence may be retained in a separate file and the location and holder of the file should be clearly recorded on the Datixweb record.

3.4 Identifying problems

A number of tools can be used for identifying the problems e.g. Multidisciplinary meeting, brainstorming / brainwriting, Nominal group technique etc. Please see the Corporate Governance Hub site and SEA and RCA methodology for further guidance regarding these tools.

Problems may relate to the direct provision of care e.g. actions or omissions by staff or absence of guidance to enable action to take place – failure to monitor, observe or act, incorrect decision with hindsight, not seeking help when necessary.

Problems may be identified which are not associated with direct provision of care e.g. issues with decisions, procedures and systems – failure to undertake risk assessment, equipment failure.

3.5 Analysing the incident

The investigator (and/or team) should analyse the problems to identify contributory factors and root causes. For more detailed investigations an analytical tool such as fishbone, 5 Whys may be used to assist. Please see the Corporate Governance Hub site and SEA and RCA methodology for further guidance regarding these tools.
Contributory factors may be:
a) Communication factors (including verbal, written and non-verbal between individuals, teams and/or organisations)
b) Education and training factors (e.g. availability of and attendance at training)
c) Equipment and resource factors (e.g. clear machine displays, poor working order, size, placement, ease of use)
d) Medication factors (where one or more drugs directly contribute to the incident)

e) Organisation and strategic factors (e.g. organisational structure, contractor / agency use, culture)
f) Persons affected factors (e.g. clinical condition, social / physical / psychological factors, relationships)
g) Task factors (includes work guidelines / procedures / policies, availability of decision making aids)
h) Team and social factors (includes role definitions, leadership, support, and cultural factors)
i) Work and environment factors (e.g. poor/excess administration, physical environment, work load and hours of work, time pressures)

Root causes/causal factors

These are failures which had a direct causative affect on the incident. There may be more than one root cause in any incident although care should be taken to distinguish root causes from issues which merely contributed to the incident.
A root cause is a problem which, if resolved, will significantly reduce the risk of reoccurrence of the incident if not eliminate that risk entirely.

3.6 Generating solutions – Conclusions & Actions

3.6.1 Conclusions
Following analysis the key findings should be summarised along with issues that need to be addressed. Include any good practice identified as well as actions to be taken.
Formulate conclusions based upon available evidence.

3.6.2 Actions
Develop actions to help prevent or minimise recurrences thus reducing risk of future harm and ensuring patient safety is improved. Where appropriate include details of any ongoing engagement / contact with service users, family members or carers.
Actions should be SMART i.e.:

- Specific (is it clear what is being asked and of who?);
- Measurable (ask yourself whether the action is auditable);
- Accountable (who is responsible for implementing the action);
- Realistic (consult with those persons able to deliver the action);
- Time-bound (there should be a clear timeframe for implementation).

Avoid actions such as *remind staff* or *promote awareness,* but if they have to be used, explain how this will be done e.g. a poor action would be – *share updated policy with staff*. Be more specific – *send staff the specific section which has changed highlighting the change and drawing their attention to it*.
Investigators should aim to have no more than 4-5 key actions (although it may be less); the important thing is that the actions reduce the likelihood of a reoccurrence of the incident.

3.6.3 Report and dissemination
The report should be clear, free of jargon, acronyms and names and using plain English. Where technical terms are necessary a glossary may be required.

e) Organisation and strategic factors (e.g. organisational structure, contractor / agency use, culture)
f) Persons affected factors (e.g. clinical condition, social / physical / psychological factors, relationships)
g) Task factors (includes work guidelines / procedures / policies, availability of decision making aids)
h) Team and social factors (includes role definitions, leadership, support, and cultural factors)
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Investigators should aim to have no more than 4-5 key actions (although it may be less); the important thing is that the actions reduce the likelihood of a reoccurrence of the incident.

3.6.3 Report and dissemination
The report should be clear, free of jargon, acronyms and names and using plain English. Where technical terms are necessary a glossary may be required.

It is important to note that unless there are specific exceptions, the patient / service user or family of a patient / service user have a right to the full investigation report under the Data Protection Act 1998 (ref NPSA Guidance on Writing and Investigation Report. Aug 08). The findings of the report should be shared with all other stakeholders as appropriate and ensuring confidentiality.

3.6.4 Action Plans

Action Plans should be generated for incidents graded as major or catastrophic severity and high or extreme risk. Lower grades than this may also use action plans where the actions require monitoring closely due to their complexity and/or cross service responsibility.

The individual accountable for the investigation has responsibility for ensuring the preparation of an action plan.

Developing an action plan

- Overall responsibility for the action plan must be with the individual who commissioned the Investigation.
- Where an action identified is outside the area of responsibility of the individual accountable for the investigation, discussion and agreement must be reached with the relevant manager for taking that action forward.
- Timescales for each action must be agreed with the person responsible for implementing the action.
- Every action plan should include the following:
    - The reference number of the incident
    - Date Investigation completed
    - Date of the latest version of the action plan
    - Version number

Monitoring

The individual accountable for the investigation is responsible for setting up directorate level monitoring and review processes to ensure actions are progressed as planned.

Learning

Where learning has been identified, this should be shared as appropriate (see the Policy for Sharing Learning)

3.7 The Investigation process, where an Incident is also a Complaint.

When an adverse incident is being investigated and is also a complaint, the investigation will continue and the outcome of the investigation may form part of the complaint response.

SIGNATORIES

Name Dr Cathy Jack
Title Deputy Chief Executive/ Medical Director

Date: 24 January 2018

Name Martin Dillon
Title Chief Executive

Date: 24 January 2018

Belfast Health and Social Care Trust

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT

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

WHAT HAPPENED?

WHY DID IT HAPPEN?

WHAT HAS BEEN LEARNED?

WHAT HAS BEEN CHANGED?

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

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

THE INVESTIGATION TEAM :

INVESTIGATION TERMS OF REFERENCE:

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT GUIDANCE

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

WHAT HAPPENED?

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

WHY DID IT HAPPEN?

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

WHAT HAS BEEN LEARNED?

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

WHAT HAS BEEN CHANGED?

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

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

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

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

P.E.A.C.E. Interview Model

Planning & Preparation	**E**ngage & Explain	**A**ccount Clarification & Challenge	**C**losure	**E**valuation
•Plot events on a timeline for information retention •What is known about interviewee and what needs to be established •Points to prove, facts and issues •Practical issues (5 W's) •Aim & objectives •Written Plan	•Engage in a conversation •First impressions •Explain purpose of interview •Reasons, routines, outline, expectations •Assess needs of the interviewee	•Uninterrupted account •High use of questions summaries •Expanding & clarifying the account •Question loop.. Open, probe, summarise as appropriate, link •Done chronologically, methodically •Lock the person down into their account •Challenge the inconsistencies & contradictions •Use the words of the interviewee, words of others and contradictory information / evidence •Non accusatorial •Ask the interviewee to explain the differences between their account and the evidence	•Summarise account for mutual understanding •All areas fully covered •Explain future activities •Facilitate positive attitude of accurate and reliable information •Review needs of interviewee •Maintain professional style	• Evaluate information obtained • Aims & objectives reached • Re-evaluate evidence in investigation • Evaluate own performance • Evaluated by lead • Identify areas of improvement

Test User3

Belfast Health and Social Care Trust

BHSCT Incident Approval Form

Click for: • **Trigger Lists** – list of events that must be reported as incidents

Click for: • **Incident Dashboard Guidance**

Click for: • **Approving Managers Guidance** - includes guidance on approving and follow-up, searching and running reports on incidents.

TEST | TEST

10. Investigation

For guidance: ***Click*** • **Procedure for Grading an Incident** **and** • **Procedure for Investigating an Incident (excluding SAIs).**

Risk grading

Click for the ***Consequence & Likelihood Tables*** to assist you in completing this section.

Please note:

The **consequence** of the incident differs from **severity**. **Consequence** should be scored based on what the outcome **COULD** have been.

	Consequence				
Likelihood of recurrence	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost Certain	○	○	○	○	○
Likely	○	○	○	○	○
Possible	○	○	○	○	○
Unlikely	○	○	○	○	○
Rare	○	○	○	○	○
	Grade:				

Method of Review/Investigation

Method of review/investigation that will be, or has been used.

Click **here** for further guidance.

More than one option can be chosen.

- ☐ Local Informal Review
- ☐ Significant Event Audit (SEA)
- ☐ Root Cause Analysis (RCA)
- ☐ Patient Safety & Clinical Governance Meeting (incorporating M&M)
- ☐ Structured Judgement Review (SJR)
- ☐ Post Fall Review
- ☐ Post Pressure Ulcer Review
- ☐ Adult Safeguarding Review (ASR)
- ☐ Child Safeguarding Review (CSR)
- ☐ Perinatal Mortality Review Tool (PMRT formerly SCOR)

- [ ] Case Management Review (CMR)
- [ ] Joint Protocol Investigation
- [ ] COVID Death Review
- [ ] Independent External Review (e.g. Royal College)
- [ ] Review methodology still to be agreed

Outcome of Review/Investigation
Brief summary of review/investigation findings including any further actions planned or taken to prevent re-occurrence.

If a SEA, RCA and/or action plan has been completed, attach the report/plan to the incident record (at Section 7).

When the review/investigation is complete, amend the Approval status to **Approved, investigation complete**.

Date investigation completed (dd/MM/yyyy)

Lessons learned
Brief summary of any learning identified.

Is this incident reportable under RIDDOR?

- ○ No
- ○ Yes

Investigator / Managers Access
Use to give others access to incident.

Ensure you make contact and agree roles BEFORE adding names here.

(NOTE: this will send them an email with a link + description of the incident). **(Click for further guidance).**

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for Service Users, Family Members and Carers

Belfast Health & Social Care Trust (BHSCT)

Revised November 2016 – Version 1.1

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

Can a complaint become a SAI?

Yes, if during the follow up of a complaint the Belfast Health & Social Care Trust identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The Belfast Health & Social Care Trust will discuss with you how the SAI will be reviewed and who will be involved. The Belfast Health & Social Care Trust will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;
- Are offered advice in the event that the media make contact.

What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by Belfast Health & Social Care Trust (BHSCT) staff that is acceptable to you.

How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

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

- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the Belfast Health & Social Care Trust (BHSCT) to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the Belfast Health & Social Care Trust (BHSCT).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is
Your link person's job title is

Contact number
Email: .....**TRUST.HSCNI.NET**

Hours of work

Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number: 0800 917 0222