Questions:

I am writing to request information under the Freedom of Information Act 2000 in relation to the governance, oversight, and operation of Serious Adverse Incident (SAI) reviews within Health and Social Care in Northern Ireland.

This request relates specifically to the interpretation and application of the 2016 "Procedure for the Reporting and Follow-Up of Serious Adverse Incidents".

1. Please provide any guidance, policy documents, memoranda, briefing papers, or correspondence held by SPPG which define or describe the extent to which an SAI Review Panel is independent of the commissioning Trust.

2. Please provide any recorded information which clarifies whether a Health and Social Care Trust retains responsibility for ensuring that an SAI Review Panel complies with the 2016 SAI Procedure, including adherence to:
   a) required timescales
   b) Terms of Reference
   c) Methodology
   d) engagement with service users and families

3. Please provide any guidance or recorded information held by SPPG regarding whether a Trust can require an SAI Review Panel to engage with families in accordance with the 2016 Procedure.

4. Please provide any documents, guidance, or correspondence which address what actions are available to a Trust where an SAI Review Panel or its Chair fails or refuses to comply with the 2016 Procedure.

5. Please provide any recorded information which clarifies whether a Trust has the authority to:
   a) appoint or remove panel members
   b) amend or enforce Terms of Reference
   c) intervene where a panel is not complying with required procedures

6. Please provide any guidance, internal communications, or briefing documents held by SPPG which discuss the distinction between:
   a) independence of panel findings and conclusions, and
   b) the Trust's responsibility for the conduct and governance of the SAI review process

7. Please provide any recorded information which sets out the role of the Designated Review Officer (DRO) in circumstances where:
   a) there are concerns about panel conduct
   b) the review process is not compliant with the 2016 Procedure

8. Please provide copies of any audit reports, review findings, or oversight documentation produced by or for SPPG since 2016 which relate to:
   a) compliance of Trusts with the SAI Procedure
   b) governance or performance of SAI Review Panels

9. Please provide any correspondence between SPPG and any Health and Social Care Trust since 2020 where concerns were raised about:
   a) failure of an SAI panel to engage with families
   b) delays in SAI reviews
   c) non-compliance with Terms of Reference or procedures

10. Please confirm whether SPPG holds any recorded information that supports or states that a Trust:
    a) cannot instruct or require an SAI Review Panel to take specific procedural steps (such as meeting families), or
    b) cannot intervene where a panel is failing to comply with the SAI Procedure.

Responses:

1. The regional SAI Procedure stipulates the level of independence required for Level 2 and Level 3 reviews; I refer you to section 5.0 in the link below.

   Procedure-for-the-reporting-and-follow-up-of-SAIs-2016 - DOH/HSCNI Strategic Planning and Performance Group (SPPG)

   Health and Social Care Trusts (HSCs) have internal policies for the management of SAIs, aligned with the regional SAI Procedure to include level of independence to be used when establishing review panels.

2. The procedure referenced above provides the required timescales in relation to the SAI process, requirements in respect of terms of reference, templates used for completion of SAI reports and guidance relating to engagement with service users and families.

   HSC Trusts will have their own mechanisms/policies and procedures to adhere to the regional procedure as well as their own internal governance arrangements in relation to compliance. You may wish to contact the HSC Trusts who may be in a position to provide further information. Contact details are included, see appendix 1.

3. Within the regional SAI procedure, addendum 1 'A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI' provides guidance to HSC Trusts on engagement with families.

   As referenced above, HSC Trusts will have their own internal mechanisms/policies and procedures for the management of SAIs, including engagement with families. You may wish to contact the HSC Trusts who may be in a position to provide further information. Contact details are included, see appendix 1.

4. HSC Trusts will have their own internal governance arrangements which may include actions to be taken when there is non-compliance at panel level in respect of the SAI process. You may wish to contact the HSC Trusts who may be in a position to provide further information. Contact details are included, see appendix 1.

5. See response to point 4 above.

6. As referenced in response to question 1 the SAI procedure provides guidance on the independence of level 2 and 3 reviews.

   The conduct of SAI review panels commissioned by a Trust will be the responsibility of the Trust in line with its own internal governance arrangements, aligned with the regional SAI Procedure. You may wish to contact the HSC Trusts who may be in a position to provide further information. Contact details are included, see appendix 1.

7. The DRO Protocol, see appendix 2, sets out the role of the DRO, which is to quality assure, challenge and escalate where required, specifically:

   a) Where the DRO, or other SPPG / PHA professional, has concerns regarding the composition, independence or appropriateness of the review panel, these concerns will be raised and addressed directly with the relevant HSC Trust.
   b) Where the DRO, or other SPPG / PHA professional, identifies that the review process does not meet the required standards, he/she will challenge the review and seek further assurance.

   It is acknowledged since the implementation of the DRO protocol new arrangements have been put in place by way of the introduction of multi-disciplinary professional groups who support the work of a DRO. I refer you to the Terms of Reference, see appendix 3.

8. **Audit Reports** - SPPG do not have any audit reports produced by or for SPPG since 2016 in respect of the SAI procedure.

   Review Findings & Oversight Documentation - Upon receipt of your request DOH has taken some time to consider the information held which would be relevant to your request. Whilst DOH does hold information to inform a response; the process of:

   - finding the requested information, or records containing the information;
   - retrieving the information or records; and
   - extracting the requested information from records

   would be a significant exercise. An initial review has identified 4968 records and we have been advised it would far exceed the cost limit of £600.

   The Information Commissioners Office (ICO) website provides advice around fees and cost limits (https://ico.org.uk/for-organisations/foi/guide-to-managing-an-foi-request/charging-a-fee-and-cost-limits/) and identifies cost limits for a Government Department at £600 or 24 hours at a cost of £25/hour. The DOH therefore considers Section 12 of the FOI Act to be relevant on this occasion and is therefore refusing this element of your request on the grounds of cost.

9. Upon receipt of your request DOH has taken some time to consider the information held which would be relevant to your request. Whilst DOH does hold information to inform a response; the process of:

   - finding the requested information, or records containing the information;
   - retrieving the information or records; and
   - extracting the requested information from records

would be a significant exercise. An initial review has identified 3361 records and we have been advised it would far exceed the cost limit of £600.

The Information Commissioners Office (ICO) website provides advice around fees and cost limits (https://ico.org.uk/for-organisations/foi/guide-to-managing-an-foi-request/charging-a-fee-and-cost-limits/) and identifies cost limits for a Government Department at £600 or 24 hours at a cost of £25/hour. The DOH therefore considers Section 12 of the FOI Act to be relevant on this occasion and is therefore refusing this element of your request on the grounds of cost.

10. SPPG does not hold any such information. You may wish to contact the HSC Trusts who may be in a position to provide further information. Contact details are included, see appendix 1.

Date response issued: 29th April 2026
Reference Number: DOH 2026-0077

Appendix 1

Trust contact details:

Belfast Trust:

Public Liaison
Belfast HSC Trust
1st Floor, Nore Villa
Knockbracken Healthcare Park
Belfast
BT8 8BH

Email: publicliaison@belfasttrust.hscni.net

Northern Trust:

Information Governance Office
Northern Health and Social Care Trust
Causeway House
8e Coleraine Road
Ballymoney
County Antrim
Northern Ireland
BT53 6BP

Tel: 028 2766 1293
Email: info.governance@northerntrust.hscni.net

Southern Trust:

Head of Information Governance
Informatics
Southern Health and Social Care Trust
Ferndale
Bannvale Site
10 Moyallen Road
Gilford
BT63 5JY

Tel: 028 3756 1458
Email: foi.team@southerntrust.hscni.net

South Eastern Trust:

Information Governance Department
South Eastern Health and Social Care Trust
Lough House
Ards Hospital
Church Street
Newtownards
BT23 4AS

Email: informationgovernance@setrust.hscni.net

Western Trust:

FOI Office
Lime Villa
Gransha Park
Clooney Road
Londonderry
BT47 6WJ

Email: foi.request@westerntrust.hscni.net

Contact details for each of the Health and Social Care Trusts in Northern Ireland can be found on their websites should you wish to redirect your request to them. The links to the five Trust's are as follows:

Websites with further contact details:

http://www.belfasttrust.hscni.net/

http://www.northerntrust.hscni.net/

http://www.southerntrust.hscni.net/

http://www.setrust.hscni.net/

http://www.westerntrust.hscni.net/

Health and Social Care Board

Public Health Agency

Protocol for the Role of a HSCB/PHA Designated Review Officer (DRO) allocated to a Serious Adverse Incident (SAI)

Revised: March 2017

Version 1.0

Contents

1.0 Background

The requirement on HSC organisations to routinely report Serious Adverse Incidents (SAIs) to the Department of Health (DoH) ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA). During 2012/13 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013.

A further review was undertaken in November 2016 and issued to all Arm's Length Bodies (ALBs) for full implementation on 1 January 2017. The procedure provides guidance to all Arms Length Bodies in relation to the reporting and follow-up of SAIs arising during the course of business of a HSC organisation/Special Agency or commissioned service.

2.0 Role of the HSCB/PHA in the SAI Process

- Responsible for the effective implementation of the procedure for the reporting and follow up of SAIs across the region;

- Ensuring there are mechanisms in place for SAIs to be reviewed by relevant professionals/senior officers;

- Ensuring there are adequate safety and quality structures within the HSCB/PHA so that trends, best practice and learning is identified, disseminated and implemented in a timely manner in order to prevent recurrence;

- Identify any immediate/medium/long term strategic issues which contributed to the incident and that need to be addressed, and communicate these to the relevant commissioning service;

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

3.0 What are the HSCB/PHA Safety and Quality Structures relating to SAIs?

It is important that when a SAI occurs, that there is a systematic process for reviewing the incident and identify potential learning. The key aim being to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across health and social care as a whole.

The HSCB and PHA therefore have developed a safety and quality structure that provides an effective mechanism for identifying and disseminating regional learning across the province.

- **Quality Safety and Experience (QSE) Group**

QSE is a jointly chaired, group that provides an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

A Regional SAI Review Subgroup reports to, and supports the work of the QSE Group.

- **Regional Serious Adverse Incident Review Sub-Group (RSAIRSG)**

The RSAIRSG is chaired by the HSCB Governance Manager and the PHA Senior Manager for Safety, Quality and Patient Experience. Membership comprises of professional representatives from the HSCB and PHA; RQIA are also in attendance.

The RSAIRSG has responsibility to ensure that trends, examples of best practice and learning in relation to SAIs are identified and disseminated in a timely manner.

- **SAI Professional Groups**

A number of professional groups from individual programmes of care have recently been established which allow DROs who share the same area of expertise to meet and discuss SAI reviews and where relevant identify regional learning prior to closure of the SAI. These professional groups also provide support to DROs when they may require advice in relation to specific SAIs.

The groups benefit from:

- Multi-professional input / wider circle of experience;
- Group sign off, decisions not focused on one individual;
- More complete understanding of the range of SAI issues within these service areas leading to the identification of regional trends.

- **Safety Quality and Alerts Team (SQAT)**

SQAT, which is closely aligned to the work of QSE, is responsible for performance managing the implementation and assurance of Regional Safety and Quality Alerts / Learning Letters / Guidance issued by HSCB/PHA in respect of SAIs.

SQAT is a multidisciplinary group with representatives from the HSCB and PHA and is chaired by the PHA Medical Director/ Director of Public Health. The Group meet fortnightly to co-ordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DoH, HSCB, PHA and other organisations. This 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.

An overview of the Safety and Quality Structures is outlined in Appendix 1.

- **HSCB Governance Team**

The HSCB Governance Team provides the co-ordination, administrative support to all of the above groups and to individual DROs in relation to the management of SAIs from notification to closure of a SAI.

4.0 What is a DRO?

A DRO is a senior professional/officer within the HSCB / PHA who has a degree of expertise in relation to the programme of care / service area where a SAI has occurred.

5.0 What is the role of a DRO?

The DRO has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI;
  - where a DRO believes the SAI review is not being undertaken at the appropriate level.

- Agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- Reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for Level 2 and 3 RCA Reviews, including service user/family/carer engagement and liaising with other professionals (where relevant);

- Liaising with reporting organisations via the Governance Team, where:

  - More information is required in relation to a Level 1 summary report. (Whilst the HSCB will not routinely receive the full Level 1 SEA report, these can be requested.)

  - There may be concerns regarding the robustness of the Level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented.

- Identification of regional learning, where relevant;

- Surveillance of SAIs to identify patterns/clusters/trends.

- Escalate concerns/issues as necessary to the Director and onwards to the respective Chief Executive as required.

6.0 Process

The following details the systematic approach in relation to the nomination of a DRO to a SAI and the process that follows until such time as the SAI can be closed. (A flowchart reflecting each step of the SAI process is detailed in Appendix 2.)

Step 1 - Notification of SAI

- SAI notified to Governance Team by Reporting Organisation;

- Governance Team.
  - Records SAI on the Datix Risk Management System;
  - Forward SAI Notification to DRO as per Regional DRO Listing or Allocation Flowchart and copy to relevant Directors/Senior Managers (current listing and flowcharts available via the following Link http://insight.hscb.hscni.net/resources/safety/);
  - Where the DRO is not automatically allocated from a Flowchart the Regional Lead/s will assign a DRO (this may be a Regional Lead or another member of staff from within their programme of care / area of specialism). Governance Team will forward SAI Notification to the assigned DRO;

- Acknowledge receipt of SAI Notification to reporting organisation and advise on date for submission of learning summary/review report.

Step 2 - Immediate Actions

- DRO will consider SAI and if they decide it to be of major concern they will liaise immediately with their Director with a view to bringing it to the attention of the Chief Executive;
- If required, the DRO will liaise with the Reporting Organisation regarding any immediate actions required. This will be carried out in conjunction with the Governance Team;
- Governance Team will update DATIX accordingly.

Step 3 - Submission of Learning Summary/Review Report/Additional Information

- Governance Team will liaise with Reporting Organisation with regard to review report deadlines i.e. reminders, DRO queries etc;
- Reporting Organisation submit learning summary/review report to serious.incidents@hscni.net (Governance Team);
- Governance Team forward learning summary/review report to DRO;
- DRO will liaise with other professional leads, including RQIA (where relevant) on receipt of learning summary/review report. For those SAIs that are medication related, the DRO may wish to liaise with the Secondary Care Medicines Governance Team (refer to appendix 2)
- If DRO and professional leads (where relevant) are not satisfied with learning summary/review report, DRO will request additional information from the Reporting Organisation until adequate assurance is provided.
- When a DRO has received all the information it is expected the reporting organisation will be informed within a period of 12 weeks that the SAI has been closed.

Step 4 - Closure of SAI

- When a DRO is satisfied with learning summary/review report, and where relevant any additional information that has been requested, he/she informs the HSCB Governance Team they are content to close the SAI in line with HSCB/PHA 'Criteria for Closing SAIs' (Appendix 3);

- The HSCB Governance Team refers the SAI to the relevant SAI Professional Group;

  - Acute;
  - Maternal and Child Health (Including Acute Paediatrics);
  - Elderly Services and Physical Disability and Sensory Impairment;
  - Mental Health and Learning Disability Services;
  - Prison Health;
  - Integrated Care;
  - Corporate Services;
  - Childrens Services – Social Care;
  - Adult Services – Social Care.

- SAI discussed at SAI Professional Group meeting and the following agreed:
  - SAI closed with regional learning and referred to RSAIRG and/or QSE Group either for noting or discussion;
  - SAI closed without regional learning.

- Governance Team closes SAI on DATIX and informs the Reporting Organisation (and RQIA where applicable) that SAI has been closed.

Step 5 – Regional Learning Identified

- Once regional learning has been identified by the Professional Group a DRO may be required to:
  - Refer learning to Network or Group that has already been established;
  - Draft an article for inclusion within a newsletter or draft a reminder or best practice or learning letter;
  - Attend a meeting of the RSAIRG or QSE group to discuss proposed learning;
  - Be involved in a Thematic Review or Task and Finish Group.

  A flowchart outlining the approval process and dissemination of regional learning can be accessed via the following link.

  http://insight.hscb.hscni.net/resources/safety/

7.0 Supporting the DRO Process

7.1 Datix

In order to ensure Statutory Information Governance requirements are adhered to, all communication for each stage in the process should be communicated by the DRO to the HSCB Governance Team. This ensures the Corporate Record for each SAI is fully documented on the Datix Risk Management System.

7.2 DROs Supporting Information

Appendix 4 provides DROs with some supporting information which they may wish to consider on receipt of SAI notifications and learning summary/review reports**.**

7.3 Escalation Process for DRO Requests

Throughout the process there may be occasions where the reporting organisation does not agree with a DRO request. Examples include:

- escalate a SAI to a higher level review;
- amend a review report;
- issues around family engagement;
- requests for additional information are withheld;
- request for a SAI following notification of an Early Alert;
- where a DRO/Professional has been made aware of an incident that they feel should be reported as a SAI.

On these occasions, DROs should follow the escalation process as detailed below:

Stage 1 – Reporting organisation notifies the DRO that they do not agree with their request

- DRO discusses the SAI at the next relevant SAI Professional Group and if agreed the reporting organisation is notified via the Chair of the Professional Group.

Stage 2 - If the reporting organisation does still not agree:

- The DRO informs the relevant HSCB/PHA Director;
- Relevant HSCB/PHA Director discusses this with the relevant Director within the Reporting Organisation.

Stage 3 – If the Reporting Organisation is still not in agreement:

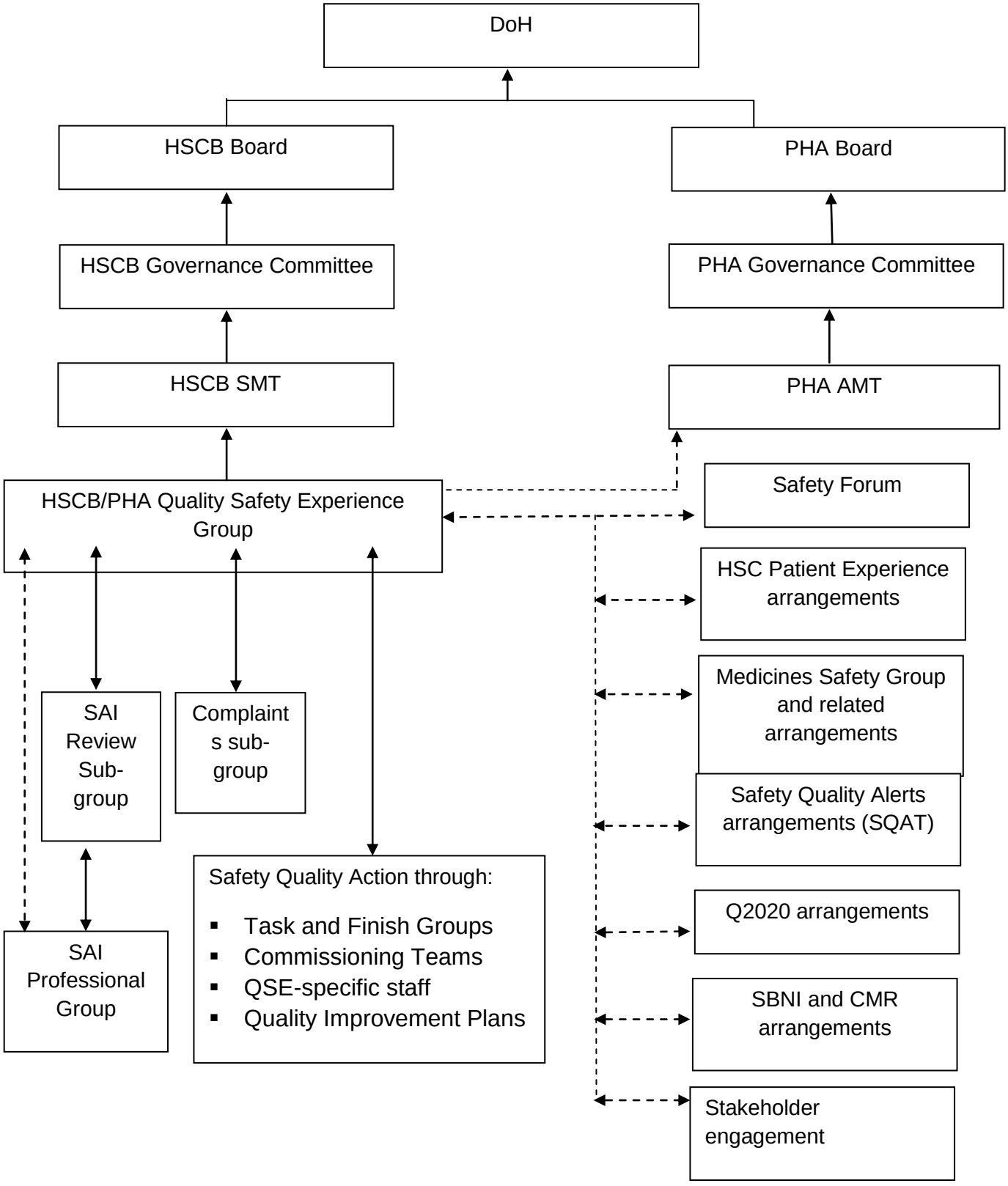
- This should be listed for consideration at QSE.

7.4 Interface Incidents Process

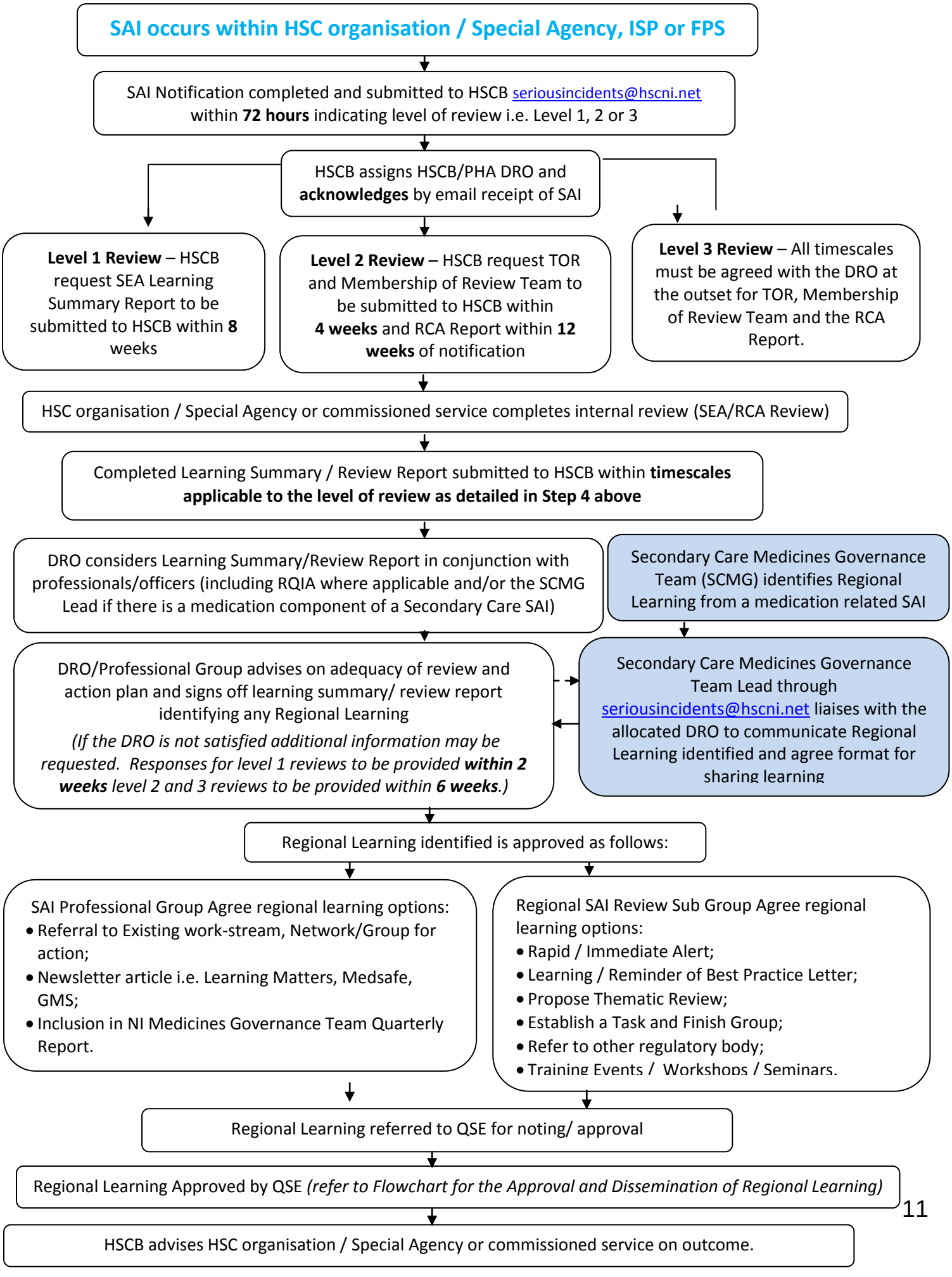
The HSCB/PHA process for the management of interface incidents notified to the HSCB can be accessed via the following link:
http://insight.hscb.hscni.net/resources/safety/

Appendix 1

HSCB/PHA SAFETY AND QUALITY STRUCTURES



SAI PROCESS AND IDENTIFICATION OF REGIONAL LEARNING FLOW CHART – KEY STAGES



Appendix 3

CRITERIA FOR CLOSURE OF SAIs

A DRO can close an SAI when it meets one of the following three criteria:

1. An independent evaluation of the learning summary/review report received from the reporting organisation has been undertaken by a nominated HSCB/PHA Designated Review Officer (DRO) in conjunction with other officers/professionals (including RQIA) where relevant.

   Prior to closure the DRO must be satisfied that:

   - Format and content of the learning summary/review report is in line with regional templates for Level 1 and level 2/3 Reviews;

   - Review has been carried out appropriately by the reporting organisation (this is only applicable for level 2/3 reviews as the quality assurance of Level 1 reviews is the responsibility of the reporting organisation);

   - All reasonable steps have been taken to prevent recurrence;

   - Recommendations and actions are appropriate and where required there are performance mechanisms in place via the HSCB Governance Team to monitor these;

   - Any queries arising from the learning summary/review report have been resolved including confirmation of how local learning has been disseminated and regional learning identified;

   Other specifics of independent evaluation/review DRO may wish to consider are the Reporting Organisation:

   - has confirmed that it has discharged all statutory requirements;
   - has confirmed that all necessary safeguarding requirements associated with the incident are in place;
   - confirms details of any disciplinary action arising from the incident.

2. DRO has been informed the SAI has transferred to another relevant investigatory process i.e.

    - Case Management Review;
    - Public Inquiry;
    - Independent Expert Inquiry.

3. Following initial notification DRO is advised by reporting organisation that following preliminary reviews, incident is no longer considered a SAI. DRO will consider in conjunction with other officers/professionals, requesting additional information from reporting organisation if necessary; prior to de-escalating SAI and closure.

Appendix 4

Supporting Information for Designated Review Officers

1) At the time the SAI is notified

Immediate Actions

- Is the DRO satisfied that the Trust have taken reasonable actions to reduce the risk of recurrence pending the full review report. HSCB/PHA recognise that this cannot prejudge the outcome of the full review and that what appear to be the circumstances at the time of reporting, may not be substantiated through review;
  - The DRO should also consider if the HSCB/PHA have previously issued regional learning in relation to a similar type incident. In those circumstances, it may be appropriate to ask the Trust whether or not they have:
- Brought the incident to the attention of individual(s) staff involved to ensure that all are aware and to do an immediate review of the circumstances that led to the incident;
- Provided training/refresher training on relevant policies/procedures for the staff involved
- Informed other staff in the unit of the incident.

Level of Review

Do you agree with the level of review the Trust has proposed to undertake?

The nature, severity and complexity of serious incidents vary on a case-by-case basis and therefore the level of response should be dependent on and proportionate to the circumstances of each specific incident. The appropriate level of investigation will be proposed by the provider and agreed by the DRO upon notification, however the level of review may change as new information or evidence emerges as part of the review process.

- **Level 1 Review – Significant Event Audit (SEA)**

  Concise, internal review which is suited to less complex incidents which can be managed by individuals involved in the incident at local level.

- **Level 2 Review - Root Cause Analysis (RCA)**

  A comprehensive internal review which includes an independent element and is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors.

- **Level 3 Review - Root Cause Analysis (RCA)**

  This level of review is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors. It is required where the integrity of the review is likely to be challenged or where it will be difficult for an organisation to conduct an objective review internally.

  The HSC Regional Risk Matrix (Appendix 5) assist organisation to determine the level of seriousness and subsequently the level of review to be undertaken. DROs can similarly use this matrix to determine if they agree with the level of review being undertaken.

2) At the time the SAI Review Report is received

In your best professional judgment and from the information available to you:

- Has the family been involved appropriately?

- Where appropriate, has the Coroner been notified?

- Was membership of the Review Team appropriate for the level of review undertaken?
- From the information in the report, does it appear that the Review Team identified and reviewed the factors that led to the incident correctly and thoroughly?

- Do the conclusions reflect the facts of the incident?

- Do the recommendations address the underlying contributing factors?

- Is the Action Plan a reasonable set of actions to address the issues/recommendations identified by the review?

- Is there regional learning and if yes, what is that and how should it be handled
  - Learning Matters newsletter article
  - Learning Letter
  - Bespoke piece of work
  - Other?

- To the best of your knowledge, are you aware of other SAIs where the factors have been similar to this SAI?

- Can the SAI be closed – yes/no?

Appendix 5

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

SAI Professional Group

Terms of Reference

1. Purpose of the Group

To ensure collective, multidisciplinary decision making on the management of SAI Reviews and the identification of regional learning in line with the 'Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)'.

SAI Professional Groups provide a systematic process for reviewing incidents to identify and agree on potential regional learning to be disseminated across the wider service to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across Health and Social Care as a whole.

2. Objectives of the Group

Level 1 Reviews

Members of the SAI Professional Group must:

- Ensure review reports have been signed off by the relevant professional or operational director within the reporting organisation given that the process assigns reporting organisations the responsibility for quality assuring Level 1 SEA reviews, ensuring the robustness of the report and identifying learning prior to submission to the SPPG;
- Establish if regional learning identified by the reporting organisation should be shared with the wider service and consider the most appropriate method of dissemination.

Level 2/3 Reviews

Members of the SAI Professional Group must:

- Consider and approve Terms of Reference and Team Membership for Level 2 and Level 3 reviews, as required;
- Consider Root Cause Analysis (RCA) Reports to ensure a robust review has been conducted. If there are concerns, SAI Professional Group members should liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received;
- Consider all recommendations of suggested / proposed learning documented within the review report. In addition, identify any related learning to be communicated across the HSC and consider the most appropriate method of dissemination;
- Review Action plans ensuring they clearly set out how/when each recommendation will be implemented, with named leads responsible for each action point. As required, SPPG/PHA to follow up with the reporting organisation to ensure successful delivery of the action plan;
- Identify any immediate/medium/long term strategic issues which contributed to the incident and need to be addressed, communicate these to the relevant commissioning service.

All Levels of Review

Members of the SAI Professional Group must:

- Agree on appropriate closure of the incident;
- Ensure the timely development of regional learning for approval by the Weekly Incident and Learning Review Group and onward referral to Safety Brief;
- Ensure timely and appropriate level of engagement afforded to service users/families/carers by the reporting organisation throughout the review;
- Liaise with other Professional Colleagues as required;
- Escalate areas of concern as appropriate to Safety Brief for guidance;
- Record any local learning identified following a SAI Review;
- Surveillance of SAIs to identify patterns/clusters/trends;
- Verify regional codes, as assigned upon notification, to be used in conjunction with CCS2 Coding to identify regional recurring themes / trends;
- Ensure all communication between SPPG/PHA and reporting organisation is conveyed between the SPPG Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the SPPG DATIX risk management system.

3. Accountability of the Group

Each SAI Professional Group provides assurance to safety brief that any urgent action is taken following the receipt of SAI Review Reports and that any areas of concern are promptly escalated.

4. Frequency of Meeting

SAI Professional Groups reviewing Level 1 SAIs meet on a fortnightly basis however Groups considering Level 2/3 reviews meet on a monthly basis.

Meetings will be held more frequently, as required, in line with the number SAI review reports within the system to ensure a timely review and identification of learning.

5. Quorum

Each SAI Professional shall be quorate by the attendance of three members of the Group. Expertise / advice can be sought from SPPG/PHA colleagues as required.

6. Revision of Terms of Reference

The Terms of Reference will be reviewed in twelve months (March 2023) or earlier as required.