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

HSC Public Health Agency

SPPG/PHA Safety and Quality

Annual Learning Report

April 2024 - March 2025

EDITION 22

Foreword

This report captures the lessons we have learned during this reporting period from those safety and quality processes where, the Strategic Planning and Performance Group (SPPG) and Public Health Agency (PHA) have a regional oversight role.

It reflects our ongoing journey to understand, improve and embed lessons that have emerged and signifies our joint commitment to continuously improve the services we commission for the population we serve.

From every incident reviewed, complaint or feedback received to audits undertaken, offers an opportunity to strengthen our systems and deepen our understanding. By learning from what goes well and what could be better, we ensure that our services remain responsive, compassionate and grounded in evidence.

The report highlights key themes, patterns and actions taken in response to what we have learned during 2024/25. It also celebrates the contributions of staff across all levels who have engaged with these processes openly and constructively. Their commitment to transparency and improvement is what drives meaningful change.

As we look ahead to 2025/26, we remain focused on working with key stakeholders fostering a culture of continuous learning that is shared and impactful and where safety and quality are not just outcomes but the foundation of how we care.

Key Learning at a Glance

Embedding learning in how we lead, communicate, govern and innovate is enabling faster, safer and more responsive care for patients and families. The following are examples of key messages detailed throughout the report:

Strengthening how we communicate, share learning, lead teams, and define roles will drive meaningful and sustainable change in Falls prevention.

Timely access to medicines for patients and therefore prompt symptom management, increasing patient / family satisfaction.

Development and Implementation of robust governance systems and standardisation of processes.

Ongoing learning in respect of Children's Autism and ADHD services through engagement sessions both for services across the region and for commissioners in understanding the needs of the services.

Paramedics now registered as non-medical prescribers for the first time in Northern Ireland.

New models of prescribing has resulted in benefits to patients, healthcare professions and the healthcare system.

Contents

Introduction and Purpose

Delivering safe, effective and person-centred care is the cornerstone of our health and social care service. The SPPG and the PHA have both jointly and individually a requirement to provide clarity, direction and support to Health and Social Care (HSC) organisations in respect of regional safety and quality processes. By supporting organisations to learn from these processes is a vital part of fostering a culture of continuous improvement, accountability and resilience.

The purpose of this report is to provide an overview of regional learning identified from the key safety and quality processes that fall within the responsibility of the SPPG and PHA for the reporting period 1 April 2024 - 31 March 2025.

It aims to:

- Capture key learning from incidents, audits, complaints, patient/service user feedback and opinion and other processes that have influenced practice and policy
- Highlight themes and trends in processes that have informed operational improvements
- Share insights across our health and social care teams and services to promote a culture of openness, learning and collaboration
- Demonstrate impact by showing how learning has led to tangible changes in care delivery, risk reductions and service enhancement

Regional Safety and Quality Processes/Data Sources

- ***Serious Adverse Incidents***
- ***HSC Trust / Primary Care Complaints***
- ***Early Alerts***
- ***Regulation Quality Improvement Authority (RQIA)***
- ***Safety and Quality Alerts (consist of a range of Alerts such as NPSA, Audits, Regulatory Reports from RQIA, National Reports, Departmental Circulars)***
- ***Case Management Reviews***
- ***Domestic Homicide Reviews***
- ***National Institute for Health and Care Excellence (NICE)***
- ***Mothers and Babies: Reducing risk through Audits and Confidential Enquiries***
- ***Safeguarding***
- ***Untoward Events***
- ***Adverse Incidents***
- ***Falls***
- ***Pressure Ulcers***
- ***Dysphagia***
- ***Infection Control***
- ***Child Deaths***
- ***Maternity / Perinatal Mortality Review Tool***
- ***Frailty***
- ***District Nursing***

Mechanisms used by SPPG/ PHA to Share Learning

The management of the identification and dissemination of regional learning is the responsibility of the SPPG in conjunction with the PHA. A range of mechanisms are in place to fulfil this responsibility and are outlined right:

Safety and Quality Learning Letters, Reminders of Best Practice and Professional Letters may be issued:

- where guidance has not previously been disseminated,
- where guidance already exists but it is deemed appropriate to issue a reminder to reiterate key points or strengthen understanding; or
- to reinforce standards and guidelines that are already in place to a specific professional group.

Newsletters shared across the HSC:

- Provide a platform for disseminating learning and best practice from a range of diverse topics to a broad audience across HSC.

Referral to a Regional Network/Forum:

- Learning from SAIs are shared with established Regional Groups to consider and disseminate within their local forums, as appropriate.

Thematic Reviews:

- In-depth reviews which examine similar types of SAIs to ensure that patterns are considered within the regional context ensuring recommendations and key learning points are disseminated across the HSC.

Safety and Quality Events:

- Provide a platform for collaborative learning across the region, whether in person or virtual, supporting knowledge sharing across our health and social care system, and facilitates the exchange of specialist knowledge and best practice.

Regional Collaboration and Stakeholder Involvement – who helps us learn?

The learning captured in this report reflects the collective efforts of a wide range of stakeholders across the HSC. We are particularly grateful for the contributions of professional/clinical staff from within SPPG and PHA, HSC Trust staff, primary care providers and their teams, community partners, patients/service users, carers and others. Each have played a vital role in shaping our understanding of safety and quality enriching our learning and strengthening our shared commitment to safe, effective and person-centred care.

This regional approach ensures that learning is not only embedded locally but shared widely, supporting continuous improvement across our HSC system.

HSC Quality Themes

The DoH Quality 2020 Strategy created the strategic framework to protect and improve quality in health and social care in Northern Ireland. To ensure clarity, relevance and strategic alignment, with the SPPG Safety and Quality Framework, the learning from this report is reflected around the five core HSC Quality Themes:

These themes reflect the fundamental dimensions of high-quality health and social care and provide a consistent framework for analysing and sharing learning across the wider HSC. By grouping insights under these themes, we can better understand how different aspects of care can interact, where improvements are needed and how learning translates into action.

This thematic approach supports transparency and accountability and allows all stakeholders to engage in a meaningful way seeing not only what has been learned but how it aligns to regional priorities.

Ultimately, the use of these five themes ensures that learning is not siloed but integrated across all services, helping those deliver safer, more effective and responsive care to our population.

Theme 1

Transforming the Culture

Transforming the Culture: Embedding Safety, Quality, and Compassion at Every Level

The theme " Transforming the Culture" reflects our strategic focus on creating a workplace environment where safety and quality are not just priorities but deeply embedded values that guide decisions, interaction, and improvement effort.

This transformation is about more than changing processes; it's about shifting mindsets. Over the past year, we have worked to foster a culture of openness, learning, and psychological safety where staff feel empowered to speak up, share ideas, and take ownership of quality outcomes. We have strengthened leadership visibility, encouraged cross-team collaboration, and promoted behaviours that support respectful, inclusive, and patient-centred care.

By transforming the culture, we are laying the foundation for sustainable improvement - where excellence is driven not by compliance alone, but by a shared commitment to doing what's right.

The following section highlights the initiatives, stories, and metrics/analysis that demonstrate how cultural change is taking root.

Learning from Hospital Inpatient Falls

The aim is to ensure that every fall leads to local learning, shared learning and meaningful change in practice – ultimately reducing the likelihood of future falls.

Post Falls Review Process

A Shared Learning Form (SLF) is submitted to the PHA falls inbox falls.learning@hscni.net following a Post - Fall Review on fall incidents of Inpatient Falls resulting in moderate/major, catastrophic harm. This enables:

- Regional analysis of falls trends across HSC Trusts
- Thematic learning from a sample of cases
- Sharing of improvement opportunities across the system

Between April 2024 and March 2025, the PHA received:

- 181 SLFs (compared with 148 last year, April 2023- 2024)
- 94 inpatient falls analysed in depth under five themes:
  - What happened
  - What went well before the fall
  - What went well after the fall
  - What could we improve
  - What we have learned

What the data tells us

What went well before the fall

- ***Consistent use of risk assessment and care planning before a fall occurred.***
- ***Communication and patient engagement were strong and remain critical to safe care.***
- ***While environment and system factors were less frequently identified, they underpin effective falls prevention and should not be overlooked.***
- ***Sustaining strengths in Risk Assessment, Care Planning, and Communication will continue to drive safe practice.***

About the Pareto Chart:

A Pareto chart is a type of bar chart that shows both the size of each category and a line that adds them up as a total. It helps us see which areas make the biggest difference. The idea is based on the 80/20 principle – meaning that a small number of causes often account for most of the results. In this report, the Pareto charts show which themes explain the majority of strengths and improvement opportunities.

Chart 1 shows that most of the positive actions taken before a fall were linked to risk assessment and care planning, which made up 83% of the reports. The second most common theme was communication, learning, and patient engagement, at 11%. The final theme, environment, staffing, and systems, accounted for 6%.

The line on the chart shows the cumulative total: by the time we include the first two themes, we have already explained 94% of positive actions. Adding the third theme brings the total to 100%. This means that the majority of strengths lie in just the first two areas.

What went well after the fall

- Strong evidence of risk management and post-fall care planning, reflecting clinical vigilance and responsive care.
- Leadership actions and communication with patients, families, and teams were balanced and multidisciplinary.
- Environmental adjustments supported safety, though featured less often.

Strengthening practice in these areas will enhance outcomes for patients following a fall.

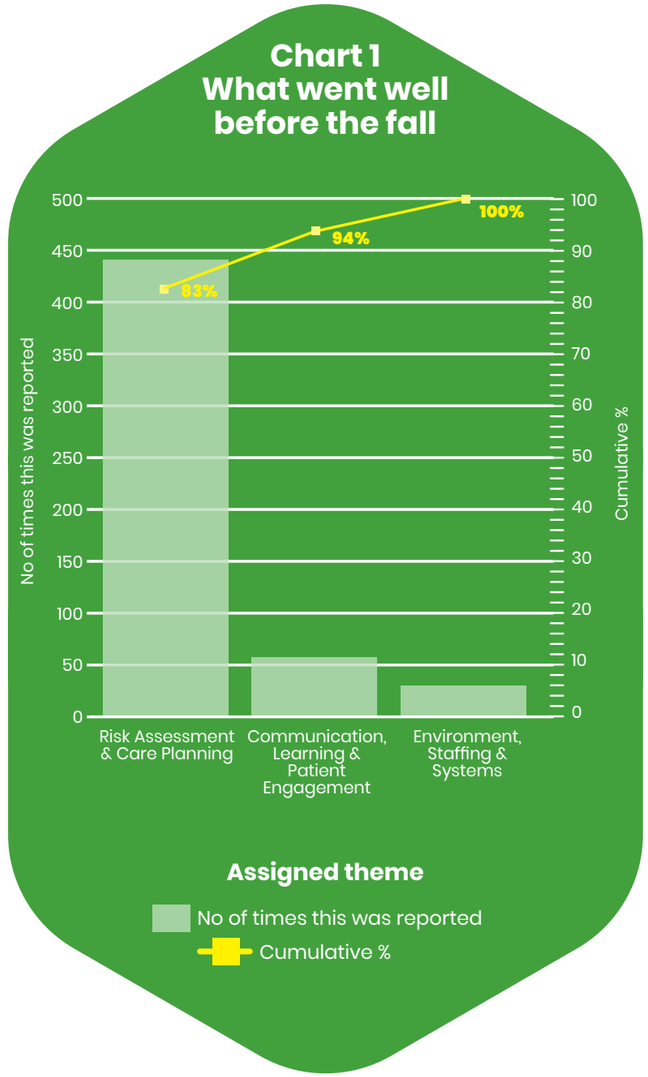
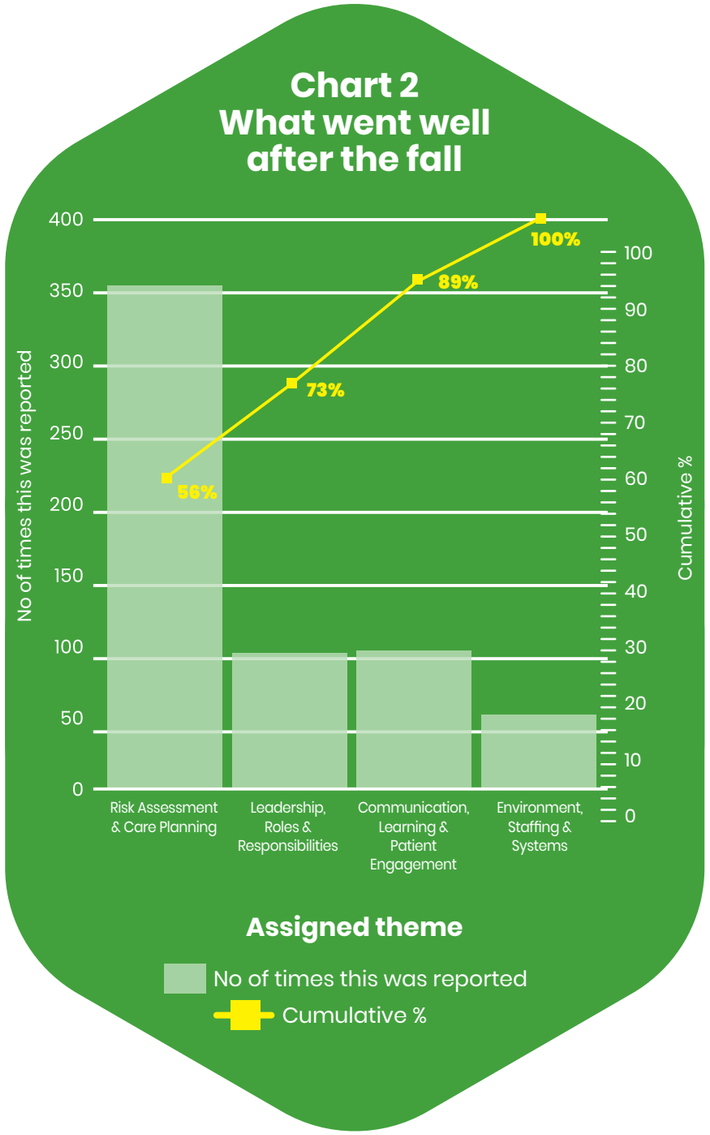


Chart 2 shows that the majority of strengths after a fall were linked to risk assessment and care planning, which made up to 56% of the reports. The next two themes were leadership, roles and responsibilities (17%) and communication, learning and patient engagement (17%). The final theme environment, staffing, and systems, accounted for 11%.

The line on the chart shows the cumulative total: adding the first theme explains over half of the strengths (56%). Including leadership and communication brings this to 89%. Adding the final theme brings the total to 100%. This highlights that almost nine out of ten strengths relate to the first three themes.



What could we improve

The majority of improvement opportunities sit within four areas:

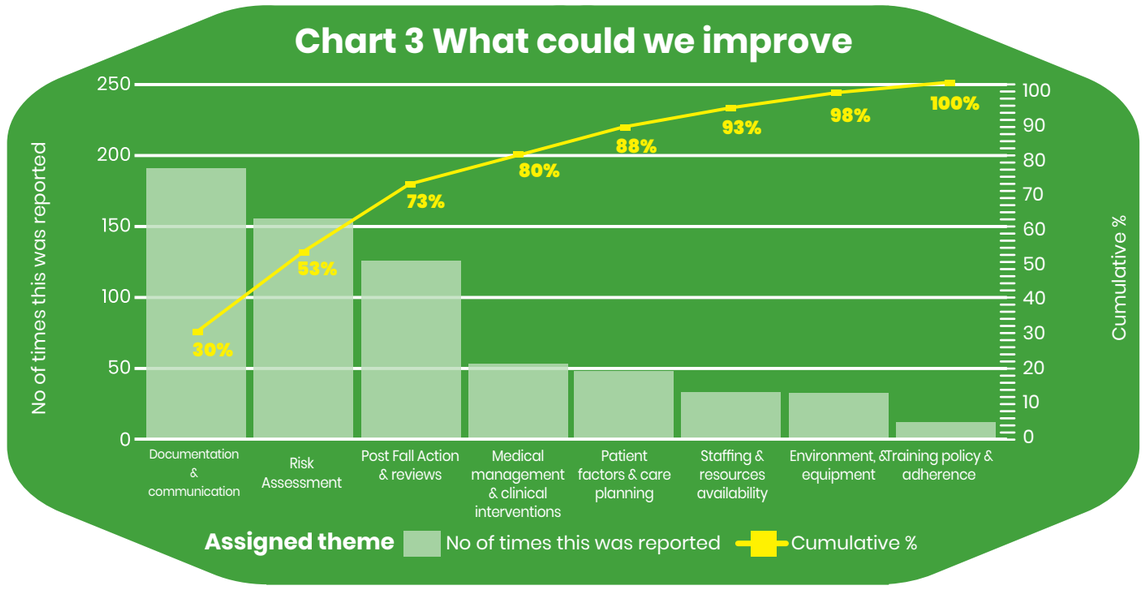
1. Documentation and communication.
2. Risk assessment.
3. Post–fall actions and review.
4. Medical management and clinical interventions.

Together these represent around 80% of all opportunities for improvement.

Chart 3 shows that most improvement opportunities relate to documentation and communication (30%), followed by risk assessment (23%), and post-fall actions and reviews (19%). Together these account for almost three-quarters of all improvement needs.

The next most common theme is medical management and clinical interventions (12%), while the remaining themes – patient factors, staffing and resources, environment and equipment, and training – each account for much smaller proportions.

The cumulative line shows that by focusing on the first four themes, we can address around 80% of all opportunities for improvement, highlighting where efforts should be prioritised.



What we have learned

The Pareto analysis shows that focusing improvement efforts on three themes will yield the greatest impact:

- Communication
- Leadership
- Training

Most learning relates to how we communicate, share learning, lead teams, and define roles. Strengthening these will drive meaningful and sustainable change.

Why it matters

- Focuses improvement where it will have the greatest impact.
- Promotes efficiency by concentrating on the few factors that make the biggest difference.
- Supports decision-making when resources (time, people, money) are limited.
- Ultimately, helps reduce harm and improve patient safety.

Next steps

- Results will be shared in a Learning from Falls newsletter with HSC colleagues during Falls Week in September 2025.
- The Regional Inpatient Falls group, chaired by the PHA will host a workshop on 18 September 2025. This will bring together colleagues from nursing, allied health, safer mobility and frailty services to:
  - Reflect on findings
  - Share experiences
  - Agree a collaborative workplan for the year ahead

NI Frailty Network Fundamentals of Frailty Education Programme

What we did:

Education has been a priority of the Frailty Network since its inception. Educating the workforce about prevention, identification and management of Frailty will lead to improved outcomes and experience of service users and staff and can have a positive impact on system pressures.

Following a scoping study, the Education Task and Finish Group concluded that whilst there were some programmes available to provide training in some of the Frailty syndromes, there was little available in terms of dedicated Frailty education. This resulted in collaboration with HSE Ireland to secure access to the Fundamentals of Frailty Programme which was operating across Ireland. In order to improve access to the content, a series of online modules have been developed in collaboration with the HSC Clinical Education Centre. The aim is to roll out a tiered education programme across the HSC and Primary Care in the first instance.

- Tier 1 - general awareness (one e-learning module).
- Tier 2 - Non-registered or pre-registered staff working with older adults (Tier 1 + four additional e-learning modules).
- Tier 3 - Registered clinical staff working with older adults (Tier 2 plus three Face-to-Face modules with case studies and group work).

What were the results?

- During the reporting period, over 500 staff accessed and completed these online modules, which would equate to Tier 2 learning.
- We have also identified and trained a number of Facilitators who are equipped to deliver face to face training to those identified as having Tier 3 learning needs.
- Through NIMDTA, over 80 trainee GPs received the full Tier 3 learning programme. Evaluations for the programme have always been extremely positive in all settings.

"This was a really good teaching that applies to daily practice.

Thank you"

"I will feel much more confident in providing a comprehensive assessment during Geriatric patient interaction"

"Really brought the need to address frailty and not just accept it as an expected state"

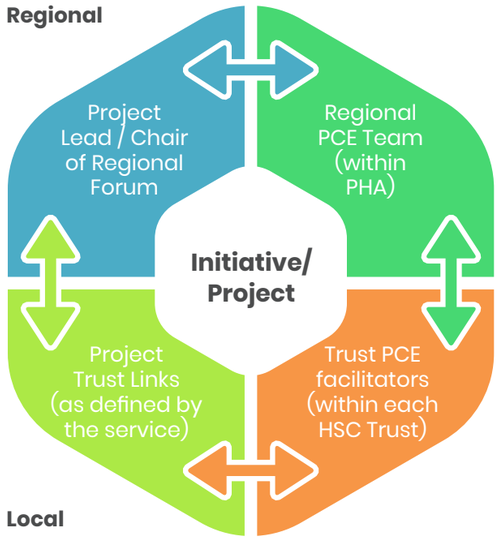
"It was a good event, learnt how to recognise frailty, different scoring systems and community resources for helping people with frailty"

Comments on the left highlight some of the ways trainees indicated they will put learning into practice.

Regional Patient Client Experience (PCE) Programme

The Regional Patient Client Experience (PCE) Programme seeks to proactively enable service users, families and carers to share their narrative/stories of Health and Social Care Northern Ireland (HSCNI) through mechanisms which enables local and regional analysis, and can lead to learning and change at all levels of the system. Through proactively engaging with stories voices of people with lived experience is both a driver for quality improvement and an evaluation of the impact of the care we deliver. There are two mechanisms led by the Public Health Agency (PHA) in collaboration with Health and Social Care Trusts and key stakeholders across the wider HSCNI – Online User Feedback and 10,000 MORE Voices. Each initiative is built around four key partnerships (see figure 1). This partnership approach is essential to create a culture committed to listening to the experiences shared and embedding learning and change.

Figure 1. Core Partnerships within Regional PCE Programme



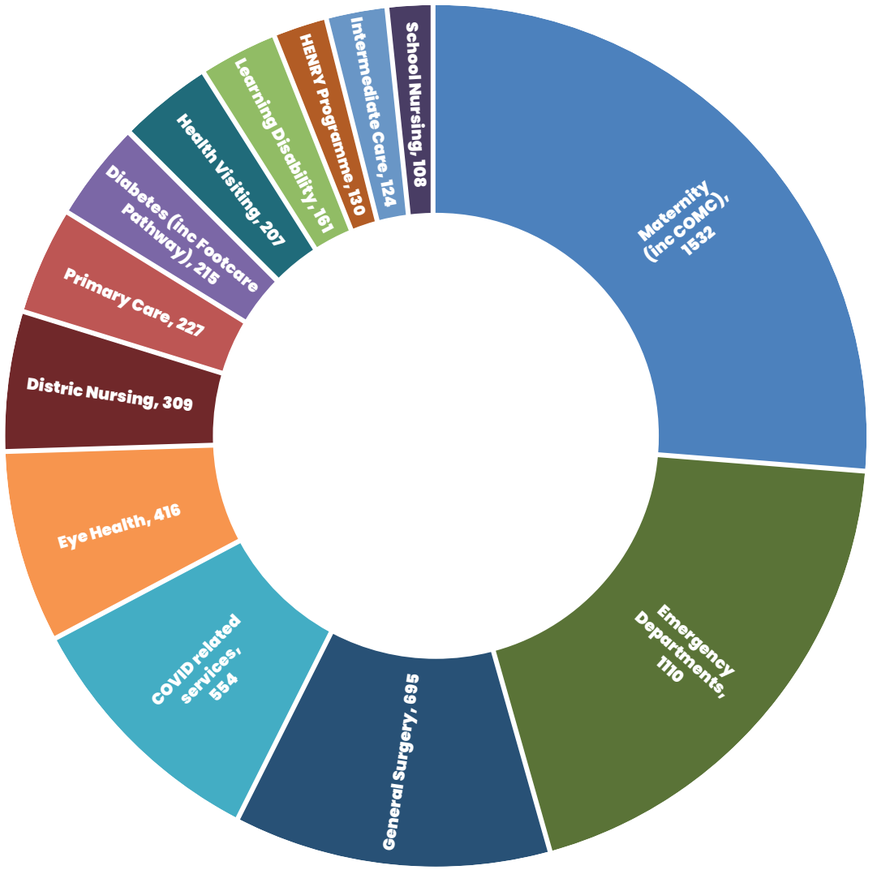
Foundational to the Regional PCE Programme is to enable learning at every level of the system. Each individual organisation has access to their data to support ongoing learning with services and organisations, built upon robust data collection methods and analysis. Through each mechanism the PHA has regional oversight to the experience shared by service users, families and carers and supports the processes for sharing learning.

(1) Care Opinion - An Online User Feedback Service

This service provides opportunity for service users, families and carers to share feedback anonymously, about their experience of care. It delivers a two way feedback mechanism whereby services can provide a response to the stories shared, identify changes which can be made and collate learning for each organisation. Each story highlights areas of good practice, supporting learning from excellence and also areas where improvements can be made.

Currently there were 19,958 stories shared directly by service users, families or carers with 73% receiving a response from the service within seven days. Through the two-way feedback mechanisms a timely response within seven days demonstrates services are listening to the feedback shared on Care Opinion. This also supports services to engage on a regular basis with feedback and to identify changes – either through an individual story or collective analysis of stories. At a local service level 589 stories have been recorded on the website as creating a change, however this number is not reflective of stories which have been included in Quality Improvement initiatives, research or organisational analysis. At a regional level 5788 stories have been analysed and presented to Regional or Strategic Forums to influence and inform service development (Figure 2).

Figure 2. Number of Care Opinion stories analysed for Regional/Strategic forums



(2) 10,000 MORE Voices - Deeper studies of experience through defined projects

This initiative offers a deeper exploration of experience around a defined service area or profession. The focus is to demonstrate person-centred healthcare practices through the perspective of the service user, family or carer.

It is built upon a change model whereby each project supports translation of learning (Figure 3). Analysis is undertaken through Sensemaker®. This is a web based software built upon principles of ethnography to identify the mass sense of experience through analysis of micronarrative and explore areas for improvement.

Figure 3. Change Model Underpinning 10,000 MORE Voices

1 **Design** Design of the SenseMaker process and collection instrument.

2 **Story Collection** Listening to people's stories using the SenseMaker instrument.

3 **Emergent Pattern Analysis** Representing all the patterns across the entire story set and for specific subgroups.

4 **Sensemaking Conversations and Identifying Improvement** Making sense of the data: drawing conclusions and insights that inspire action.

5 **Actions & Experiments** Carrying out project interventions both as experiments and concrete actions.

Throughout a financial year there are four regional projects undertaken through 10,000 MORE Voices with timeframe determined through a project outline. In 2024/2025 the key projects developed focused upon:

1 The experience of Shared Decision Making (linked to NICE Guidance NG 197)
2 The experience of Residents living within a Care Home
3 The experience of Multidisciplinary Teams within Primary Care
4 The experience of Primary Care Nurses within Primary Care service

Each project follows through the change process and is at varying stages. The learning from data analysis includes a series of staff workshops to enable local staff to engage with the stories and support context prior to the publication of a regional report. Local Trust data is also available through an Emerging Themes report. The Regional report provides key messages drawn from the experiences of service users, families and carers shared through the survey. Final reports are published on the Engage website. The key messages inform and influence the commissioning, design, development and evaluation of service through the commissioning Regional Forum.

(3) Bespoke Projects

It is recognised that there are areas of work where the Regional PCE programme needs to be agile and adapted to support meaningful engagement on sensitive experiences. This may involve adapting the delivery of a project or developing a unique approach (often as part of a wider Engagement plan).

An example of a bespoke project is the introduction of Digital Story Telling (based upon the Welsh Framework). This is currently being tested through PHA team to understand how individual stories can be presented for learning at every level of HSCNI. This initiative is likely to build upon someone sharing their experience through a complaint, through exploration of a difficult experience or part of an investigation. In 2025/2026 this will be explored as part of training programmes for staff relating to key messages from people with learning disabilities and key messages from parents and families who have experienced a Sudden and Unexpected Death of an Infant or Child (SUDIC).

Never Events - PHA and South Eastern Trust (ECHO Session)

One of the Speciality Doctors in Public Health, presented the SAI data on never events in Northern Ireland from 2017 to 2024.

Key Points:

- Never events are serious, preventable safety incidents.
- The most common types of never events include wrong site surgery and retained foreign objects.
- Data showed an increase in never events from 2020 onwards, possibly influenced by the COVID-19 pandemic.
- The importance of thorough documentation, standardized procedures, and continuous learning was emphasized.

Following this there were three case studies presented and then these were discussed in breakout rooms.

Key Learnings and Takeaways

- Thorough Documentation: Ensuring precise and detailed documentation at all stages of patient care.
- Standardized Procedures: Implementing and adhering to standardized procedures and checklists to prevent errors.
- Psychological Safety: Creating an environment where staff feel safe to speak up and raise concerns.
- Continuous Learning: Sharing experiences and learnings across teams and organizations to improve patient safety.

Theme 2

Strengthening the Workforce

Strengthening the Workforce: Building Capability, Confidence and Culture

The theme "Strengthening the Workforce" reflects our key focus on empowering our people as the foundation of safe, high-quality care. Over the past year, we have invested in developing the skills, resilience, and leadership recognising that a well-supported, well-trained work force is essential to delivering excellence.

This theme highlights our commitment to creating an environment where staff feel valued, equipped, and confident to contribute to continuous improvement. From enhanced induction and training programs to wellbeing initiatives and leadership development, we have taken meaningful steps to support staff across the HSC so they are not only competent but also deeply engaged in the safety and quality agenda.

By strengthening the workforce, we are fostering a culture of accountability, collaboration, and innovation—where every individual understands their role in maintaining high standards and feels empowered to speak up, learn, and lead.

The following section outlines progress we have made during the reporting period and priorities that will guide future safety and quality related strategies.

New Models of Prescribing (NMOP):

Implementation of HS21 Prescribing by Foyle Hospice Community Prescribers Pathfinder

What we did:

Many people with life limiting conditions wish to have their palliative care needs met in the community. However in recent years access to timely prescribing and dispensing of palliative medication has been highlighted as an issue within complaints, especially in out of hours period. Medical and non-medical prescribers employed by the hospice sector are unable to prescribe in the community setting as no process exists to provide them with cipher codes and prescription pads. The Foyle pathfinder project was established to explore how this barrier could be addressed.

There is a growing number of qualified non-medical prescribers (NMPs) working in the community setting. However, the process to support both hospice-employed medical and non-medical prescribers to issue HS21 prescriptions in the community continues to be limited. It is essential that additional prescribing models are considered and developed to ensure this patient population with specialist palliative care needs are adequately met by maximising capacity as far as possible within existing resource. A pathfinder was established in 2024 to address these challenges by facilitating hospice-employed specialist palliative care nurse and specialty doctor prescribers to issue HS21 prescriptions to patients living in their own homes or a care home.

A Task and Finish group, led jointly by SPPG and PHA involving a number of key stakeholders from Foyle Hospice, the SPPG, the PHA, Northern Ireland General Practitioners Committee (NIGPC), the Western Health and Social Care Trust (WHSCT) and the Medicines Optimisation Innovation Centre (MOIC), overseen the pathfinder, developing a standard operating procedure (SOP), which detailed both governance frameworks and training and competency arrangements. The Foyle Hospice cipher number was used alongside HS21 triplicate prescription pads for the purposes of the pathfinder.

An independent evaluation was carried out by the Medicines Optimisation and Innovation Centre (MOIC) and data was collected at baseline, midway and at the end of the pathfinder.

Outcomes included:

- Timely access to medicines for patients and therefore prompt symptom management, increasing patient/family satisfaction.
- Timely review of symptoms to support the safe and effective titration of palliative medications.
- Reduced pressures on other services such as the GP, District Nursing and Western Urgent Care, thereby increasing their capacity for other clinical duties.
- Development and Implementation of robust governance systems and standardisation of processes.
- Proficient time management for Hospice clinicians and improved clinic efficiency due to the reduction in the number of steps needed and time taken to access prescriptions.
- Encouragement of professional autonomy, clinical responsibility, and increased professional standing leading to increased job satisfaction.

What were the results?

Data shows that HS21 prescribing in the community reduced the number of steps and time required for a patient to obtain a prescription and their medicines:

- The baseline data confirmed that an average time of 4 hours and 43 minutes was calculated from the start of a typical homecare visit until the new HS21 was available for collection from the GP.
- Upon introduction of the pathfinder this time was reduced to 30 minutes until the new HS21 was written by the Hospice prescriber.
- The pathfinder has influenced positive partnership working and as a result of the pathfinder's success, it has been recommended that HS21 prescribing is adopted incrementally into standard practice by all Hospice settings throughout Northern Ireland.

Project ECHO Northern Ireland

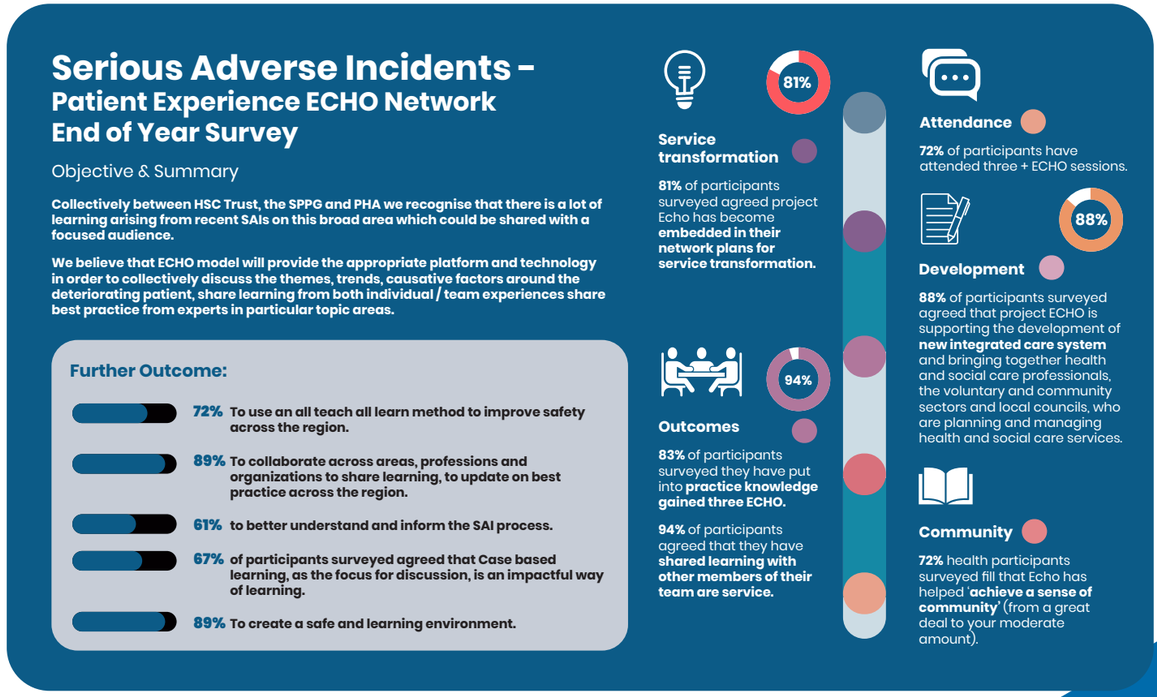
Project ECHO (Extension of Community Healthcare Outcomes) is a worldwide movement providing an online learning and support methodology. It supports knowledge sharing between professionals from across health and social care, and facilitates the exchange of specialist knowledge and best practice.

Project ECHO: SAI - Patient Experience

During the reporting period an ECHO project focusing on SAI - Patient Experience was led by the PHA Safety, Quality and Innovation team. All Trusts were represented as well as DoH and SPPG in both participants and presenters. The sessions are as below:

1. SAI redesign - DoH
2. Sharing the Learning from Patient Safety Incidents - Belfast Trust
3. Never Events - PHA and South Eastern Trust
4. NIAS Systems, controls and communication. The role of the 6th Healthcare Trust in building a collaborative learning system - NIAS
5. Confronting confirmation bias - A case study -Western Trust
6. Learning from Excellence - Southern Trust
7. Communication
   a. Data on SAIs/Complaints related to Communication- SPPG
   b. It's Good to Talk - Implementation of a Communication Strategy- Northern Trust

All sessions were well attended and many more had also registered for the sessions and can review later on Moodle. Further details on each session are detailed throughout the report. See below infographic of the end of year survey results.



Regional Learning from Mental Health SAIs ECHO Network

The Regional Learning from Mental Health SAIs ECHO Network 2024/25 was identified as the appropriate platform and technology to collectively discuss the themes, trends and causative factors emanating from a Level 3 SAI Independent Review and the resulting Regional Strategic Action Plan, and other SAIs. The purpose of which is to share learning from both individual and team experiences, share best practice from experts in particular topic areas thus ultimately changing practice to prevent the re-occurrence of SAIs.

This ECHO network welcomed people from all areas of health, social care, government departments, first response organisations such as Northern Ireland Ambulance Service (NIAS) and Police Service of Northern Ireland (PSNI), Out of Hours GP and Regional Emergency Social Work Service to learn from each other.

Organisations presented best practice examples, initiatives and learning from particular topic areas in the ECHO sessions. A total of eight sessions, taking place monthly via Zoom.

- The first ECHO session was held on 18 September 2024 and the theme was 'Case – What happened.' The session was facilitated by Martina McCafferty (SPPG) and Eilish Deeney (PHA) and this session highlighted the key points themes, trends and causative factors emanating from a Level 3 SAI Independent Review and the resulting Regional Strategic Action Plan.
- Session 2 held on 23 October 2024 was the 'Regional Mental Health Service (Reducing variation)' and the guest speaker was Gavin Quinn (Head of Regional Mental Health Service, SPPG).
- Session 3 took place on 27 November 2024. The theme of this session was Multi-agency working, and guest speakers were from NIAS who presented on NIAS Mental Health Practitioners in Control Room and the Complex Cases team, and PSNI, who presented on Multi-agency Support Hubs.
- Session 4 took place on 22 January 2025. The theme for this session was Mental Health (NI) Order 1986 – Review of legislation and guidance, presented by QUB and a Tiered training model for staff, presented by SHSCT.
- Session 5 took place on 19 March 2025 and the theme was Places of Safety. WHSCT led this session, presenting on a scoping review entitled 'How safe is our place of safety for those in mental health crisis, boarded in Emergency Departments (EDs)' and also Adult Mental Health Crisis and Inpatient Improvement work with the overall aim of reducing length of time an adult registered with mental health services spends in ED waiting on assessment or access to an inpatient ward.

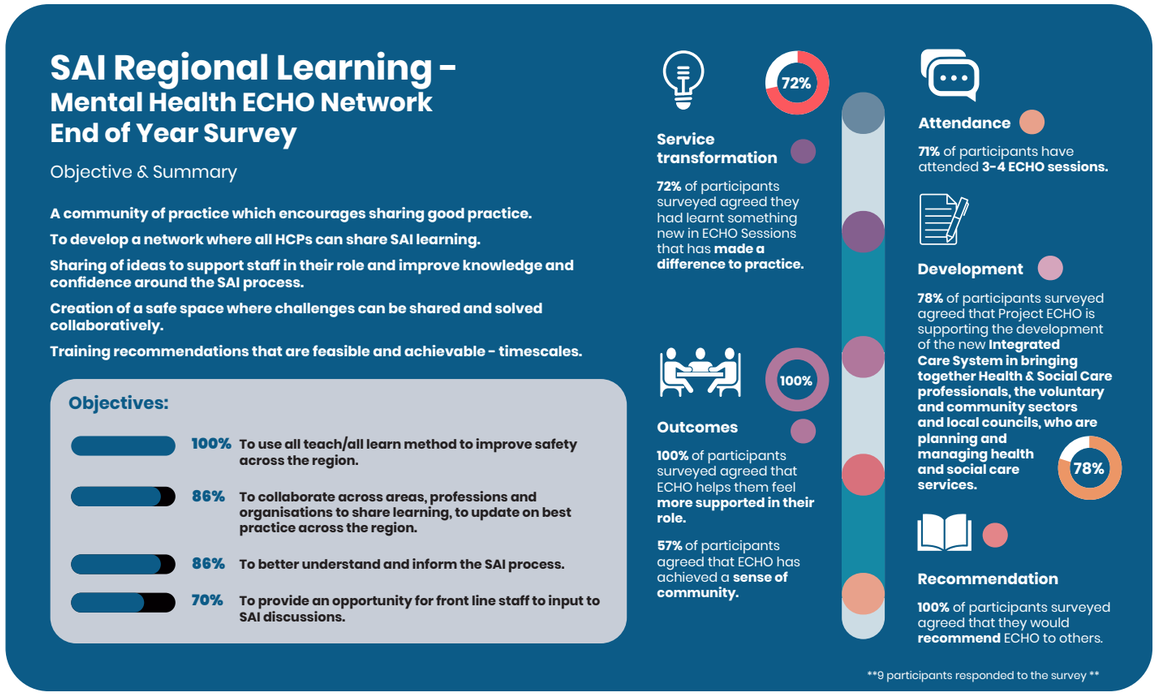
Further sessions planned for April, May and June 2025 will include:

- an update from the Mental Health Pharmacy Regional Forum on developments around medicines management in Mental Health.
- a session to be led by NHSCT on Interfaces and Information Sharing.
- a session on 'Engaging Service Users and families' to be led by SEHSCT.

Attendance at sessions ranged from 45-50 individuals but there are over 150+ registered for this ECHO programme, who can access the recorded sessions at a time more convenient for them.

Registered participants were predominantly HSC staff, in mental health services.

See below infographic of the end of year survey results.



Communication

The final session of the 2024/25 SAI - Patient Experience ECHO programme focused on communication which has been a recurring theme in patient experience complaints as well as SAIs.

Colleagues from SPPG safety team presented regional data on communication issues in SAIs and complaints highlighting themes and trends, in particular those involving internal staff communication, patient communication and record keeping.

This was followed by NHSCT staff presenting on the implementation of a communication strategy within the NHSCT.

The presentation focused on key learning issues since its implementation:

1 - Importance of Communication:

Communication is a critical factor in patient safety and experience. It is essential to address communication issues proactively to prevent adverse incidents and complaints.

2 - Data-Driven Insights:

Analysing data from SAIs and complaints helps identify recurring themes and areas for improvement. This can guide the development of targeted strategies to enhance communication.

3 - Proactive Communication Strategies:

Implementing structured communication strategies, like the Five Ds Approach, can significantly improve patient and family experiences. It encourages healthcare professionals to engage proactively with patients and their families.

4 - Collaboration and Continuous Improvement:

Ongoing collaboration with various stakeholders, including Northern Ireland Pubic Service Ombudsman (NIPSO), and Trust colleagues, is crucial for developing effective frameworks and procedures. Continuous improvement efforts, such as the use of Power BI, can enhance data analysis and decision-making.

5 - Cultural Shift:

Encouraging a cultural shift towards proactive and compassionate communication can lead to better patient outcomes and satisfaction. Training and support for healthcare professionals are essential to embed these changes.

Shared Learning - Dissemination of safety messages, learning from Patient Safety Incidents

The second session of the SAI - Patient Experience ECHO Programme on 27 June 2024 focused on improving learning and communication from incidents, enhancing staff engagement, and strengthening the safety culture within clinical settings.

Presentations were led by HSC Trust clinicians on the following topics:

1. Shared Learning Questionnaire

The aim of the presentation/discussion was to assess staff engagement in respect of learning from Serious Adverse Incidents (SAIs).
Following discussion, it was agreed there was a need to:

- foster a just culture and improve communication pathways to support open discussion ensuring that staff are aware of recommendations and learning from SAIs.
- develop accessible resources such as a learning library and facilitate learning through safety briefs, handovers, and multidisciplinary meetings.

2. ED Education Stations

This presentation was delivered to improve the dissemination of safety alerts and learning in the Emergency Department.

The HSC Trust created an 'ED Education Station' which facilitated face-to-face communication, displays for interesting cases, safety newsletters, QR Codes for learning materials and a dedicated email for Safety Notices.

There has been positive feedback from staff regarding the creation of the Education Station, 90% of staff have found the station to be useful with increased engagement and awareness of safety learning.

3. Improving M&M Meetings

The third presentation was to enhance effectiveness and attendance of Morbidity and Mortality (M&M) meetings.

The introduction of structured reviews, learning from excellence to highlight positive outcomes, and the creation of M&M hot topic summaries for wider dissemination across the HSC Trust has increased attendance and engagement at M&M meetings and improved learning and sharing of valuable information.

Key Learnings

1. Just Culture – Emphasising a culture where staff feel safe to discuss incidents without fear or blame.
2. Effective Communication – Utilising various methods e.g. email, face-to-face meetings, education stations to disseminate information and share learning.
3. Multidisciplinary Involvement – Engaging a wide range of staff in the learning process to ensure comprehensive understanding and implementation.
4. Structured Learning – Implementing structured reviews and summaries to highlight key learning points and ensure they are accessible to all staff.
5. Continuous Improvement – Using feedback and suggestions to continuously improve the processes for learning from incidents.

Learning from Excellence

On 25 March 2025, an ECHO session was delivered focusing on the 'Learning from Excellence' (LfE) initiative. The session provided insights into the concept and its implementation in healthcare settings.

A presentation, led by SHSCT introduced the concept of Learning from Excellence (LfE), which centres on identifying and learning from episodes of outstanding practice in healthcare. Its aims are twofold, to enhance the quality and safety of care, and to acknowledge and celebrate staff for their exceptional contributions. Recognising staff for their contributions helps boost morale, strengthen engagement, and enhance overall performance across the organisation.

Participants were divided into breakout groups to explore specific case studies and identify key learnings. Discussions highlighted the importance of strong team connections and the value of sharing best practices across teams. Participants also emphasised the need to recognise leadership at all levels, as a means of fostering a positive and collaborative work environment.

Newsletters

Newsletters provide a platform for disseminating learning and best practice from a range of diverse topics to board audience across the HSC. The following are examples of newsletters produced by SPPG and PHA.

Learning Matters Newsletter is produced by PHA/SPPG and provides a method of sharing learning relating to serious adverse incidents, complaints, reviews and patient experience across Northern Ireland. During the reporting period, one Learning From Newsletter was produced. The Learning from Falls newsletter was issued in September 2024 to share information and key learning from inpatient falls across HSC Trusts. More detail on Learning from Hospital Inpatient Falls can be found under Theme 1 - Transforming the Culture.

General Medical Services (GMS) Newsletter - GMS newsletter is produced by the Primary Care Directorate, SPPG, for general practices across Northern Ireland. It is intended to be informative and a compliment to the information and resources available to practices on the HSC Primary Care Intranet site.

NI Medicines Management Newsletter - These newsletters are produced for general practice and community pharmacy by the Regional Pharmacy and Medicines Management Team. During the reporting period, 12 newsletters and four Newsletter Supplements were issued.

Pharmacy Regional News (PRN) - These newsletters are produced for community pharmacists and their team by the Regional Pharmacy and Medicines Management Team to highlight learning from adverse incidents. During the reporting period, one newsletter and one supplement was produced.

A summary of some of the key articles have been included in the body of the report under the relevant theme.

Deteriorating Patient

Aim
During the reporting period a review of SAIs involving a failure to recognise the deteriorating patient was undertaken

Results
In order to have some information to support this a Public Health Registrar carried out an analysis of SAIs regarding the deteriorating patient. Seventy-four reports were initially identified over a 32month period. Of these, 29 were included and 45 were excluded. Reports were excluded if they did not relate to an incident where failure to recognise the deteriorating patient and/or sepsis were identified.

Thematic analysis
Six phases of reflexive thematic analysis (Braun and Clarke, 2006)

- **Familiarisation** with the data
- **Code data**
- Generate **initial themes**
- Review and develop themes
- **Redefine, define and name themes**
- Produce the report: last look at analysis, decide order of themes, use examples

Key themes

Five key themes were identified;

- the service in which the SAI occurred being under pressure

'capacity and demand at the time limited timely responses from NIAS'
'delay in getting service user into department due to occupation by other patients'
'ICU team under cognitive and stress burden - lost track of time'
'busyness of the department, high numbers of ED attenders, high acuity of patients waiting on inpatient beds and 3 complex patients in the resus section of ED requiring one to one care with multiple teams in attendance is noted'

- communication issues

'unclear whether nursing or medical team made aware of standby call'
'medical staff should have told nurses there would be a delay to review'
'patient feels staff did not listen to her concerns'
'misleading communication in x-ray report'
'wife reported she had highlighted that patient had symptoms of sepsis and delirium to admitting nurse and doctor and did not feel listened'

- failure to follow protocol

'GCS not monitored according to policy'
'no vital signs recorded on triage'
'patient had sepsis red flag symptoms and ED consultant should have been actively informed, attending in person if patient not responding to treatment within one hour'

- a lack of patient-centred care

'staff involved in the care of this patient relied on NEWS scores rather than other potential features such as increasing infection markers or change in patient behaviour.'
'diagnosis was not based on full and current picture of patient'
'patient feels staff did not listen to her concerns'
'no evidence that demonstrated bedside handovers were part of routine practice during nursing handovers'
'escalation of care should be based on pain and nausea, not just NEWS'

- Failure to recognise and/or escalate the deteriorating patient

'patient uncooperative at times? Evolving clinical picture'
'the crew did not consider a sepsis diagnosis despite clinical picture and wife's input'
'pulse recorded as 162 prior to discharge, discussed with consultant'
'The initial observations of low temperature, fast heart rate and low blood pressure with a fast respiratory rate should have raised suspicions for potential sepsis and therefore, there should have been consideration for admission and intravenous antibiotics'
'Given the history of recurrent urinary tract infections and antibiotics for same plus reported new confusion concerns should have been raised as to query sepsis'
'It is unclear if there was recognition of the seriousness of the amount of oxygen Mr X was requiring'

As a result of these findings the PHA are convening regional group to develop protocols regarding the deteriorating patient.

Management and Monitoring of Communications Received in Respect of Service Users

What happened?

A number of Serious Adverse Incidents (SAIs) reviewed by Professional Officers from SPPG/PHA related to failure of appropriately managing communications received in respect of service users via email and telephone message service. This resulted in a delay in the completion of appropriate assessments.

What did we do?

It was agreed a Reminder of Best Practice letter should be issued. Reminders of Best Practice letters are disseminated where guidance already exists but it is deemed appropriate to issue a reminder of guidance previously issued.

The letter was issued to the wider HSC in relation to the Management and Monitoring of Communications received in respect of Service Users and was issued to all programmes of care in-year. All HSC Trusts were reminded it is their responsibility to have appropriate procedures in place to ensure the efficient management of communications received in respect of service users and ensure these are being adhered to. Trusts were directed to the Standard Email Communications Policy, developed by the Business Services Organisation (BSO) and asked to review and as necessary, update their procedures and systems to ensure they reflect the requirements under the current guidance.

What was the Key Learning?

HSC Trusts should have clear Standard Operating Procedures which cover the following key learning points:

- The creation, management and deactivation of generic email accounts.
- Robust management arrangements for any email account receiving or issuing service user referral/correspondence.
- Ensure staff appropriately manage the mailboxes for which they are responsible.
- Employing the use of Automatic Replies (Out of Office) for any periods when a staff member is out of office or the account is inactive.
- The timely deactivation of any email account which is no longer active.
- The use of automated telephone message facility to include informing the caller of alternative contact numbers outside working hours and for emergencies.

Theme 3

Measuring Improvement

Measuring Improvement: Turning Insight into Impact

The theme "Measuring Improvement" reflects our commitment to evidence-based progress in safety and quality. It underscores the importance of using data, feedback, and performance metrics not only to track change but to drive meaningful outcomes across our services.

This theme highlights how we've strengthened our approach to monitoring, evaluating, and learning from our activities—ensuring that improvements are not only implemented but sustained. Through robust audit processes, incident reviews, patient and staff feedback, and benchmarking against national standards, we have built a clearer picture of what works and where further action is needed.

By measuring improvement, we are creating a culture of transparency and accountability—where success is defined not just by intentions, but by measurable results.

This section of the report highlights the tools, frameworks, and stories behind our progress, and outlines how we will continue to refine our methods based on analysis to ensure every improvement leads to safer, higher-quality care.

Understanding the experiences of service users and staff is central to our commitment to safe, quality and continuous improvement. This section presents an overview of serious adverse incidents (SAIs) and complaints reported during the year to SPPG, highlighting key themes, trends, and areas of concern.

SAIs are events that result in significant harm or risk to individuals, requiring a review to understand what happened so organisations can identify both local and regional learning for the wider HSC. Complaints, while often less severe in nature, provide valuable insight into service user dissatisfaction, unmet expectations, and potential safety risks.

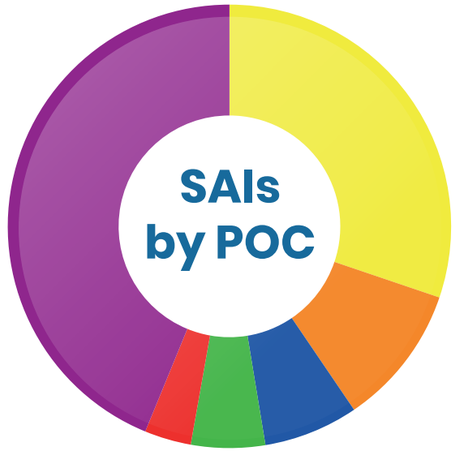
By triangulating data from serious incidents, complaints, and other sources including service user and staff feedback, we gain a more comprehensive understanding of system-wide issues. This integrated approach enables us to identify recurring patterns, validate concerns across multiple channels, and prioritise targeted interventions.

The following analysis outlines the volume and nature of serious incidents and complaints during the reporting period which is linked to learning included in other sections within the report. It also demonstrates how triangulated intelligence has informed strategic decision-making and strengthened our safety and quality assurance processes.

How many SAIs have been reported?

During the period 1 April 2024 - 31 March 2025, SPPG received 592 SAI notifications from across HSC Organisations. This is an increase from the previous reporting period, whereby 552 SAIs were notified in 2023/24.

Of the 592 SAIs received by HSC Trusts, 259 (43.8%) related to Acute Services, 179 (30.2%) to Mental Health and Learning Disability, 61 (10.3%) to Maternity and Child Health, 41 (6.9%) to Family and Childcare (inc CAMHS), 32 (5.4%) to Older People, Physical Disability and Sensory Impairment, 20 (3.4%) to Primary Health and Adult Community (includes GPs) and Corporate Business / Other.



Despite the increase in the total number of SAIs reported in 2024/25, the number reported relating to Family and Childcare (inc CAMHS) and Older People, Physical Disability and Sensory Impairment decreased from the previous reporting period.

Of the 592 SAIs received, 185 (31.3%) of SAIs were reported by BHSCT, 101 (17.1%) by SEHSCT, 90 (15.2%) by SHSCT, 86 (14.5%) by WHSCT, 86 (14.5%) by the NHSCT, 38 (6.4) by NIAS and 6 (1.0%) by Primary Care.

SAIs are conducted at a level appropriate and proportionate to the complexity of the incident under review, they may be Level 1, 2 or 3. Reporting Organisations use a HSC Regional Risk Matrix to determine the level of review to be undertaken Of the 592 SAIs received, the majority 534 (90.2%) of SAIs were reported as a level 1, 53 (9.0%) as a level 2 and 5 (0.84) as a level 3.

The SAI Process is currently being redesigned to develop a more streamlined process, focusing on learning and improvement rather than process-driven reviews. An update on the ongoing work is detailed in section Theme 4 of this report.

SPPG Oversight of Regional Complaints

HSC Trusts are responsible for investigating complaints received by them. SPPG maintains oversight of all HSC complaints.

In 2024/25 there was 5,483 complaints relating to 8,805 complaint issues raised across the HSC. This has increased from 4,779 in 2023/24. Over the last five years, all six HSC Trusts reported an increase in the number of complaint issues received.

Each complaint issue received is recorded against the POC of the patient/client to whom the complaint relates. If a complaint is made by a user of HSC Trust facilities who is not a patient/client, the complaint issue will be recorded against the POC of that service. Of the 8,805 complaint issues received by HSC Trusts in 2024/25, more than half (4,718, 53.6%) related to the Acute POC. Along with Acute, three other POCs accounted for 80% (7,084) of all complaint issues received; Acute POC (4,718, 53.6%), Family and Child Care POC (889, 10.1%), Maternal and Child Health POC (796, 9.0%) and Mental Health POC (681, 7.7%)

The top three themes of complaint subject remain unchanged:

- Quality of Treatment and Care (2217)
- Communication/Information (1922)
- Staff Attitude and Behaviour (1300)

The three top themes account for 61.7% (5439) of all complaint issues received during 2024/25. Complaints related to 'Communication/ Information' issues account for 21.8% (1,922) of complaint issues received. This includes all issues of communication and information provided to patients/clients/families/carers regarding any aspect of their contact with staff.

In the BHSCT, the highest number of complaints issues related to 'Communication/ Information' 614 (25.5%). It was the second largest category in the SEHSCT, SHSCT and WHSCT.

The Northern Ireland Public Services Ombudsman (NIPSO) is currently developing a Model Complaints Handling Procedure (MCHP), scheduled for publication on 1 July 2025 and full implementation by 1 January 2026. In preparation for this, SPPG has collaborated with representatives from HSC Trusts and SPPG's Primary Care Directorate to agree on a standardised dataset. This dataset is designed to enhance both local and regional intelligence and surveillance, enabling organisations to identify emerging themes, trends, and areas of concern, both locally and across the wider healthcare system.

The dataset follows a consistent coding structure, where each complaint 'issue' is classified not only by the clinical specialty involved but also by a structured taxonomy designed to identify the nature of the concerns raised. Complaints are further categorised into eight main categories, each broken down into sub-categories that specify the types of problems reported. This detailed coding system supports targeted organisational learning and improvement.

Primary Care Complaints

Complaints in relation to Primary Care Services are reported by contracted practices (General Medical, Dental, Optometry and Community Pharmacy) to the SPPG Primary Care Complaints Team who share them, where appropriate, with Primary Care Clinical Advisers to identify whether there are any clinical, professional, regulatory issues which may require further action and to consider any potential regional learning.

Primary Care contractors have in place mechanisms for cascading local learning internally within their own organisations/practices. The management of dissemination and associated assurance of any regional learning is the responsibility of the SPPG/PHA.

In 2024/25 272 complaints were received by SPPG Complaints Team regarding FPS practices - a 51% increase compared to 2023/24. Of the 272 complaints received, 253 (93%) related to GPs, 18 Dental, one community pharmacy and for the second year none related to ophthalmic services.

Of the 272 complaints received, the highest complaints subject was 94 relating to Treatment and Care - Quality. Table 1 shows the main complaints subjects.

Table 1 - Main Subject of Complaints Issues

Treatment and Care - Quality	94
Staff Attitude & Behaviour	48
Other	35
Date for appointment - waiting time	30
Clinical Diagnosis	16

In this reporting period, of the 272 complaints, 220 (95%) were handled under Local Resolution. Local Resolution is the first stage of the HSC Complaints Procedure. The purpose is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint. In the case of FPS practices, local resolution involves a practitioner seeking to resolve the complaint through discussion and negotiation.

Honest broker is the term used to describe the role of the SPPG Complaints Team in supporting and advising FPS on the handling of complaints. The Honest broker will act as an intermediary and is available to both the complainant or Practice/ Practitioner staff throughout the complaints process. The SPPG Complaints Team acted as Honest Brooker in 52 complaints in 2024/25 compared to 41 handled in 2023/24.

Strengthening Intelligence, Data Integration and Learning

Over the past year, SPPG has made significant improvements in the way we capture, analyse, and learn from SAIs and Complaints. A key enhancement has been the introduction of specialty-level coding across all Trusts, ensuring that both SAIs and complaints are now categorised according to the specific area of care in which the issue occurred. This additional layer of intelligence complements existing CCS coding for SAIs and the newly developed regional complaints dataset, providing a richer and more comprehensive understanding of trends and areas for improvement.

To enhance analytical capability, SPPG has implemented Power BI, a business intelligence and data visualisation platform, to support real-time analysis of SAI and complaints data. Power BI enables the integration of multiple data sources, allowing us to explore themes across specialties, service categories, and geographical areas. Through the use of interactive dashboards, heat maps, and visual analytics, we can now more effectively identify emerging trends, monitor performance, and inform targeted improvement actions.

Work continues across SPPG and PHA Directorates to establish a triangulated approach that links complaints and SAI data with other safety and quality processes. This integrated model will support a more comprehensive understanding of the system, enabling earlier identification of risks and more co-ordinated responses to issues of concern.

Safety and Quality Dashboards are also being launched across SPPG and PHA, providing an accessible, visual platform for staff to monitor key metrics and themes. Training will be delivered to ensure that all relevant teams can confidently interpret and use the interactive dashboards to drive improvement.

Theme 4

Raising the Standards

Raising the Standards: A Commitment to Excellence in Safety and Quality

The theme "Raising the Standards" reflects our commitment to continuous improvement, accountability, and excellence in all aspects of safety and quality. Over the past year, we have taken deliberate steps to elevate practices, empower teams, and strengthen governance arrangements around safety and quality processes supporting organisations to achieve the highest standards of care for the population we serve.

This theme captures the essence of our journey—from refining policies and procedures to embracing new ways of working and fostering a culture of learning. It highlights how we've responded to challenges, turning insights into action and setting new benchmarks for performance.

By raising the standards, we are not only meeting regulatory expectations but exceeding them—driven by a shared purpose to protect, support, and deliver the best possible outcomes for those we serve.

This section of the report highlights the strategic priorities that we have focused on throughout the year and will build upon next year and beyond.

SAI Redesign

As referenced in Strengthening the Workforce theme, the second SAI ECHO Programme was launched in the first quarter of the year. The first session on 23 May 2024 exclusively focused on the current redesign of the SAI Process and was attended by staff from a range of disciplines across the HSC.

Departmental policy leads who are leading on the redesign presented the the aims of the new framework for learning and improvement, moving away from the term "serious adverse incident" (SAI) to a more streamlined process, focusing on learning and improvement rather than process-driven reviews.

Key points included:

- Evidence Base for Change: Recommendations from various inquiries and reviews highlighted the need for a more effective process.
- Project Outputs: A new framework supported by standards and guidance, including different review methodologies.
- Managed Transition: Ensuring a smooth transition from the current process to the new framework.
- Core Themes: Engagement and support for patients, families, and staff, proportionate response, governance, and accountability, and system-wide learning.

Participants were divided into breakout rooms to discuss their initial thoughts on the outlined approach: Key feedback themes included:

- Support for the New Approach: Strong endorsement for the proposed changes, emphasizing the importance of learning and improvement.
- Training and Competency: The need for training leads and ensuring they have the appropriate skills and support.
- Public Confidence: Ensuring the new process is robust and maintains public and staff confidence.
- Hot Debriefs: Importance of timely debriefs to identify staff needing further support and simulate debriefs for training.

Departmental policy leads also presented the approach to supporting staff within the new framework emphasizing a just, learning-focused culture:

- Compassionate Engagement: Ensuring staff involved in reviews receive compassionate and empathetic support.
- Communication: Keeping staff informed and involved throughout the review process.
- Tiered Support: Providing different levels of support based on individual needs, from emotional first aid to expert support.
- Open Just Learning Culture: Aligning with the regional being open framework to empower staff to speak out and use restorative models.

The session concluded with a summary of the discussions and a call to continue the journey towards a learning healthcare system. Participants were encouraged to stay engaged and participate in future sessions and the upcoming public consultation on the SAI Redesign.

SAI Re-design Public Consultation
A public consultation seeking views on the new draft Regional Framework for Learning and Improvement from Patient Safety Incidents and supporting documentation was subsequently launched on 10 March 2025.

Following the closure of the public consultation, Departmental policy leads will consider all responses received, publish a Consultation Response report, and finalise proposals for the Minister of Health's consideration.

Managed Transition
In the interim, whilst the extant SAI guidance must continue to be followed, SPPG and PHA will introduce some incremental enhancements and adjustments that remain aligned to the extant process but will assist in the transitioning of the current process to a new Framework.

Regional Falls in Care Homes Pathway and Bundle

What we did:
In 2024/25 work continued to support Care Homes and the 15,000 residents who live in Nursing and/ or a Residential care setting. The Regional Falls in Care Homes Pathway and Bundle continued its evolution. [Regional Falls in Care Homes Pathway and Bundle | Department of Health] In June 2024 a workshop was held in Seamus Heaney Centre with key stakeholders including General Practitioners, NIAS, Emergency Department staff, Care Home staff, service user representative and Trust Care Home Support teams. This workshop agreed key changes to the clinical management of a resident who has experienced a fall with the aim of supporting staff in homes with decision making with the support of colleagues in primary care and NIAS. It also reduces the harm to residents who experience a long lie after a fall. This aligns with the corporate plan to reduce falls and to lead and implement initiatives to ensure people who live within care homes have good health and wellbeing and improved quality of life.

A key element in the promotion of safer mobility and falls prevention in care homes is ensuring residents are engaged with and motivated on a daily basis. Central to this is a culture of providing engagement and activities to support meaningful connections. This approach has been supported by the Meaningful Engagement in Care Homes ECHO. This ECHO network is led by the Public Health Agency and brings together care home and activity staff, occupational therapists, physiotherapists, linking generations, Age NI and service users to share learning and explore opportunities for building connections in care homes.

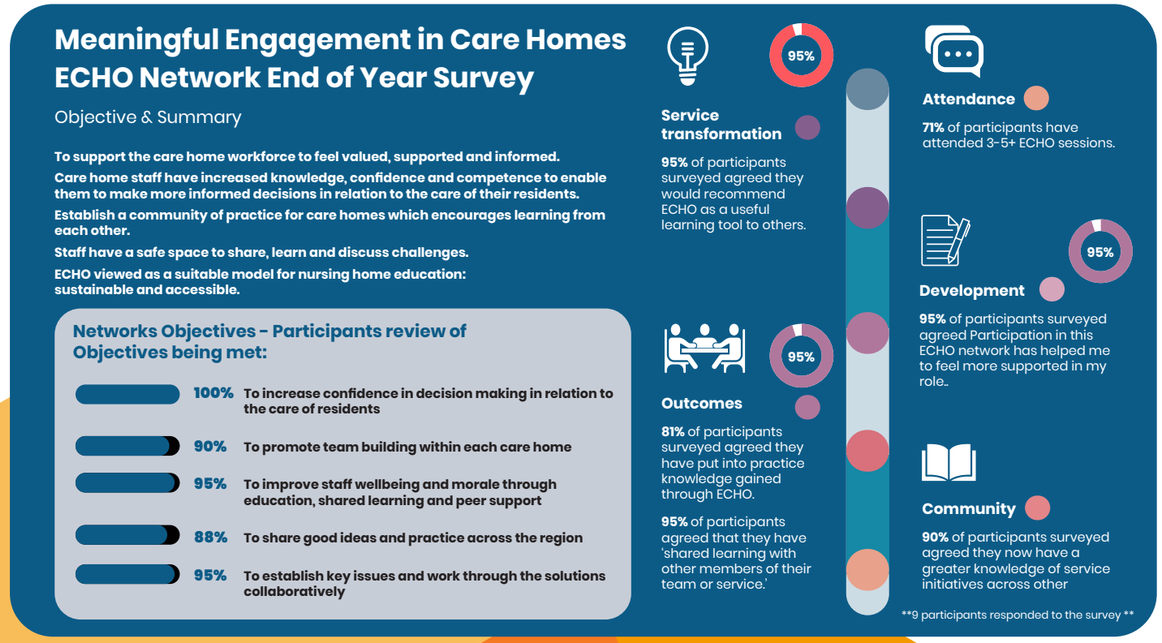
What were the results?
Post Falls Guidance

- Total number of falls reported to NIAS by care homes fell from 3782 in 2022/23 to 2967 in 2023/24. This represents a decrease of 21.6%
- Total number of residents conveyed to ED as a result of a fall fell from 2490 in 2022/23 to 1675 in 2023/24. This represents a decrease of 32.8%

ECHO programme participants surveyed reported:

- 100% increased confidence in decision making in relation to the care of residents.
- 95% of participants surveyed said they felt an improvement their wellbeing and morale through the education, shared learning and peer support.
- 90% of participants surveyed said the programme helped promote team building within each care home.

The end of year survey results are in the infographic below.



Redevelopment of the PHA's 'Minding Your Head' website

What we did:

A project team was establish comprising the Mental Health and Suicide Prevention Health Improvement Team and Communications Team to review the Minding Your Head website and make recommendations for the site. This review was necessary to bring the information provided up to date to improve quality and safety of the website for the population and also to address IT security risks associated with the existing website. A business case and service specification was developed for the redevelopment of the Minding Your Head site, the scope of the redevelopment was a 'like-for-like' purpose to provide:

- ***information on suicide prevention, mental health and emotional wellbeing for the general population.***
- ***a service directory for suicide prevention, mental health and emotional wellbeing services.***
- ***information on suicide prevention, mental health and emotional wellbeing training.***
- ***information on suicide prevention, mental health and emotional wellbeing campaigns.***

The project team undertook stakeholder engagement involving other PHA staff, Community and Voluntary sector and HSC Trusts. They also reviewed the learning from the Early Intervention and Prevention Digital Discovery project.

A design refresh was undertaken and new content was developed. The project team focused on user journeys, health literacy and embedding clear calls to action in site. 'Minding Your Head' integrates the continuum of care needs that an individual may have in relation to mental health, emotional wellbeing and suicide prevention by enabling users to:

- Learn how to protect their wellbeing.
- Identify if the symptoms they are experiencing could be a mental health condition.
- Understand what they can do to help themselves.
- Find out what local services are available - filtering to their specific needs.
- Understand when they should contact their GP.
- Know what to do/ who to contact if they need immediate help.

The site also integrates to other sources of support including Youth Wellness Web, Family Support NI, Bereaved NI and more to ensure the public can access the right support at the right time. The site can be accessed via the following link www.mindingyourhead.info

Critical Safety Alert:

Preventing Catheter Length Mix-ups - A Life-Threatening Error That Can Be Prevented

A shared learning template was received from a Trust regarding harm caused by a female length catheter being used on a male within a care home setting. This led to a learning presentation being developed and shared with care home leads and will now be more widely disseminated within acute settings also.

See learning below

Between 2006 and 2008, the National Patient Safety Agency documented 114 serious incidents where female-length catheters were incorrectly inserted into male patients.

These errors resulted in:

- 7 significant haemorrhages
- 2 cases of acute renal failure
- 2 cases of impaired renal function
- 1 death (partly attributed to complications)

Why This Happens and Why It Is Dangerous

The Problem: Female catheters are designed to be 20-26cm long, while the male urethra is approximately 20cm long. When a female catheter is inserted into a male patient, the retention balloon can inflate inside the urethra rather than in the bladder.

The Consequences:
This causes severe urethral trauma, including:

- Intense pain and bleeding
- Penile swelling and urinary retention
- Potential need for surgical intervention
- Risk of renal failure

Anatomy Refresher

- Female urethra: 3-4cm long (catheter: 20-26cm)
- Male urethra: 20cm long (catheter: 40-45cm)
- Standard-length catheters are safe for both genders
- Female-length catheters must NEVER be used in males

Safe Storage Practices - Your Responsibility

Physical Separation

- Store female and male catheters in completely different areas
- Use separate bins, shelves, or storage rooms
- Never store together, even temporarily

Visual Systems

- Colour coding: Pink/purple containers for female catheters, blue/green for male/standard
- Clear labelling: Large, prominent labels stating “FEMALE CATHETER” or “MALE/STANDARD CATHETER” with length specifications
- Original packaging: Keep catheters in manufacturer packaging with clear length indicators

Verification Protocols

- Two-person check: Especially in high-risk settings, have a colleague verify catheter length before use
- Emergency preparedness: Ensure emergency carts have separate, clearly marked sections
- Pre-procedure checklist: Always include catheter length verification

Red Flag Signs of Incorrect Catheter Use

Watch for these warning signs that may indicate wrong catheter selection:

- Severe pain during or after insertion
- Blood in urine (haematuria)
- No urine return or poor flow
- Penile swelling
- Patient expressing unusual distress

Remember: Some healthcare professionals mistakenly assumed poor urine flow meant the patient had low output, missing the critical sign of balloon misplacement.

Your Action Plan

Before Every Catheter Insertion:

- Check patient gender and catheter length requirements
- Verify catheter packaging clearly shows correct length
- When in doubt, use standard-length catheter (safe for all patients)
- Have a colleague verify in high-risk situations

Documentation Requirements:

- Date, time, and type of catheter used
- Catheter length and balloon size
- Batch number and manufacturer
- Any difficulties or complications encountered

If You Suspect an Error:

- Do not flush the catheter
- Change immediately if wrong length suspected
- Report incident following local procedures
- Document thoroughly for learning and improvement

Key Takeaway

Standard-length catheters work safely for both male and female patients. The shorter female catheter is designed purely for dignity purposes when wearing skirts. When unsure, always choose the standard length.

This is not just about following procedures – it’s about preventing severe patient harm and potential fatalities. Your attention to catheter storage and verification protocols can save lives.

PHA are engaging directly with Trusts and Care Homes to take forward this learning during 2025/26.

Dysphagia

The RQIA review of the implementation of recommendations to prevent choking incidents in Northern Ireland was published in May 2022. There were a series of 12 recommendations.

Recommendation 12 states that

"All HSC Trusts should raise awareness amongst staff of the regional trigger list and should foster a culture of reporting choking incidents, including near-misses, with staff from all staff groups being supported to submit an incident report.

Where individual cases are examined, these should be reviewed in accordance with 'just culture' principles. Each HSC Trust should have arrangements for trend and theme analysis of adverse incidents, the learning of which should be used to inform improvements within HSC Trusts and shared across the system."

This recommendation has been adopted at a regional level with the agreement of the HSC Trusts. A structured process is now in place to gather Serious Adverse Incident (SAI) and Adverse Incident (AI) data quarterly, using a standardised template. This enables the identification of incident numbers, recurring themes, and the clinical areas in which these incidents occur. The data is analysed each quarter to detect regional patterns and inform targeted actions by Dysphagia NI.

The findings are shared with stakeholders through a regular newsletter and during Regional Dysphagia NI Group meetings. Additionally, a "theme of the month" initiative has been introduced as part of the Swallow Aware campaign to highlight key messages.

Some Stats

On a quarterly basis, Trust Dysphagia Co-ordinators extract data from Datix and analyse before submitting to PHA. The total number of choking adverse incidents reported from 1 April 2024 - 31 March 2025 was 1,323. There is not a significant fluctuation in adverse incidents reported in the previous year 2023/24 (n=1271)

Note: Q1- Q3 data is for four out of five Trusts only
In Q3 one Trust reported an internal issue with ordering IDDSI compliant meals.

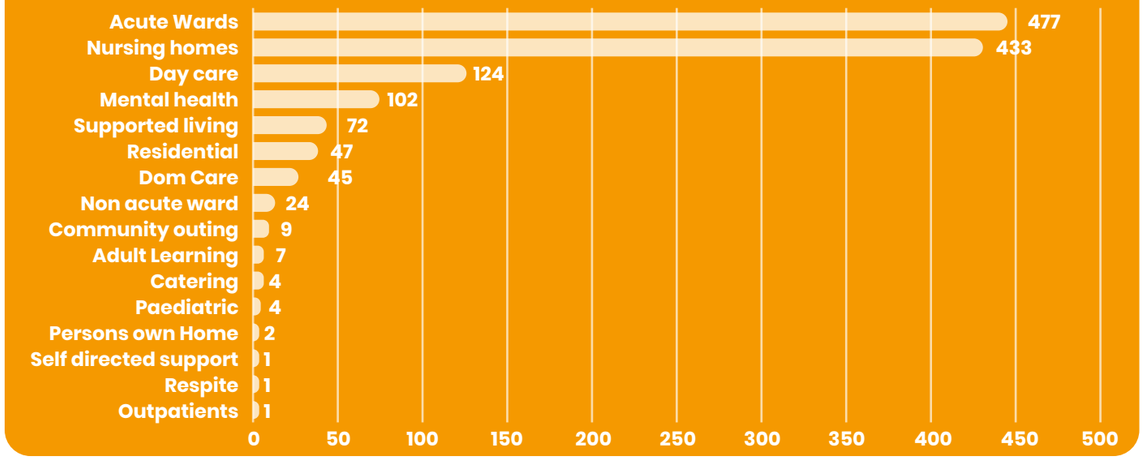
Of the Choking Adverse Incidents reported, the top five settings consistently appear at the top across all quarters with only minor shifts in ranking. The top setting was Acute wards 447, Nursing Homes 443, day care 124, mental health 102 and supported living 72. October to December 2024 saw a rise in Acute Wards adverse incidents due to an internal issue with ordering IDDSI compliant meals – see Figure 1.

Each choking adverse incident is themed. During the reporting period, the top three themes were:

- Choke with no evident reason (277)
- REDS not followed (253)
- Incorrect supervision level i.e. not as detailed in the REDS (70)

(Note each incident may be associated with more than one theme).

Figure 1: Choking Adverse Incidents per Setting - 1 April 2024 - 31 March 2025



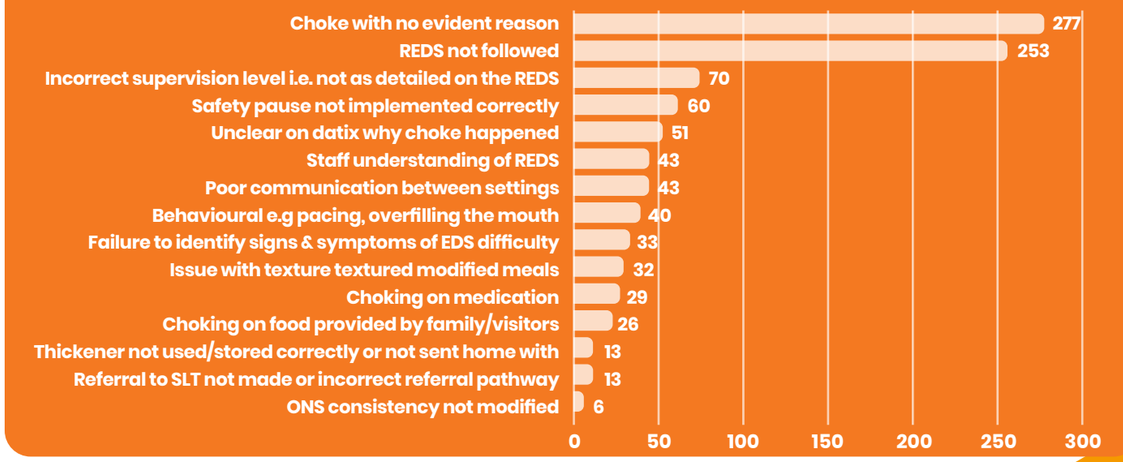
Quarterly distribution of adverse incident themes per setting showed a steady increase in theme choke with no evident reason reported. This could be due to increased awareness of the requirement to report adverse incidents on the Datix system. The theme REDS not followed has also seen a gradual increase in reporting which could be due to auditing of the Mealtimes Matter process.

This initiative complements the regional Mealtimes Matter framework and audit tool. A supporting video - **Regional Mealtimes Matter Video - Information for Staff -** was launched in May 2025 to provide an overview of the framework. However, a recent survey has indicated challenges with the full implementation of Mealtimes Matter across various settings, particularly within Emergency Departments.

In response, Dysphagia NI has undertaken a piece of work which will investigate the contributing factors specific to ED. Going forward SAIs and AIs for ED will be recorded as a specific service area as this data was originally included in the broader acute setting category.

This work is in its early stages and will continue to evolve with input from key stakeholders.

Figure 2: Choking Adverse Incidents - top 15 Themes 1 April 2024 - 31 March 2025



Look-Alike Sound-Alike (LASA) Medication Errors

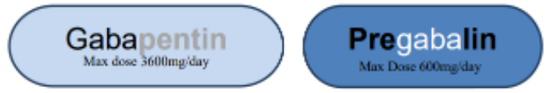
What was the issue?

Medicines that look-alike or sound-alike also known as (LASA) medicines are a well-recognised cause of medication errors. These errors can occur at any stage of medication use prescribing, transcribing or documenting, dispensing, administering and monitoring. In 2023, 5% of the community pharmacy incidents reported to the SPPG documented a LASA as a contributory factor in a dispensing error, and most commonly involved mix-ups between pregabalin and gabapentin.

What did we do?

Learning is identified from individual incidents but it is also important to look for themes such as when the same incident occurs more than three times in any pharmacy within six months. It was noted that dispensing incidents involving pregabalin and gabapentin were being reported more frequently five times within the 2023/24 financial year increasing the likelihood of recurrence and potentially the risk grading of these incidents. A learning article highlighting the issue of dispensing errors with pregabalin and gabapentin and the risks involved was planned. However, in 2023 the World Health Organisation published a document focussed on Medication safety for look-alike, sound-alike medicines. It was felt important to produce a Newsletter Supplement on the topic of LASAs to not only bring attention to the pregabalin and gabapentin issue but also highlight proposed measures within this document that could potentially minimise LASA errors from occurring.

What was the Key Learning?



- Incidents occurring where gabapentin dispensed instead of pregabalin or vice versa. Pregabalin is roughly six times as potent as gabapentin. Increased risk of harm if pregabalin is provided in place of gabapentin. Conversely, if gabapentin is dispensed instead of pregabalin, the medical indication (e.g. epilepsy or pain) may worsen.
- While there is limited evidence available on the effectiveness of solutions for addressing the impact of LASA errors, the Acronym STEER was proposed to STEER community pharmacy away from LASA dispensing errors.

S ystem Changes

T hree Point Check

E ducate staff

E ngage patients

R eport incidents

Midazolam oromucosal pre-filled syringes - prescribe and dispense WHOLE syringes

What was the issue?

A patient had been prescribed midazolam oromucosal pre-filled syringes indicated for the treatment of prolonged seizures and advised to use half a syringe. Midazolam oromucosal pre-filled syringes are not graduated, therefore it is not possible to accurately administer half a dose using the pre-filled syringes. Dosing requires the whole syringe to be administered at any one time.

What did we do?

Previous learning had been issued around these types of incidents with oromucosal midazolam and the potential for serious harm (Medicines Safety Alert in 2012, Safety and Quality Learning Letter 2014 and 2018). Despite this learning the incident was still being reported. It was felt necessary to remind GPs and Community Pharmacists of the different brands of midazolam oromucosal, the doses and actions for both when prescribing or dispensing midazolam oromucosal pre-filled syringes, this was done by way of a newsletter article.

What was the key learning?

- Ensure oromucosal midazolam pre-filled oral syringes are prescribed as a complete dose which is appropriate to the patient's age and as the specific brand and product requested by the Trust Epilepsy Team or other specialist team.
- Ensure the clinical check includes dose appropriateness
  - Pre-filled oral syringe doses are standard for a given age range.
  - Some paediatric patients may have a dose based on weight at 300mcg/kg.

  rather than age but any dose outside the appropriate age range should be confirmed with the prescriber.
- Never prescribe as a "part dose", and never dispense with instructions for a "part dose".

Theme 5

Integrating the Care

Integrating the Care: Connecting Services for Safer, Seamless Experiences

The theme " Integrating the Care" reflects our commitment to delivering coordinated, person-centred care across organisational boundaries. It highlights how we are working to break down silos, improve communication across teams and settings, and ensure that every patient journey is safe, consistent, and responsive to individual needs.

This year, we have focused on strengthening partnerships—across primary, secondary, and community care, creating more joined-up pathways by aligning systems, sharing information, and fostering collaborative working, we are improving continuity of care, reducing risks, and enhancing outcomes.

Integrating the care also means listening to patients and carers, understanding their experiences, and designing services that reflect their realities.

This section of the report showcases some of those initiatives, innovations, and collaborative efforts that are helping us build a more connected, compassionate, and high-quality care system.

Children's Autism and ADHD services

Provision for children's services for neurodivergent (ND) conditions such as Autism (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) have seen increased demand for assessment and intervention over the past number of years. Access to these services were severely affected during Covid which intensified the already heightened demand on these services and waiting list to access them. Developing evidence indicates that ND conditions are often comorbid and they should be addressed holistically to meet the needs of those referred for support.

In April 2024 commissioners in SPPG Community Care Directorate instigated monthly Heads of Service meetings for paediatric ASD and ADHD services. This was to help understand and address;

- the growing demand across the region and how this can be managed.
- developing regional consistency, by learning from best practice in each Trust.
- meeting NICE Guidelines consistently when delivering services.
- applying the Integrated Elective Access Protocol (IEAP) to ensure equality of access.
- managing referrals who have accessed private health equally to those who cannot afford private health.
- to inform the development of integrated inclusive care pathways that are child centred and needs led.

Since these meetings began they have supported these condition-led services to become more integrated with better care pathways for children and young people with comorbid presentations. Although the services do not have the capacity to meet demand, the learning exchanged between HSC Trusts has evidenced improved service. Learning is ongoing through these engagements' sessions, for services across the region and for commissioners, in understanding the needs of the services. To date this has included:

- a regional referral form being developed and agreed,
- an agreed and consistent approach to managing referrals that receive a private diagnosis, and
- a regionally agreed protocol is in place for assessing and recognising private diagnosis.

Non-Medical Prescribing (NMP) Allied Health Professionals and Nurses

What was the Issue

Controlled drugs are subject to additional legal controls, including restrictions on who can prescribe them, as they carry a higher risk of being misused or causing harm. Supplementary prescribers can prescribe controlled drugs, but only in accordance with a service user's clinical management plan. Independent prescribers cannot prescribe controlled drugs unless specified in the Misuse of Drugs Regulations (Northern Ireland) 2002, as amended.

Amendments introduced on 15 November 2019 allow Podiatrist and Physiotherapist Independent Prescribers to prescribe from a limited list of controlled drugs for the treatment of organic disease or injury. Amendments introduced on 31 December 2023 also allow Paramedic and Therapeutic Radiographer Independent Prescribers to prescribe and administer a limited number of controlled drugs.

PHA regional leads for non-medical prescribing for Allied Health Professions (AHPs) and Nurses respectively work closely to promote non-medical prescribing as enhanced practice to meet population health need.

There are three types of non-medical prescribing;

- Community Practitioner Nurse Prescribing (CPNP)
- Independent prescribing
- Supplementary prescribing

Nurses and AHPs are responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about the clinical management required, including prescribing. The medication prescribed will depend on the prescribing type e.g. CPNPs can only prescribe from the Nurse Prescribers Formulary (NPF) for Community Practitioners.

As independent prescribers, Nurses, Physiotherapists, Paramedics, Radiographers and Podiatrists can prescribe any licensed medicine provided it falls within their individual area of competence and respective scope of practice - Physiotherapists, Paramedics, Radiographers and Podiatrists can only prescribe from a limited range of controlled drugs. Nurses can prescribe all controlled drugs in schedules two - five of the British National Formulary.

As supplementary prescribers, Nurses, Physiotherapists, Podiatrists, Paramedics, Radiographers, Dietitians and Optometrists may prescribe any medicine (including controlled drugs), within the framework of a patient-specific clinical management plan, which has been agreed with a doctor.

What we did:

The PHA supported SPPG with the introduction of New Models of Prescribing which allows prescribers working at interfaces between HSC Trusts and General Practice to prescribe a medication directly to the patient which can then be dispensed in the community.

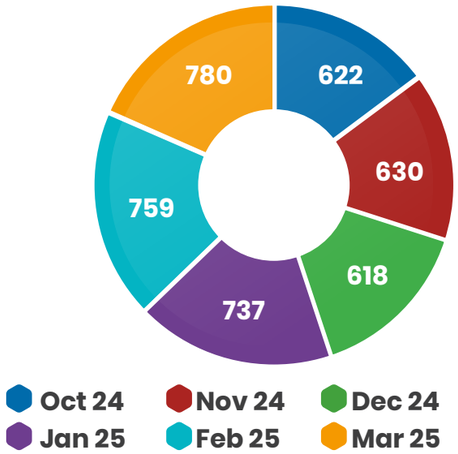
Outcomes

- Regular meetings of the regional Nursing Non-Medical Prescribing Forum and the regional AHP Non-Medical Prescribing Forum, chaired by the PHA to:
  - Share and discuss regional and local NMP developments.
  - Share best practice.
  - Raise the profile of NMP and
  - Promote NMP as a valuable service delivery option.
- New models of prescribing has resulted in benefits to patients, healthcare professions and the healthcare system. Patient benefits include quicker access to medicines in the outpatient setting, fewer risks with medication due to less need for transcription between professions and optimal titration to therapeutic doses of treatment.
- Paramedics registered as non-medical prescribers for the first time in Northern Ireland.
- The implementation of the Foyle Hospice Pathfinder Project which is included in Strengthening the Workforce theme

Table 1: Number of items prescribed by AHPs between October 2024 and March 2025 broken down by HSC Trust

	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Total
Oct 24	67	61	199	80	215	622
Nov 24	65	62	217	97	189	630
Dec 24	94	81	205	91	147	618
Jan 25	66	75	204	91	301	737
Feb 25	57	69	188	104	341	759
Mar 25	54	73	178	101	374	780
	403	**421**	**1191**	**564**	**1567**	**4146**

Total Number of Items Prescribed by AHPs between October 2024 and March 2025



NIAS Systems, controls and communication

Northern Ireland Ambulance Service (NIAS) led on three presentations throughout the ECHO session on 28 November 2024. The focus was on the need for collaborative learning systems and the importance of systematic, data-driven improvements.

The first presentation highlighted the value of routine care in learning and improving healthcare systems. It emphasised the importance of:

- improving learning systems ensuring that providers work with stakeholders to learn from routine care and improve as a result.
- human infrastructure, investments in networks, collaboration, and a conductive culture is crucial.
- data utilization, ensuring there is the technical capability to analyse data and implement improvements.
- whole system thinking, recognising the challenges faced by the system-wide pressures, such as Emergency Department (ED) handover delays, which are having an impact on the entire healthcare system.

A second presentation was delivered providing an overview on the emergency call room operations, noting:

- Emergency Medical Priority Dispatch System (MPDS) is used to assess and prioritise calls based on the nature of the injury or illness.
- Call Stack Management is used to categorise and prioritise calls to ensure the sickest patients receive timely care.
- Decision on the type of care and resources needed are informed by MPDS codes.
- The challenges faced by staff due to the number of increased calls, duplicate calls, and the impact on staff morale and patient care.

The final presentation centred on the human impact of system-wide pressures, illustrated through case studies. These examples included patients waiting in the community, nursing homes, and ambulances outside EDs highlighted the serious consequences of delays in care.

Delayed responses contribute to patient deterioration, intensify pressure on healthcare staff, and present ethical challenges in delivering appropriate care.

The presentation emphasised the need for a holistic, system-wide approach where risks are jointly assessed, shared, and managed across all sectors.

The key learning points from the session were the need to:

- Have a community focus. Investing in community services and resources to reduce the burden on ED and improve patient care.
- Raise public awareness and educate the public on when to call an ambulance and ensure they are aware of alternative care pathways.
- Implement standardised care pathways.
- Enhance communication and collaborative learning across the healthcare system.
- Improve support for mental health patients to prevent unnecessary ED visits.

Embedding System Learning to Reduce Harm from Inpatient Falls

What we did:

Falls prevention work continues to evolve regionally, aligning with the PHA's Corporate Plan 2025-2030 and its commitment to improving safety, outcomes, and learning through system-wide collaboration. Aligned with the new System Learning, Transformation and Governance team, this work focuses on embedding consistent high practice that can be measured, shared and sustained.

The Regional Inpatient Falls Prevention Group chaired by a PHA Nurse Consultant brings together multidisciplinary teams from all Trusts. It sets strategic direction on falls prevention for adult inpatient care, supports the development of regional pathways, and strengthens data-informed decision-making.

The group's work supports transformation by;

- Reviewing and updating regional guidance.
- Thematic analysis of falls incidents to inform strategy.
- Using regional learning to inform QI and address emerging system issues.

The Adult Inpatient Falls Key Performance Metric has been reviewed and refreshed by the Regional Nursing and Midwifery Quality and Assurance Network (NMQAN), co- chaired by the PHA and Belfast Trust.

What were the results?

Work is ongoing to embed this metric into the Encompass system to enable high-quality, patient-centred care to be tracked reliably and consistently against regional key metrics. This collaborative work has been developed with input from the Falls Leads within the Regional Adult Inpatient Falls Prevention Group, supported by a robust, digital-first approach to assurance and improvement.

This work directly contributes to PHA Corporate Plan priorities by;

- Reducing preventable harm through improved fall surveillance.
- Building internal capability in Trusts to lead and sustain improvements.
- Embedding evidence - informed practice through digital assurance methods.

Next Steps

SAI Redesign

A public consultation seeking views on the new draft Strategic Regional Framework for Learning and Improvement from Patient Safety Incidents and supporting documentation was launched on 10 March 2025 and closed on 20 June 2025.

Consultation responses offered both quantitative insights and detailed qualitative feedback. Departmental policy leads are undertaking a detailed analysis of the consultation responses, which will be followed by the preparation of a draft Consultation Response Report. Informed by the consultation feedback, the Department will take the necessary steps to finalise the draft proposals for the Minister of Health's consideration.

Interim Arrangements

SPPG are working closely with Trusts to introduce some incremental enhancements and adjustments that remain aligned to the extant process but will assist in the transitioning of the current process to the new Framework.

It is the intention that SPPG will issue a letter to HSC organisations advising of the implementation of interim arrangements with effect from the 1 July 2025, highlighting the needs for organisations to continue to operate in a way that maintains patient safety, supporting learning as well as preparing for cultural and procedural change.

Surveillance

SPPG and PHA are exploring a healthcare surveillance system that integrates various data sources. Work continues in enhancing visualisation tools and dashboards to support trend analysis, heat mapping and interactive drill-down features for deeper insights.

PHA Safety and Quality Update

The Safety and Quality Team has developed a Safety and Quality Update to share key information, resources, links, and communications that support patient safety and encourage shared learning.

Our main audience is HSC staff, particularly those working on the frontline who may not always have regular access to a computer. The update is designed to bring all relevant resources and information together in one easily accessible place.

The Safety and Quality update will be published on a quarterly basis, featuring new resources and communications.

SAI Themes

Work related to the potential themes identified for 2024/25 will continue and be incorporated into next year's learning report. These themes include:

- **Placenta Accreta Spectrum Task and Finish Group**
- **Inter-Hospital Transfers**
- **Adult Safeguarding within Northern Ireland Prisons**
- **Testicular Torsion**

Glossary of Terms

AI	Adverse Incidents
BHSCT	Belfast Health and Social Care Trust
Dashboard	Feature which displays information on one screen to allow trends and themes to be identified
Datix	A risk management information system designed to collect and manage data on a range of safety and quality processes.
DOH	Department of Health
DRO	Designated Review Officer - a senior professional/officer within the SPPG/PHA who has a degree of expertise in relation to the programme of care/service area where a SAI has occurred
Early Alert	Process to ensure DoH (and Minister) receive prompt and timely details of events which may require urgent attention or possible action by the DoH.
ECHO	Extension of Community Healthcare Outcomes – Project ECHO NI is a pioneering telementoring programme providing an online learning and support methodology
GP	General Practitioner
HSC	The Health and Social Care system for Northern Ireland
NHSCT	Northern Health and Social Care Trust
NIAS	Northern Ireland Ambulance Service
NIPSO	Northern Ireland Public Services Ombudsman
PCARE	Primary Care - services that people receive from GPs, Dentists, Community Pharmacists/Chemists and Opticians
Power BI	Power BI is a business intelligence tool which enables users to turn data into interactive dashboards, charts, and reports
PHA	Public Health Agency
POC	Programmes of Care are divisions of healthcare within the Northern Ireland HSC. In total, there are nine Programmes of Care
Regional Risk Matrix	A matrix which is used to categorise potential risks, incidents, complaints and claims; facilitates the prioritisation of risk in terms of likelihood and impact (consequence). In doing so, this will help identify the nature and degree of action required and levels of accountability for ensuring such action is taken.
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident
SAI Professional Groups	Established within each programme of care to ensure collective, multi-disciplinary 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)'
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
SPPG	Strategic Planning and Performance Group of the Department of Health
Triangulated learning	Data analysis selected from a range of safety and quality processes, collated to better inform learning
WHSCT	Western Health and Social Care Trust

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

HSC Public Health Agency

This document can be requested in alternative formats.

For more information on the alternative formats available and the timescales involved, please contact SPPGCommunications@hscni.net