HSC SAFETY FORUM

ANNUAL REPORT

2009-2010

Contents

1. INTRODUCTION

This is the first HSC Safety Forum Annual Report, outlining a brief summary of the work and main achievements that have taken place during the year 1 April 2009 – 31 March 2010.

During 2009-2010 the HSC Safety Forum continued to be a reliable source of energy, knowledge and support in the drive to continually improve health and social care across N Ireland. It still retains its key aim to be a recognised and respected support not only to providers of care but also to key stakeholders such as the DHSSPS Safety, Standards and Quality (SQS)Directorate, the HSC Board (HSCB), the Public Health Agency (PHA) and both Universities.

The year 2009-2010 has seen the Forum facilitate a total of 6 collaboratives; deteriorating patients, medication safety, mental health, perinatal, SSI (C-Section) and VTE prevention. It supported 2 Trusts for improvement work in prototypes in Clinical Microsystems and Transforming Care at the Bedside.

Other work has included the provision of support to Trusts in their work on implementing the WHO Surgical Site Checklist, provision of improvement science training to HSC staff and hosting a number of breakfast seminars.

The Forum has continued to work closely with key stakeholders such as the Performance Management and Service Improvement Directorate (PMSID) of the HSC Board. This work outlined in Section 3 (page 6) has fostered the building of relationships between the HSCB and the Forum and generated greater awareness of improvement science methodology.

A new Assistant Director took up post within the Forum in July 2009 further strengthening its commitment to supporting HSC organisations to continually improve safety and quality.

It is also important to acknowledge the continued commitment and support that HSC organisations, in particular HSC Trusts, have given in driving forward the safety and quality agenda. The Safety Forum looks forward to building on this work in partnership with all HSC organisations in 2010-2011.

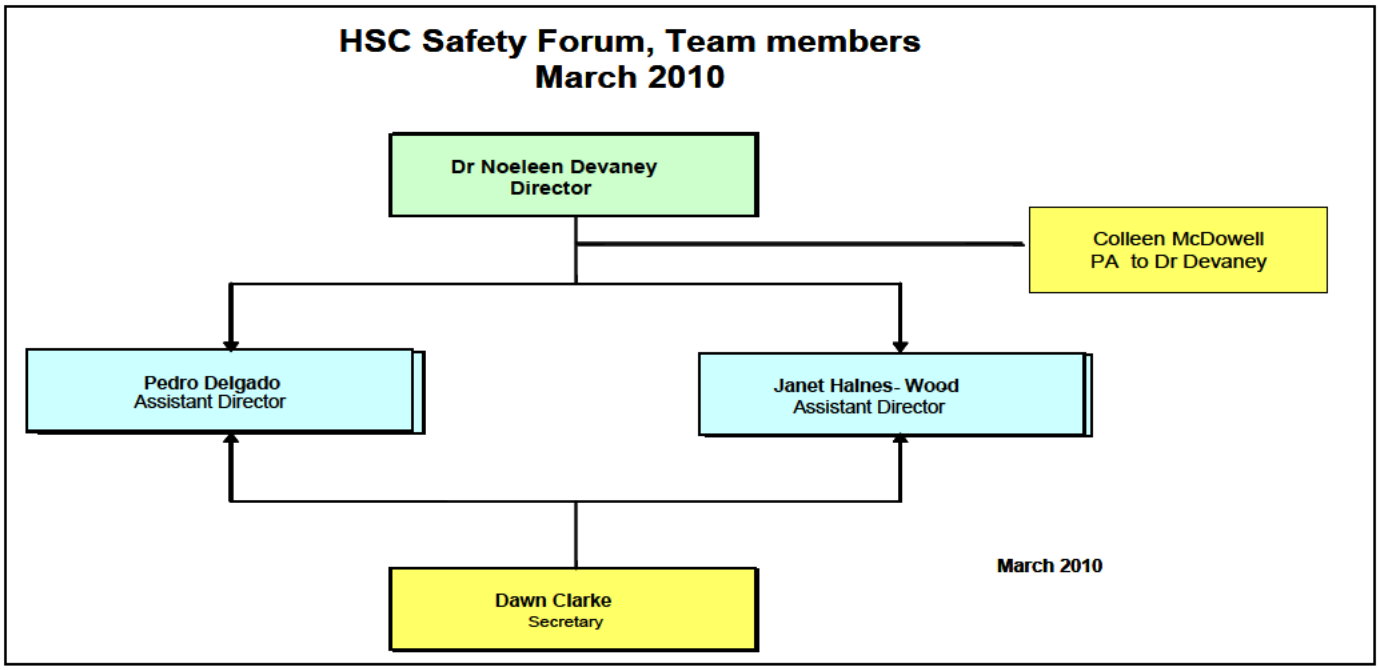
In the spirit of sharing the work undertaken in patient safety with others on both a nationally and international stage, an article was accepted and published in Healthcare Risk Report (December 2009/January 2010) entitled “Safety Improvement in Northern Ireland’s Health and Social Care Services”, a presentation was given on the work ongoing in Transforming Care at the Bedside at the National Forum in Quality and Safety in Orlando (December 2009), and a poster on the Journey of Patient Safety in Northern Ireland was presented at the International Forum for Quality and Safety in Healthcare, April 2010 (in Nice).

2. HSC SAFETY FORUM WORKING ARRANGEMENTS

This section briefly outlines the working arrangements of the Safety Forum (referred to as the Forum from this point) during the year 2009-2010.

During 2009-2010 the Forum expanded with the appointment of a 2nd Assistant Director and a permanent Band 3 secretary to support the 2 Assistant Directors. The appointment of the 2nd Assistant Director was in line with the plan outlined in the Operating Framework 2008-2009 to ensure that the full spectrum of Health and Social Care is encompassed in the work of the Forum (Fig. 1)

Figure 1 Members of the HSC Safety Forum



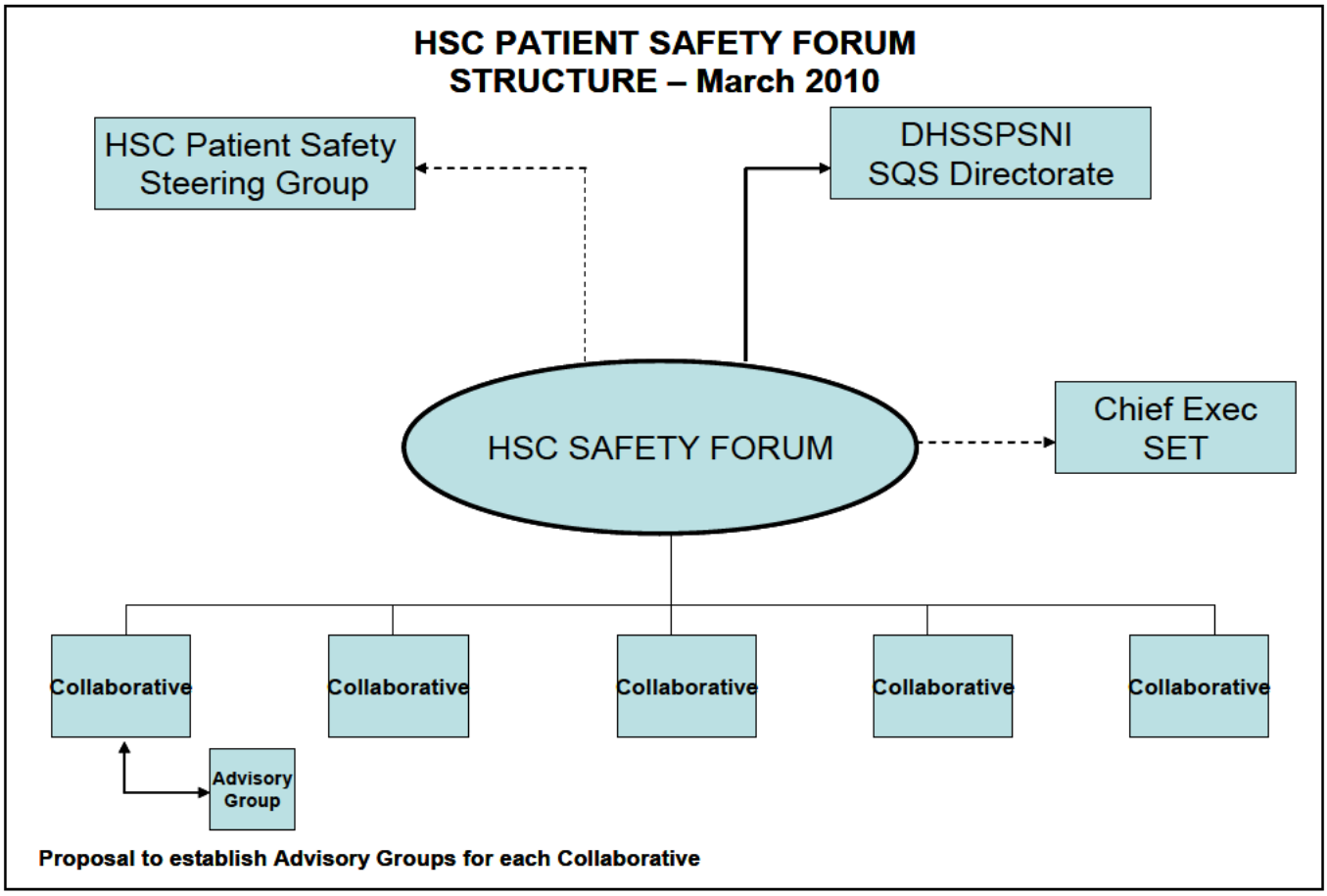
Whilst accountability lies with the DHISSPSNI, a Safety Forum Steering Group was formed (See Fig. 2) to oversee the work of the Forum. It held its inaugural meeting in August 2009. It was agreed that this Committee will:

- Discuss the general direction the Forum takes;
- Agree a programme of work taking account of regional HSC priorities (eg. Programme for Government, Priorities for Action, etc);
- Submit a business plan to the Deputy Chief Medical Officer via the Safety, Quality & Standards Directorate for agreement on an annual basis at the beginning of each financial year
- Review progress against its objectives and aims
- Provide quarterly feedback to the Safety, Quality and Standards Directorate, DHSSPSNI and the Health Foundation (who had provided a non-recurrent grant to the Forum) on progress against the business plan.

The membership of the Committee reflects the multidisciplinary nature of HSC encompassing all key stakeholders of the Forum (See **Appendix A** for list of members). The Committee met quarterly and copies of the minutes can be accessed through the HSC Safety Forum website (www.hscsafetyforum.com).

Figure 2 (page 5) outlines the HSC Safety Forum structure and accountability.

Figure 2. Structure of HSC Safety Forum as a Regional Organisation



Below are the **Key Objectives** for the Forum providing direction for the work undertaken:

- Assist HSC organisations as they strive to deliver safe, high quality health and social care within an open learning culture
- Build and develop quality improvement capability in line with internationally recognised theory and practice across the health and social care spectrum including primary care
- Act collaboratively with key stakeholders to progress the safety and quality agenda regionally
- Proactively raise awareness of the importance of public and individual involvement in improving the safety of health and social care and support commissioners and providers of services in engaging with patients and clients to improve safety and quality
- Build and strengthen expertise, knowledge and skills of the HSC Safety Forum Team

The remainder of this Report will summarise the work undertaken during the year 2009-2010 to achieve the key objectives.

3. Assist HSC organisations as they strive to deliver safe, high quality health and social care within an open learning culture

The Forum continued its collaborative work to support Trusts in working towards achievement of the PfA 2009-2010 Safe and effective care targets for:

- Surgical Site Infection, C-Section and orthopaedics
- Deteriorating patients/Crash Calls
- Mental Health
- VTE

The collaboratives were well attended, there being an average of 30 people in attendance at each Learning Set with all Trusts being represented.

Feedback from these collaboratives was positive and some comments from those who attended:

> *"Collaborative useful to give opportunity to meet with other teams and share experiences and hear how other teams have overcome problems",*
>
> *"Useful to find that at the workshops everyone has similar problems"*
>
> *"Useful to review our own progress against information presented by Forum and other teams".*

The Surgical Site Infection, Deteriorating Patients (crash calls), and Mental Health collaboratives all reached the Learning Set 5 stage by January 2010.

Learning Set 2 of the prevention of VTE collaborative was also held in January 2010.

Work has been ongoing throughout the year on a Performance Management template. The Forum has worked closely with both the PMSID and Trusts with regard to this and the template now includes run charts. This is the template that Trusts use to report on a monthly basis to the PMSID on their progress with the safe and effective care targets as outlined in Priorities for Action (PfA). An example of the reporting ranges used in this Template is outline on Page 7, Figure 3.

The Forum was also invited to report on Trusts' progress against these targets from an improvement methodology perspective. This has fostered the building of relationships between the HISCB and the Forum and generated greater awareness of improvement science methodology.

Across the region compliance against the targets has been good. This reflects the significant amount of work that has been undertaken by all Trusts towards meeting these targets.

Figure 3

Colour description	Process measure standard	
Green - target fully achieved	95% or above (reliable)	
Green / Amber - target substantially achieved / missed only by a narrow margin	More than 85%	Green / amber
Amber - target partly achieved	Between 50% and 85%	
Amber / red – work done but limited progress	Between 35% and 50%	Amber / red
Red - target not achieved	Lower than 35%	

The aim of the work being undertaken is to ensure the implementation of safe and reliable systems that will support the achievement of the targets outlined in PfA. Significant work has been undertaken by all Trusts to meet these targets. All improvement methodology begins with testing in pilot areas and only when Teams are satisfied that they have achieved reliability in this pilot area, will then fully implement in this area and look to spreading across the organisation. It should be noted that this can take time but will ultimately result in both consistency and reliability. Implementation and spread remain challenging areas in all improvement work.

A summary of the progress is outlined below.

3.1 SSI, Orthopaedics and C-Section

The bundle, within orthopaedics has been reliably implemented. Within C-Section, compliance with the surgical site bundle sits in the green/amber range. There is currently work ongoing in collaboration with HISC to validate Surgical Site C-Section infection rates.

3.2 Critical Care

A regional definitions document was agreed, produced and shared at the learning sessions. This included an agreement with HISC and CCaNNI to take a lead on ICU related safety and quality initiatives including a surveillance implementation strategy.

3.3 WHO Surgical Site Checklist

Work on the WHO Surgical Site Checklist began following a regional agreement to have 50% theatres reliably implement this checklist.

A collaborative was not held for this work, with Trusts agreeing to include work on the Checklist into their local Quality Improvement Plans and carry out work internally.

The Forum has provided support when required and held a meeting in March 2010 with all trusts to report their progress. Whereas all Trusts are working on implementing the Checklist, there is variation as regards progress and the 50% target has not been achieved. At this meeting, the importance of measuring compliance was highlighted and Trusts agreed to measure and report this on the Northern Ireland Extranet.

3.4 VTE

Trusts began posting baseline measures from October 2009 and are demonstrating 65-100% compliance with appropriate prophylaxis (by March 2010), but encountering significant challenges with ensuring that risk assessment is being undertaken.

The collaborative made a decision to develop a regional patient information and regional poster.

Following discussion at Learning Set 2, the Belfast Trust agreed to undertake pilot work on relevant and useful outcome measures regarding VTE.

A VTE workshop was also planned for June 2010, to be facilitated by speakers from King's College and the Lifeblood Thrombosis Charity.

3.5 Mental Health

Learning Set 5 was reached in January 2010. The measures being reported on in Risk Assessment and Multidisciplinary Team reviews demonstrated 95% compliance and above. The measure on Multidisciplinary Care Planning shows 83% compliance but again demonstrating a clear trend of improvement since the collaborative began. A decision will be made over the summer on the future of this collaborative and agreement sought in taking forward other areas of work in Mental Health.

3.6 Perinatal

Learning Sets 3-5 were held for the Perinatal collaborative during the year. Trusts initial work focused on compliance with the Electronic Foetal Monitoring bundle and by end of March, results demonstrated varied compliance with this bundle ranging from amber – amber/green. This is a large bundle and Trusts are struggling to ensure compliance with all elements.

Additional work is planned for inclusion into this Collaborative in relation to Induction of Labour. This will begin in September 2009.

3.7 Medication Safety

A primary/secondary care interface medication safety collaborative was commenced, following an initial meeting in June 2009 to seek agreement on this topic. Measures focused on medicines reconciliation on admission and discharge.

Learning sets 1 and 2 were held during the year and reporting began on the Extranet in January 2010. Trusts, involved in waves 1 and 2 of the Safer Patients' Initiative had already begun work in this area and their learning to date proved vital to taking this work forward.

From early on in the work, a need for an electronic system was identified to ensure timely and accurate medicines reconciliation. Work will continue throughout 2010-2011.

3.8 Stroke

Work began in October 2010 within the Belfast HSC Trust as a pilot site to support the PfA 2009/2010/201 thrombolysis stroke target.

An agreement was reached to commence a regional Stroke Collaborative focusing on thrombolysis; Learning Set 1 scheduled to begin in June 2010. Links were also forged with the Regional Stroke Strategy Group and ongoing work in relation to the development of the regional Stroke Dataset.

3.9 Social Care

Preliminary discussion took place with Board and Trusts in regards to the identification of a topic for a social care collaborative. It was suggested that the topic be chosen from the regional Project to improve the interface between Mental Health and Children's Services.

This will be further progressed during 2010-2011.

3.10 Frameworks for continuous improvement

(a) Transforming care at the bedside (TCAB)

During the year TCAB prototype work was commenced in one ward in the South Eastern Trust. This demonstrated positive results; a 48% reduction of in-patient falls. The Trust has put a plan in place to spread TCAB to additional wards.

A poster describing this work was accepted for the International Forum for Quality and Safety in Healthcare, April 2010 (in Nice).

A regional TCAB collaborative was proposed and discussed at the HSC Safety Steering Group in November 2009. Initial agreement was secured that this could begin in the autumn of 2010 and will be included in the 2010-2011 HSC Safety Forum Business Plan.

(b) Clinical Microsystems

A prototype for Clinical Microsystems commenced at the Belfast HSC Trust, RVH Emergency Department. This was led by the Clinical Director. The global theme chosen by the Team was flow through the Emergency Department. Work continued to show positive results on focused interventions.

A poster describing the work was also accepted for the International Forum for Quality and Safety in Healthcare, April 2010 (in Nice).

3.11 Primary Care

Preliminary meetings took place with NIMDTA and general practitioners (GPs) regarding improvement methodology. This included an evening session for GPs, in partnership with NIMDTA, to explore implementing clinical Microsystems within practices. Initial interest was expressed and this will be progress during 2010-2011.

A half day training event, in the use of the Primary Care Trigger Tool was organised, for May 2010, by the Forum, in conjunction with NIMDTA and the NHS Institute for Innovation and Improvement.

4. Build and develop quality improvement capability in line with internationally recognised theory and practice across the health and social care spectrum including primary care.

4.1 Improvement Science Training

(a) Initially, bespoke training had been offered, by the Forum, to each Trust, however due to specific winter pressures in 2009, this was deferred and agreement was made that sessions on generic improvement science would be offered to all HSC organisations.

Over the year, 5 training sessions, were therefore, were held with a further one planned for June 2010.

Overall a total of over 100 staff attended these sessions drawn from Trusts, Public Health Agency, HSC Board, DHSSPSNI, Business Services Organisation, RQIA and NI Ambulance Service.

A half day training session on the Global Trigger Tool was provided for Trust staff in March 2010. Three out 5 Trusts attended this training.

4.2 Patient Safety Officer Executive Programme

Utilising the Health Foundation resource as agreed, one place per Trust was offered for at attendee at the IHI's Patient Safety Officer Executive Development Programme. All Trusts availed of this opportunity (one Trust deferred attendance to the autumn of 2010) including the Ambulance Service.

Since 2008 at total of 13 representatives have attended this Programme across all Trusts within NI providing a body of expertise to further drive patient safety and quality within the organisations.

4.3 Scottish Patient Safety Fellowship (SPSF)

Over the year 2009-2010, 2 applicants, nurse and doctor, were awarded a place on the SPS Fellowship

Both reported that the attendance on this Programme enhanced their capacity to drive the patient safety agenda within their own organisation and provided excellent international networking opportunities.

4.4 Breakfast Seminars

Educational breakfast seminars continued throughout 2009-2010 and were well attended.

Speakers were:

- Jason Leitch, Scottish Patient Safety Programme (May 2009),
- Marjorie Godfrey (June 2009); Quality by Design: Achieving strategic outcomes in healthcare through Clinical Microsystem development",
- Steven Allder, (September 2009), Clinical System Improvement,
- Anthony Staines (March 2010), Strategies for holistic improvement: learning from high performance organisations.

A further evening seminar was also scheduled for June 2010 with Jim Easton, NHS Director for Improvement and Efficiency.

5. Act Collaboratively with key stakeholders to progress the safety and quality agenda regionally

Implicit in the work of the Forum is that of working collaboratively with all key stakeholders. This can be evidenced through the HSC Safety Steering Group meetings, via collaboratives, specific meetings with bodies such as DHSSPSNI, HSC Board, Public Health Agency, NIPEC, RQIA and GAIN in order to identify key priorities and opportunities to work together.

Some of this collaborative work has been outlined in section 3.1 in regards to the work that took place between the Forum and Performance Management/Service Improvement Directorate of the HSC Board regarding a Performance Management Template for the Safe and Effective Care Targets.

Other examples of collaborative working include:

- Bi-monthly meetings held between the Forum and Trust Patient Safety Officers
- Establishment of a QUB IHI Open School Chapter
- As part of the QUB Medical School, a Patient Safety Module is offered as a Student Selected Component. This was the 2nd year that this has been available
- Visit to Bombardier, a high performing manufacturing company, to learn from another industry. This was well received by those who attended. A further visit was set up for Copeland Emerson, but unfortunately had to be cancelled
- Establishment of Collaborative specific Advisory Groups (to include doctors, nurses, pharmacists) to support the work of each collaborative and drive for improvement
- Involvement in a National Learning Set ……..
- Links have been established with the Health Foundation's Safer Patients' Network which was set up to take forward the work of the Foundation's Safer Patients Initiative (SPI)

5.1 Evaluation of Forum

As part of the evaluation of the work of the Forum, a questionnaire Survey was carried out in May for the period 2009-2010. Via Survey Monkey a link was sent to key stakeholders.

Results showed that:

- 90% stakeholders believed that the HSC Safety Forum has been effective in its role
- 90% stakeholders were either satisfied or very satisfied with the support provided by the Safety Forum.

When asked if there was anything that the Forum could do differently responses included:

- Identification of key issues which should be prioritised in education and training courses for health professionals and students
- An annual workshop event to agree priorities for the year
- Ongoing programme of training and development for key personnel
- Regular summary of ongoing work and progress
- To be inclusive of other areas outside acute

Positive comments were also received:

- I am a strong supporter of the Forum as a force for good care
- We have very much appreciated the help, support and advice, particularly in relation to training of key personnel regarding patient safety issues and techniques. The networking opportunities have also been beneficial and the contact with the Forum has greatly assisted in focussing us on patient safety

As the Forum further develops, all the feedback received from both this Evaluation and from regular feedback through each of the Collaboratives, will be taken into account to plan for the future.

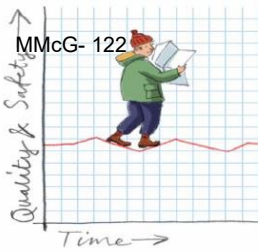
6. Proactively raise awareness of the importance of public and individual involvement (PPI) in improving the safety of health and social care and support commissioners and providers of services in engaging with patients and clients to improve safety and quality

In recognition of the importance of involving patients in improving patient safety, meetings were held between the Forum and the Patient Client Council. A patient representative was identified and now is a full member of the HSC Safety Forum Steering Group.

In addition, a Conference on the theme, Patient Involvement in Ir Patient Safety, was originally scheduled to be held on 19 November 2009. Due to significant pressures on Trusts at that time, this was rescheduled for May 2010.

This work will continue to be progressed throughout 2010-2011.

Trusts are continuing to work on the PPI standards and the importance of patient involvement is reinforced within each collaborative.



7. Conclusion

As stated in the introduction, this is the first Annual Report of the HSC Safety Forum. It outlines the key work undertaken by the Forum during 2009-2010 against its key objectives. It is not all encompassing of the patient safety work in Northern Ireland. There are Trust and many regional networks undertaking improvement work in many areas.

The Forum, however, provides a vehicle for organisations throughout the HSC to share their views and shape the patient safety agenda.

There are encouraging signs of improvement and sustainability in a number of areas described in this Report and work still required on others.

This is a journey and, as such, will develop and progress. Priorities will be identified for patient safety work and it is important that areas other than acute become involved in this work. Early links have been made with both social and primary care and these must be built on over the coming year.

The Forum, itself, will be undergoing changes during the coming year with proposals that it transfers to the Public Health Agency. This should enable further linkages with health and social care and support co-ordination of initiatives.

Importantly, all this work has been led by front-line staff and thanks should go to them for their continued commitment.

HSC Safety Forum Steering Committee Members
(as of March 2010)

Dr Eddie Rooney (Chair)	Chief Executive	Public Health Agency
Ms Simona Arena	Programme Manager	The Health Foundation
Mrs Hazel Baird	Head of Governance and Patient Safety	Northern HSC Trust
Mr Gerry Bond	Patient Representative	
Dr Noeleen Devaney	Director	HSC Safety Forum
Mr Shane Devlin	Director of Customer Care and Performance	Business Services Organisation
Miss Janet Haines-Wood	Assistant Director	HSC Safety Forum
Dr Carolyn Harper	Director of Public Health/Medical Director	Public Health Agency
Mrs Mary Hinds	Director of Nursing & Allied Health Professions	Public Health Agency
Mrs Maeve Hully	Chief Executive	Patient & Client Council
Dr Jim Livingstone	Director of Safety, Quality and Standards	DHSSPS
Dr Patrick Loughran	Medical Director	Southern HSC Trust
Mr Tom McGarey	Risk Manager	NI Ambulance Service
Dr David McManus	Medical Director	NI Ambulance Service
Dr Charlie Martyn	Medical Director	South Eastern HSC Trust
Mr Hugh Mullen	Director of Performance Management and Service Improvement	HSC Board
Dr Tony Stevens	Medical Director	Belfast HSC Trust
Dr David Stewart	Medical Director & Director of Service Improvement	RQIA
Mr Richard Wray	Consultant & Divisional Clinical Director	Western HSC Trust

Noel McCann
Director of Planning & Performance Management

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Room D4.13, Castle Buildings
Stormont Estate
Belfast, BT4 3SQ

[redacted]
Email:
[redacted]

Your Ref:
Our Ref: HSS (PPM) 05/05

Date: 10 June 2005

For Action (with enclosures):

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies

For information (without enclosure):

Chief Executive, HPSS Regulation & Improvement Authority
Chief Officers, HSS Councils
Directors of Public Health in HSS Boards
Directors of Social Services/Social Work in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
Directors of Pharmacy in HSS Boards and Trusts
Directors of Nursing in HSS Boards and Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups
General Medical, Community Pharmacy,
General Dental & Ophthalmic Practices

Dear Colleague

REPORTING OF SERIOUS ADVERSE INCIDENTS WITHIN THE HPSS

Introduction

1. Circular PPM 06/04, issued in July 2004, provided interim advice for HPSS organisations and Special Agencies on the reporting and management of serious adverse incidents and near misses.

2. The purpose of this Circular is to provide an update on safety issues; to underline the need for HPSS organisations to report serious adverse incidents and near misses to the Department in line with Circular PPM 06/04; and to request details of senior managers who have been assigned overall responsibility for the reporting and management of adverse incidents.

Update on Safety Issues

Safety Group

3. The Department established a Safety in Health and Social Care Steering Group initially to advise on the future role and function of the Northern Ireland Adverse Incident Centre (NIAIC), with particular emphasis on the establishment of NIAIC accountability boundaries. However, the Steering Group considered that there was a need for the Department to take a broader, more systematic approach to safety within the HPSS and to provide greater strategic direction on the recording, reporting and investigation of all adverse incidents and near misses.

4. As part of this work, the Steering Group commissioned Deloitte to carry out a scoping exercise on adverse incidents and near miss reporting in the HPSS and special agencies; and to evaluate the Northern Ireland Adverse Incident Centre.

Key Findings of Deloitte Report

5. The Deloitte report acknowledged that, within HPSS organisations, there is a consistent drive to improve the reporting and management of adverse incidents, based on a common belief and understanding of the benefits it can bring to patient and client safety and care. However, the report also noted inconsistencies in approach, including incident reporting systems, monitoring, collation, analysis and follow-up.

6. The report's key recommendations included the need for:

- a consistent approach to the definition and coding of adverse incidents and near misses;
- more Departmental guidance on risk assessment, reporting structures and links to other organisations;
- the development of improved reporting systems to support the analysis and audit of incidents and the development of mechanisms to improve learning and knowledge;
- links between local reporting arrangements and national, statutory, and confidential reporting mechanisms;
- the development of guidance on local investigations and reviews; and
- improved training and development of staff in the use of risk assessment tools, such as root cause analysis.

Further Work

7. In line with these proposals, a number of projects are now being taken forward by the Department. These include:

- work to standardise definitions and coding;
- the development of formal links with the National Patient Safety Agency; and
- the development of a safety framework for the HPSS.

8. Further information about progress with each of these projects will be issued at a later date.

Reporting Incidents

9. Circular HSS (PPM) 06/04 indicated that the Department, in collating information on serious adverse incidents and near misses, would feed back relevant analysis to the HPSS. In line with this undertaking, a small group has been established in the Department, which reviews all incidents that are notified. It is planned that regular feedback will be issued to the HPSS, including an annual report.

10. As the first step in this process, a briefing session has been arranged for safety managers on 15 June, when the Department will be providing feedback on the operation of the reporting and management arrangements established by Circular PPM 06/04.

11. In the meantime, it is important that notifications required under the interim guidance should continue to be provided to the Department. Safety managers should review the operation of local procedures on a regular basis to ensure that all serious adverse incidents are being reported to the Department.

12. All HPSS organisations are reminded that incidents which are regarded as falling in any of the categories below should be notified to the Department in accordance with the procedures outlined in the guidance:

- **incidents regarded as serious enough to warrant regional action to improve safety or care within the broader HPSS;**
- **incidents which are likely to be of public concern;**
- **incidents which are likely to require an independent review.**

13. All other existing systems should continue to be used. In particular, HPSS organisations should continue to report incidents involving medical devices and equipment to the NIAIC.

Management Arrangements

14. Circular PPM 06/04 indicated that HPSS organisations and Special Agencies should be developing a culture of openness. In that context, it requested all HPSS organisations and Special Agencies to nominate a senior manager at board level who would have overall responsibility for safety and the reporting and management of adverse incidents within the organisation. To assist with future communications on safety issues, the Department has decided to establish a central list of these safety managers.

Action

15. A copy of the Deloitte Report is enclosed for your information; also enclosed is a specific section relating to your Trust, Board or Special Agency as appropriate. Taken together, these should be used to inform the safety agenda within your organisation.

16. Chief Executives of Boards, Trusts and Special Agencies should ensure that copies of the Deloitte Report are available for distribution as appropriate.

17. In line with paragraph 14 above, I should be grateful if you would let Jonathan Bill [redacted] have details of your safety manager – their name, position and contact details, **by 30 June 2005**.

Yours Sincerely

NOEL McCANN

Department of Health, Social Services and Public Safety
An Roinn Sálinte, Serbhísí Sóisialta augus Sábháilteacht Phioblí

Subject:
Reporting and follow-up on serious adverse incidents

Circular Reference: HSS (PPM) 02/2006

Date of Issue: 20 March 2006

For action by:

- Chief Executives of HSS Trusts
- Chief Executives of HSS Boards
- Chief Executives of Special Agencies
- Chief Executive of Central Services Agency
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Officers, HSS Councils
- Directors of Public Health in HSS Boards
- Directors of Social Services in HSS Boards and Trusts
- Directors of Dentistry in HSS Boards and Trusts
- Directors of Pharmacy in HSS Boards and Trusts
- Directors of Nursing in HSS Boards and Trusts
- Directors of Primary Care in HSS Boards
- Medical Directors in HSS Trusts
- Chairs, Local Health and Social Care Groups
- Chairs, Area Child Protection Committees
- Chief Executive, Regulation & Quality Improvement Authority
- Chief Executive, Mental Health Commission

Summary of Contents:

The purpose of this Circular is to notify a number of important points about the reporting and management of Serious Adverse Incidents (SAIs)

Enquiries:

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

Quality & Performance Improvement Unit
DHSSPS
Room D2.4
Castle Buildings
Stormont
BELFAST
BT4 3SQ

[redacted]

Related documents

HSS (PPM) 06/2004
HSS (PPM) 05/2005

Superseded documents

Circular HSS4 (OS) 1/73 - Notification of Untoward Events in Psychiatric and Special Care Hospitals

HSS (THRD) 1/97 - Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability

Annexes A and B to Circular HSS (PPM) 06/04

Status of Contents:

Action

Implementation:

Immediate

Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Noel McCann
Director of Planning & Performance Management

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

For action:

Chief Executives of HSS Trusts
Chief Executives of HSS Boards
Chief Executives of Special Agencies
Chief Executive of Central Services Agency
General Medical, Community Pharmacy
General Dental & Ophthalmic Practices

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Directors of Social Services in HSS Boards and Trusts
Directors of Dentistry in HSS Boards and Trusts
Directors of Pharmacy in HSS Boards and Trusts
Directors of Nursing in HSS Boards and Trusts
Directors of Primary Care in HSS Boards
Medical Directors in HSS Trusts
Chairs, Local Health and Social Care Groups
Chairs, Area Child Protection Committees
Chief Executive, Regulation & Quality Improvement Authority
Chief Executive, Mental Health Commission

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Email:
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Circular HSS (PPM) 02/2006

20 March 2006

Dear Colleague

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS

Introduction

1. Circular HSS (PPM) 06/2004, issued in July 2004, introduced new interim reporting procedures for serious adverse incidents (SAIs) and near misses for HSS Boards, Trusts, Agencies and Family Practitioner Services. Since then, the Department has been monitoring the operation of the system and the purpose of this circular is to notify a number of important points about the reporting and management of SAIs.

2. In particular, this guidance:

   - draws your attention to certain aspects of the process which need to be managed more effectively;
   - notifies important changes in the way that SAIs should be reported in future; and
   - provides a revised report pro forma which should be used in all future reports.

3. This guidance also clarifies the processes that the Department has put in place to consider SAIs notified to it and outlines the feedback that will be made available to the HPSS.

Areas for improvement

4. On the basis of the review that the Department has undertaken, it is clear that a number of areas need to be improved:

Nominated Reporting Officers - for an HPSS organisation to comply with the current risk management controls assurance standard, the senior manager at board level with overall responsibility for the reporting and management of adverse incidents should consider the incident against the criteria set out in HSS(PPM) 6/2004. Having a nominated officer at board level provides assurance that incidents are being dealt with appropriately. However, the Department is concerned to note that incidents continue to be reported from a variety of sources within some organisations (in some cases, causing duplicate reporting). This potentially undermines the development of a coherent, co-ordinated and effective approach to incident management within organisations.

It is recognised that circumstances differ in the primary care environment. However, the principles of having a nominated lead to co-ordinate the reporting of incidents is just as relevant. As part of having effective governance arrangements, practices should report SAIs to their area HSS Board. Therefore it is important that both HSS Boards and practices have a nominated lead. It is recognised that different terms are used to mean the same thing in primary care, such as significant events, critical incidents or untoward events. Those events or incidents which occur at practice level and which can be classified as SAIs, should be communicated, within the specified timeframe, by the practice to the relevant HSS Board in the first instance. The HSS Board is responsible for the onward report to the Department of those events or incidents which meet the definition of an SAI. This will include specifying which criteria in HSS (PPM) 06/2004 is relevant in the context of the incident.

The arrangements in place within your organisation should be reviewed to ensure that incident management is co-ordinated and working effectively and that your designated senior manager is aware of those incidents reported to the Department as SAIs and that each meets the criteria set out below.

Appropriate reporting – whilst this circular relates to the reporting of SAIs to the Department, it should be noted that organisations should continue to follow existing reporting mechanisms in order to fulfil their statutory obligations (for example to RQIA or MHC(NI)) and national or local reporting commitments (such as National Confidential Enquiries or under *Co-operating to Safeguard Children*).

HSS (PPM) 06/2004 outlined the steps to be taken by the designated senior manager when alerted to an SAI. The manager has to consider whether the incident should be reported to the Department where it is likely to:

- be serious enough to warrant regional action to improve safety or care;
- be of public concern (such as serious media interest); or
- require an independent review.

A number of incidents reported do not fall into these categories. Although the Department continues to encourage organisations to use the SAI reporting system - and would advise organisations to report if in any doubt – there is a need to ensure that reports made to the Department are serious **and** fall within one or more of the categories set out above.

Children's Homes - in particular, the Department is receiving a substantial number of reports about children who go missing without permission from children's homes. A follow-up report usually arrives (within 24 hours) confirming that the child has been located. Schedule 5 to the Children's Homes Regulations sets out the statutory requirements for notification of such cases. **The Department should only be notified if the criteria set out above apply**. In particular, if an organisation intends to contact the media to assist it in locating a child or if a felony is suspected, the Department should be informed under the SAI reporting system, prior to notification being made to the media. In all other cases, unless they fulfil the SAI reporting criteria, incidents about children who go missing without permission should not normally be reported to the Department.

Confidentiality - incident reports sometimes include details about patients' or clients' names. This practice should be discontinued. All incident reports should be anonymised – generally the gender and age of the patient or client is sufficient detail. To aid any follow-up enquiries, however, you should provide the organisation's incident identifier number.

Delay in Reports - unless there is reasonable justification, a report to the Department should be submitted within 72 hours of the incident being discovered. Where an incident involves the death of a person every effort should be made to submit a report within 24 hours. There has been a number of incidents where the time delay in reporting has been considerable; in some cases, these have been accompanied by an explanation for the delay. Some, however, have failed to provide any explanation.

Electronic Reporting - some organisations have indicated concerns about reporting SAIs by e-mail, chiefly on the basis of uncertainty as to whether the information has been received by the Department. The SAI electronic system has a dedicated e-mail address which is regularly checked. However, in order to provide an additional assurance to the reporting organisation, a response acknowledging receipt of an incident report will in future be issued to the sender's e-mail address. If an organisation fails to receive such a response within 24 hours, it should contact the Department to ensure that the incident report has been received.

Revised Notification Arrangements

5. Previous guidance indicated that, until further notice, HPSS organisations should continue to use existing reporting systems alongside the SAI procedures introduced in 2004. In order to reduce duplication, however, it has been decided to discontinue the requirement to submit separate notifications to the Department in the case of untoward events in mental health, learning disability, nursing and residential homes and child care. When an SAI report is received on these issues, it will be forwarded to the relevant point within the Department. Existing guidance, contained in Circulars HSS4 (OS) 1/1973 (Notification of Untoward Events in Psychiatric and Special Care Hospitals) and HSS (THRD) 1/1997 (Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability) is now discontinued.

6. All other existing reporting systems should continue to be used.

Amendments to the SAI Report Proforma

7. The SAI Report proforma (formerly attached as Annex B to Circular HSS (PPM) 06/04) has been revised and is set out in the Annex to this letter. The additional elements are:

- Box 1 - provision for the organisation's own incident identifier number – this will facilitate easier tracing should the Department need to seek further information about the incident.
- Box 2 – in completing this section, reference should be made to any previous SAIs reported which are connected to this particular incident.
- Box 3 – now displays the SAI criteria for reporting to the Department and asks for an explanation as to why the incident meets the criteria.
- Box 4 – extended to include the incident classification as initially assessed by the organisation.
- Box 5 – extended to include the question "Are there any aspects of this incident which could contribute to learning on a regional basis?".
- Box 7 – inclusion of RQIA and facility to record the date on which other organisations are notified. ***Trusts and practices should note that all SAIs should be reported to their commissioning HSS Board as a matter of course***. These reports will help inform HSS Boards with regard to meeting their statutory duty of quality on the services they commission by providing an overview of the quality of service provision and, where appropriate, will facilitate regional learning. In the case of primary care practices, HSS Boards should report to the Department those 'significant events' which are SAIs and fall within the criteria of HSS (PPM) 6/2004.
- Box 8 – as outlined above, it is important that the Chief Executive and the designated senior manager is aware of the incident before the report is submitted to the Department.

Learning from Adverse Incidents

8. The Serious Adverse Incident process is not a performance management tool. However, a key objective in the process is to ensure, where possible, that lessons are learned from adverse incidents and that the quality of services is improved. The Department has, therefore, put in place arrangements to review incidents reported to it on a regular basis and to feed back relevant analysis to the HPSS. In this context, the Serious Adverse Incident Group in the Department meets on a monthly basis to consider reports submitted. It may seek clarification from organisations on the outcome of incidents to determine whether regional guidance is needed. In the case of independent reviews, the Department may also provide guidance as to specialist input into such reviews.

9. In June 2005, the Department provided a first regional briefing on SAIs, focusing on the key issues emerging from incidents reported until then. A further briefing event will take place later this year. Additionally, the Department intends to publish a report later this year which will summarise the key issues emerging and recurrent problems being encountered across the region. It is intended that this will assist organisations to review their clinical and social care governance processes, strengthen their incident reporting arrangements and improve the quality of services.

Action

10. All HPSS organisations are requested to:

- note the areas for improvement identified at paragraph 4 above and ensure that action is taken to address these;
- review the arrangements in place within organisations to ensure that incident management is co-ordinated and working effectively, that designated senior managers are aware of those incidents reported to the Department as SAIs and that such incidents meet the criteria set out in paragraph 16 of HSS (PPM) 06/2004;
- note that existing procedures (under 1973 and 1997 guidance) for the notification of untoward events in mental health services and learning disability are now discontinued;
- cancel Circulars HSS4 (OS) 1/73 (Notification of Untoward Events in Psychiatric and Special Care Hospitals) and HSS (THRD) 1/97 (Notification of Untoward Events in Psychiatric and Specialist Hospitals for people with Learning Disability);
- note the amendments that have been made to the SAI Report Pro-forma; and
- ensure that the revised Pro-forma is brought into use immediately.

11. This Circular will be reviewed in 2007.

12. A copy of this Circular is being sent to designated senior managers responsible for incident reporting in HSS Boards, Trusts and Agencies.

Yours sincerely

NOEL McCANN

ANNEX

SERIOUS ADVERSE INCIDENT REPORT			
1. Organisation: **Incident Identifier No.**			
2. Date and brief summary of incident:			
3. Why incident considered serious: (i) warrants regional action to improve safety or care within the broader HPSS; (ii) is of public concern; or (iii) requires an independent review.	**Briefly, explain why this SAI meets the criteria:**		
4. Immediate action taken: **Classification of incident as initially assessed by organisation: Catastrophic / Major / Moderate / Minor / Insignificant**			
5. Is any regional action recommended? Y/N (if 'Yes', full details should be submitted): **Are there any aspects of this incident which could contribute to learning on a regional basis?**			
6. Is an Independent Review being considered? Y/N (if 'Yes', full details should be submitted):			
7. Other Organisations informed:		**Date informed**	Other (please specify) Y/N
HSS Board	Y/N		
HM Coroner	Y/N		
Mental Health Commission	Y/N		
NIHSE	Y/N		
PSNI	Y/N		**Date informed:**
RQIA	Y/N		
8. I confirm that the designated senior manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Department. (*delete as appropriate*) **Report submitted by:** (name and contact details of reporting officer) **Date:**			

Completed proforma should be sent, by email, to:

adverse.incidents@dhsspsni.gov.uk
If e-mail cannot be used, fax to (028) 9052 8126