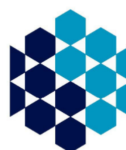
Jim Livingstone
Director of Safety, Quality and Standards



Department of
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POLICY CIRCULAR

Subject:

Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

Circular Reference: HSC (SQSD) 22/2009

Date of Issue: 30 March 2009

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

Related documents

HSS (PPM) 06/2004: Reporting and follow-up on SAIs: Interim guidance
HSS (PPM) 05/2005: Reporting of SAIs within the HPSS
HSS (PPM) 02/2006: Reporting and follow-up on SAIs
HSS(MD) 12/2006: Guidance Document – "How to Classify Incidents and Risk"
DS 154/06: Emergency Care Reform – Definition & Guidance Framework
HSS(MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports
HSS(MD) 06/2006: Memorandum of Understanding – Investigation Patient/Client Safety Incidents
HSC(SQSD) 19/2007: Reporting and follow-up on SAIs/Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Departments

For Information to:
- Chief Officers, HSS Councils
- Chief Executive designate, Patient and Client Council
- Director of Public Health designate, PHA
- Director of Performance Management designate, HSC Board
- Directors of Social Services in HSS Boards and HSC Trusts
- Directors of Dentistry in HSS Boards
- Directors of Pharmacy in HSS Boards
- Directors of Nursing in HSS Boards and HSC Trusts
- Directors of Primary Care in HSS Boards
- Medical Directors in HSC Trusts
- Chairs, Area Child Protection Committees
- Chief Executive, Regulation & Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Superseded documents

Status of Contents:

Action

Implementation:

Initial phase: From 01 April 2009

(To be reviewed by 30 June 2009)

Summary of Contents:

The purpose of this Circular is to advise HSC organisations of the interim arrangements on adverse incident reporting which are being introduced following a review of the existing adverse incident reporting and learning systems.
The Circular provides guidance on the initial phase of the transition arrangements which will be put in place to manage the phasing out of the Department's existing Serious Adverse Incident reporting system, and the establishment of a new Regional Adverse Incident and Learning (RAIL) system.

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Any enquiries about the content of this Circular should be addressed to:
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Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-circulars.htm

Dear Colleague

LEARNING FROM ADVERSE INCIDENTS AND NEAR MISSES REPORTED BY HSC ORGANISATIONS AND FAMILY PRACTITIONER SERVICES

The current system for reporting Serious Adverse Incidents occurring in health and social care settings to the Department was established in July 2004. That system built upon information systems already established by Trusts on adverse incidents generally. During 2008 the Department carried out a review of the SAI system to ensure that this arrangement for reporting of serious adverse incidents remained fit for purpose and consistent with the new organisational and accountability arrangements due to come into effect from 1 April with the establishment of the new Health and Social Care Board and the Public Health Agency. The Department has worked in partnership with a range of stakeholders across the HSC in the course of this review and has, as a consequence, agreed a new model for the management of learning, especially that of a regional nature, arising from adverse incident reporting. This is to be known as the Regional Adverse Incident and Learning (RAIL) system.

The Departmental Board and the Minister have now endorsed the principles of the RAIL system and the Department will shortly establish project structures, in partnership with HSC stakeholders, to manage the development and implementation of the new RAIL system.

In order to ensure a smooth transition as the new HSC bodies assume their roles and responsibilities, there will be a phased implementation of the new RAIL system which will ultimately entail ending, during this year, the need for reports on Serious Adverse Incidents (SAIs) being sent to the Department by HSC Trusts or the HSC Board.

The purpose of this circular is to provide specific guidance on important initial changes to the operation of the current SAI reporting arrangements during the first quarter of 2009/10. These immediate changes should lead to a reduction in the number of SAIs that are required to be reported to the Department in the interim.

A further circular will issue shortly giving details about the next stage in this phased implementation which will be put in place to manage the transition from the SAI reporting system, through its cessation and then the establishment of the RAIL system.

You are asked to ensure that this circular is widely communicated to staff.

Yours sincerely

Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

The operation of the SAI System during the first quarter of 2009/10

1.1 The establishment of the new regional organisations, the Health & Social Care Board (HSC Board) and the Public Health Agency (PHA), together with the extended remit of the Regulation & Quality Improvement Authority (RQIA) from 1 April, means there will be revised roles and responsibilities in relation to arrangements for the reporting and monitoring of adverse incidents; ensuring that learning has been implemented and shared more widely as appropriate; and in providing assurance to the Department that effective systems are in place. However in order to ensure continuity in reporting arrangements during this transitional phase, the Department's current SAI reporting system will remain in place for a short interim period until the HSC Board and the PHA achieve their full functionality.

1.2 Therefore those adverse incidents and near misses which meet the criteria for reporting to the Department set out in Circular HSC(SQSD) 19/07, should continue to be submitted to the Department in accordance with existing arrangements and within the usual timescales. There will, however, be two exceptions to this, details on which are set out in paragraph 1.3 below.

1.3 From 1 April, revised reporting arrangements will apply in respect of:

(i) ***Suspected suicides*** - Those adverse incidents which meet the statutory requirements for reporting to the Mental Health Commission should now be reported to the Regulation and Quality Improvement Authority, in line with the transfer of functions from the MHC to RQIA, which takes effect from 1 April. The current SAI reporting template may still be used to alert RQIA to these deaths during this interim period.

Consequently, the reporting of suspected suicides through the SAI system to the Department should cease. The Department will continue to consider other SAIs relating to mental health services during this short period, including learning on interface issues with mental health services and it will ensure that this is shared with RQIA; and

(ii) ***Under 18s admitted to adult mental health/learning disability facilities*** – HSS Boards already operate monitoring systems to track admissions and the care being given to these patients. To avoid duplication, there should only be a single channel of notifying these occurrences to the HSC Board and the reporting of these **admissions** as SAIs should be discontinued. However, as part of its extended remit, RQIA will need to be advised when these admissions take place. Therefore the notification that is made to the HSC Board should also be copied to RQIA and should contain sufficient assurance that Departmental guidance[1] is being adhered to with regard to the risk assessment, treatment and care of these young people. This does not, however, preclude the need to report as an adverse incident any occurrence where a patient has come to harm whilst in such a placement.

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[1] Under 18 year olds in Adult Mental Health Facilities (DHSSPS, 13 March 2006) and Under 18 year olds in Adult Learning Disability Facilities (DHSSPS, 15 October 2008)

1.4 Until further notice, HSC Trusts and Family Practitioner Services should continue to report serious adverse incidents to the new HSC Board using current channels of communication, and in particular, the specific contact points in the four HSS Boards.

The next phase of implementing RAIL during 2009/10

2.1 It is planned that the new RAIL system, to be located in the Public Health Agency, will be implemented, in partnership with key stakeholders in the process, over the next two years, subject to testing of the feasibility, cost and value for money of the system. However the cessation of reporting Serious Adverse Incidents to the Department is expected to be achievable within the next few months.

2.2 A further circular will issue shortly which will focus on the detail of:

(i) managing the phasing out and cessation of the Department's SAI reporting system, and the establishment of a new RAIL system; and

(ii) the roles and responsibilities of the key stakeholders in reporting and managing adverse incidents during the transition period.

Jim Livingstone
Director of Safety, Quality and Standards

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Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Phase 2 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

Circular Reference: HSC (SQSD) 08/2010

Date of Issue: 30 April 2010

For action by:

- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NI Blood Transfusion Service
- Chief Executive, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

Related documents

DS 154/06 – Emergency Care Reform – Definition & Guidance Framework
HSS(MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports
HSS(MD) 06/2006: Memorandum of Understanding – Investigation Patient/Client Safety Incidents
HSC (SQSD) 22/2009: Phase 1 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

For Information to:

- Chief Executive, Patient and Client Council
- Director of Public Health, PHA
- Director of Performance Management, HSC Board
- Directors of Social Services in HSC Board and HSC Trusts
- Director of Dentistry in HSC Board
- Director of Pharmacy in HSC Board
- Directors of Nursing in HSC Board and HSC Trusts
- Director of Primary Care in HSC Board
- Medical Directors in HSC Trusts
- Chair, Regional Area Child Protection Committee
- Chair, Regional Adult Protection Forum
- Chief Executive, Regulation and Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Superseded documents

HSS (PPM) 06/2004: Reporting and follow-up on SAIs: Interim guidance
HSS (PPM) 05/2005: Reporting of SAIs within the HPSS
Letter from Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 1 November 2005
HSS (PPM) 02/2006: Reporting and follow-up on SAIs
HSS(MD) 12/2006: Guidance Document – "How to Classify Incidents and Risk"
Letter from the Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 11 September 2006
HSC(SQSD) 19/2007: Reporting and follow-up on SAIs/Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Departments
Letter from Chief Social Services Officer 'Serious Adverse Incidents involving Looked After Children in Residential Care entering the Juvenile Justice Centre' , 15 May 2008

Summary of Contents:
The purpose of this Circular is to advise HSC organisations of revised arrangements for adverse incident reporting which are being introduced following a review of the existing adverse Incident reporting and learning systems.
The Circular provides guidance on:
(i) the transitional reporting arrangements which will be put in place pending the full establishment of a new Regional Adverse Incident and Learning (RAIL) system, and
(ii) the revised reporting roles and responsibilities of stakeholder organisations.

Status of Contents:

Action

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

From 1 May 2010

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Dear Colleague

LEARNING FROM ADVERSE INCIDENTS AND NEAR MISSES REPORTED BY HSC ORGANISATIONS AND FAMILY PRACTITIONER SERVICES

Introduction

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

The new RAIL model will reflect the statutory responsibilities of Health and Social Care organisations and will introduce a more coherent and comprehensive regional system for reporting incidents. This will ensure that safety messages and regional learning are identified and disseminated in a consistent and effective manner, and will provide a focus on driving improvements in the quality and safety of services through ensuring that important learning is used to inform and improve practice. It will also ensure that the Department and the Minister are informed of significant events in a timely fashion through the establishment of an Early Alert system, and the arrangements for this will be the subject of a separate circular.

The purpose of this circular is to provide specific guidance on:

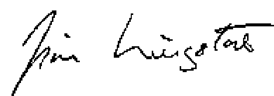
a) the arrangements which will be in place following the transfer of the existing Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency, pending the establishment of RAIL, **Section 1**; and

b) the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department, **Section 2**.

This guidance will take effect from 1st May 2010. These arrangements will remain in place until the full implementation of the RAIL system, at which point they will be reviewed.

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

Yours sincerely



Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Section 1: Reporting Serious Adverse Incidents

1.1 This section outlines the revised arrangements for reporting and management of serious adverse incidents, pending the full implementation of the new RAIL system.

Changes to the reporting of Serious Adverse Incidents

1.2 The requirement on HSC organisations to routinely report SAIs to the Department will cease with effect from the 1st May 2010. Those SAIs which have been reported to the Department up until this date will be reviewed by the Department, with a view to transferring responsibility for any follow-up action that may be required to the HSC Board, working with the PHA. However, it is likely that the Department will wish to retain oversight responsibility for a small number of incidents reported prior to 1st May 2010 where it considers there are particular or significant issues in relation to regional learning, and these will continue to be considered by the Department SAI Review Group, which will remain in operation for a limited period of time to facilitate this. Consequently the Department may continue to request appropriate follow-up information from reporting organisations in relation to these particular cases.

1.3 ***Reports to the HSC Board –*** In line with the operational guidance[1] issued by the HSC Board and PHA to HSC Trusts in parallel with this circular, all incidents which meet the criteria for SAIs as defined in this operational guidance should be reported to the HSC Board with effect from the 1st May 2010. Family Practitioner Services should maintain their existing arrangements for reporting SAIs to the HSC Board.

1.4 The HSC Board will acknowledge receipt of each SAI notified to it, and will obtain any necessary professional advice from the appropriate health and social care professional within the PHA or HSC Board. The PHA and the HSC Board will jointly determine whether any immediate action is required. The HSC Board will ensure that all relevant professional disciplines are involved as appropriate in the management of the incident. The HSC Board will request an incident investigation be carried out by the reporting organisation, to be forwarded to it within 12 weeks in line with current practice. In this regard, incident reviews should continue to be conducted and submitted in the format outlined in HSS (MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports, included at Appendix 3 of the HSC Board/PHA operational guidance. In addition, the National Patient Safety Agency's toolkit is available for investigations which require a full root cause analysis[2].

1.5 The HSC Board will establish a system to ensure that the reports of investigations are discussed by relevant multi-disciplinary staff from the HSC Board and the PHA to identify any learning recommendations arising, and the most appropriate methods of sharing and/or disseminating the lessons therein. The HSC Board will liaise with the Department as appropriate regarding the most effective mechanisms for disseminating any regional guidance which may be required.

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[1] http://www.hscboard.hscni.net/consult/Policies/HSCB%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010.pdf

[2] http://www.nrls.npsa.nhs.uk/resources/?entryid45=59901

1.6 HSC organisations will retain their existing responsibility for reporting, managing, investigating, analysing and learning from adverse incidents/near misses occurring within their organisation in accordance with criterion 4 of the core Risk Management Controls Assurance Standard (CAS). The Risk Management CAS is being updated in line with this circular and will be available on the Department's website from June 2010. These responsibilities are described in more detail in **Section 2**. Similarly the HSC Board will retain existing responsibilities with regard to adverse incidents occurring in Family Practitioner Services.

1.7 ***Reports to the Regulation and Quality Improvement Authority (RQIA)*** - RQIA will continue to require incidents to be reported to it in accordance with the new statutory responsibilities it assumed associated with the transfer of functions from the Mental Health Commission, as detailed in the 2007 UTEC Committee guidance [3]. These include incidents involving ***suspected suicides*** and ***under 18s admitted to adult mental health and learning disability facilities*** as referred to in circular HSC(SQSD) 22/09.

1.8 The RQIA also has extended responsibilities under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Under the 'national preventative mechanism' (NPM), there is a statutory requirement to inform RQIA of the death of any patient or client not resulting from natural causes (including homicides), physical, sexual or other serious assaults and allegations/incidents of abuse in hospital or community services. This should involve, where appropriate, collaborative working with the HSC Board. Further details of RQIA responsibilities in respect of reporting and investigation of incidents are set out in Section 2.

1.9 ***Reporting of suspected suicides -*** From 1st May 2010, SAIs involving suspected suicides are to be reported to both the HSC Board and RQIA in the first instance. However, the management and follow-up of reported incidents with the reporting organisation will be undertaken by the HSC Board and PHA, who will liaise with RQIA in this process.

1.10 ***Reporting of incidents under Children Order Statutory Functions –*** Incidents/events relating to;

(a) the admission of under 18s to adult mental health and learning disability facilities;
(b) children from a looked after background who abscond from care settings, which includes trafficked children and unaccompanied/asylum seeking children;
(c) children from a looked after background who are admitted to the Juvenile Justice Centre or Young Offenders' Centre;
(d) placements outside of the regulated provision for 16-17 year olds; and
(e) serious incidents necessitating calling the police to a children's home

will no longer be reported through the SAI reporting system. With effect from 1st May 2010 such incidents/events should instead be reported directly to the Social Care and Children Directorate at the HSC Board. Details of the arrangements for such notifications are set out in the operational guidance issued by the Social Care and Children Directorate at the HSC Board.

[3] www.dhsspsni.gov.uk/utec_guidance_august_2007.pdf

1.11 ***Breach of 12 hours A&E standard*** – the Performance Management & Service Improvement Directorate within the HSC Board will continue to monitor breaches of this standard. The reporting of these should be emailed direct to hscbinformation@hscni.net using the existing proforma.

Section 2: Roles, Responsibilities and Accountability Arrangements for incident reporting pending the establishment of RAIL

Health and Social Care Trusts

2.1 HSC Trusts are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide.

2.2 HSC Trusts are required to:

- Maintain a system to record and track adverse incidents/near misses in their organisation;
- Adhere to guidance issued by the HSC Board/PHA with regard to managing SAIs;
- Take any immediate steps necessary to prevent re-occurrence of harm;
- Investigate incidents using a method proportionate to the incident (and in compliance with the requirements set out in the joint Memorandum of Understanding between the HSC, Coroner's Service, PSNI and Health and Safety Executive on investigating patient or client safety incidents[4]) and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board and PHA that the requirements above are being met.

Family Practitioner Services

2.3 Family Practitioner Services are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses within the context of the services that they provide. They will be required to produce evidence of learning as part of their clinical and social care governance arrangements which the HSC Board may use as part of its performance monitoring and service improvement or contractual monitoring arrangements.

2.4 Family Practitioner Services are required to:

- Maintain a system to record and track adverse incidents/near misses in their practice;
- Report to the RQIA and the HSC Board all actual or suspected suicides of patients registered with a GP practice and in receipt of secondary mental health care services in the last two years;

[4] http://www.dhsspsni.gov.uk/ph_hss(md)_6_-_2006.pdf
http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

- Investigate incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally, to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board that the requirements above are being met.

Health and Social Care Board

2.5 In line with the HSC Board's performance management and accountability functions, it will hold Trusts and Family Practitioner Services to account for the effective discharge of their responsibilities in reporting and investigating adverse incidents and near misses, and will provide assurance to the Department that these responsibilities are being met and that learning is being implemented. In general terms, the HSC Board is responsible for maintaining those adverse incident reporting and monitoring mechanisms it considers necessary to enable it to carry out the full range of its commissioning, performance management and service improvement functions effectively, ensuring appropriate multidisciplinary involvement of HSC Board and PHA health and social care professionals.

2.6 The HSC Board, working with the PHA, will be responsible for the management of SAI reporting under the arrangements set out in its operational guidance, pending the full implementation of the RAIL system. In addition, the HSC Board is responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.7 The HSC Board is required to:

- Maintain a system to manage SAI reporting, in partnership with the Agency, in line with the arrangements set out in the operational guidance issued in tandem with this circular, pending the implementation of the RAIL system;
- With input from the PHA, hold Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Hold Family Practitioner Services to account for the responsibilities outlined in paragraph 2.4 and provide assurance to the Department that these responsibilities are being met;
- Maintain a system to record and track adverse incidents/near misses that occur within the HSC Board;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents@dhsspsni.gov.uk;
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met; and
- Participate as a member of the RAIL implementation project.

Public Health Agency

2.8 The PHA, through its integrated commissioning responsibilities with the HSC Board, will support the HSC Board in holding HSC Trusts and Family Practitioner Services to account for the discharge of their responsibilities and ensuring that regional learning is identified and disseminated, and will work with the Board to maintain a system for managing SAIs, pending the full establishment of the RAIL system.

2.9 The PHA will assume lead responsibility for implementing the RAIL system, including securing professional input as appropriate. In addition, the PHA will have responsibility for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.10 The PHA is required to:

- Work with the HSC Board to maintain a system to manage SAI reporting, pending the establishment of the RAIL system;
- Maintain a system to record and track adverse incidents that occur within the PHA;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents@dhsspsni.gov.uk;
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met;
- Support the HSC Board in holding Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Work collaboratively with the Department and the HSC Board to develop and progress the support structures and processes which will underpin the new RAIL system;
- Be responsible for the operational management of the RAIL system, once established; and
- Nominate the Project Director and provide administrative support for the RAIL implementation project.

Regulation and Quality Improvement Authority

2.11 From 1st April 2009, RQIA assumed responsibility for those incident reporting requirements which were previously the domain of the Mental Health Commission. This includes oversight of adverse incidents occurring within the mental health and learning disability programmes of care, establishing trend analysis and reporting on regional learning from such incidents or issues.

2.12 RQIA is also a named organisation under the UK's National Preventative Mechanism (NPM) established in accordance with the Optional Protocol to the Convention Against Torture (OPCAT). Under the NPM, RQIA is required to visit places of detention, regularly examine the treatment of persons deprived of their liberty, access all information referring to the treatment of those persons as well as their conditions of detention and make recommendations to the relevant authorities.

2.13 The RQIA will:

- Require HSC Trusts to continue to report adverse incidents to it where there are underlying statutory obligations to do so;
- Require HSC Trusts to share reports of adverse incidents occurring in a mental health and learning disability setting in accordance with discharging its new functions under the HSC (Reform) Act (NI) 2009[5]; and
- Require the HSC Board to share other relevant monitoring information in relation to mental health and learning disability programmes of care.

The Department

2.14 In line with its core functions and the revised accountability arrangements which came into effect from April 2009 following the re-organisation of services as part of the Review of Public Administration, the Department will:

- Continue to host the SAI Review Group for a limited period, and will progress a small number of existing SAIs, along with dissemination as appropriate of any regional learning arising from new incidents;
- Oversee the project management arrangements for the implementation of the RAIL system;
- Seek assurance from the HSC Board/PHA on the effectiveness of the interim incident reporting arrangements within HSC Trusts and Family Practitioner Services;
- Seek assurance from the PHA that it will be in a position to effectively operate the RAIL system, including securing professional input to identifying and cascading regional learning.

[5] 2009 c.1 (N.I.)

Timetable for Implementation of RAIL

3.1 It is planned that the RAIL system will be implemented, in partnership with key stakeholders in the process, on a phased basis over the next one to two years, subject to testing of the feasibility, cost and effectiveness of the system.

3.2 As part of the implementation process, a business case for the establishment of the administrative and IT support structures around the RAIL system will be developed, and a number of pilots will be rolled out and tested across the HSC.

Conclusion

3.3 This guidance circular covers the interim reporting arrangements for the initial phase of that implementation process, setting out the roles and responsibilities of all stakeholder bodies in this period, and will be reviewed when the RAIL system is established. Revised guidance will be issued when the new arrangements are in place.

Jim Livingstone
Director of Safety, Quality and Standards

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POLICY CIRCULAR

Subject:

Early Alert system

Circular Reference: HSC (SQSD) 10/2010

Date of Issue: 28 May 2010

For action by:

- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
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- Chief Executive, Business Services Organisation
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- General Dental & Ophthalmic Practices

For Information to:

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

Related documents

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

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

Superseded documents

Summary of Contents:

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

Status of Contents:

Action

Implementation:

From 1 June 2010

Enquiries:
Any enquiries about the content of this Circular should be addressed initially to:
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Additional copies:
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http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-guidance.htm

Dear Colleague

ESTABLISHMENT OF AN EARLY ALERT SYSTEM

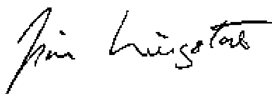
In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department, and the implementation of the Regional Adverse Incident and Learning (RAIL) system (Circular HSC (SQSD) 22/2009).

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

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

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

Yours sincerely



Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Introduction of an Early Alert System

Purpose of the Early Alert System

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

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

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

Criteria for using the Early Alert System

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

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

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

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

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

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

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

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

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

Operational Arrangements

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

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

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

ANNEX A

☒ **Initial call made to** [ ] **(DHSSPS) on** [ ] **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name [ ] Organisation [ ]

Position [ ] Telephone [ ]

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

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

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

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Appropriate contact within the organisation should further detail be required:

Name of appropriate contact [ ]

Contact details: Telephone (work or home) ………………………………………………

Mobile (work or home) ………………………………………………..

Email address (work or home) ………………………………………

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

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FOR COMPLETION BY DHSSPS:

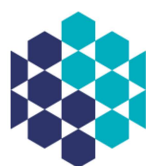
Early Alert Communication received by: ………………………………….. Office: ……………………………..

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

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

MAHI - STM - 089 - 5768

MMcG- 135



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

QUALITY 2020

A 10-YEAR STRATEGY TO PROTECT AND IMPROVE QUALITY IN HEALTH AND SOCIAL CARE IN NORTHERN IRELAND

November 2011

Minister's Foreword

As Minister of Health and Social Services and Public Safety, the guiding principle for me, and I know for the vast majority of people working in health and social care, is to protect and improve the quality of our services. The strategy set out in this document is designed to provide a clear direction over the next 10 years to enable us to plan for the future while ensuring this principle is preserved, whatever the challenges we may encounter.

Clearly we face challenges in the immediate future on the financial front, but there are many other factors that we must also grapple with in the longer term which require that we plan now so as to be able to best address those challenges and maintain high quality services.

The people using HSC services must be at the heart of everything we do. We will be measured by how we focus on their needs by delivering high quality as they deal with pain and distress. This means the services we provide must be safe, effective, and focused on the patient.

Health and social care services in Northern Ireland are already internationally recognised for excellence in a number of areas, and these services are provided by thousands of staff who apply great skill with compassion to ensure the best possible outcomes and experiences of care for their patients and clients. Their continuing determination to deliver high quality care, whatever the constraints, is fundamental to achieving the right outcomes.

This strategy, therefore, has the great advantage of building on an already strong foundation. It gives a clear commitment to sustainable improvement and high standards, safe services and putting people first.

Edwin Poots, MLA
Minister of Health and Social Services and Public Safety

A VISION FOR QUALITY

Quality

Every day hundreds of thousands of people, old and young, are treated and cared for by highly skilled and dedicated professionals in our health and social care services. Some in their homes, some in hospitals, some in community settings, some because they are ill, some because they need care and support. Most of these people are in distress or pain. Some need urgent treatment. Some have to live with chronic conditions over many years. All of them deserve and seek one thing above all. To know that the service provided is of high quality.

But what is "quality", a word so often used but so little understood? The dictionary definition is "*degrees of excellence*". We know that quality can be high, low or somewhere in between. We also know that to make quality high normally requires a range of things to be present. Usually no one factor can define it. Whether it's holidays (facilities, food, comfort, service, etc) or cars (economy, power, safety, reliability, etc), the excellence is derived from how that product or service performs across a range of factors.

So how should we define quality for health and social care in Northern Ireland? One of the most widely influential definitions in healthcare was produced in the United States by the Institute of Medicine in 2001. It proposed six areas in which excellent results would lead to high quality or excellence overall: safety, timeliness, effectiveness, efficiency, equity, and patient-centredness.

> *"No one wants luxury; people just want to be safe and given the proper care."* (A Carer)

The European Union describes high quality healthcare as care that is "*effective, safe and responds to the needs and preferences of patients.*" Many other countries, including England, Scotland, Australia and the Republic of Ireland, have likewise focused on 3 key components, although not to the total exclusion of the others in the list of 6 above. Many countries have chosen to subsume those elements of *timeliness, efficiency and equity* under the heading of *effectiveness.* For Northern Ireland this 10-year quality strategy takes a similar approach defining quality under 3 main headings:

- **Safety** – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

- **Effectiveness** – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.

- **Patient and Client Focus** – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Everyone expects the best care possible when they or a family member falls ill or needs social care support. In Northern Ireland this is provided by health and social care (HSC) services, for the most part free at the point of use, and funded by the taxpayer at a cost of around £4 billion a year. It is different in one important aspect from the National Health Service (NHS) in Great Britain in that it provides integrated health and social care services.

It is a highly complex, sophisticated and increasingly technological service involving a wide diversity of some 70,000 people working together in multidisciplinary teams, providing services day and night, in all weathers, often dealing simultaneously with conditions that are very common as well as those that are very rare, and dealing in a compassionate and professional manner through more than 15 million engagements each year (hospital admissions, in-patient appointments, consultations, etc) with patients, clients, families and carers at times when they are suffering and vulnerable.

For all these people it is a fundamental expectation that the service provided will be as **safe** as possible. The fact is of course that in such a highly complex and stressful environment things will go wrong. The reasons why are many and varied. And thankfully it is only in a tiny proportion of cases that do go wrong. But a high quality healthcare service needs to protect and improve by learning from all such occasions and so minimising the chances of them happening again. There can never be room for complacency. Safety will always be an aspect of quality that needs to be guarded.

Equally, a high quality service should mean that the services provided are the right ones at the right time in the right place. In other words they are **effective** in dealing with the patient or client's clinical and social needs. Too often there is evidence that wasteful procedures or inefficient systems are being employed and internationally recognised best practice is not used where it can be.

Thirdly, and just as importantly, services must be focused primarily on the needs of the patient and client as a person not an element in a production process. There is abundant evidence that such an approach delivers improved health and well being outcomes. There is also more than enough evidence, particularly in recent reports within the UK alone (and internationally) that when the dignity of the person is not respected, or people are not effectively involved in decision making about their health and well-being, or indeed listened to when they complain or raise concerns, that quality suffers and declines.

Undoubtedly the amount of money available for health and social care services affects the quality of care, but other factors such as behaviours, attitudes and the way services are designed, are also very relevant. There is much evidence to show that money is not the only determinant of high quality. When some say "*we cannot afford higher quality at this time*" they overlook the fact that low quality, so often the result of inappropriate behaviours and attitudes, costs more.

Over the last decade, health and social care services in Northern Ireland have taken important steps forward in improving quality. The consultation paper *Best Practice – Best Care* (April 2001) made proposals for setting standards, ensuring local accountability and improved monitoring and regulation. New legislation in 2003 introduced a statutory Duty of Quality for Boards and Trusts. This also led to the establishment of the Regulation and Quality Improvement Authority (RQIA) as an independent body, one of whose main functions is to promote improvement in the quality of health and social care services. *Safety First* (March 2006) produced a framework for sustainable improvement.

In 2009 the HSC Reform Act introduced a new statutory Duty of Involvement for all the main HSC bodies. This required them to involve people at a personal and public level in making decisions about service design and delivery. Together these initiatives have made a positive impact on safety, effectiveness and patient/client focus. The object of this strategy is to build on that foundation so as to widen and deepen the impact over the next decade in terms of protecting and improving quality in health and social care..

As we face the next 10 years, with all its challenges and uncertainties – not least funding – this is when we most need a strategy to protect and improve quality across all health and social care.

Purpose of a quality strategy

How will a new quality strategy help to protect and improve quality and achieve excellence in the three areas described above? Fundamentally a strategy is simply a plan to achieve a result over the long term. In this case a period of 10 years has been selected to deliver results for quality because much of what needs to be done simply cannot be achieved overnight but will take time, regardless of money. The strategy is intended to provide a clear direction for all of us, taking account of the strengths and weaknesses of the present system, so that we can better tackle the future challenges and opportunities faced.

It will provide a vision of what we can achieve, a mission statement of how to get there, and specific goals and objectives to make that vision become a reality over the ten years. It will give us the long-term perspective needed to plan and design future services and deliver outcomes to the highest quality possible.

There are already many examples, often recognised internationally, of high quality or excellence within health and social care in Northern Ireland. Such examples, based on recent evidence, include the focus on early years and early interventions, the treatment of cancer and head injuries; neurosurgery, innovative mental health facilities, the new Health and Care Centres with their one-stop approach to treatment and care, and many others. But even more

importantly, there are also thousands of individual staff who apply great skill with compassion, giving patients and clients the best possible outcome and experience of care at times of personal crisis. They show an unshakeable determination to deliver high quality care, whatever the constraints.

Consequently, this strategy has the great advantage of building on an already very strong foundation, while still recognising that no system is beyond improvement. There is a clear imperative to remain committed to continuous improvement, to maintain high standards and to achieve even higher degrees of excellence – in other words, to protect and improve quality.

How the strategy was developed

This strategy was devised by a project team convened by the Department. Over 100 people, some employed in health and social care and some users of these services, came together at four workshops to discuss priorities for safety, effectiveness and patient/client focus. The outputs from each workshop were referred to an international reference group made up of 18 highly respected professionals and academics for quality assurance. The essence of what was discussed at the workshops was also brought by the Patient and Client Council (PCC) to a wider public cross-section of almost 100 people in the community for comment, and focus group meetings were held with over 150 frontline staff working in health and social care at 10 venues around Northern Ireland. In all, some 350 people, from many different backgrounds, have contributed significantly to the development of this quality strategy (you can see quotations from some of them in this document).

> *"We are already world leaders in some areas but in Northern Ireland we never talk enough about our successes."* – a community nurse

The strategy was then published for public consultation in January 2011 and attracted 46 responses from a wide range of health and social care, voluntary and charity bodies, as well as individuals. There was very broad support for the strategy and many helpful comments and suggested amendments, many of which have since been incorporated in this final version of the strategy. This consultation process, building on the highly inclusive development process, has further strengthened the integrity, purpose and focus of the strategy, reinforcing the underlying support for its implementation. It has also fundamentally confirmed that protecting and improving quality really is the first priority for all those concerned with achieving the best health and well being outcomes.

Principles, values and assumptions

The strategy identifies a number of **design principles** that should continue to inform planners and practitioners over the next 10 years. A high quality service should:

- be holistic in nature.
- focus on the needs of individuals, families and communities.
- be accessible, responsive, integrated, flexible and innovative.
- surmount real and perceived boundaries.
- promote wellbeing and disease prevention and safeguard the vulnerable.
- operate to high standards of safety, professionalism and accountability.
- be informed by the active involvement of individuals, families and communities, HSC staff and voluntary and community sectors.
- deliver value for money ensuring that all services are affordable, efficient and cost-effective.

In delivering high quality health and social care this strategy also identifies the need to promote the following **values**:

- **Empowerment** - supporting people to take greater responsibility for their own health and social well-being, and putting people at the centre of service provision.
- **Involvement** - ensuring that service users, their carers, service providers and the wider public are meaningfully involved, and if necessary supported, at all stages in the design, delivery and review of services at an operational and a strategic level so that, as far as possible, services are personalised.
- **Respect** - respect for the dignity of all people who use the service, their carers and families and for all staff and practitioners involved in service delivery.
- **Partnership** - engaging collaboratively across all disciplines, sectors and specialisms in health and social care, including the voluntary and independent sectors, to ensure an integrated team-based approach, and working with people in their local communities.
- **Learning** - promoting excellence in service delivery and founded on evidence-based best practice to achieve improvement and redress.
- **Community** - anchoring health and social care in a community context.
- **Continuity** - ensuring a co-ordinated and integrated approach to health and social care in all health and social care sectors, and ensuring continuity of care across the system.

- **Equity and Equality** - fairness and consistency in service development and delivery.

While it is impossible to predict exactly what will happen over the next 10 years, the strategy also identifies 8 strategic **planning assumptions** (which will be adjusted as circumstances change) that are fundamental. These are:

- **Political** - health, social services and public safety will continue to remain the responsibility of a devolved Administration.

- **Structural** - the present Departmental and HSC organisational will remain broadly unchanged but delivery structures will continue to evolve.

- **Economic** – very significant resource constraints and challenges will continue to impact on services requiring a robust focus on efficiency and effectiveness of service design.

- **Social** - an ageing society will have greater need for health and social care; general demands and expectations on quality including involvement will continue to rise; there will be an increased focus on safeguarding vulnerable people and groups; there will be continued challenges in addressing the impact of obesity, deprivation, drugs and alcohol.

- **Technology** - the effective use of information and technology in health and social care will increase in importance.

- **Rights** - the need to promote and protect human rights and equality will increase in a diverse society.

- **Environment** - the pressure to minimise waste of all kinds and maximise the use of sustainable resources will increase.

- **Service Delivery** - there will continue to be advances and changes in the science underpinning treatment and care, as well as emphasis on prevention and self managed care and a continued move towards caring for people in their own homes.

A strategic Vision for quality

Ultimately every patient and client, and their families and carers, wants to receive the best care at the time they most need it to achieve the best outcome possible. In order for this to be a reality for all the people of Northern Ireland, the 10-year quality vision for health and social care is:

"To be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care."

This is a bold statement and will require continuous improvement, concerted effort, commitment and determination if it is to be achieved by 2020. It must be acknowledged that many aspects of current services and many of the people working in health and social care are already world-class and worthy of celebration. So the strategy starts from a strong position. But high quality cannot be assumed to remain constant against the challenges that inevitably lie ahead. There is always room for learning, innovation and improvement.

This vision statement is intended to inspire and motivate all of us and give a shared sense of purpose and direction. As Abraham Lincoln said "*Far better to aim high and just miss the target, than aim low and just reach it.*"

> *"We need to identify who is best at providing high quality and see what they are doing. It is not good enough to settle for second place; we must aspire to be the best."* - a GP

Mission statement

In terms of how the vision is to be achieved, the strategy mission statement is:

"In order to become an international leader for excellence in health and social care, the inherent motivation of staff to deliver high quality must be supported by strong leadership and direction at all levels, along with adequate resources, in order to:

- ***focus on improved health and social well-being for all;***
- ***provide the right services, in the right place, at the right time;***
- ***develop effective partnerships and communication between those who receive and those who provide services;***
- ***create a culture of learning and continuous improvement that is innovative and reinforced by both empirical and applied research;***
- ***devise better ways of measuring the quality of services; and***
- ***protect and enhance trust and confidence in the service provided."***

Succeeding in this mission will depend crucially on good leadership and partnership working. Excellence is something that should be obvious not only to professionals working within health and social care but to individual patients and clients and their families. There will be a need to embrace change positively and find innovative ways of dealing with problems with highly motivated, skilled and engaged staff and volunteers.

STRATEGIC GOALS AND OBJECTIVES

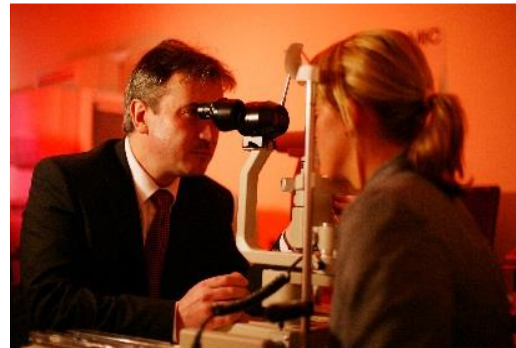
Setting strategic goals

The mission statement summarises how we can realise the vision of being an international leader in the excellence of health and social care. But it is the specific actions taken during the life of this 10-year strategy that will drive that positive change. To that end the strategy identifies 5 strategic goals to be achieved by 2020. Achieving them will help make the vision a reality.

1. **Transforming the Culture** - This means creating a new and dynamic culture that is even more willing to embrace change, innovation and new thinking that can contribute to a safer and more effective service. It will require strong leadership, widespread involvement and partnership-working by everyone.

2. **Strengthening the Workforce** - Without doubt the people who work in health and social care (including volunteers and carers) are its greatest asset. It is vital therefore that every effort is made to equip them with the skills and knowledge they will require, building on existing and emerging HR strategies, to deliver the highest quality.

3. **Measuring the Improvement** – The delivery of continuous improvement lies at the heart of any system that aspires to excellence, particularly in the rapidly changing world of health and social care. In order to confirm that improvement is taking place we will need more reliable and accurate means to measure, value and report on quality improvement and outcomes.



4. **Raising the Standards** - The service requires a coherent framework of robust and meaningful standards against which performance can be assessed. These already exist in some parts, but much more needs to be done, particularly involving service users, carers and families in the development, monitoring and reviewing of standards.

5. **Integrating the Care** - Northern Ireland offers excellent opportunities to provide fully integrated services because of the organisational structure that combines health and social care and the relatively small population that it serves. However, integrated care should cross all sectoral and professional boundaries to benefit patients, clients and families.

These 5 goals are developed in more detail below. Pairs of objectives for each goal are described in terms of why they are important, the actions to be taken, who might take the lead in each case, and, crucially, what will be the expected outcomes. Fundamentally, this sets out the difference this strategy can make for the future quality of health and social care.

TRANSFORMING THE CULTURE

Objective 1: We will make achieving high quality the top priority at all levels in health and social care.

Why is it important?

An emphasis on high quality will improve the experience of all those who use and work in health and social care services. It will also make those services safer for all.

What will be done?

- The delivery of high quality services will be central to the commissioning process.
- A consistent regional definition of what constitutes high quality in every service will be established and accountability for its delivery made part of governance arrangements.
- The use of best practice and improvement methods will be promoted and adopted across the health and social care system.
- Staff and service users' awareness of their individual roles and responsibilities in ensuring high quality outcomes for health and social care will be maximised.
- A culture of innovation and learning that creates more quality-focused attitudes and behaviours among HSC staff will be promoted.

"Often it's the little things that make a big difference to people's lives and make our own job worthwhile." – a social worker

How will we know it is working?

- The number of adverse incidents and near misses reported will increase steadily reflecting a stronger reporting and learning culture – serious adverse incidents will decline in number.
- Increased evidence of more effective complaints resolution and learning.
- Improved levels of satisfaction by both staff and the public.
- Quality, embracing safety, effectiveness and patient/client experience, will be a standing top item on the agenda of all boards and top management teams within the health and social care system.
- Waste caused by inappropriate variations in treatment or care will reduce.

Objective 2: We will promote and encourage partnerships between staff, patients, clients and carers to support decision making.

Why is it important?

There is already a body of evidence from around the world that involving patients and clients in decisions about their care and treatment improves the outcome and their satisfaction with the services they receive and at the same time reduces demands on services. Workshops conducted in the preparation of this strategy also confirmed that this is an important issue for a wide range of service users.

What will be done?

- Best practice standards will be established for informing patients, clients and carers based on what has been successful elsewhere.
- Regular patient and client surveys as well as other creative approaches to getting feedback, such as 'patient/client narratives' will be conducted in collaboration with the PCC.

- Effective and meaningful partnerships to support shared decision-making for HSC staff, patients, clients and carers will be created, including the voluntary and independent sectors.
- Patients, clients and carers will be involved in the design and delivery of education and training to all staff working in health and social care.
- The needs and values of individuals and their families will always be taken into account.

How will we know it is working?

- There will be clear evidence of user involvement arising from effective implementation of Public and Personal Involvement (PPI) Consultation Schemes at all levels of decision making in health and social care from individual care to corporate management.
- There will be baseline information and regular monitoring on how involvement changes over time.
- Evidence on compliance by HSC bodies with all relevant equality and involvement standards.

STRENGTHENING THE WORKFORCE

Objective 3: We will provide the right education, training and support to deliver high quality service.

Why is it important?

No matter how good our systems and procedures are, they all rely on staff who are motivated, skilled and trained to implement them. This is fundamental to the delivery of safe and effective services. Increasingly these systems and procedures must include personal and public involvement in their design and operation.

What will be done?

- Opportunities for continuous learning by staff will be resourced and planned in order to continuously improve quality.

- Increased knowledge and skills in the principles of PPI will be promotoed among all HSC staff.

- Arrangements will be made to involve service users and carers more effectively in the training and development of staff.

- A customised Healthcare Quality training package for all staff working in health and social care (with mandadtory levels of attainment dependent on job responsibilities) will be developed, with possible links to regulation and dovetailed with existing and emerging training and development strategies across HSC.

- Better use will be made of multi-disciplinary team working and shared opportunities for learning and development in the HSC.

- Regular feedback from staff and service users and carers will be sought alongside commissioned research on quality improvement.

> *"We need constantly to look for simpler and faster ways of disseminating learning, to staff who need to know, to improve quality."* - a hospital doctor

How will we know it is working?

- HSC service organisations will be recognised as employers of choice.

- Evidence for improved outcomes for patients and clients will be published.

- Increasing levels of competence among HSC professiojnals will be evidenced through professional revalidation and appraisal.

- There will be evidence from research of reducing errors in service delivery arising from "human factors".

Objective 4: We will develop leadership skills at all levels and empower staff to take decisions and make changes.

Why is it important?

Strong leadership is the key to effecting change and we believe that giving front-line staff autonomy to take more decisions locally, provided this is balanced with clear accountability, is the best way to secure improved quality and productivity.

What will be done?

- Top management teams will be expressly accountable for quality improvement within their organisations.
- Each HSC organisation will produce an annual quality report and be responsible for making improvements year-on-year.
- Staff will be actively supported through service change programmes.
- Change champions will be trained and supported in the latest improvement techniques.
- A renewed emphasis will be placed on generating robust and relevant research to support innovation and quality improvement building on links with local research organizations.

How will we know it is working?

- Evidence of increased authority being delegated to front-line decision makers wherever practical.
- Evidence of health and social care staff at all levels driving quality improvements.
- Every organisation or team will be involved in making their work safer, more effective and patient/client centred.

MEASURING THE IMPROVEMENT

Objective 5: We will improve outcome measurement and report on progress for safety effectiveness and the patient/client experience.

Why is it important?

Safety, effective treatment and a good experience of the care received, whether in hospital or the community, and whether provided by the public, voluntary or independent sectors, lies at the heart of a high quality service. We need to compile good baseline data and be able to measure that this is happening and let everyone have this information in as accessible a way as possible.

What will be done?

The HSC Board, Public Health Agency and Trusts will work with the RQIA, PCC and others to:

- devise a set of outcome measures, with quality indicators, focused on safety, effectiveness and patient/client experience.
- agree a set of effective quality performance targets, involving service users to drive improvement.
- monitor quality improvement year-on-year and compare our performance with the rest of the UK, the Republic of Ireland and internationally.
- publish a regional annual quality report that is widely available.

"We expect healthcare leaders and healthcare professionals to be intolerant of defects or errors in care and constantly seeking to improve, regardless of their current levels of safety and reliability." - a doctor

How will we know it is working?

- There will be a set of effective and measurable quality targets agreed within the first year of the strategy implementation.
- All HSC organisations will meet quality performance targets.
- There will be evidence of steady improvement in the public's reported experience of health and social care.

Objective 6: We will promote the use of accredited improvement techniques and ensure that there is sufficient capacity and capability within the HSC to use them effectively.

Why is it important?

Within the large and complex health and social care system there is always scope for improvement. To achieve best outcomes it is important to review what happens and look for improvements with the aid of skillfully applied accredited techniques.

What will be done?

- A set of improvement methods and techniques for use in the HSC will be agreed and HSC staff will be trained and resourced to use them.
- Capacity and capability will be built up within the HSC to achieve the desired results.
- Audit techniques to measure how standards are being met will be further developed.
- Research and innovation will be encouraged.
- Benchmarking with other health and social care organisations outside Northern Ireland will be conducted to ensure that there is up-to-date information available on best practice.

How will we know it is working?*

- The number of avoidable deaths will decrease steadily.
- The number of healthcare associated infections will be reduced year on year.
- All HSC facilities will meet established standards for cleanliness.
- There will be 95% or higher satisfaction ratings from the public with the safety of care in the HSC.
- There will be 95% or higher satisfaction ratings from staff with the safety of care in the HSC.

(* These indicators may be further refined and developed during the implementation planning process.)

RAISING THE STANDARDS

Objective 7: We will establish a framework of clear evidence-based standards and best practice guidance.

Why is it important?

It is essential that we work to agreed standards that represent best practice and are clearly understood by staff, users and relatives alike. Standards should be authoritative and concise and help achieve high quality in the most cost effective way.

What will be done?

- Information on national and international standards will be gathered and standards developed, where necessary, to deliver best practice.
- A coherent regional framework for standards and guidelines will be established.
- A Web-based system will be established to allow easy access to the framework of standards and related information.

"Even though there is always change I think it is important that we ensure we are not seen to be stagnant, but an evolving organization, always striving for the best." – a public health consultant

How will we know its working?

- Standards will be evidence-based and effectively applied.
- Standards will be kept up-to-date and easily accessible to all.
- The meeting of standards will demonstrate measurable improvements in the quality of services, becoming safer, more effective and more patient/client-centred.

Objective 8: We will establish dynamic partnerships between service users, commissioners and providers to develop, monitor and review standards.

Why is it important?

Increasingly standards should span both health and social care sectors and be developed by partnerships that include all those involved in providing and receiving a service. They should also be monitored periodically and reviewed if they are to continue to be fit for the purpose they were designed.

What will be done?

- An advisory group, representative of HSC organisations and including service user and carer representation, will be set up to harmonise processes in relation to the application of standards.

- A new structure will be created for drafting and agreeing standards and guidelines that gives meaningful inclusion to those affected by them.
- A performance management mechanism will be put in place to ensure standards are achieved by means of audit and compliance measurement within set timescales.
- An incentives mechanism will be created to better ensure compliance with quality standards in all health and social care settings.
- The use of Service Frameworks will be extended.
- Surveys of the public will be conducted to seek feedback on compliance with standards.

How will we know it is working?

- Quality targets published in Priorities for Action will be met.
- All parts of health and social care will be able to demonstrate compliance with the standards.
- Information on standards, and associated compliance information, will be easily accessible on-line.
- New standards will only be introduced after full and effective consultation.

INTEGRATING THE CARE

Objective 9: We will develop integrated pathways of care for individuals.

Why is it important?

Northern Ireland already has an integrated health and social care system, but in order to be truly effective there should be seamless movement across all professional boundaries and sectors of care. This has implications for the timely transfer of information and how data is held. Improvements in this area will make a significant contribution to raising the quality of care and outcomes experienced by patients, clients and their families.

What will be done?

- More effective and secure information systems will be established to record and share information across HSC structural and professional boundaries (and with other relevant Departments and agencies as appropriate).
- Service users will be given a greater role in, and responsibility for, information transfer (e.g. patient held records, patient smart cards, etc).
- Barriers to integrated multidisciplinary and multi-sectoral working will be identified and removed.
- Annual targets for use of personal care plans will be established.

"The first premise, indeed the whole point of a health service, is to deliver what its customer needs. In other words – put the patient first."
– a service user

How will we know its working?

- Patients, clients, carers and HSC staff will collaborate in developing individual care pathways.
- Patients and clients will be able to move between different sectors and specialties within health and social care without undue delay or the transfer resulting in avoidable information errors or resultant harm.
- Patient and client information will be available to staff and carers when it is required.
- There will be evidence of consistent quality of care experienced by patients and clients across all settings.

Objective 10: we will make better use of multi-disciplinary team working and shared opportunities for learning and development in the HSC and with external partners

Why is it important?

It is increasingly recognised that the effectiveness of treatment and care given to patients and clients is enhanced by a holistic approach that encourages co-operation between all those involved at every stage. Failure to address this can produce an “us” and “them” mentality, which has the potential to be detrimental to outcomes and wasteful of resources.

What will be done?

- All disciplines should contribute to a single assessment through a shared assessment framework – NI Single Assessment Tool, and for children, Understanding the Needs of Children in Northern Ireland (UNOCINI).
- More integrated treatment/care teams will be established with innovative management approaches.
- Universities will further develop inter-professional education at undergraduate and post-graduate levels in health and social care.
- MDT pre-registration and post-registration training will be revised to encourage use of multi-disciplinary training.

How will we know it is working?

- There will be a significantly more effective skills mix on teams.
- There will be increasing evidence of joint working across professional disciplines to improve quality.
- In-house organisational training will give primacy to multi-disciplinary learning.

MAKING IT HAPPEN

Managing, advising and reporting

Implementing any new strategy requires good governance arrangements and structures to deliver results at every stage of the process. This is especially true of any strategy that covers a period as long as ten years.

There are 3 important elements to implementing this strategy.

The first is **management**. A programme board, chaired by the Chief Medical Officer, will be responsible for overall control and will report on progress on the implementation of the strategy to the Minister. The board will include senior Departmental policy and professional representatives, senior executives from health and social care organisations, including the voluntary and independent sectors, and people who use health and social care services. Many others will be involved in working on individual projects reporting to the programme board in order to meet the objectives set out under each of the 5 goals. A senior official within the Department will be responsible for co-ordinating and overseeing the work of these project teams and will report to the programme board.

"We need to involve patients and their carers in both the design and implementation of the quality strategy." - a patients' representative

The second is **advice**. A Quality Advisory Forum will meet twice a year and include a wide range of "stakeholders", e.g. patients, clients, carers, trade unionists, relevant professional bodies, academics and HSC front-line staff (not senior executives) and representatives from the voluntary and independent sectors. The Forum will facilitate comment on regular 6-monthly reports provided by the programme board and comment on progress against the objectives set. It will be able to suggest changes, voice concerns to the programme board and thus provide transparent accountability. This will help to reinforce the consensual and inclusive approach that has characterised the development of the strategy.

The third is **reporting.** It is proposed that each health and social care organisation will publish a freestanding Quality Report every year. These reports will state clearly the progress made in each organisation towards meeting the goals of the strategy and also comment on the improvement made to the quality of services commissioned, delivered or promoted within the previous twelve months by that organisation. The reports will make use of new "quality indicators" to be developed by the quality programme. The purpose of this report is to increase accountability against the "duty of quality" that health and social care organisations are required by law to meet. Furthermore, quality should be given the top position on the agenda for meetings of all senior management teams and boards within these organizations.

Engagement and Involvement

The relationship and exchange of information between the Department and health and social care organisations and the wider public will be important in driving this strategy forward. A new Quality Interface Group will be established with representation from all HSC bodies, and patient/client representation, to consider all proposals for new best-practice guidance, guidance under development and the dissemination and evaluation of guidance on all quality issues concerning safety, effectiveness and patient/client focus.

The Department will set up and manage a dedicated Quality Website to provide access to all relevant policy documents and guidance circulars. While this will be provided primarily for health and social care services, it would be available to everyone and the Department would take active steps to bring such guidance to the notice of a wide range of interests, including patient, client and carers' groups and the independent sector. The object would be to make information easily accessible and include links to related websites nationally and internationally.

The Implementation process

This strategy provides a clear vision of **where** we want to get to over the next 10 years in terms of quality healthcare; a high-level mission statement of **how** we plan to get there; and, most importantly, **what** we need to achieve in concrete terms to deliver that vision - the strategic goals.

Achieving those goals will require a detailed, rigorous and inclusive implementation planning process which is to carried out over the next 6 months. We have established an implementation planning team drawing on a diverse range of interests including service users, commissioners, providers and led by a senior official in the Department. That team will finalise an implementation plan and submit it for Ministerial approval by February 2012 to enable the detailed work to follow that will secure those strategic goals, and thus our strategic vision.

It will obviously be necessary to keep the strategy under review so that it remains fit for purpose, not least because the nature and scale of challenges to be faced in the future are always subject to change. If we are not ready to adjust our plans to deal with changing circumstances, then we are likely to be blown off course and failing to realise our end objectives.

It will also be essential that the people served by health and social care services, and those who work in the system, are kept fully informed of progress being made. Annual reports on progress being made in protecting and improving quality in health and social care will be widely accessible.

CONCLUSION

The 10-year Quality Strategy

This strategy is designed to protect and improve quality in health and social care over the next 10 years. During this period, services will undoubtedly face many great challenges. Some of those are already clear, such as funding for health and social care services, but some will only become clear as time passes.

In any event, there is a clear need to be prepared and ready to tackle those challenges strategically and effectively if the quality of services, so important to peoples' lives and wellbeing, are to be protected and improved. This is especially so because health and social care services are large and complex and can take time to change in ways that are safe and effective.

"The quality of services is inextricably linked to raising awareness and earning commitment." - a hospital doctor

This strategy will aid our preparedness and readiness and provide an enduring framework within which policy and service design can better develop.

The Department will give leadership in its implementation. But leadership will also be required in all parts, and at all levels, of the Health and Social Care service, as well as through partnership with patients, clients, carers and communities.

Produced by:
Department of Health, Social Services
and Public Safety,
Castle Buildings, Belfast BT4 3SQ
Telephone: (028) 9052 8321
Textphone: (028) 9052 7668
www.dhsspsni.gov.uk
November 2011

From the Chief Medical Officer
Dr Michael McBride

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

BY EMAIL

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

Castle Buildings
Stormont
BELFAST
BT4 3SQ

Email:

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

Dear Colleagues

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

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

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

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

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

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

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

You are asked to:

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

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

- Ensure full compliance with the guidance.

Thank you for your assistance in this matter.

Yours sincerely

DR MICHAEL MCBRIDE

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

☒ **Initial call made to** [ ] **(DHSSPS) on** [ ] **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name		Organisation	
Position		Telephone	

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

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

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

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………………………………………………………………………………………

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact [ ]

Contact details: Telephone (work or home) ………………………………………………

Mobile (work or home) …………………………………………………..

Email address (work or home) ……………………………………………

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

FOR COMPLETION BY DHSSPS:

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

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

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

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

Reference: HSC (SQSD) 64/16

Date of Issue: 28 November 2016

EARLY ALERT SYSTEM

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

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

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

Related documents

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

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

Superseded documents: N/A

Implementation: Immediate

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

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

Issue

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

Action

Chief Executive, HSCB and PHA should:

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

Working for a Healthier People

INVESTORS IN PEOPLE

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

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

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

Background

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

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

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

Purpose of the Early Alert System

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

Criteria for using the Early Alert System

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

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

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

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

4. *The event may attract media interest;*

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

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

6. *The following should always be notified:*

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

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

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

Operational Arrangements

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

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

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

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

Enquiries:

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

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: 028 9052 3775
qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Paddy Woods

Distributed for information to:

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

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

MMcG- 137

ANNEX A

Initial call made to [ ] **(DoH) on** [ ] **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name [ ] Organisation [ ]

Position [ ] Telephone [ ]

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

1. ***Urgent regional action***
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……………………………………………………………………………………………

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: [ ]

Contact details:

Email address (work or home) ……………………………………………………………

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

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

FOR COMPLETION BY DoH:

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

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

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

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

Reference: HSC (SQSD) 5/19

Date of Issue: 27th February 2019

EARLY ALERT SYSTEM

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

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

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

Related documents

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

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

Superseded documents:

HSC (SQSD) 64/16: Early Alert System

Implementation: Immediate

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

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

Issue

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- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

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

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

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

Background

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

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

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

Purpose of the Early Alert System

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

Criteria for using the Early Alert System

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

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

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

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

4. *The event may attract media interest;*

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

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

6. *The following should always be notified:*

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

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

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

Operational Arrangements

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

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

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

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

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

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

Enquiries:

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

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: 028 9052 3714
qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Paddy Woods

Distributed for information to:

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

INVESTORS IN PEOPLE

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

HEALTHCARE POLICY GROUP

Deputy Secretary
Jackie Johnston 028 90523724

Primary Care/ Out of Hours Services
Mark

Secondary Care
Kiera Lloyd

Workforce Policy/Human Resources
Andrew Dawson

RESOURCES AND PERFORMANCE MANAGEMENT GROUP

Deputy Secretary
Deborah McNeilly

Capital Development
Brigitte Worth

Information Breaches/ Data Protection
La'Verne Montgomery

Finance Director
Neelia Lloyd

SOCIAL SERVICES POLICY GROUP

Chief Social Services Officer
Sean Holland

Child Protection/ Looked After Children (LAC's)
Eilis McDaniel

Mental Health/ Learning Disability/ Elderly & Community Care
Jerome Dawson

Social Services
Jackie McIlroy

CHIEF MEDICAL OFFICER GROUP

Chief Medical Officer
Dr Michael McBride

Deputy Chief Medical Officers
Dr Paddy Woods

Population Health
Liz Redmond

Chief Dental Officer
Simon Reid

Acting Chief Pharmaceutical Officer
Cathy Harrison

Senior Medical Officers
Dr Carol Beattie
Dr Naresh Chada
Dr Gillian Armstrong Healthcare-Associated Infections (HCAIs) (both confirmed and unconfirmed)

CHIEF NURSING OFFICER

Chief Nursing Officer
Charlotte McArdle

Deputy Chief Nursing Officer
Rodney Morton

ANNEX B

Initial call made to [ ] **(DoH) on** [ ] **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name [ ] Organisation [ ]

Position [ ] Telephone [ ]

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

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

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

……

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Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: [ ]

Contact details:

Email address (work or home) ………………………………………………………………………

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

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

FOR COMPLETION BY DoH:

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

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

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

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

Reference: HSC (SQSD) 5/19

Date of Issue: 12 November 2020

EARLY ALERT SYSTEM

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

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

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

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

Related documents

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

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

Superseded documents:

HSC (SQSD) 64/16: Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-64-16.pdf

Implementation: Immediate

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

Issue

This updated circular advises on the use of the Early Alert System with respect to COVID 19 incidents/outbreaks and also serves as a reminder to the operation of the Early Alert system. COVID 19 incidents/outbreaks that are being managed as part of a normal operational response (usual business) should not be routinely reported through the Early Alert system. Such outbreaks/incidents should continue to be reported to Health Protection Team in the PHA as notifiable disease and HSC organisations should continue to provide regular updates to HSCB through established SITREP arrangements.

Action

Chief Executives of HSCB and PHA should:

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

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

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant staff and all relevant independent sector providers.

Chief Executive of NIMDTA should:

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

Background

In June 2010, the process of reporting Early Alerts was introduced. The Early Alert protocol is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events, which may require the attention of the Minister, Chief Professional Officers and/or policy leads. The purpose of this circular is to clarify arrangements with respect to COVID 19 incidents/outbreaks and re-issue updated guidance for the procedure to be followed if an Early Alert is appropriate.

This updated circular will also serve as a reminder to HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department. The protocol, criteria and operational arrangements for the Early Alert system are provided at **Annex A**, an updated summary of departmental contact numbers is provided at **Annex B**, amendments to these guidance documents, last issued 27 February 2019, are highlighted in yellow for your attention.

During this current surge of COVID-19 incidents/outbreaks have become more prevalent across all HSC organisations, and the handling and management of many of these has become embedded in usual operational business arrangements across HSC organisations. Healthcare outbreaks that are being actively managed as part of an organisation's normal operational response should not be routinely reported

through the Early Alert System. These incidents/outbreaks in health and social care settings should instead continue to be reported to the Health Protection Team within the PHA through established processes for notifiable diseases. Such incidents/outbreaks will subsequently be notified to the Department via daily SITREPs collated by HSCB and via daily update reports shared by PHA's Health Protection service with the Chief Medical Officer's office.

It is important to note that certain COVID-19 incidents/outbreaks, including where there is a serious impact on service delivery, that are not being handled through normal operational response may fall within some of the criteria listed below in **Annex A** and therefore they may warrant an Early Alert. HSC organisations should assess events as they occur/emerge and should they determine that one or more of the criteria listed in Annexe A is met they should report through the Early Alert system as appropriate.

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

Enquiries:

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

Mr David Wilson
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ

qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Lourda Geoghegan
Deputy Chief Medical Officer

Distributed for information to:

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

INVESTORS IN PEOPLE

ANNEX A

Purpose of the Early Alert System

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

Criteria for using the Early Alert System

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

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

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

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

4. *The event may attract media interest;*

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

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

6. *The following should always be notified:*

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

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

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

Operational Arrangements

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

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

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

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

It is important that, when completing the proforma, the information about the person making the notification to the Department, the person who received the information within the Department and the date on which the information is exchanged, is accurate (for recording purposes).

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

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

ANNEX B

EARLY ALERT SYSTEM: DEPARTMENTAL OFFICER CONTACT LIST NOVEMBER 2020

HEALTHCARE POLICY GROUP

Deputy Secretary
Jackie Johnston [redacted]

Primary Care/Out of Hours Services
Chris Matthews 0[redacted]

Secondary Care
Ryan Wilson [redacted]

Workforce Policy/Human Resources
Preeta Miller [redacted]

RESOURCES AND PERFORMANCE MANAGEMENT GROUP

Deputy Secretary
Deborah McNeilly [redacted]

Infrastructure Investment
Andrew Dawson [redacted]

Information Breaches/Data Protection
La'Verne Montgomery [redacted]

Finance Director
Brigitte Worth [redacted]

SOCIAL SERVICES POLICY GROUP

Chief Social Services Officer
Sean Holland [redacted]

Child Protection/Looked After Children (LAC's)
Eilis McDaniel [redacted]

Mental Health Learning Disability/Elderly & Community Care
Mark Lee [redacted]

Social Services
Jackie McIlroy

CHIEF MEDICAL OFFICER GROUP

Chief Medical Officer
Dr Michael McBride

Deputy Chief Medical Officers
Dr Naresh Chada
Dr Lourda Geoghegan

Population Health Director
Liz Redmond

Chief Dental Officer
Simon Reid

Chief Pharmaceutical Officer
Cathy Harrison

Senior Medical Officer
Dr Carol Beattie

CHIEF NURSING OFFICER

Chief Nursing Officer
Charlotte McArdle

Deputy Chief Nursing Officer
Heather Finlay

ANNEX C

☒ **Initial call made to** [ ] **(DoH) on** [ ] **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name [ ] Organisation [ ]

Position [ ] Telephone [ ]

Criteria under which event is being notified (mark as appropriate)

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

Brief summary of event being communicated: * ***If this relates to a child please specify DOB, legal status, placement detail If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of the Safeguarding Board for Northern Ireland (SBNI).***

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

……………………………………………………………………………………………

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: [ ]

Contact details:

Email address (work or home) ……………………………………………………………

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

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

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FOR COMPLETION BY DoH:

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

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

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

INVESTORS IN PEOPLE

Memo

From: Dr Michael McBride
Chief Medical Officer

Date: 25 February 2014

To: Senior Management Team

HSC REPORTING OF EARLY ALERT SYSTEM AND SERIOUS ADVERSE INCIDENTS

The purpose of this memo is to act as a reminder to Senior Officers and Policy Leads of the current arrangements whereby HSC staff notify the Department of Early Alerts and the HSCB of Serious Adverse Incidents (SAIs). Colleagues should note that whilst an event notified as an Early Alert could also be an SAI, this will not always be the case as different criteria are used to determine which system events fall under. This also means that not every SAI will be reported through the Early Alert System.

Early Alert System

The Early Alert System was introduced from 1 June 2010 to coincide with the transfer of responsibility for the Serious Adverse Incident system from Department to the HSCB/PHA. The Early Alert arrangement requires Chief Executives and their senior staff in the HSC to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations which may require urgent attention by Minister, Chief Professionals or policy leads, and/or require urgent regional action by the Department. A copy of the guidance can be accessed at: **http://www.dhsspsni.gov.uk/hsc sqsd 10-10.pdf**

Following the establishment of the Early Alert system, an internal protocol was developed. This outlines the action to be taken if a member of staff is contacted by a HSC representative regarding an incident. A copy of the protocol, which has been updated to include this guidance is attached (**Annex 1).**

The Early Alert system preserves the governance arrangements which are associated with reporting incidents. It ensures that consideration is given as to who should have sight of the detail of event/issues, providing colleagues with the opportunity to brief Minister or to contribute to that briefing where they are not the lead official. The importance of the Early Alert System was emphasised recently at the public hearings of the Inquiry into Hyponatraemia-Related Deaths. Several witnesses gave evidence of the time when the system was not in place and when information was shared with the Department 'informally' i.e. through telephone calls only. The HSCB, Belfast Trust and the Department each gave evidence that the current arrangements help put in place valuable safeguards and foster learning. It is vital that staff follow those policies and procedures appropriately.

There are occasions when HSC colleagues share information with Departmental colleagues about events and issues, usually within the HSC organisation they work in, without any reference to the terms 'Early Alert' or 'Serious Adverse Incidents'. In some instances it will be obvious based on the guidance that the information should be formally communicated as an Early Alert whilst in others it may require a judgement to be made. **In either instance you are asked to explicitly clarify with them if they are raising the matter with the Department as an 'Early Alert' and if you feel that it is appropriate to do so you should instruct them that they must use the 'Early Alert' notification process to advise the Department of the event/issue.**

It has also become apparent that on a number of occasions HSC bodies have not followed up their initial telephone notification of an Early Alert to the Department by forwarding a completed pro-forma (attached at Annex A of the circular) providing further details of the incident to earlyalert@dhsspsni.gov.uk within 24 hours of the initial telephone notification. **Senior Officers and Policy Leads who are contacted by a HSC organisation regarding an incident are asked to remind the Officer making the Report of the need to complete the pro forma as required and e-mail this to the Department at earlyalerts@dhsspsni.gov.uk and the and HSC Board at earlyalert@hscni.net within 24 hours of notification of the event.**
Any subsequent action taken following receipt of the Early Alert pro forma should be copied to **earlyalert@dhsspsni.gov.uk**

You will wish to ensure that you have followed the agreed process to aid the smooth operation of Departmental response and this will assist you if/when decisions are subject to additional future scrutiny.

Procedure for the Reporting and Follow Up of Serious Adverse Incidents (SAI)
There may be incidents which are reported as Early Alerts and which may also be required to be reported as a Serious Adverse Incident (SAI). The requirement on HSC organisations to routinely report Serious Adverse Incidents (SAIs) to the Department of Health, Social Services and Public Safety (DHSSPS) ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA). A copy of the current guidance on the Reporting and Follow up of Serious Adverse Incidents can be accessed at:

www.hscboard.hscni.net/publications/Policies/102%20Procedure_for_the_reporting_and_followup_of_Serious_Adverse_Incidents-Oct2013.pdf

Whilst SAIs are reported to the HSCB, **you are asked, as a matter of good practice, when an Early Alert is reported to you to remind the HSC officer making the report of the need to give proper consideration as to whether or not the incident also meets the criteria to be reported as an SAI to the HSCB.** In certain instances colleagues will also be aware of the need for HSC bodies to notify the PSNI, Health and Safety Executive, Professional Regulatory Bodies, The Coroner etc. and to comply with other statutory and non-statutory requirements to report and/or around the investigation of certain types of events. In each instance it is the responsibility of the reporting organisation to comply with these requirements. **You should therefore remind the HSC Officer reporting an Early Alert of the need to identify, consider and comply with any other of these possible requirements to report or investigate the event they are reporting in line with any applicable guidance or protocols.**

Action

You are asked to:

- Note the content of this memo;

- Note the internal protocol for early alerts which has been updated to reflect the points made in this memo;

- Note the guidance in respect of both Early Alerts and Serious Adverse Incidents;

- Bring this memo and attached guidance to the attention of all staff from Grade 6 down in your area by way of reminder to make them aware of their responsibilities in relation to the operational arrangements for the reporting of Early Alerts; and of the need to remind HSC Officers who contact the Department with the details of an Early Alert of the requirement to complete the Early Alert pro forma and to send this to the Department and the HSC Board within 24 hours of notification of the event.

DR MICHAEL McBRIDE
Chief Medical Officer

Annex 1

INTERNAL PROTOCOL FOR DHSSPS EARLY ALERT SYSTEM

Revised February 2014.

1. This protocol sets out the internal operational arrangements for the Department's Early Alert system, which is designed to ensure;

   (a) that the Department and Minister are provided with timely information on significant events which have occurred within the HSC system; and;
   (b) that the Department maintains a central record of any such notification.

2. It is important to note that the Early Alert system is not designed as a replacement for the SAI system. Separate criteria have been set for events which should be notified to the Department through this channel, in the main events involving potential or actual harm to service users, and/or likely to be significant public concern and/or likely to attract media attention. While SQSD will maintain a central record of events notified through this channel, any necessary follow-up action in response to an individual alert will be for appropriate policy/professional colleagues to determine and initiate.

3. The key components of the proposed early alert system are as follows:

   a. **Initial contact by telephone call** – it will be the responsibility of a senior officer (at Director level or higher) in the reporting organization to contact by telephone a senior officer (Permanent Secretary, appropriate Deputy Secretary or Chief Professional Officer, or Assistant Secretary) in the Department to provide initial warning that an incident has occurred within the services provided by their organization. The senior Departmental officer who receives the initial contact will determine any immediate action required by the Department. This is in line with existing informal arrangements for providing the Department with early warning of significant events occurring within the HSC. There may be instances where HSC colleagues share information 'informally' with Departmental colleagues about events or issues without any reference to the terms 'Early Alert' or 'Serious Adverse Incident'. In these instances the senior Departmental Officer should explicitly clarify whether the matter is being raised with the Department as an Early Alert and, if appropriate, the HSC colleague should be instructed to use the Early Alert notification process to advise the Department of the event/issue. Criteria for incidents which should be reported through this channel have been notified to the HSC in a SQSD Guidance circular on the Early Alert System - http://www.dhsspsni.gov.uk/hsc sqsd 10-10.pdf

   b. **Follow-up notification** - It will be the responsibility of the reporting organization to follow-up the initial telephone notification by forwarding a completed pro-forma (attached at Annex A of the circular) providing further details of the incident to earlyalert@dhsspsni.gov.uk within 24 hours of the initial telephone notification. Senior Officers and Policy Leads who are contacted by an HSC organisation should remind the Officer making the

report of the need to complete the proforma and email it to the Department within this timescale. Upon receipt of the proforma, SQSD will register the incident as an Early Alert and allocate a reference number.

c. **Further action –** SQSD will be responsible for forwarding the emailed notification to appropriate policy/professional colleagues within the Department to provide detail of the event. Policy/professional colleagues should then consider any further action they need to initiate – this may include, for example, liaison with Information Office regarding handling arrangements, preparation of a submission to Minister or urgent lines to take, or any other immediate action deemed necessary, for example regional action to alert other providers to a potentially significant issue. Details of any action which they initiate in response to the early alert should also be copied to **earlyalert@dhsspsni.gov.uk .** This will facilitate SQSD in maintaining a central record of any follow-up action taken by the Department in response to individual notifications.

d. **Maintaining records - SQSD** will be responsible for maintaining a central record of events notified through this channel, including detail of any necessary follow-up action which may be initiated by policy/professional colleagues.

4. There may be incidents which are reported as Early Alerts which may also be required to be reported as a Serious Adverse Incident (SAI). It is the responsibility of HSC organisations to report SAIs to the Health and Social Care Board (HSCB), as well as investigating and implementing any recommendations arising from these. The HSCB work jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA) in addressing SAIs and the Department will look to the Board and Agency via established accountability arrangements for assurance that these responsibilities are being discharged satisfactorily. However, whilst SAIs are reported to the HSCB, when an Early Alert is reported the Department, the Departmental official should remind the HSC official making the report of the need to give proper consideration as to whether or not the incident also meets the criteria to be reported as an SAI to the HSCB. The Departmental official may also be aware of statutory and non-statutory requirements to notify other organisations (PSNI, HSE, Coroner etc.) about certain types of events. He/she should therefore remind the HSC Officer making an Early Alert of the need to identify, consider and comply with any other of these possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols.

5. SQSD will monitor the effectiveness of the Early Alert system, and will keep it under regular review.

SAFETY, QUALITY AND STANDARDS DIRECTORATE

February 2014

GUIDANCE ON THE OPERATION OF EARLY ALERT SYSTEM: MARCH 2020

Background

1. The Early Alert System requires HSC Chief Executives and their senior staff to notify the Department in a prompt and timely way of events which have occurred which may require urgent attention by Minister, Policy Leads or Chief Professional Officers.

Guidance

2. This guidance sets out the key steps for the operation of the Early Alert System which is designed to ensure;

   - The Department and Minister are provided with timely information on significant events which have occurred within the Health and Social Care (HSC) system; and;

   - The Department maintains a central record of such notifications and any subsequent action including if no action is required.

3. There may be instances where HSC colleagues share information 'informally' with a Departmental Officer about events or issues without any reference to the terms 'Early Alert' or 'Serious Adverse Incident'. In these instances the Departmental Officer **should explicitly** clarify whether the matter is being raised with the Department as an Early Alert and, if appropriate, the HSC representative should be instructed to use the Early Alert notification process to advise the Department of the event/issue. It is also important to note that the Early Alert System does not remove the requirement for HSC organisations to assess significant events against the criteria for Serious Adverse Incidents. Criteria for events which should be reported as an Early Alert are outlined in circular "HSC-SQSD-5/19 Early Alert System" and can be accessed at

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-05-19.pdf

4. A summary of the key steps in the Early Alert System are as follows:

Step1: Initial contact should be made by a telephone call from the HSC organisation to DoH

5. It will be the responsibility of a senior representative (at Director level or higher) in the reporting HSC organisation to contact by telephone **a Senior Officer in the Department (Permanent Secretary, Deputy Secretary, Chief Professional Officer, Assistant Secretary or professional equivalents)** to provide initial warning that an event meeting the Early Alert criteria has occurred.

6. The Senior Officer in the Department who receives the initial contact will **determine any immediate action** required by the Department including the need to alert other appropriate Departmental staff and/or the Private Office of the issue

7. Colleagues will need to apply an appropriate degree of judgement when determining if any immediate action is required at this stage including the need to notify the Private Office. **If it is determined that the Private Office needs to be notified, this notification should provide a brief outline of the issue together with initial lines to take** (by email is appropriate and please include earlyalert@health-ni.gov.uk in the address line).

8. The need for a formal submission to the Private Office or further briefing and advice to departmental colleagues can be determined following further assessment of the issue by the appropriate policy lead together with the HSC system i.e. after receipt of the completed Early Alert proforma (see step 3).

9. A prompt list to assist colleagues to ascertain the appropriate level of information at this stage from the reporting organisation is included at Annex A to this guidance including the Early Alert criteria.

10. The Departmental Officer should remind the HSC representative making the notification of the need to give proper initial consideration as to whether or not the event also meets the criteria to be reported under the SAI process.

11. The Departmental Officer should also remind the HSC representation making the notification of the need to consider and comply with any other possible requirements to report or investigate the event they are reporting in line with any other relevant applicable guidance or protocols (e.g. Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), Professional Regulatory Bodies, the Coroner etc.) including compliance with GDPR requirements and the mandatory requirement to notify the Information Commissioner's Office (ICO) about any reportable personal data breaches.

Step 2: Submission of Early Alert proforma to the Department by the HSC organisation

12. It will be the responsibility of the reporting organisation to follow up the initial telephone notification by forwarding a completed proforma providing further details of the event to **earlyalert@health-ni.gov.uk** within 24 hours of the initial telephone notification. Senior Officers who are contacted by a HSC organisation should remind the HSC representative making the notification of the need to complete the proforma and email it to the Department within this timescale. Upon receipt of the pro-forma, Safety Strategy Unit (SSU) will register the incident as an Early Alert and allocate a reference number.

Step 3: On receipt of the completed proforma from the HSC organisation

13. SSU will be responsible for forwarding the completed notification to appropriate policy/professional colleagues within the Department. In some instances, the Early Alert could cover a number of policy areas in which case SSU will attempt to identify a lead policy area however will also copy into the issuing email other policy areas that may apply.

14. Policy/professional colleagues on review of the notification should then consider any further action they need to initiate. This may include, for example; further liaison with SSU in regards to clarification of the lead policy area; liaison with the HSC organisation to ascertain further details surrounding the event, reminding the HSC organisation to give proper consideration as to whether or not the event also meets the criteria to be categorised as an SAI; the need to identify, consider and comply with any other possible requirements to report or investigate the event in line with any other relevant applicable guidance or protocols (e.g. statutory and non-statutory requirements to notify other organisations such as the Police Service for Northern Ireland (PSNI), Health and Safety Executive (HSE), Professional Regulatory Bodies, the Coroner etc.); liaison with the Department's Private Office including the Press Office regarding handling arrangements including preparation of a submission to Minister or any other immediate action deemed necessary such as the need for regional action to alert other providers to a potentially significant issue.

15. DoH Policy/professional colleagues are responsible for ensuring that all information and records of action taken in respect to Early Alerts is managed in accordance with Departmental policy and guidance available on the Departments Intranet site at: http://nics.intranet.nigov.net/health/articles/information-and-records-management-guidance.

16. Details of any action **including notification that no action** is required in response to the Early Alert should also be copied to **earlyalert@health-ni.gov.uk**. This will assist Safety Strategy Unit in maintaining a central record of actions taken by the Department in response to individual notifications.

Annex A

Early Alert Prompt List for Departmental Senior Officers

Reporting Criteria under which event is being notified (tick as appropriate)

- Urgent regional action is required
- The need to contact patients/clients about possible harm
- Press release about harm
- Potential or actual media interest
- Police involvement
- Events involving children
- Suspension of staff or breach of statutory duty

Prompt List

- Does the event actually meet the Early Alert Criteria i.e. is there a more appropriate process/protocol to handle the issue, particular if there may be potential GDPR implications?
- Establish what happened and when.
- Is urgent action required by the Trust, DoH or any other body? (e.g. is action necessary to ensure no further patients are affected within Trust and regionally/nationally; to mitigate impact on affected patients; to investigate the event; to manage impact on service and staff; to communicate with patients/public, staff, regulatory bodies, police, Coroner etc.)
- If yes, summary of what has been done?
- What is the scope of the event – restricted to the Trust or potentially wider?
- What is the likely scale/number of patients affected/possibly affected?
- Remind caller to submit Early Alert proforma to DoH and HSCB within 24 hours.
- Remind caller to consider if event is an SAI and to follow up appropriately.
- Consider if there are any GDPR issues and consult with the DPO if required.
- Ask caller to send you a copy of Trust press statement (holding or other) if available.
- Determine if the Private Office together with the Press Office need to be immediately notified of the event.

- Determine if other immediate action is required by DoH (including internal action/communications).
- Send details of the call by e-mail to: earlyalert@health-ni.gov.uk

HSS (PPM) 3/2002

Room 107
Dundonald House
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BELFAST
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To: Chief Executives, HSS Boards
Chief Executives, HSS Trusts
Chief Executive, CSA
Chief Executives, HSS Special Agencies
Chief Officers, HSS Councils

21 June 2002

CORPORATE GOVERNANCE: STATEMENT ON INTERNAL CONTROL

1. In May 2001 the Department issued guidance on Corporate Governance. Circular HSS (F) 24/2001 refers. The guidance set out the developments in relation to the implementation of a Statement of Internal Control.

2. HPSS bodies have, since 1999, been required to submit a Statement on the System of Internal Financial Control as a first step in a process that would eventually include organisational and clinical controls. In DAO 5/2001, the Department of Finance and Personnel set out its decision that Northern Ireland Departments, like their GB counterparts, should adopt the key provisions of the Combined Code (Turnbull). The Turnbull report states that 'a sound system of internal control depends on a thorough and regular evaluation of the nature and extent of the risks to which the company is exposed'. It further states that the purpose of internal control 'is to help manage and control risk rather than to eliminate it'.

Implementation of a Statement of Internal Control

3. One of the most important provisions of Turnbull concerns the movement from a requirement for Accounting Officers to make a Statement on Internal Financial Control (SIFC) to a much wider Statement on Internal Control (SIC). Such a statement would be signed by the Accounting/Accountable Officers and will cover not only the financial control mechanisms, which were covered by the SIFC, but also the procedures in place to manage wider risks within an organisation. These revised statements will therefore require Chief Executives of bodies sponsored by the Department to confirm that mechanisms are in place within their organisations to

ensure that risks to the achievement of aims and objectives have been identified and that adequate procedures are in place to manage those risks.

4. For 2001/02 Accounting/Accountable Officers are able to make a transitional statement describing, inter alia, the actions underway to enable a full SIC to be made from 2003/3004.

Controls Assurance

5. Controls Assurance is essentially a process that will enable HPSS organisations to provide evidence that they are doing their reasonable best to manage themselves so as to meet their objectives and protect patients, staff, the public and other stakeholders against risk of all kinds. It is a means by which Chief Executives as Accountable Officers can discharge their responsibilities and will enable them to provide assurances to the Department, the Assembly and the public. In taking forward this agenda, the Department intends to take advantage of the work that has already been done within the NHS Controls Assurance Project, including the development of risk management standards and supporting criteria in key modules as follows:

   Risk management – standards and criteria covering the key requirements of a system that should be in place to manage risk.

   Financial controls – standards and criteria covering the key requirements for managing risk associated with financial resources.

   Organisational controls – standards and criteria covering key areas of organisational risk.

   Clinical and social care controls – standards and criteria for managing risk associated with clinical and social care processes.

6. All of these standards will eventually provide the focus for a common system of risk management across the HPSS. Clearly a great deal of work remains to be done in terms of developing standards in respect of clinical and social care governance, however, in the interim Statement of Internal Control in the Department's 2001/2002 Accounts, it will be necessary to demonstrate that the process is underway and that further progress will be made during 2002/2003. This is all the more important in the context of a soon to be published NIAO report on 'Compensation Payments for Clinical Negligence', which includes a substantive section on minimising exposure to future claims through risk management. The report is likely to the subject of discussion by Public Accounts Committee in the near future.

Action Required

7. As a first step in the transition from SIFC to SIC, the Department has decided to adopt a common risk management model for itself and all of its associated bodies. In order to take full advantage of the work already done by the NHS in England, the Department has chosen to adopt the same internationally recognised model as the NHS. That model is AS/NZS 4360: 1999 and the Department is currently pursuing the issue of a single licence agreement, for itself and its satellite bodies, with Standards

Australia International. HPSS bodies must now begin work to ensure that their internal risk management procedures are brought into line with that model by 31 March 2003. A core standard and supporting criteria for risk management in the HPSS will be developed by the Department and promulgated as soon as possible.

8. The NHS has already done a great deal of work to develop a consolidated set of standards in respect of organisational controls. The Department has been examining the relevance of those standards to the HPSS and the Departmental Board has decided that they should be adapted, in consultation with the HPSS, for use here. The Board further determined that the Department should begin by focusing on 6 key areas:

- Financial Management
- Governance
- Risk Management (Core Standard)
- Medicines Management
- Human Resources
- Medical Equipment and Devices

9. The DHSSPS Directors with lead responsibility for these issues will take forward the work to adapt the standards into an appropriate form for use here and will involve the HPSS in this process. The adaptation of the six identified standards will commence immediately and it is expected that departmental officials will shortly make contact with relevant HPSS bodies to seek their input to the process.

10. The development of clinical and social care governance, as set out in Best Practice Best Care, will add another important pillar to the overarching structure of controls assurance. These two projects, important in their own right, are linked closely through the risk management process. It will be important to ensure a high degree linkage as they both go forward, leading eventually to a single approach to the management of clinical and non-clinical risks.

11. For 2002/03, HPSS bodies will be expected to:

- ensure that the appropriate structures are in place to implement controls assurance, taking account of linkages with clinical and social care governance;
- conduct a baseline self-assessment of compliance with the AS/NZS 4360:1999 risk management model and any control standards that may be issued by the Department;
- formulate a prioritised action plan with clearly assigned responsibilities in the light of the assessment's findings;
- provide an assurance statement within their annual report/accounts for 2001/02 (see Circular HSS(FAU) 18/2002);
- ensure that appropriate arrangements are in place to verify the assurance statement.

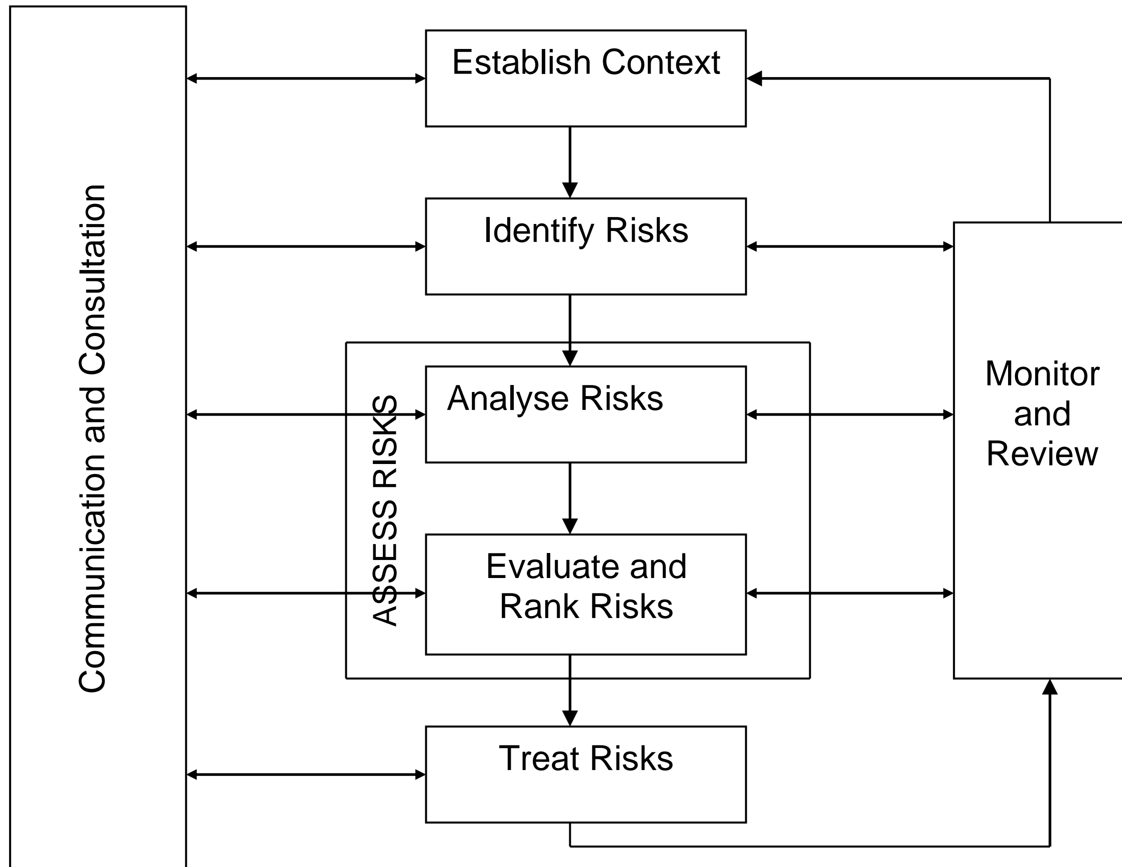
12. In pursuit of these objectives the Department would expect to see the following processes put in place by HPSS bodies:

- a strategy for identifying a picture of risk across the organisation's financial, organisational and clinical/social care systems, agreed by the Audit Committee or other relevant committee of the board;
- action plans to evaluate, assess and control the extent of risk, which include the implementation of any controls assurance standards that may be issued the Department;
- designation of an executive board member with specific responsibility for risk management
- establishment of a central Risk Management Team and local facilitators to implement the strategy and prioritise the highest risks;
- an agreed approach/structure to ensure cooperation between all those involved e.g. internal/external/expert/and clinical audit teams;
- a standard training programme for staff to help them understand and carry out risk management, controls assurance and self-assessment;
- an adequate system for reporting the extent to which any controls identified are being effectively and consistently applied;
- a mechanism for ensuring that reports of risk assessments and audits are brought to the attention of senior managers and the Audit Committee, or other relevant committee of the board, to ensure that formulation of action plans and clearly assigned responsibilities for improvements have been agreed and subsequently followed up.

13. The Department would like to establish a region-wide baseline from where it can develop a strategic approach to risk management, the promulgation of standards, establishment of controls and ongoing monitoring of their effectiveness. We fully understand that some organisations may be further developed than others in this field. In order, therefore, to obtain a clearer picture of the current situation within the HPSS, I should be grateful if you would let me have a short position report (4-5 pages at most) on where your organisation is in terms of developing risk management procedures, giving some indication of when you expect to be able to achieve the objectives and implement the processes set out in paragraphs 11 and 12 above. The report should also assess the extent to which your existing arrangements fit the overview of the model in AS/NZS 4360:1999, as set out in the appendix to this circular. Please let me have your reports no later than 31 July 2002 and it would be helpful if, at the same time, you would provide contact details for the person with lead responsibility for risk management within your organisation.

14. If you have any queries about the content of this circular, please contact me on 028 [redacted] or Claire Thompson on [redacted]

RAY MARTIN
Deputy Director
Planning and Performance Management Directorate


Risk Management Process
AS/NZS 4360: 1999 – Risk Management
Communication and Consultation
Establish Context
Identify Risks
ASSESS RISKS
Analyse Risks
Evaluate and Rank Risks
Treat Risks
Monitor and Review

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

HSS (FPM) 6/2002

Room 107
Dundonald House
Stormont
BELFAST
BT4 3SF

To: Chief Executives, HSS Boards
Chief Executives, HSS Trusts
Chief Executive, CSA
Chief Executives, HSS Special Agencies
Chief Officers, HSS Councils

26 July 2002

AS/NZS 4360: 1999 - RISK MANAGEMENT

1. Circular HSS (PPM) 3/2002 announced that the Department had decided to adopt a common risk management model for itself and all of its associated bodies. In order to take advantage of pioneering work already underway in England, the Department has chosen the same internationally recognised Standard AS/NZS 4360: 1999 already in use by the NHS.

2. Over recent weeks we have been pursuing with Standards Australia International the matter of a single licence agreement for the Department of Health, Social Services and Public Safety and all of its satellite bodies. Those negotiations have now been concluded successfully and a full copy of the Standard is being sent to all HPSS bodies electronically. **It should not be made available to anyone outside your organisation.**

3. In adopting the Standard, the Department is not seeking to impose absolute uniformity of risk management systems across the HPSS. A great deal of good work has already been done and it is not our intention that this should be wasted. The Standard itself recognises that the design and implementation of risk management systems must be influenced by the organisation's objectives, services, processes and practices. It is meant therefore to provide a common and recognisable set of principles to inform and guide the approach of DHSSPS and its associated bodies to risk management. As in the NHS, it will also provide the basis for the Risk Management Core Standard for Controls Assurance.

HSS (PPM) 8/2002

Room 107
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To: Chief Executives, HSS Boards
Chief Executives, HSS Trusts
Chief Executive, CSA
Chief Executives, HSS Special Agencies
Chief Officers, HSS Councils (for information)

11 October 2002

RISK MANAGEMENT IN THE HEALTH AND PERSONAL SOCIAL SERVICES

1. In the penultimate paragraph of Circular HSS (PPM) 3/2002 HPSS bodies were asked to submit short reports on their progress to July 2002 in terms of developing organisation-wide systems of risk management. Those reports have now been analysed in detail and specific issues are being raised with individual bodies, as appropriate. This circular offers further clarification on general points that have emerged during the reporting process.

Organisation-wide system of risk management

2. Risk management is the term applied to a logical and systematic method of establishing the context, identifying, analysing, evaluating, treating, monitoring and reporting risks associated with <u>any</u> activity, function or process that will enable HPSS bodies to minimise losses and maximise opportunities. It is as much about identifying opportunities as avoiding or mitigating losses. HPSS bodies engage in a range of different activities and must therefore develop risk management systems appropriate to the nature of their business objectives. Whatever the system, however, it must conform to the principles set out in AS/NZS 4360: 1999 and it must embrace all aspects of the body's activity, whether they be financial, organisational, clinical or social care. This requirement is now reflected in the Department's Public Service Agreement. A number of July progress reports indicated that, while good work was being done, it tended not to embrace all aspects of business activity.

Objectives for 2002/03

3. The key objectives for 2002/03 are related to the establishment and consolidation of the fundamental structures and processes necessary to underpin a sound system of risk management in the HPSS. Risk management is not a new concept to the HPSS and the Department expects that HPSS bodies should have these basic arrangements in place as part of their normal good governance arrangements. Their implementation should not be dependent upon additional funding but, as part of the June Monitoring Round, the Department allocated recurrently, through HSS Boards, an additional £500,000 on a matched funding basis in support of, inter alia, the development of risk management capacity within the HPSS.

8. It is envisaged that controls assurance standards will eventually provide the focus for a common approach to controlling key areas of potential risk and reporting on the effectiveness of those controls across the HPSS. Controls assurance standards will not replace the need for wider rigorous approach to risk management but they will help the HPSS to focus on identifying and treating key areas of risk and assessment of compliance with the standards will provide evidence of the effectiveness of an HPSS body's overall risk management strategy. Circular HSS (PPM) 3/2002 identified six priority areas where it is intended to develop HPSS controls assurance standards during 2002/03. It has now been decided that Records Management will be added to that initial list of six.

9. The July reports indicate that some HPSS bodies are already making use of the NHS standards to test the effectiveness of their existing procedures. Whilst this can be an important tool for an HPSS body in assessing its own development, it should be borne in mind that there are very important structural, legislative and service differences between the NHS and the HPSS. It is not possible, therefore, to simply lift the NHS controls assurance standards and apply them in Northern Ireland. The important work of developing our own is already underway. The HPSS will be fully engaged in the process and standards will be introduced within a managed timetable.

Clinical and social care governance

10. Arrangements for clinical and social care governance are being developed within the Best Practice – Best Care agenda and will lead to the introduction of standards covering key aspects of the services delivered by the HPSS. The addition of clinical and social care will mean that, eventually, standards will exist for all aspects of governance within the HPSS. Again, these standards will not replace the need for the wider rigorous approach to risk management that must underpin all aspects of governance but they will help the HPSS to focus on identifying and treating key areas of risk.

11. The Department has already shared with the HPSS a draft circular setting out its proposals for taking forward clinical and social care governance. Your responses have all now been received and are being analysed in detail before a final version of the implementation circular is drawn up. As this agenda evolves, the HPSS will be fully engaged in planning its implementation within a managed timetable.

Progress review

12. In order to maintain momentum, the Department intends to seek a further short progress report from HPSS bodies at 31 December 2002. As with the July report, it will focus on progress in achieving the 2002/03 objectives set out in Circular HSS (PPM) 3/2002. A formal request, setting out the format the report should take, will be issued nearer the time.

13. If you have any queries about the content of this circular, please contact me on [redacted]

RAY MARTIN
Deputy Director
Planning and Performance Management Directorate