Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

October 2015 – March 2016

June 2016

CONTENTS

SECTION 1

1.0 BACKGROUND AND INTRODUCTION

From 1 May 2010 the responsibility for the management and follow up of Serious Adverse Incidents (SAIs) transferred from Department of Health, Social Services and Public Safety (DHSSPS) to the Health and Social Care Board (HSCB) working jointly with Public Health Agency (PHA) and collaboratively with Regulation Quality Improvement Authority (RQIA). In response, the HSCB issued the Procedure for the Reporting and Follow up of SAIs (the Procedure) to all HSC organisations and Special Agencies.

During 2012/3 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013 for implementation on 1 October 2013 and with full operational implementation on 1 April 2014.

2.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The current arrangements for managing SAIs reported to the HSCB/PHA are:

- Regional reporting system for all SAIs;
- SAIs are reviewed by senior professional officers; in addition, the HSCB senior management team receives and considers all SAIs on a weekly basis;
- SAIs are allocated to a nominated professional officer, who is the Designated Review Officer (DRO) responsible for reviewing and scrutinising reports;
- SAI Review Sub Group (SAIRSG) meetings to consider reports, identify themes and learning;
- Overarching HSCB-PHA Quality Safety and Experience (QSE) Group to consider the issues identified by the SAIRSG and agree actions and assurance arrangements;
- The Safety and Quality Alerts (SQA) Team provide an assurance mechanism for any actions to be taken forward as a result of regional learning;
- Escalation if required in respect of:
    - timescales for receipt of SAI and review reports
    - assurances for action being taken forward by reporting organisations following the investigation.

3.0 WORK TAKEN FORWARD DURING THE REPORTING PERIOD

REVIEWS

During the reporting period the DHSSPS commissioned two regional projects from Guidelines and Audit Implementation Network (GAIN) who are now aligned within RQIA. The titles of the two projects are:

- Identifying Learning from SAIs across Northern Ireland (*including the death of a Patient*);
- Examining learning arising from SAIs involving suicide, homicide and serious self-harm

Both projects are being carried out in partnership with the HSCB, PHA and HSC Trusts. In taking the projects forward, a Project Board and Project Team has been established for each, with membership drawn from all relevant organisations.

SERVICE USER/FAMILY CARER ENGAGEMENT

In line with regional guidance HSC Trusts have continued to engage with service user/family/carer engagement involved in SAIs and submit engagement checklists following the review of SAIs.

The checklist enables easier data input and more meaningful information output, allowing for a systematic approach to monitor this information. (*APPENDIX C provides an analysis of HSC Trusts service user/family/carer engagement received for the period 1 October 2015 to 31 March 2016).*

In addition, HSC Trusts undertook follow up exercises to review service user/family/carer engagement where 'further engagement planned' had been indicated on engagement checklists (*received by the HSCB*).

TRAINING

- **Annual Regional SAI Learning Event**

  The HSC Safety Forum hosted the 2nd Annual Regional SAI Learning Workshop on the 11 March 2016 at Mossley Mill, Newtownabbey. The workshop built on the success of the 2015 event; providing an opportunity to share learning from SAIs, with a number of case studies being presented by HSC Trusts and Integrated Care across a wide range of programmes of care. A member of staff also shared his experience of the process and the impact it had on him and his family.

  Dr Tom Frawley, NI Ombudsman opened the workshop with a presentation on *'When Things go wrong; the voice of the patient'* and Dr Michael Morrow (Regional Lead N.I. Medical and Dental Training Agency NIMDTA) shared the links between SAIs, Human Factors and Simulation. This was followed by Dr

Gavin Lavery (HSC Safety Forum) presenting on '*when things go wrong for staff*'

Over 170 attended the event and 90% of feedback rated the event as very good or excellent.

- **Regional Governance Leads Workshop**

A regional governance leads workshop was held on 8 December 2015 in The Antrim Forum and was attended by Governance Leads within the HSCB, PHA and the six Trusts.

The workshop provided an opportunity to discuss:

- mechanisms for building on existing governance structures
- taking forward recommendations from the Regional Learning System project
- the benefits of involving Lay Persons in the SAI process

A further workshop is planned for 10 June 2015 in Clotworthy House, Antrim.

- **HSC Trust SAI Workshops**

A SAI workshop is to be held in BHSCT on 18 April 2016 for senior staff involved in the SAI process within the Trust. The workshop will also be attended by HSCB/PHA DRO's and other staff involved in the SAI process.

The SHSCT is also planning a SAI Event on 28 June 2016 and have invited staff from HSCB, PHA and the DHSSPS.

CHILD DEATH NOTIFICATIONS

The report "The Right Time, The Right Place" by Sir Liam Donaldson on governance arrangements across the HSC (January 2015) indicated that the current requirement for all child deaths to be reported and investigated as SAIs seemed to be having "*a detrimental effect on the system*". He also stated that "*the process itself was distressing for families, burdensome for staff, and was not producing any useful learning*". Hence, he recommended that, "*the deaths of children from natural causes should not be classified as Serious Adverse Incidents.*" This was an issue the HSCB/PHA had already identified and work had commenced on an alternative arrangement for child death notification.

Circular HSS (MD) 1/2016 Process for the Reporting of Child Deaths, issued 13 January 2016) advised that all child deaths will be recorded on a Child Death Notification form (CDNf) and reviewed at Trust Mortality and Morbidity (M and M) meetings from 1 February 2016. Within the BHSCT, their electronic system will produce the form and in all other Trusts will commence using a paper based process until such times as the fully implemented Regional Mortality and Morbidity

review system is operational. This process will be introduced and regarded as a pilot with review being performed after one year.

In line with this circular the HSCB Chief Executive also wrote to all Department Arm's Length Bodies on 13 January 2016, attaching revised SAI criteria (see appendix A) , and indicating that, any incident involving the death of a child which meets the redefined SAI criteria will continue to also be reported and reviewed as a SAI. However, the death of other children, including those with a terminal illness where death was expected, will not in future be automatically reported as SAIs. Instead they will be reviewed under the new CDNf, and review at M and M meeting system, with reporting to the HSCB/PHA being by way of the CDNf. The new system will also allow for cases to be subsequently reported as SAIs following a M&M meeting, should that be necessary.

4.0 SAIs REPORTED DURING PERIOD OCT 2015 - MAR 2016

During the period 1 October 2015 to 31 March 2016, the HSCB received 272 SAI notifications. This represents a decrease on the previous six months (April - Sept 2015) when 342 SAI notifications were reported to HSCB.

A breakdown of these SAIs by reporting organisation and programme of care is detailed at Appendix B.

5.0 DE-ESCALATION OF SAIs

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, it is recognised that SAI reports can be based on limited information at the time of reporting and further investigation may identify that the incident no longer meets the criteria of a SAI.

In such instances a request can be submitted, by the reporting organization, to de-escalate or withdraw the SAI, however, the decision to approve the de-escalation/withdrawal will be made by the HSCB/PHA Designated Review Officer.

During the reporting period four (4) SAI notifications received were de-escalated/withdrawn.

6.0 DUPLICATE SAI REPORTING

On occasions a notification may be received from one or more organisations relating to the same incident. In such instances, a lead organisation will be identified to take forward the investigation and follow and the duplicate notification will be closed.

During the reporting period three (3) duplicate SAI notifications were received.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

HSCB/PHA STRUCTURE FOR LEARNING FROM SAIs

It is important that when a serious event or incident occurs, that there is a systematic process for investigating and learning from incidents. The key aim from this process is to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole.

The HSCB, working closely with the PHA, is responsible for identifying and disseminating regional learning from its monitoring role in relation to SAIs, complaints and patient client and experience.

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

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

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

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

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

  The process is overseen by a joint PHA/HSCB SQAT which is a multidisciplinary group chaired by the PHA Medical Director/ Director of Public Health. The Group meet fortnightly to co-ordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DHSSPS, HSCB, PHA and other organisations. This provides a mechanism for gaining regional assurance that alerts guidance have been implemented or that there is an existing robust system in place to ensure implementation.

  The HSCB/PHA SQAT issue a Bi-annual Report on Safety and Quality Alerts. This report provides an overview of the alerts reviewed by the SQAT in the reporting period and details key safety / quality improvements following the issue of alerts.

  The latest edition and previous issues of the PHA/HSCB Report on Safety and Quality Alerts are available to access using the following link:

http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html#TopOfPage

SAI LEARNING MECHANISMS

Possible **Learning actions** following the review of SEA / RCA review reports:

- **Local organisation actions**

- **Regional actions**

  - ***Disseminate***
    - Issue a urgent Learning Letter
    - Issue a Learning Letter / Alert
    - Include an article in the Learning Matters Newsletter or Medicines Safety Matters Newsletter or GMS Newsletter

  - ***Implement***
    - Through an existing work stream or established group
    - Through a Thematic Review
    - Establish a task and finish group

  - ***Inform others***
    - Refer to other regulatory body
    - Commission or organise training event/workshop

2.0 DISSEMINATION OF LEARNING INITIATIVES

Learning from SAIs is a significant element to improving practice. However the HSCB and PHA are cognisant that each and every SAI has an impact on individuals and families. Therefore, whilst for the purposes of this report patient identifiable information has been removed, this is not intended to diminish the personal impact that these incidents have had on the individuals involved.

The following initiatives were identified as part of the SAI review process and relate to learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in previous reports as part of on-going work.

THE FOLLOWING ITEMS ARE NEW LEARNING ISSUED SINCE LAST REPORT:

- **SQR-SAI-2015-015** - Management and advice for patients clients with swallow dysphagia problems

- **SQR-SAI-2015-016 -** Management of Patients who are on combined anticoagulant and or antiplatelet therapy pre and post a procedure surgery

- **SQR-SAI-2016-017** - Safe use of oral bowel cleansing agents
- **SQR-SAI-2016-018** - Reminder of risks associated with long term oral bisphosphonate therapy
- **SQR-SAI-2016-019 -** Residual Anaesthetic Drugs in Cannulae and Intravenous Lines

SAFETY AND QUALITY BEST PRACTICE REMINDER LETTERS RELATING TO ALLTHE ABOVE ARE AVAILABLE TO ACCESS USING THE FOLLOWING LINK:

http://intranet.hscb.hscni.net/documents/Learning_Letters/Safety%20and%20Quality%20Best%20Practice%20Reminder%20Letters/index.html

LEARNING FROM SAIs WITHIN FAMILY PRACTITIONER SERVICES (FPS)

There are a range of other initiatives across the HSC where learning from SAIs is shared with FPS practitioners to reduce the risk of recurrence. There have been a number of SAI related learning communications issued to FPS including the following:

- Medicines Safety Briefing – Electronic Care Record - issued to GPs in October 2015
- Medicines Safety Matters Newsletter - Focus on the Non-Vitamin K Oral Anticoagulants Vol 5 Issue 2 issued to GPs and community pharmacists in October 2015
- High risk medicines posters for GPs and Community Pharmacists issued in November 2015
- Medicines Safety Matters Newsletter for GPs and Community Pharmacists which featured an article on errors that occurred due to incorrect transcribing from hospital letters by GPs, some of which resulted in SAIs - issued in December 2015
- Community Pharmacy poster and counter leaflets “Are you the right person?” issued in March 2016
- GMS Update Newsletter Winter 2016– ‘Learning from two undiagnosed pregnancy SAIs issued to GP practices
- GMS Update Newsletter Autumn 2015 – ‘Reduce the risk of prescription fraud occurring within your GP Practice’ issued to GP Practices

Resources relating to the above are available at the following links:

http://www.medicinesgovernance.hscni.net

http://primarycare.hscni.net/3634.htm

http://primarycare.hscni.net/gms_newsletter_main.htm

NEWSLETTER – "LEARNING MATTERS"

An essential element of improving services is the dissemination of information and a variety of methods are used to ensure learning is shared such as learning letters, alerts and reports. In addition the PHA/HSCB has developed a newsletter to compliment the other methods and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

Learning Matters Newsletter provides a method of sharing learning relating to SAIs, complaints, reviews and patient experience across Northern Ireland. The fifth edition will be issued in April 2016 and will cover the following topics:

- Residual Anaesthetic Drugs
- Consider the diagnosis of HIV
- Patients receiving prophylactic enoxaparin
- Magnetic Resonance Imaging (MRI) Referrals
- Prescription of IV Fluids
- National Patient Safety Alerts
- Reminder of Best Practice Guidance (SQR) Letters

Previous editions of the newsletter can be viewed at:

http://www.hscboard.hscni.net/publications/Learning%20Matters/index.html

http://www.publichealthagency.org/publications/learning-matters-newsletters

THEMATIC REVIEWS

Thematic Reviews are commissioned by the HSCB/PHA QSE Group, to review trends and patterns. These in-depth reviews ensure that local patterns are considered within the regional and national context and ensuing recommendations and key learning points are disseminated across the HSC.

Following an in-depth review of SAI reports, the following thematic review was issued during the reporting period:

- ***THEMATIC REVIEW OF PATIENTS WITH A FALL RESULTING IN MODERATE TO SEVERE HARM AND REPORTED AS A SAI***

The purpose of this thematic review was to identify recurrent themes found within the reported SAIs and to consider any regional learning and any further

actions required to reduce/prevent reoccurrence of these incidents. This review included all the relevant SAIs reported, within HSC, across all programmes of care for the six month period 1October 2013 to 31 March 2014.

The reasons why patients fall are complex and have numerous contributing factors such as physical illness, mental health, medication, age and environmental factors. A number of themes were identified within this review, which are reflected within the report.

There is work already underway to address the main issues from the themes identified within this report. The key proposal was for HSC Trusts to manage falls resulting in moderate to severe harm as adverse incidents and to undertake a post falls review internally unless there are particular issues or there is identified learning that needs to be investigated through the SAI process. The aim would be for HSC Trusts to review these on a quarterly basis and present a summary for discussion at the Regional Falls Group meetings, where trends and themes could be identified. This group will adopt a regional approach to the management of patient falls across HSC Trusts. This approach will be reviewed in April 2017. This review was issued on 16th March 2016 to the relevant HSC organisations.

OTHER LEARNING ACTIONS

There are a range of other learning actions, which existing work streams or groups are taking forward or have been asked to consider by the HSCB/PHA, as a result of learning identified from SAIs. Examples include:

- Maternity Quality Improvement Collaborative
- Maternity Strategy Implementation Group
- Secondary Care Medicines Governance Team
- Bamford Adult Sub Group
- Regional Radiology Network

SECTION 3

NEXT STEPS

1.0 THEMATIC REVIEWS

Following an in-depth review of SAI reports, the following thematic reviews were undertaken:

- ***REGIONAL REVIEW OF SAIs RELATING TO PATIENTS ON INSULIN***

A request was made by the Regional SAI Group to review and identify the numbers and types of SAIs relating to patients on Insulin, across all programmes of care.

The purpose of this review is to identify recurrent themes found within the reported SAIs, to consider any regional learning and whether any further actions are required to reduce/prevent reoccurrence of these incidents.

This review has almost completed and will be issued in the coming months.

2.0 SAI LEARNING EVENT

Work is already underway in relation to organising the third Annual Regional SAI Learning Event The HSC Safety Forum have asked DROs and HSC Trusts to earmark SAIs over the coming months which they would consider valuable in sharing learning across the region.

3.0 REVISIONS TO THE SAI PROCESS

Over recent weeks, the HSCB/PHA have been liaising with HSC Trust professionals and HSC Governance Leads with a view to streamlining the current SAI process in respect of Level 1 SEA reviews.

The proposal would assign reporting organisations the responsibility for quality assuring the review of Level 1 SEAs with HSCB/PHA focusing on the learning outcomes following review.

Further discussion/engagement on the proposal with all relevant organisations will take place over the coming weeks.

SECTION 4

CONCLUSION

The HSCB and PHA want patients, carers and their families to feel confident about the quality and safety of health and social care services in Northern Ireland. There is a continued commitment to learn from SAIs, to improve services and to reduce the risks of recurrence, both within the reporting organisations and across the HSC as a whole. The dissemination of learning following SAIs and ensuring that quality improvements are embedded into practice remains a key priority for the HSCB/PHA.

This report demonstrates actions planned and achieved in the period from October 2015 – March 2016. It also highlights the broad range of work that is routinely undertaken and reaffirms our commitment to safety, effectiveness and patient and client focus.

Since the last report, five learning letters/reminders of best practice have been disseminated to the relevant HSC organisations. The next "Learning Matters" newsletter will be issued in April 2016, to compliment the other methods of learning and to provide a forum where learning from SAIs, reviews and complaints is shared regionally and in a format that reaches all levels of staff across the wider HSC.

HSCB/PHA has continued to work with HSC Trust colleagues in relation to enhancing service users/families involvement in the SAI process.

Quality, Safety and Patient Experience are a significant focus for the HSCB and PHA and both organisations will work in partnership with the HSC to improve the quality of care by learning from incidents and improving standards regionally.

APPENDIX A

REVISED CRITERIA FROM 1 FEBRUARY 2016

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI criteria

- serious injury to, or the unexpected/unexplained death of:
  - a service user (*including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit*)
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility;

- unexpected serious risk to a service user and/or staff member and/or member of the public;

- unexpected or significant threat to provide service and/or maintain business continuity;

- serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

- serious self-harm or serious assault *(including homicide and sexual assaults*)
  - on other service users,
  - on staff or
  - on members of the public

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare*

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

services) and/or learning disability services, in the 12 months prior to the incident;

- suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

- serious incidents of public interest or concern relating to:
    - any of the criteria above
    - theft, fraud, information breaches or data losses
    - a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

APPENDIX B

ANALYSIS OF SAI ACTIVITY OCTOBER 2015 – MARCH 2016

The HSCB has **received 272 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[2] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 and Chart 1 below provide an overview of all SAIs reported by organisation and includes **year on year comparison** of activity for the same **reporting period 1 October 2015 to 31 March 2016.**

TOTAL ACTIVITY	Oct 14 - Mar 15	Oct 15 - Mar 16
BHSCT	84	75
BSO	2	0
HSCB	1	1
NHSCT	71	38
NIAS	2	0
PCARE	13	11
PHA	1	0
SEHSCT	59	51
SHSCT	86	56
WHSCT	47	40
Totals:	**366**	**272**

Table 1

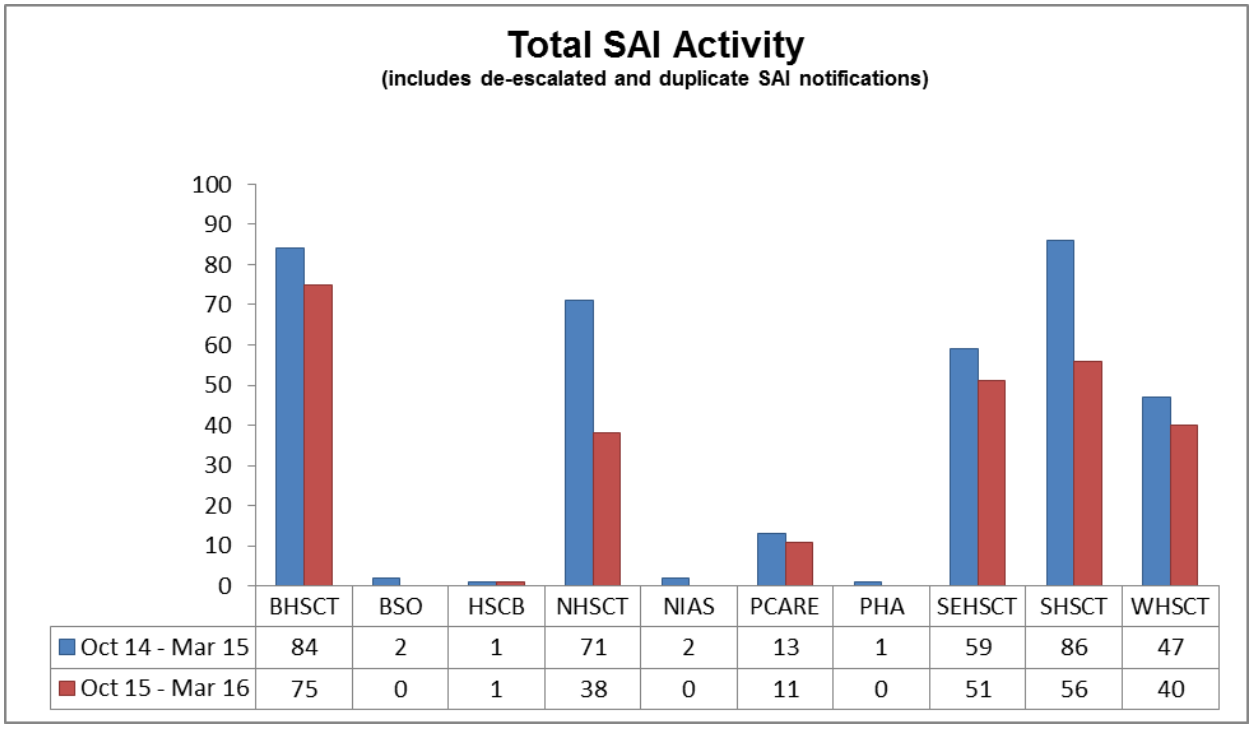


Chart 1

[2] Source- HSCB DATIX Information System

SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate or withdraw the SAI.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further review under the SAI process. This information is considered by the HSCB/PHA DRO prior to approving any de-escalation. During the reporting period **four (4) SAI notifications** received were subsequently **de-escalated/withdrawn**.

TOTAL DE-ESCALATED/WITHDRAWN	Oct 14 - Mar 15	Oct 15 - Mar 16
BHSCT	0	2
NHSCT	3	0
PCARE	2	0
SHSCT	0	1
WHSCT	1	1
Totals:	**6**	**4**

DUPLICATE SAI NOTIFICATIONS

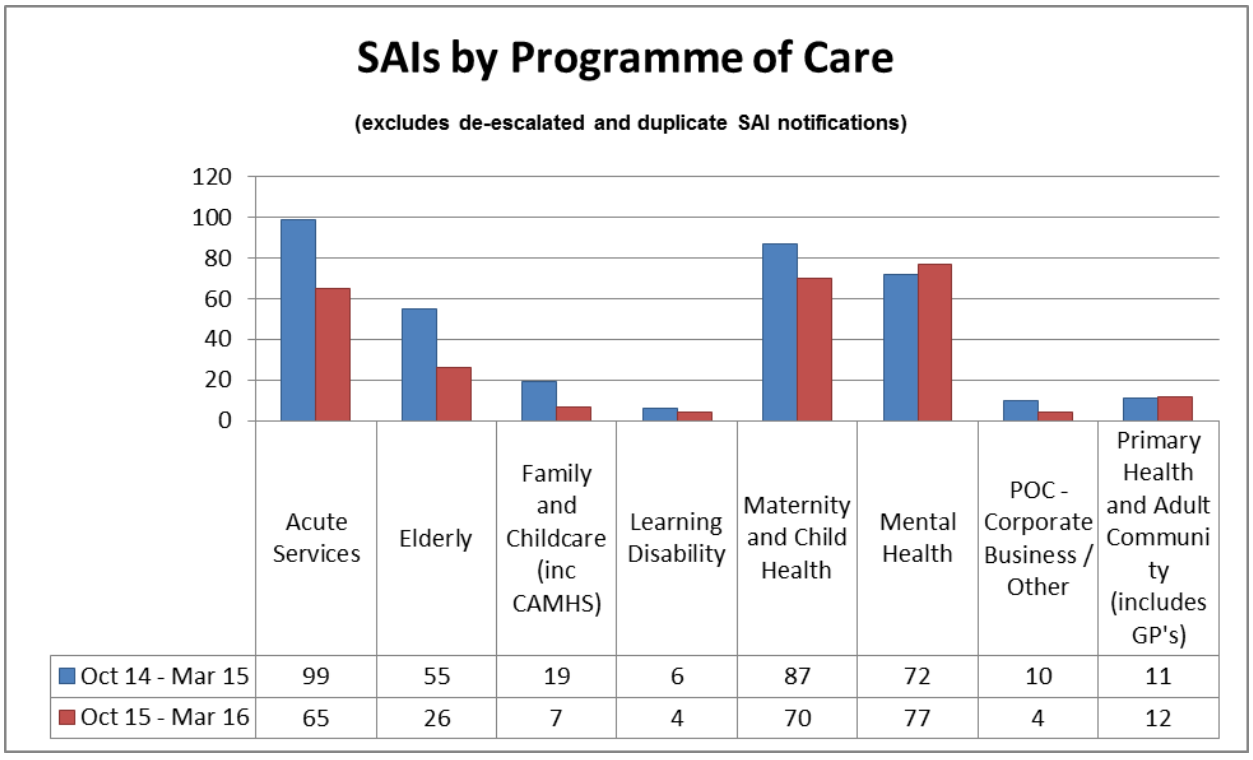
A notification may be received from one or more organisation but relating to the same incident. During the reporting period three (3) duplicate SAI notifications were received.

SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

De-escalated and duplicate SAI notifications have been **excluded** from the analysis in the remainder of this report.



ACUTE SERVICES

ORGANISATION	Oct 14 - Mar 15	Oct 15 - Mar 16
BHSCT	23	21
NHSCT	18	7
NIAS	2	0
SEHSCT	16	6
SHSCT	26	14
WHSCT	14	17
Totals:	**99**	**65**

Current period: Sixty-five (65) SAIs were reported. The top four groups related to the following classifications/categories. Seventeen (17) incidents being the most reported in any one category.

Classification/category

- Accident that may result in personal injury
- Diagnosis failed or delayed
- Treatment, procedure
- Medication

Since the revised SAI criteria were introduced (October 2013), there has been an increase in the number of reported incidents relating to falls; within the above classification/category: accident that may result in personal injury, 26% of the reported SAIs (n=17) for this programme of care relate to slip, trips, falls and collisions in an acute setting.

MATERNITY & CHILD HEALTH

ORGANISATION	Oct 14 - Mar 15	Oct 15 - Mar 16
BHSCT	40	30
HSCB	1	0
NHSCT	6	5
SEHSCT	10	8
SHSCT	14	17
WHSCT	16	10
Totals:	**87**	**70**

Current period: Seventy (70) SAIs relating to maternity and child health were reported. The revised SAI criteria (October 2013) included an additional requirement to report 'any death of a child in receipt of HSC services (up to eighteenth birthday)'. 76% of the reported SAIs (n=53) for this programme of care relate to HSC Child Death Notifications.

FAMILY & CHILD CARE

ORGANISATION	Oct 14 - Mar 15	Oct 15 - Mar 16
BHSCT	3	1
NHSCT	8	2
SEHSCT	5	3
SHSCT	1	0
WHSCT	2	1
Totals:	**19**	**7**

Current period: Seven (7) SAIs relating to family and childcare were reported. The largest classification/category group (n=5) related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	Oct 14 - Mar 15	Oct 15 - Mar 16
BHSCT	0	2
NHSCT	18	1
SEHSCT	1	7
SHSCT	32	14
WHSCT	4	2
Totals:	**55**	**26**

Current period: Twenty (26) SAIs reported related to older people services. The largest classification/category group (n=18) related to slips, trips, falls and collisions.

MENTAL HEALTH

ORGANISATION	Oct 14 - Mar 15	Oct 15 - Mar 16
BHSCT	11	15
HSCB	0	1
NHSCT	13	20
PHA	1	0
SEHSCT	26	24
SHSCT	12	10
WHSCT	9	7
Totals:	**72**	**77**

Current period: Seventy seven (77) SAIs relating to adult mental health services were reported. 83% (n=64) related to suspected / attempted suicides* or unexpected deaths.

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

LEARNING DISABILITY SERVICES

ORGANISATION	Oct 14 - Mar 15	Oct 15 - Mar 16
BHSCT	4	1
NHSCT	2	2
WHSCT	0	1
Totals:	**6**	**4**

Current period: Four (4) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

No reported incidents

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	Oct 14 - Mar 15	Oct 15 - Mar 16
PCARE	11	11
SEHSCT	0	1
Totals:	**11**	**12**

Current period: Twelve (12) SAIs relating to Primary Health and Adult Community were reported. The classification/category group (n=6) was 'Medication'.

CORPORATE BUSINESS

ORGANISATION	Oct 14 - Mar 15	Oct 15 - Mar 16
BHSCT	2	0
BSO	2	0
NHSCT	3	1
SEHSCT	1	2
SHSCT	1	0
WHSCT	1	1
Totals:	**10**	**4**

Current period: Four (4) SAIs were reported relating to corporate business.

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents

Analysis of Checklists RECEIVED 1 October 2015 to 31 March 2016

Table 1a - Analysis of Engagement with patient/family/carer	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**48**	**100.0%**	**38**	**100.0%**			**43**	**100.0%**	**41**	**100.0%**	**26**	**100.0%**	**196**	**100.0%**
Patient/Service User/Family **not informed** incident was being investigated as an SAI	9	18.8%	5	13.2%			16	37.2%	2	4.9%	2	4.9%	**34**	**17.3%**
Patient/Service User/Family **informed** incident was being investigated as an SAI	39	81.3%	33	86.8%			27	62.8%	39	95.1%	24	95.1%	**162**	**82.7%**

Table 1b - Analysis of Rationale for patient/ family/carer not informed that incident was being investigated as an SAI	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Not informed	**9**	**100%**	**5**	**100%**			**16**	**100%**	**2**	**100%**	**2**	**100%**	**34**	**100%**
Case identified as a result of review exercise	1	11.1%	0	0.0%			0	0.0%	0	0.0%	0	0.0%	**1**	**2.9%**
Impact on health/safety /security and/or wellbeing	1	11.1%	1	20.0%			6	37.5%	1	50.0%	0	0.0%	**9**	**26.5%**
No NOK or contact details	5	55.6%	1	20.0%			6	37.5%	0	0.0%	0	0.0%	**12**	**35.3%**
Not applicable	0	0.0%	0	0.0%			0	0.0%	0	0.0%	1	50.0%	**1**	**2.9%**
Other rationale provided	2	22.2%	3	60.0%			4	25.0%	1	50.0%	1	50.0%	**11**	**32.4%**

Table 2a - Analysis of SEA/RCA Reports shared/not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**48**	**100.0%**	**38**	**100.0%**			**43**	**100.0%**	**41**	**100.0%**	**26**	**100.0%**	**196**	**100.0%**
SEA/RCA Report shared	8	16.7%	12	31.6%			8	18.6%	17	41.5%	17	65.4%	**62**	**31.6%**
SEA/RCA Report not shared	40	83.3%	26	68.4%			35	81.4%	24	58.5%	9	34.6%	**134**	**68.4%**

Table 2b - Analysis of SEA/RCA Reports not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Report not shared	**40**	**100.0%**	**26**	**100.0%**			**35**	**100.0%**	**24**	**100.0%**	**9**	**100.0%**	**134**	**100.0%**
Case identified as a result of review exercise	1	2.5%	0	0.0%			0	0.0%	0	0.0%	0	0.0%	**1**	**0.7%**
Draft Review Report shared with SU/FAM	1	2.5%	2	7.7%			0	0.0%	0	0.0%	0	0.0%	**3**	**2.2%**
Family withdrew	1	2.5%	0	0.0%			1	2.9%	0	0.0%	1	11.1%	**3**	**2.2%**
Declined report	0	0.0%	0	0.0%			1	2.9%	0	0.0%	1	11.1%	**2**	**1.5%**
Final Review Report to be shared with SU/FAM	26	65.0%	14	53.8%			14	40.0%	17	70.8%	3	33.3%	**74**	**55.2%**
Impact on health/safety /security and/or wellbeing	3	7.5%	3	11.5%			7	20.0%	3	12.5%	0	0.0%	**16**	**11.9%**
No NOK or contact details	4	10.0%	1	3.8%			6	17.1%	0	0.0%	0	0.0%	**11**	**8.2%**
No response to correspondence	1	2.5%	2	7.7%			2	5.7%	3	12.5%	1	11.1%	**9**	**6.7%**
Other rationale provided	3	7.5%	4	15.4%			1	2.9%	0	0.0%	3	33.3%	**11**	**8.2%**
Review Report discussed with SU/FAM	0	0.0%	0	0.0%			3	8.6%	1	4.2%	0	0.0%	**4**	**3.0%**

NOTE: The data recorded in the above tables are reported from a 'live' database and will be subject to change following planned/further engagement