Bill, Jonathan

From: Bill, Jonathan
Sent: 28 May 2004 15:06
To: McCarthy, Miriam
Subject: Impartial Reporter Briefing

Miriam

I attach briefing that I prepared in response to Minister's queries about numbers and the dates of the establishment of the Safety in Health & Social Care Steering Group and its commissioning of the Deloitte scoping exercise on the reporting of untoward incidents.

It may be useful if after receiving her latest briefing Minister homes in on this area of vulnerability.

Lucy Crawford x brief.doc (40 ...

Jonathan

010-023- 149

The Reporting of Untoward Incidents to the Department

There is no unified reporting of untoward incidents in the HPSS to the Department.

The Department's NI Adverse Incident Centre based in Health Estates receives reports of, and investigates, untoward incidents associated with medical equipment and devices. Since 1998 there have only been 4 reported cases of death involving medical equipment or devices. To put this in context NIAIC received 241 reports of incidents in 2003 and has received 82 so far this year.

Elsewhere it has been the practice for Chief Executives and Medical and Nursing Directors in the HPSS to bring *significant* untoward incidents resulting in death to the attention of the Chief Medical Officer. This might occur 3 or 4 times a year. In addition there are other areas where untoward incidents are notified to the Department such as homicides or suicides involving psychiatric patients, again the numbers are very small (2/3 annually). However these are not collated centrally. In addition Minister will be aware that in March 2004 the Department introduced procedures to ensure the reporting of incidents of violence against staff working in the HPSS.

Safety in Health & Social Care Steering Group

The Safety in Health & Social Care Steering Group was established in the Department in early 2003 to provide advice to the Department on a strategic approach to the recording, reporting and investigation of adverse incidents and near misses. This reflected the emphasis nationally and internationally on developments to promote delivery of safe and effective care and was seen as an integral part of the wider quality agenda.

As part of this work, the Steering Group in December 2003 commissioned Deloitte to:

- carry out a scoping exercise on adverse incidents and near miss reporting in the HPSS and special agencies; and

- evaluate the NI Adverse Incident Centre.

Deloitte Report: Summary

The detailed review of the systems used to report and record incident and near miss reporting in Northern Ireland revealed one overwhelmingly finding: inconsistency of approach.

This inconsistency existed in nearly every aspect of incident and near miss reporting, from defining an incident or near miss within each organisation to the procedures for reporting and collating the information and how the information was analysed and used within each organisation. The only consistent element within each organisation was the drive to improve incident reporting based on a common belief and understanding of the benefits it accrues to patient safety and care. The report characterised the HPSS incident reporting systems as having: ***"Inconsistencies in Process – Consistency in Spirit"***

Whilst significant variations existed in how organisations undertake the reporting of incidents and near misses, common practice did exist in many areas. Overall, most organisations use the same basic structure to report, record and analysis incident and near miss information, although it was noted that the incident reporting system in each organisation had evolved at different levels and in different ways.

The review demonstrated that a significant level of the organisations involved have put considerable effort and resource into their incident reporting system recently, but that most policies and procedures reviewed are still considered as evolving or in development. No organisation stated that it has fully developed its system and 100% incident reporting is considered unattainable by all organisations.

<u>SHSCG's Proposals for Action</u>

The Safety in Health and Social Care Group believe that the broad content of the Deloitte Report on adverse incident reporting systems and the evaluation of NIAIC

should be endorsed. The Group proposes (but this still requires Departmental and Ministerial agreement) that to progress the strategic approach to the recording, reporting and investigation of adverse incidents and near misses:

- Departmental links with **National Patient Safety Agency** should be formalised. The main links with NPSA are likely to cover dedicated training, "risk" tools and the cascade of local implementation of "safety solutions", including participation in pilot sites to facilitate "solutions development", as appropriate. *A Service Level Agreement is currently being developed to cover these key areas, including the development of the role of a local Safety Manager, under the auspices of NPSA.*

- Work needs to be commissioned at an early stage, to develop **regional guidance on standardisation of adverse incident definitions** and to develop and facilitate standardisation of coding on electronic systems, to ensure consistency of approach to the development of a local centralised reporting mechanisms, and enhancing any links with NPSA in the future.

- **Interim guidance** is developed by the Department on the reporting and investigation of serious adverse incidents. *This has been done and will be issued to the HPSS imminently.*

- There is a need to have a **Safety Unit**, probably based in the Department, to provide a focus for the further development of reporting systems and guidance on adverse incidents and near misses to the HPSS.

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Q What is the Department doing to improve the reporting of adverse incidents?

A A Safety in Health & Social Care Sub-Committee was established early 2003 to provide advice to the Department on a strategic approach to the recording, reporting and investigation of adverse incidents and near misses.

The sub-committee commissioned a scoping exercise in December 2003 on adverse incidents and near miss reporting in the HPSS and special agencies. This work was completed in March 2004. The recommendations of this review are still being considered, however:

The Department expects to formalise its relationship with the National Patients Safety Agency this year.

Further work will be carried out to develop a more consistent approach to the reporting of adverse incidents in HPSS.

Meanwhile, interim guidance is being issued to the HPSS imminently on the reporting to the Department of serious adverse incidents.

010-023- 153