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

Date: 10 June 2005

For Action (with enclosures):

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

For information (without enclosure):

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

Dear Colleague

REPORTING OF SERIOUS ADVERSE INCIDENTS WITHIN THE HPSS

Introduction

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

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

Update on Safety Issues

Safety Group

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

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

Key Findings of Deloitte Report

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

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

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

Further Work

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

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

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

Reporting Incidents

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

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

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

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

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

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

Management Arrangements

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

Action

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

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

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

Yours Sincerely

NOEL McCANN