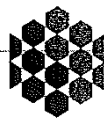


Noel McCann
Director of Planning & Performance Management



Department of
**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

www.dhsspsni.gov.uk

For action:

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

For information:

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

Dear Colleague

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Circular HSS (PPM) 02/2006

20 March 2006

REPORTING AND FOLLOW-UP ON SERIOUS ADVERSE INCIDENTS

Introduction

1. Circular HSS (PPM) 06/2004, issued in July 2004, introduced new interim reporting procedures for serious adverse incidents (SAIs) and near misses for HSS Boards, Trusts, Agencies and Family Practitioner Services. Since then, the Department has been monitoring the operation of the system and the purpose of this circular is to notify a number of important points about the reporting and management of SAIs.
2. In particular, this guidance:
 - draws your attention to certain aspects of the process which need to be managed more effectively;
 - notifies important changes in the way that SAIs should be reported in future; and
 - provides a revised report pro forma which should be used in all future reports.

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

Areas for improvement

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

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

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

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

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

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

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

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

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

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

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

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

Revised Notification Arrangements

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

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

Amendments to the SAI Report Proforma

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

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

Learning from Adverse Incidents

8. The Serious Adverse Incident process is not a performance management tool. However, a key objective in the process is to ensure, where possible, that lessons are learned from adverse incidents and that the quality of services is improved. The Department has, therefore, put in place arrangements to review incidents reported to it on a regular basis and to feed back relevant analysis to the HPSS. In this context, the Serious Adverse Incident Group in the Department meets on a monthly basis to consider reports submitted. It may seek clarification from organisations on the outcome of incidents to determine whether regional guidance is needed. In the case of independent reviews, the Department may also provide guidance as to specialist input into such reviews.
9. In June 2005, the Department provided a first regional briefing on SAIs, focusing on the key issues emerging from incidents reported until then. A further briefing event will take place later this year. Additionally, the Department intends to publish a report later this year which will summarise the key issues emerging and recurrent problems being encountered across the region. It is intended that this will assist organisations to review their clinical and social care governance processes, strengthen their incident reporting arrangements and improve the quality of services.

Action

10. All HPSS organisations are requested to:

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

11. This Circular will be reviewed in 2007.

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

Yours sincerely



NOEL McCANN

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

Completed proforma should be sent, by email, to:

adverse.incidents [REDACTED]

If e-mail cannot be used, fax to [REDACTED]

