Adams, James (DHSSPS)

From: Lawson, Elaine
Sent: 06 March 2009 12:54
To: Adams, James
Cc: Perkins, Roisin; Coyle, Briege; McGeown, Paula
Subject: FW: Submission: SUB/81/2009 PROPOSED NEW MODEL FOR REGIONAL ADVERSE INCIDENT LEARNING SYSTEM
Attachments: sub.81.a.2009.DOC; sub.81.2009.DOC; SUB.81.2009.pdf

All - to note

Jim - to trim in SAI review container pl.

E

-----Original Message-----
From: Scullion, Sean
Sent: 05 March 2009 17:28
To: Lawson, Elaine; 'jmcclean[redacted]
Subject: FW: Submission: SUB/81/2009 PROPOSED NEW MODEL FOR REGIONAL ADVERSE INCIDENT LEARNING SYSTEM

Good news!

-----Original Message-----
From: Livingstone, Jim
Sent: 05 March 2009 17:25
To: Scullion, Sean
Subject: Fw: Submission: SUB/81/2009 PROPOSED NEW MODEL FOR REGIONAL ADVERSE INCIDENT LEARNING SYSTEM

To see

----- Original Message -----
From: suzanne.beaney[redacted] <suzanne.beaney[redacted]
To: Livingstone, Jim
Cc: Robinson, Philip; Morrow, Norman; Bradley, Martin; Brown, Linda; Thompson, Julie; Boyd, Linda (SSI); Holland, Sean; McMaster, Ian; McCarthy, Miriam; Secondary Care; Baxter, Clare; Jendoubi, Christine; Private Office
Sent: Thu Mar 05 15:25:24 2009
Subject: Submission: SUB/81/2009 PROPOSED NEW MODEL FOR REGIONAL ADVERSE INCIDENT LEARNING SYSTEM

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Unclassified

From: Suzanne Beaney
Private Office
To: Livingstone Jim (Dr)
Date: 05/03/2009

Action Copy: Robinson Philip (Mr)
Morrow Norman (Dr)
Bradley Martin (Mr)
Brown Linda (Ms)

Thompson Julie
Holland Sean (Mr)
McMaster Ian (Dr)
McCarthy Miriam (Dr)
Baxter Clare (Ms)
Jendoubi Christine
Office Copy

SUB/81/2009:PROPOSED NEW MODEL FOR REGIONAL ADVERSE INCIDENT LEARNING SYSTEM

The Minister has read and approved your submission of 26/01/2009.

Many thanks.

Suzanne Beaney (Private Office)

Room C5.4 Castle Buildings Tel: [redacted]

OffName

From: Dr Jim Livingstone SUB/
Safety, Quality & Standards Directorate

Date: xx Jan 2009

To: 1. Dr Carolyn Harper

2. Dr Michael McBride

3. Michael McGimpsey

PROPOSED NEW MODEL FOR REGIONAL ADVERSE INCIDENT LEARNING SYSTEM

Issue:	**Following a review of the existing arrangements for reporting Serious Adverse Incidents (SAIs), a proposed new model for providing Minister with early warning of adverse incidents and for strengthening arrangements for learning from these has been developed in partnership with the HSC.**
Timescale:	**Routine**
Presentational issues:	**There may be some limited media interest in the new reporting arrangements.**
FOI Implications:	**Not disclosable - relates to policy in development, but fully disclosable in due course.**
Financial implications:	**Initial set up costs will be met from with existing programme funds – a business case will be developed to quantify further resource implications, although these are not expected to be significant.**
Legislation implications:	**None.**
Executive Referral:	**Not required, but the Health and Social Services Committee should be informed in advance of any announcement.**
Special Advisor:	**For information.**
Recommendation	**That Minister notes the outcome of the review of SAI reporting and approves the proposed model and associated development plan.**

Introduction

1. This paper sets out proposals for a new model intended to improve and strengthen arrangements for ensuring that the Department and thus Minister are made aware in a timely fashion of significant incidents occuring in the HSC, in particular those likely to attract media or public interest. The proposed new model will also strengthen the existing arrangements for identifying, disseminating and implementing regional learning arising from adverse incidents occurring in the HSC. Minister is asked to consider and approve the proposals for this revised model, and the supporting strategic development plan.

Background

2. HSC organisations are required to have an agreed process in place for reporting, managing, analysing and learning from adverse incidents, and are held accountable for this through RQIA inspections of HSC organisations against the Quality Standards, which RQIA use to independently assess the quality of care commissioned and provided by HSC organisations.

3. HSC bodies have had well established adverse incident systems in place for some time. In July 2004, however, the Department established an interim Serious Adverse Incident (SAI) reporting system, effectively creating an additional layer of reporting at a regional level building on already existing Trust-based systems. The SAI reporting system requires Boards and Trusts to report to the Department those adverse incidents which are considered serious **and** which meet one or more of the following criteria:

    (i) warrants regional action or learning to improve safety or care;
    (ii) is of public concern (such as serious media interest); or
    (iii) requires an independent review.

    The regional definition of an adverse incident is "***any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation***". (Safety First, DHSSPS, March 2006)

4. The existing SAI reporting system has a number of objectives;

- to fulfil an early warning function for the Department, so that Minister can be made aware of significant events in a timely manner;
- to encourage an open and learning reporting culture, acknowledging that lessons need to be shared in order to improve service user and staff safety and apply best practice in assessing and managing risks; and
- to provide feedback on high level analysis and themes arising from reporting incidents and ensure that the service is alerted to emerging learning.

5. A Departmental Serious Adverse Incident Review Group was formed in 2005 to consider each SAI reported. Since 2004, there have been 1172[1] SAIs notified to the Department. The numbers of incidents being reported can make it difficult to quickly identify those which are of sufficient significance to warrant Minister being notified. In addition, having such a volume of largely undifferentiated SAIs notified and therefore known to the Department creates its own vulnerabilities, potentially leaving the Department open to criticism for perceived lack of action, and the necessary investigative follow-up amounts to a major workload implication within the Department.

Review of the current reporting system

6. A review of the SAI Reporting mechanism has been carried out and a summary of the key findings are included at **Annex A** for your information.

Proposed New Model

7. The review identified a number of weaknesses and risks associated with the existing arrangements, and the proposed new model for reporting and learning from adverse incidents is intended to address these. It has been developed in consultation with around 200 HSC staff from a range of backgrounds and been strongly endorsed by them in a recent workshop. A diagrammatic representation of the revised model is set out in the flow chart at **Annex B.**

[1] Figure as at 28.11.08 (DHSSPS)

Early Alerts

8. While in most cases the existing SAI system provides Minister with early warning of significant events, there is a risk that the system can become clogged up with relatively insignificant incidents. The revised model will provide for a more effective early warning system for the Department and Minister, with significant incidents identified and highlighted to the Department through an agreed portal, so that Minister can be briefed in a timely fashion and appropriate lines prepared.

9. Specific criteria will be set for incidents which should be notified through this channel, such as when specific regional action is needed, eg issuing an urgent communication; when the Trust plans to issue a press release, or intends to contact patients or clients about harm or an incident of potential harm; or where the police are involved in a death or other serious crime related to harm. There have been a number of cases recently which have highlighted the importance of this early notification function – for example the recent incident involving renal dialysis patients where a telephone call through professional lines meant that briefing was prepared for Minister immediately.

RAIL System

10. The model also envisages the establishment of a new Regional Adverse Incident Learning (RAIL) system which will be responsible for ensuring that regional learning is identified from things that have either gone wrong or nearly gone wrong. The system will include a small team responsible for managing the RAIL functions and identifying and disseminating regional learning and recommendations, either directly to the HSC or via recommendation to the Department. The Department would be advised of major learning which may be issued regionally as guidance or standards to the HSC, or which may inform other Departmental functions such as policy development and review, legislative change or priority setting.

11. The new model will also encourage the reporting of 'near-misses'. These have not been routinely notified under the present system, but can often have significant regional learning that may serve to prevent an adverse incident from

occurring in the future. These will be captured in the new reporting system and will be analysed to determine whether any learning can be gleaned and disseminated across the service. The aviation industry has found that airlines with high levels of reporting of incidents and near misses have lower levels of serious incidents; high reporting levels are considered to reflect organisations with safety and learning embedded as everyday behaviours.

Location

12. While various options were considered for the location of RAIL, the recommendation is to locate it within the Regional Agency for Public Health and Social Well-being (the Agency). The function of RAIL – to contribute to improvement in the safety and quality of services through effective dissemination of lessons learned from adverse incidents and near misses – fits best with the preventative focus of the Agency. The Agency is also has a specific role in safety and quality at Director level and with embedded social and primary care staff, can bring a professional identity and leadership to RAIL. In addition, the 'special relationship' with the Regional Board would facilitate a robust means of ensuring that regional learning identified and disseminated by the Agency is taken into account through commissioning.

13. While the emphasis is on learning, the performance of the new model will be monitored to ensure that this objective is in fact being achieved. It must be emphasised that this model seeks to facilitate a change in culture in the service away from a reluctance to report for fear of sanction, to one of a willingness to report to ensure learning and improved services while still retaining appropriate governance protections. This will not be easy and the new model itself can only facilitate such a change, not deliver it.

Accountability

14. The proposed model will strengthen accountability arrangements through clear responsibilities and lines of accountability for each of the participating bodies. Trusts and Family Practitioner Services will be responsible for reporting incidents occurring within their organisations and supporting and promoting reporting by their staff; for investigating these within specified timescales and to a required

standard and implementing any subsequent required local actions. They will also be responsible for reporting and sharing any regional learning arising from their investigations, and for implementing regional learning issued by RAIL or the Department. They will be held to account for these functions by the Board and Agency working in partnership and escalating formal monthly performance management arrangements if necessary.

15. The Agency will be responsible for hosting and running RAIL and will be accountable to the Department for establishing effective mechanisms to ensure that regional learning messages are being identified and disseminated effectively across all service providers.

16. The Department will be responsible for effective dissemination of any major regional learning identified through the RAIL network. RQIA will be responsible for independently assuring that the various bodies are meeting their responsibilities.

Interface with national reporting systems

17. The option of contracting with the National Patient Safety Agency (NPSA) to establish a link with the National Reporting and Learning Service was considered as an option for reporting arrangements in Northern Ireland. While the NRLS has recently enhanced its reporting format and content, the conclusion was that a local system offered sufficient additional benefits in terms of local professional ownership and identity with the feedback received. However, it will be important to ensure that the NI system is able to interact with national reporting and learning structures and systems, both in terms of disseminating national learning messages locally, and ensuring that any local learning informs the national picture as appropriate. RAIL will therefore develop interface arrangements with national learning bodies to facilitate appropriate exchanges of information.

Strategic Development Plan

18. A proposed pathway for introducing the proposed changes and implementing the new model is set out in the strategic development plan, which is attached for your information at **Annex C**.

Financial Implications

19. There will be financial implications associated with the proposals for the new system, primarily arising through the medium term of the implementation plan and relating to the supporting IT infrastructure. However, it is not possible at this stage to quantify the likely extent of these costs ahead of the development of a business case for a regional database system which the new model will use. A Business Case to support proposals affecting financial resources (capital and revenue) will in due course be developed as part of the Strategic Development Plan.

20. An evaluation of the effectiveness of possible early pilots will inform the decision to roll out the reporting system more widely, and should also provide useful estimates of the likely costs of introducing a regional system. There are also likely to be some costs associated with staff training, although it should also be noted that these could be offset against possible savings on staff time (both Departmental and HSC) currently expended in investigation and following up of Serious Adverse Incidents in the current reporting system.

Summary and Recommendations

21. The present incident reporting arrangements have been in place since 2004, and the review of these has pointed out a number of significant weaknesses which mean that they do not operate effectively either as a reliable early warning alert system for the Department and Minister, nor as a consistent mechanism for identifying important lessons about the safety of service users. The new model has been designed to address these failings, and has been developed in partnership with, and is supported by, the HSC. It proposes a coherent and comprehensive system for reporting incidents in a manner that will ensure that Minister is kept informed of significant incidents in a timely fashion, and that safety messages and regional learning are identified and disseminated in a consistent and effective manner, with a corresponding focus on driving improvements to the quality and safety of services through ensuring that important learning is used to inform and improve practice.

43. Minister is asked to:

- approve the proposed new model for regional incident reporting and learning and the associated implementation plan.

Attachments

Tab A – Summary of findings of review of existing Serious Adverse Incident Reporting system

Tab B - Proposed new model for Regional Adverse Incident Reporting and Learning

Tab C – Proposed Strategic Development Plan

Freedom of Information

Policy in Development – not disclosable

SAFETY, QUALITY AND STANDARDS DIRECTORATE

Copy distribution:

Special Advisor
Secretary
Dr Morrow
Mr Bradley
Linda Brown
Mrs Julie Thompson
Sean Holland
Dr McMaster
Dr McCarthy
Clare Baxter
Christine Jendoubi

ANNEX A

Review of the current reporting system

1. An internal review of the SAI Reporting mechanism was conducted between December 2007 and May 2008. Key findings included:
   - SAIs contain insufficient information on which a professional/policy judgement can be made;
   - SQSD has difficulty in obtaining input from some professionals and policy directorates at key stages;
   - The scope of analysis of data is restricted by the (undifferentiated) volume and the fact that it is recorded on a spreadsheet and not a database; and
   - Learning is currently disseminated in a variety of ways: professional letters or alerts for more urgent learning; development of policy or guidance; and on an annual basis in the form of the *Supporting Safer Services* report. It is questionable whether this is the best method of sharing information to ensure that services improve.

2. Following on from this, and in recognition that the internal Departmental SAI reporting systems are part of the service wide arrangements for reporting and learning from adverse incidents, a review of the wider policy on adverse incident reporting and learning has been carried out since June last year. The aim of the review was to produce an outline design of a system that achieves change in practice as a result of learning from harm or near miss experiences in the HSC.

Weaknesses/risks in the current reporting system

3. The review of the existing arrangements has identified a number of weaknesses and concerns. The system has expanded in an ad-hoc and inconsistent fashion, with a number of instances where reporting requirements have been added to address

individual policy imperatives which have not always been in accordance with the original purpose of the system (i.e. learning from adverse incidents).

4. 'Finding the needle in the haystack' – the sheer numbers of SAIs being reported through the existing system can lead to inconsistencies in identifying those where Minister needs to be forewarned of potential media or public interest, or which require immediate action to address patient safety issues. Data collection systems used vary across providers – although the Trusts use a common Datix reporting system, GPs, community pharmacists and other providers do not use this system and as a consequence information can be gathered inconsistently. There remains a wide variation in interpretation of how incidents should be classified, despite extensive work to arrive at a common understanding of this – largely because the definitions employed are inherently subjective.

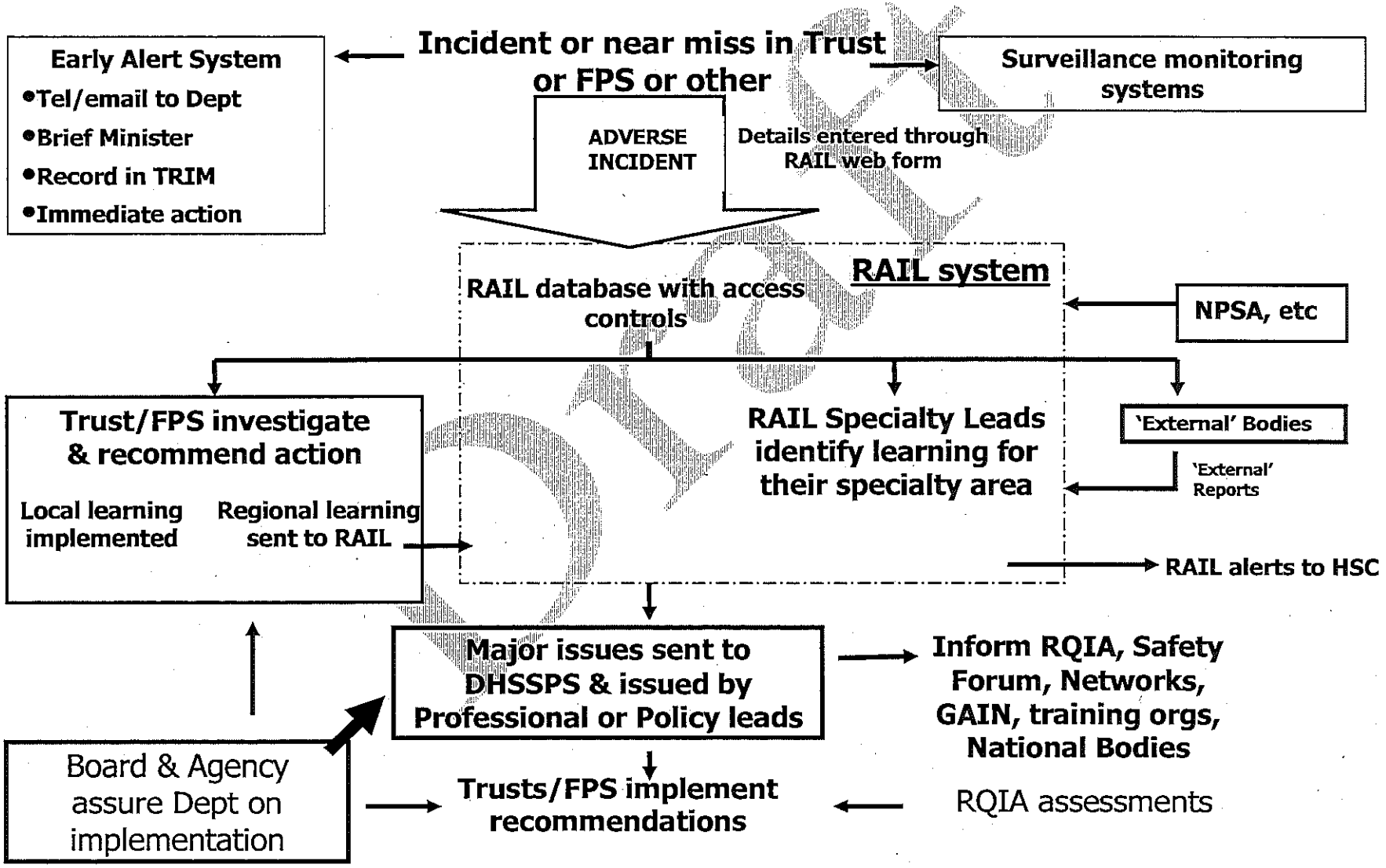
5. There are also concerns that the present reporting system has encouraged a mindset amongst providers and commissioners that responsibility for follow-up action transfers to the Department when they notify the Department of an incident. Lack of clarity on roles and responsibilities has contributed to Trusts not being held sufficiently to account for implementing changes in practice arising from learning. Timescales for reporting incidents are short (within 24 hours where a death has occurred, within 72 hours in other cases) and as a consequence, the information provided is often limited, making it difficult to arrive at consistent and informed judgements on the relative seriousness of individual incidents, and the appropriate course of action required.

6. There is a further risk that the reporting system as presently constituted may inadvertently lead to an under-reporting of incidents – the current system is perceived by many staff as being primarily investigative and punitive, and a lack of feedback to reporting staff can raise questions about the value of reporting as a learning tool.

7. Near misses (ie incidents where things nearly went wrong, or went wrong but caused no harm) can often deliver as much learning as actual adverse incidents, but the potential opportunity for learning that they offer is lost at present as these are not currently routinely collected, either regionally or locally.

Proposed New RAIL System

ANNEX B



ANNEX C

STRATEGIC DEVELOPMENT PLAN

INTRODUCTION OF CHANGES TO HSC ADVERSE INCIDENT & LEARNING SYSTEMS

2008/09 – 2010/11

ACTION REQUIRED	BY:
IMMEDIATE: NEXT THREE MONTHS [JAN – MAR 09]	
Following DMB & Minsterial approval, further develop concept New Model for HSC Adverse Incident Reporting & Learning through consultation: • with HSC CEOs; and • key stakeholders, including Service Delivery Unit	27.02.09
Consider new NPSA guidance on 'triggers' for different levels of investigation and its applicability locally	27.02.09
Develop a process for notification of an early alert from HSC or FPS professional to appropriate senior professional within the Department, including appropriate record keeping in TRIM using a brief proforma for recording details of summary of event and contact details of HSC staff member who can provide additional detail if required by Departmental officials	27.02.09
Establish separate monitoring systems in place between individual policy directorates and commissioning or provider organisations where required (eg. under 18s in adult facilities, use of JJC, A&E breaches]	31.03.09
Criterion 4 of risk management controls assurance standard revised to reflect	31.03.09

ACTION REQUIRED	BY:
interim changes	
Develop draft Terms of Reference and proposed membership of Regional Adverse Incident Learning (RAIL) Group (as part of New Model) and the role of its Steering Committee and its Network in conjunction with shadow CEOs of RHSCB, RAPHSW and RSSO.	31.03.09
Develop draft proposals for Project to introduce New Model (to be set out in Project Initiation Document) Prepare Business Case for RAIL investment (capital and revenue) Alert HSC ICT Programme Board of potential developments	31.03.09
Guidance on interim SAI reporting arrangements (ie. Circs 06/04, 05/05, 02/06 and 19/07) replaced with revised guidance on ***Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS.*** Circular will explain: • Early alert requirements • New reporting arrangements, including removal of SAI reporting criteria • New responsibilities and accountabilities • Development implementation plan for RAIL	31.03.09
MEDIUM TERM: RPA TRANSITION PHASE [APR 09 – MAR 10]	
Introduce New Model for HSC Regional Adverse Incident and Learning on	31.03.10

ACTION REQUIRED	BY:
phased basis including possible use of pilot projects	
New regional bodies – RHSCB and RAPHSW – establish their adverse incident procedures	30.04.09
Recruit RAIL staff A core operational group of six members approximately who will manage the regional learning element of the adverse incident/near miss reporting system.	30.06.09
Secure nominations to RAIL Steering Committee and build Network	30.06.09
Recruit/identify RAIL Project Director & other members Time-bound project group established to oversee, monitor, analyse and implement PID. This will include: • exploring appropriate supportive IT systems in conjunction with the Regional Business Services Organisation and key HSC personnel, • developing a communications strategy which will ensure maximum impact from regional dissemination of learning, • developing regional reporting forms, • establishing sessional procedures, • pilot study/test period in selected areas, and • producing transitional protocols	30.08.09
1st meeting RAIL Steering Committee and Network (as part of New Model) <u>Steering Committee Chaired by RAPHSW</u>	31.08.09

ACTION REQUIRED	BY:
– to meet at least quarterly, to provide input to work of RAIL. It will have core membership from: • from key regional stakeholders - DHSSPS, RHSCB, SBNI (ACPC Chairs on interim basis), HSC Trusts, HSC Safety Forum, PCC, and RQIA. <u>RAIL Network</u> - will include representation from across HSC organisations and family practitioner services who will liaise with RAIL on learning issues. It will include, as necessary co-opted membership: • from HSENI, • from Education & Training (undergraduate and postgraduate), • Criminal Justice Service, • the public, • RQIA • others	
Department feeds in learning to RAIL Group from its SAI caseload	30.09.09
RAIL Scope & develop the IT requirements for individual databases and data warehouse to include • a minimum dataset based on need of each key stakeholder group (eg. what is needed and what it is needed for), • address regional application of codes, • appropriate search facilities by code, key word, or other method, and • development of a business case for related capital costs.	30.09.09

ACTION REQUIRED	BY:
Pilot sites trained in web form	31.10.09
Web form tested and refined by pilot sites	31.03.10
LONGER TERM: NEW REGIONAL STRUCTURES FULLY IN PLACE [APR 10 – MAR 11]	
Evaluation of pilots and decision on future development or not	30.06.10
Further pilot sites added & testing continues	31.12.10
Further evaluation and decision on long term direction	31.03.11
Guidelines based on New Model developed and issued	30.06.11
Develop web-based approach to Early Alert system to DHSSPS (from HSC Extranet)	30.06.10
Project Group to explore potential and make recommendations regarding: • extending function of RAIL Group to include learning from claims and complaints; • extending functions of incident reporting system to – o facilitate receipt of reports from patients/clients or their carers/families; o expand to include independent sector providers	30.09.10
Standing down of Project Director and project team	31.10.10
Criterion 4 of risk management controls assurance standard revised to reflect final changes	31.03.11

ACTION REQUIRED	BY:
Commission review from RQIA to seek independent assurance as to how the new system is embedding in HSC organisations and FPS during 2011/12	31.03.11

SUB. 81. 2009

From: Dr Jim Livingstone
Safety, Quality & Standards Directorate

SUB/ Noted and approved by Minister 5/3 JM
cleared by PR 18.2.09

Date: xx Jan 2009

To: 1. Dr Carolyn Harper

2. Dr Michael McBride

3. Michael McGimpsey

PROPOSED NEW MODEL FOR REGIONAL ADVERSE INCIDENT LEARNING SYSTEM

Issue:	**Following a review of the existing arrangements for reporting Serious Adverse Incidents (SAIs), a proposed new model for providing Minister with early warning of adverse incidents and for strengthening arrangements for learning from these has been developed in partnership with the HSC.**
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Special Advisor:	**For information.**
Recommendation	**That Minister notes the outcome of the review of SAI reporting and approves the proposed model and associated development plan.**