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Department of
Health, Social Services and Public Safety
www.dhsspsni.gov.uk

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÂNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

For action by:

- Chief Executives, HSC Trusts
- Chief Executives, HSS Boards
- Chief Executive designate, HSC Board
- Chief Executive designate, Public Health Agency
- Chief Executive, NIBTS
- Chief Executive designate, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For information to:

- Chief Officers, HSS Councils
- Chief Executive designate, Patient and Client Council
- Director of Public Health designate, PHA
- Director of Performance Management designate, HSC Board
- Directors of Social Services in HSS Boards and HSC Trusts
- Directors of Dentistry in HSS Boards
- Directors of Pharmacy in HSS Boards
- Directors of Nursing in HSS Boards and HSC Trusts
- Directors of Primary Care in HSS Boards
- Medical Directors in HSC Trusts
- Chairs, Area Child Protection Committees
- Chief Executive, Regulation & Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The purpose of this Circular is to advise HSC organisations of the interim arrangements on adverse incident reporting which are being introduced following a review of the existing adverse incident reporting and learning systems.
The Circular provides guidance on the initial phase of the transition arrangements which will be put in place to manage the phasing out of the Department's existing Serious Adverse Incident reporting system, and the establishment of a new Regional Adverse Incident and Learning (RAIL) system.

Circular Reference: HSC (SQSD) 22/2009

Date of Issue: 30 March 2009

Related documents

HSS (PPM) 06/2004: Reporting and follow-up on SAIs: Interim guidance
HSS (PPM) 05/2005: Reporting of SAIs within the HPSS
HSS (PPM) 02/2006: Reporting and follow-up on SAIs
HSS(MD) 12/2006: Guidance Document – "How to Classify Incidents and Risk"
DS 154/06: Emergency Care Reform – Definition & Guidance Framework
HSS(MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports
HSS(MD) 06/2006: Memorandum of Understanding – Investigation Patient/Client Safety Incidents
HSC(SQSD) 19/2007: Reporting and follow-up on SAIs/Reporting on breaches of patients waiting in excess of 12 hours in Emergency Care Departments

Superseded documents

Status of Contents:

Action

Implementation:

Initial phase: From 01 April 2009

(To be reviewed by 30 June 2009)

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Additional copies:
Available to download from
http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-circulars.htm

Dear Colleague

LEARNING FROM ADVERSE INCIDENTS AND NEAR MISSES REPORTED BY HSC ORGANISATIONS AND FAMILY PRACTITIONER SERVICES

The current system for reporting Serious Adverse Incidents occurring in health and social care settings to the Department was established in July 2004. That system built upon information systems already established by Trusts on adverse incidents generally. During 2008 the Department carried out a review of the SAI system to ensure that this arrangement for reporting of serious adverse incidents remained fit for purpose and consistent with the new organisational and accountability arrangements due to come into effect from 1 April with the establishment of the new Health and Social Care Board and the Public Health Agency. The Department has worked in partnership with a range of stakeholders across the HSC in the course of this review and has, as a consequence, agreed a new model for the management of learning, especially that of a regional nature, arising from adverse incident reporting. This is to be known as the Regional Adverse Incident and Learning (RAIL) system.

The Departmental Board and the Minister have now endorsed the principles of the RAIL system and the Department will shortly establish project structures, in partnership with HSC stakeholders, to manage the development and implementation of the new RAIL system.

In order to ensure a smooth transition as the new HSC bodies assume their roles and responsibilities, there will be a phased implementation of the new RAIL system which will ultimately entail ending, during this year, the need for reports on Serious Adverse Incidents (SAIs) being sent to the Department by HSC Trusts or the HSC Board.

The purpose of this circular is to provide specific guidance on important initial changes to the operation of the current SAI reporting arrangements during the first quarter of 2009/10. These immediate changes should lead to a reduction in the number of SAIs that are required to be reported to the Department in the interim.

A further circular will issue shortly giving details about the next stage in this phased implementation which will be put in place to manage the transition from the SAI reporting system, through its cessation and then the establishment of the RAIL system.

You are asked to ensure that this circular is widely communicated to staff.

Yours sincerely

Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

The operation of the SAI System during the first quarter of 2009/10

1.1 The establishment of the new regional organisations, the Health & Social Care Board (HSC Board) and the Public Health Agency (PHA), together with the extended remit of the Regulation & Quality Improvement Authority (RQIA) from 1 April, means there will be revised roles and responsibilities in relation to arrangements for the reporting and monitoring of adverse incidents; ensuring that learning has been implemented and shared more widely as appropriate; and in providing assurance to the Department that effective systems are in place. However in order to ensure continuity in reporting arrangements during this transitional phase, the Department's current SAI reporting system will remain in place for a short interim period until the HSC Board and the PHA achieve their full functionality.

1.2 Therefore those adverse incidents and near misses which meet the criteria for reporting to the Department set out in Circular HSC(SQSD) 19/07, should continue to be submitted to the Department in accordance with existing arrangements and within the usual timescales. There will, however, be two exceptions to this, details on which are set out in paragraph 1.3 below.

1.3 From 1 April, revised reporting arrangements will apply in respect of:

(i) ***Suspected suicides*** - Those adverse incidents which meet the statutory requirements for reporting to the Mental Health Commission should now be reported to the Regulation and Quality Improvement Authority, in line with the transfer of functions from the MHC to RQIA, which takes effect from 1 April. The current SAI reporting template may still be used to alert RQIA to these deaths during this interim period.

Consequently, the reporting of suspected suicides through the SAI system to the Department should cease. The Department will continue to consider other SAIs relating to mental health services during this short period, including learning on interface issues with mental health services and it will ensure that this is shared with RQIA; and

(ii) ***Under 18s admitted to adult mental health/learning disability facilities*** – HSS Boards already operate monitoring systems to track admissions and the care being given to these patients. To avoid duplication, there should only be a single channel of notifying these occurrences to the HSC Board and the reporting of these **admissions** as SAIs should be discontinued. However, as part of its extended remit, RQIA will need to be advised when these admissions take place. Therefore the notification that is made to the HSC Board should also be copied to RQIA and should contain sufficient assurance that Departmental guidance[1] is being adhered to with regard to the risk assessment, treatment and care of these young people. This does not, however, preclude the need to report as an adverse incident any occurrence where a patient has come to harm whilst in such a placement.

[1] Under 18 year olds in Adult Mental Health Facilities (DHSSPS, 13 March 2006) and Under 18 year olds in Adult Learning Disability Facilities (DHSSPS, 15 October 2008)

1.4 Until further notice, HSC Trusts and Family Practitioner Services should continue to report serious adverse incidents to the new HSC Board using current channels of communication, and in particular, the specific contact points in the four HSS Boards.

The next phase of implementing RAIL during 2009/10

2.1 It is planned that the new RAIL system, to be located in the Public Health Agency, will be implemented, in partnership with key stakeholders in the process, over the next two years, subject to testing of the feasibility, cost and value for money of the system. However the cessation of reporting Serious Adverse Incidents to the Department is expected to be achievable within the next few months.

2.2 A further circular will issue shortly which will focus on the detail of:

(i) managing the phasing out and cessation of the Department's SAI reporting system, and the establishment of a new RAIL system; and

(ii) the roles and responsibilities of the key stakeholders in reporting and managing adverse incidents during the transition period.