Jim Livingstone
Director of Safety, Quality and Standards

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

AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

POLICY CIRCULAR

Subject:

Phase 2 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services

For action by:

- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NI Blood Transfusion Service
- Chief Executive, Business Services Organisation
- General Medical, Community Pharmacy
- General Dental & Ophthalmic Practices

For Information to:

- Chief Executive, Patient and Client Council
- Director of Public Health, PHA
- Director of Performance Management, HSC Board
- Directors of Social Services in HSC Board and HSC Trusts
- Director of Dentistry in HSC Board
- Director of Pharmacy in HSC Board
- Directors of Nursing in HSC Board and HSC Trusts
- Director of Primary Care in HSC Board
- Medical Directors in HSC Trusts
- Chair, Regional Area Child Protection Committee
- Chair, Regional Adult Protection Forum
- Chief Executive, Regulation and 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 revised arrangements for adverse incident reporting which are being introduced following a review of the existing adverse Incident reporting and learning systems.
The Circular provides guidance on:
(i) the transitional reporting arrangements which will be put in place pending the full establishment of a new Regional Adverse Incident and Learning (RAIL) system, and
(ii) the revised reporting roles and responsibilities of stakeholder organisations.

Enquiries:
Any enquiries about the content of this Circular should be addressed initially to:
Safety & Quality Unit
DHSSPS
Room D 1
Castle Buildings
Stormont
BELFAST

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Related documents

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) 22/2009: Phase 1 - Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

Superseded documents
HSS (PPM) 06/2004: Reporting and follow-up on SAIs: Interim guidance
HSS (PPM) 05/2005: Reporting of SAIs within the HPSS
Letter from Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 1 November 2005
HSS (PPM) 02/2006: Reporting and follow-up on SAIs
HSS(MD) 12/2006: Guidance Document – "How to Classify Incidents and Risk"
Letter from the Chief Inspector, Social Services Inspectorate 'Interface between Juvenile Justice Centre and Children in Residential Care', 11 September 2006
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
Letter from Chief Social Services Officer 'Serious Adverse Incidents involving Looked After Children in Residential Care entering the Juvenile Justice Centre' , 15 May 2008

Status of Contents:

Action

Implementation:

From 1 May 2010

BT4 3SQ
Tel: [redacted]
E-mail: sean.scullion[redacted]

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

Dear Colleague

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

Introduction

In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department and the implementation of the Regional Adverse Incident and Learning (RAIL) model.

The new RAIL model will reflect the statutory responsibilities of Health and Social Care organisations and will introduce a more coherent and comprehensive regional system for reporting incidents. This will ensure that safety messages and regional learning are identified and disseminated in a consistent and effective manner, and will provide a focus on driving improvements in the quality and safety of services through ensuring that important learning is used to inform and improve practice. It will also ensure that the Department and the Minister are informed of significant events in a timely fashion through the establishment of an Early Alert system, and the arrangements for this will be the subject of a separate circular.

The purpose of this circular is to provide specific guidance on:

a) the arrangements which will be in place following the transfer of the existing Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency, pending the establishment of RAIL, **Section 1**; and

b) the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department, **Section 2**.

This guidance will take effect from 1st May 2010. These arrangements will remain in place until the full implementation of the RAIL system, at which point they will be reviewed.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Yours sincerely

Dr Jim Livingstone
Director Safety, Quality and Standards Directorate

Section 1: Reporting Serious Adverse Incidents

1.1 This section outlines the revised arrangements for reporting and management of serious adverse incidents, pending the full implementation of the new RAIL system.

Changes to the reporting of Serious Adverse Incidents

1.2 The requirement on HSC organisations to routinely report SAIs to the Department will cease with effect from the 1st May 2010. Those SAIs which have been reported to the Department up until this date will be reviewed by the Department, with a view to transferring responsibility for any follow-up action that may be required to the HSC Board, working with the PHA. However, it is likely that the Department will wish to retain oversight responsibility for a small number of incidents reported prior to 1st May 2010 where it considers there are particular or significant issues in relation to regional learning, and these will continue to be considered by the Department SAI Review Group, which will remain in operation for a limited period of time to facilitate this. Consequently the Department may continue to request appropriate follow-up information from reporting organisations in relation to these particular cases.

1.3 ***Reports to the HSC Board*** – In line with the operational guidance[1] issued by the HSC Board and PHA to HSC Trusts in parallel with this circular, all incidents which meet the criteria for SAIs as defined in this operational guidance should be reported to the HSC Board with effect from the 1st May 2010. Family Practitioner Services should maintain their existing arrangements for reporting SAIs to the HSC Board.

1.4 The HSC Board will acknowledge receipt of each SAI notified to it, and will obtain any necessary professional advice from the appropriate health and social care professional within the PHA or HSC Board. The PHA and the HSC Board will jointly determine whether any immediate action is required. The HSC Board will ensure that all relevant professional disciplines are involved as appropriate in the management of the incident. The HSC Board will request an incident investigation be carried out by the reporting organisation, to be forwarded to it within 12 weeks in line with current practice. In this regard, incident reviews should continue to be conducted and submitted in the format outlined in HSS (MD) 34/2007: HSC Regional Template and Guidance for Incident Review Reports, included at Appendix 3 of the HSC Board/PHA operational guidance. In addition, the National Patient Safety Agency's toolkit is available for investigations which require a full root cause analysis[2].

1.5 The HSC Board will establish a system to ensure that the reports of investigations are discussed by relevant multi-disciplinary staff from the HSC Board and the PHA to identify any learning recommendations arising, and the most appropriate methods of sharing and/or disseminating the lessons therein. The HSC Board will liaise with the Department as appropriate regarding the most effective mechanisms for disseminating any regional guidance which may be required.

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[1] http://www.hscboard.hscni.net/lnews/22%20April%202010%20-%20HSCB%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010.pdf

[2] http://www.nrls.npsa.nhs.uk/resources/?entryid45=59901

1.6 HSC organisations will retain their existing responsibility for reporting, managing, investigating, analysing and learning from adverse incidents/near misses occurring within their organisation in accordance with criterion 4 of the core Risk Management Controls Assurance Standard (CAS). The Risk Management CAS is being updated in line with this circular and will be available on the Department's website from June 2010. These responsibilities are described in more detail in **Section 2**. Similarly the HSC Board will retain existing responsibilities with regard to adverse incidents occurring in Family Practitioner Services.

1.7 ***Reports to the Regulation and Quality Improvement Authority (RQIA)*** - RQIA will continue to require incidents to be reported to it in accordance with the new statutory responsibilities it assumed associated with the transfer of functions from the Mental Health Commission, as detailed in the 2007 UTEC Committee guidance [3]. These include incidents involving ***suspected suicides*** and ***under 18s admitted to adult mental health and learning disability facilities*** as referred to in circular HSC(SQSD) 22/09.

1.8 The RQIA also has extended responsibilities under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Under the 'national preventative mechanism' (NPM), there is a statutory requirement to inform RQIA of the death of any patient or client not resulting from natural causes (including homicides), physical, sexual or other serious assaults and allegations/incidents of abuse in hospital or community services. This should involve, where appropriate, collaborative working with the HSC Board. Further details of RQIA responsibilities in respect of reporting and investigation of incidents are set out in Section 2.

1.9 ***Reporting of suspected suicides*** - From 1st May 2010, SAIs involving suspected suicides are to be reported to both the HSC Board and RQIA in the first instance. However, the management and follow-up of reported incidents with the reporting organisation will be undertaken by the HSC Board and PHA, who will liaise with RQIA in this process.

1.10 ***Reporting of incidents under Children Order Statutory Functions*** – Incidents/events relating to;

(a) the admission of under 18s to adult mental health and learning disability facilities;
(b) children from a looked after background who abscond from care settings, which includes trafficked children and unaccompanied/asylum seeking children;
(c) children from a looked after background who are admitted to the Juvenile Justice Centre or Young Offenders' Centre;
(d) placements outside of the regulated provision for 16-17 year olds; and
(e) serious incidents necessitating calling the police to a children's home

will no longer be reported through the SAI reporting system. With effect from 1st May 2010 such incidents/events should instead be reported directly to the Social Care and Children Directorate at the HSC Board. Details of the arrangements for such notifications are set out in the operational guidance issued by the Social Care and Children Directorate at the HSC Board.

[3] www.dhsspsni.gov.uk/utec_guidance_august_2007.pdf

1.11 ***Breach of 12 hours A&E standard*** – the Performance Management & Service Improvement Directorate within the HSC Board will continue to monitor breaches of this standard. The reporting of these should be emailed direct to hscbinformation@hscni.net using the existing proforma.

Section 2: Roles, Responsibilities and Accountability Arrangements for incident reporting pending the establishment of RAIL

Health and Social Care Trusts

2.1 HSC Trusts are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide.

2.2 HSC Trusts are required to:

- Maintain a system to record and track adverse incidents/near misses in their organisation;
- Adhere to guidance issued by the HSC Board/PHA with regard to managing SAIs;
- Take any immediate steps necessary to prevent re-occurrence of harm;
- Investigate incidents using a method proportionate to the incident (and in compliance with the requirements set out in the joint Memorandum of Understanding between the HSC, Coroner's Service, PSNI and Health and Safety Executive on investigating patient or client safety incidents[4]) and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board and PHA that the requirements above are being met.

Family Practitioner Services

2.3 Family Practitioner Services are responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses within the context of the services that they provide. They will be required to produce evidence of learning as part of their clinical and social care governance arrangements which the HSC Board may use as part of its performance monitoring and service improvement or contractual monitoring arrangements.

2.4 Family Practitioner Services are required to:

- Maintain a system to record and track adverse incidents/near misses in their practice;
- Report to the RQIA and the HSC Board all actual or suspected suicides of patients registered with a GP practice and in receipt of secondary mental health care services in the last two years;

[4] http://www.dhsspsni.gov.uk/ph_hss(md)_6_-_2006.pdf
http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf

- Investigate incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep the affected patient/client/their family informed at all stages of the incident, investigation and follow-up;
- Send recommendations that are relevant regionally, to the HSC Board;
- Implement regional and local recommendations;
- Be able to provide evidence to the HSC Board that the requirements above are being met.

Health and Social Care Board

2.5 In line with the HSC Board's performance management and accountability functions, it will hold Trusts and Family Practitioner Services to account for the effective discharge of their responsibilities in reporting and investigating adverse incidents and near misses, and will provide assurance to the Department that these responsibilities are being met and that learning is being implemented. In general terms, the HSC Board is responsible for maintaining those adverse incident reporting and monitoring mechanisms it considers necessary to enable it to carry out the full range of its commissioning, performance management and service improvement functions effectively, ensuring appropriate multidisciplinary involvement of HSC Board and PHA health and social care professionals.

2.6 The HSC Board, working with the PHA, will be responsible for the management of SAI reporting under the arrangements set out in its operational guidance, pending the full implementation of the RAIL system. In addition, the HSC Board is responsible for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.7 The HSC Board is required to:

- Maintain a system to manage SAI reporting, in partnership with the Agency, in line with the arrangements set out in the operational guidance issued in tandem with this circular, pending the implementation of the RAIL system;
- With input from the PHA, hold Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Hold Family Practitioner Services to account for the responsibilities outlined in paragraph 2.4 and provide assurance to the Department that these responsibilities are being met;
- Maintain a system to record and track adverse incidents/near misses that occur within the HSC Board;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents@dhsspsni.gov.uk;
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met; and
- Participate as a member of the RAIL implementation project.

Public Health Agency

2.8 The PHA, through its integrated commissioning responsibilities with the HSC Board, will support the HSC Board in holding HSC Trusts and Family Practitioner Services to account for the discharge of their responsibilities and ensuring that regional learning is identified and disseminated, and will work with the Board to maintain a system for managing SAIs, pending the full establishment of the RAIL system.

2.9 The PHA will assume lead responsibility for implementing the RAIL system, including securing professional input as appropriate. In addition, the PHA will have responsibility for promoting the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that it provides.

2.10 The PHA is required to:

- Work with the HSC Board to maintain a system to manage SAI reporting, pending the establishment of the RAIL system;
- Maintain a system to record and track adverse incidents that occur within the PHA;
- Investigate such incidents using a method proportionate to the incident and complete the investigation report in a timeframe appropriate to the incident, typically no more than 12 weeks from becoming aware of the incident;
- Keep relevant parties informed at all stages of the incident, investigation and follow-up;
- Send recommendations from such incidents that are relevant regionally, to adverse.incidents[redacted]
- Implement regional and local recommendations;
- Be able to provide evidence to the Department that the requirements above are being met;
- Support the HSC Board in holding Trusts to account for the responsibilities outlined in paragraph 2.2 and provide assurance to the Department that these responsibilities are being met;
- Work collaboratively with the Department and the HSC Board to develop and progress the support structures and processes which will underpin the new RAIL system;
- Be responsible for the operational management of the RAIL system, once established; and
- Nominate the Project Director and provide administrative support for the RAIL implementation project.

Regulation and Quality Improvement Authority

2.11 From 1st April 2009, RQIA assumed responsibility for those incident reporting requirements which were previously the domain of the Mental Health Commission. This includes oversight of adverse incidents occurring within the mental health and learning disability programmes of care, establishing trend analysis and reporting on regional learning from such incidents or issues.

2.12 RQIA is also a named organisation under the UK's National Preventative Mechanism (NPM) established in accordance with the Optional Protocol to the Convention Against Torture (OPCAT). Under the NPM, RQIA is required to visit places of detention, regularly examine the treatment of persons deprived of their liberty, access all information referring to the treatment of those persons as well as their conditions of detention and make recommendations to the relevant authorities.

2.13 The RQIA will:

- Require HSC Trusts to continue to report adverse incidents to it where there are underlying statutory obligations to do so;
- Require HSC Trusts to share reports of adverse incidents occurring in a mental health and learning disability setting in accordance with discharging its new functions under the HSC (Reform) Act (NI) 2009[5]; and
- Require the HSC Board to share other relevant monitoring information in relation to mental health and learning disability programmes of care.

The Department

2.14 In line with its core functions and the revised accountability arrangements which came into effect from April 2009 following the re-organisation of services as part of the Review of Public Administration, the Department will:

- Continue to host the SAI Review Group for a limited period, and will progress a small number of existing SAIs, along with dissemination as appropriate of any regional learning arising from new incidents;
- Oversee the project management arrangements for the implementation of the RAIL system;
- Seek assurance from the HSC Board/PHA on the effectiveness of the interim incident reporting arrangements within HSC Trusts and Family Practitioner Services;
- Seek assurance from the PHA that it will be in a position to effectively operate the RAIL system, including securing professional input to identifying and cascading regional learning.

[5] 2009 c.1 (N.I.)

Timetable for Implementation of RAIL

3.1 It is planned that the RAIL system will be implemented, in partnership with key stakeholders in the process, on a phased basis over the next one to two years, subject to testing of the feasibility, cost and effectiveness of the system.

3.2 As part of the implementation process, a business case for the establishment of the administrative and IT support structures around the RAIL system will be developed, and a number of pilots will be rolled out and tested across the HSC.

Conclusion

3.3 This guidance circular covers the interim reporting arrangements for the initial phase of that implementation process, setting out the roles and responsibilities of all stakeholder bodies in this period, and will be reviewed when the RAIL system is established. Revised guidance will be issued when the new arrangements are in place.