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:

Early Alert system

For action by:
- Chief Executives, HSC Trusts
- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Chief Executive, NIBTS
- 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 and Service Improvement, HSC Board
- Directors of Social Care and Children in HSC Board and HSC Trusts
- Directors of Nursing and AHP in PHA and HSC Trusts
- Director of Integrated Care in HSC Board
- Medical Directors in HSC Trusts
- Chair, Regional Area Child Protection Committee
- Chair, Regional Adult Protection Forum
- Chief Executive, Regulation & Quality Improvement Authority
- CSCG/Risk management leads
- Unscheduled care improvement managers

Summary of Contents:

The Circular provides guidance on the operation of an Early Alert System, designed to ensure that the Department is made aware in a timely fashion of significant events occurring within HSC organisations.

Enquiries:
Any enquiries about the content of this Circular should be addressed initially to:
Safety & Quality Unit
DHSSPS
[redacted]
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: 02[redacted]
E-mail: [redacted]

Circular Reference: HSC (SQSD) 10/2010

Date of Issue: 28 May 2010

Related documents

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

HSC (SQSD) 08/2010: Phase 2 – Learning from Adverse Incidents and Near Misses reported by HSC organisations and FPS

Superseded documents

Status of Contents:

Action

Implementation:

From 1 June 2010

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

Dear Colleague

ESTABLISHMENT OF AN EARLY ALERT SYSTEM

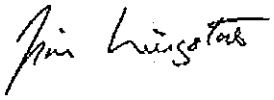
In March 2009, I wrote to you about the initial steps being taken to phase out the reporting of Serious Adverse Incidents (SAIs) to the Department, and the implementation of the Regional Adverse Incident and Learning (RAIL) system (Circular HSC (SQSD) 22/2009).

Circular HSC (SQSD) 08/2010, which issued on 30 April 2010, advised of the transfer of responsibility for managing SAIs from the Department to the HSC Board and Public Health Agency with effect from 1st May 2010, and the revised reporting arrangements which will be in place until the new RAIL system is fully implemented.

The purpose of this circular is to provide specific guidance on the arrangements which should be followed with effect from 1st June to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

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

Purpose of the Early Alert System

1.1 The Early Alert System will provide a channel which will enable Chief Executives and their senior staff (Director level or higher) in Health and Social Care (HSC) organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

It is important to note that this reporting system is intended to complement, not replace, existing channels of communication, both formal and informal.

1.2 While it is likely that some of the notifications reported as Early Alerts will also require to be managed as adverse incidents by HSC organisations, **many adverse incidents will NOT need to be reported through this channel.**

Criteria for using the Early Alert System

1.3 The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. ***Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;***

2. ***The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;***

3. ***The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;***

4. ***The media have inquired about the event;***

5. ***The PSNI is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless;***
    - *i. there has been an event which has caused harm to a patient or client and which has given rise to a Coroner's investigation; or*
    - *ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received, or*
    - *iii. the Coroner's inquest is likely to attract media interest.*

6. ***The following should always be notified:***
    i. ***the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;***
    ii. ***the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;***
    iii. ***allegations that a child accommodated in a children's home has committed a serious offence; and***
    iv. ***any serious complaint about a children's home or persons working there.***

7. ***There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.***

1.4 Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

1.5 It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

1.6 It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice speaks in person to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

1.7 The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within 24 hours of notification of the event, to the Department at earlyalert[redacted] and the HSC Board at earlyalert[redacted]

☒ **Initial call made to** _____ **(DHSSPS) on** _____ **(DATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - please confirm report has been forwarded to Chair of Regional CPC.***

.....

.....

.....

.....

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact _____

Contact details: Telephone (work or home) .....

Mobile (work or home) .....

Email address (work or home) .....

Forward proforma to the Department at: earlyalert[redacted] and the HSC Board at: earlyalert[redacted]

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....