Public Accounts Committee

Report on the Safety of Services Provided by Health and Social Care Trusts

Together with the Minutes of Proceedings of the Committee Relating to the Report and the Minutes of Evidence

Ordered by the Public Accounts Committee to be printed 27 February 2013
Report: NIA 102/11-15 (Public Accounts Committee)

REPORT EMBARGOED
UNTIL 00:01 AM on
17 April 2013

Membership and Powers

The Public Accounts Committee is a Standing Committee established in accordance with Standing Orders under Section 60(3) of the Northern Ireland Act 1998. It is the statutory function of the Public Accounts Committee to consider the accounts, and reports on accounts laid before the Assembly.

The Public Accounts Committee is appointed under Assembly Standing Order No. 56 of the Standing Orders for the Northern Ireland Assembly. It has the power to send for persons, papers and records and to report from time to time. Neither the Chairperson nor Deputy Chairperson of the Committee shall be a member of the same political party as the Minister of Finance and Personnel or of any junior minister appointed to the Department of Finance and Personnel.

The Committee has 11 members including a Chairperson and Deputy Chairperson and a quorum of 5.

The membership of the Committee since 23 May 2011 has been as follows:

Ms Michaela Boyle[1] (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Trevor Clarke[2]
Mr Michael Copeland
Mr Sammy Douglas[3]
Mr Paul Girvan
Mr Ross Hussey
Mr Mitchel McLaughlin
Mr Dathí McKay[4]
Mr Adrian McQuillan[5]
Mr Seán Rogers[6]

1 With effect from 2 July 2012 Ms Michaela Boyle replaced Mr Paul Maskey

2 With effect from 1 October 2012 Mr Trevor Clarke replaced Mr Alex Easton

3 With effect from 1 February 2013 Mr Sammy Douglas replaced Mr Sydney Anderson

4 With effect from 11 September 2012 Mr Daithí McKay was appointed to the Public Accounts Committee

5 With effect from 24 October 2011 Mr Adrian McQuillan replaced Mr Paul Frew

6 With effect from 10 September 2012 Mr Seán Rogers replaced Mr Joe Byrne

7 With effect from 23 January 2012 Mr Conor Murphy replaced Ms Jennifer McCann

8 With effect from 1 July 2012 Mr Conor Murphy resigned from the Public Accounts Committee

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List of Abbreviations used in the Report

the Committee	Public Accounts Committee
C&AG	Comptroller and Auditor General
the Department/DHSSPS	Department of Health, Social Services and Public Safety
HSC	Health and Social Care
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NRLS	National Reporting Learning System
RAIL	Regional Adverse Incident Learning
RQIA	Regulation Quality and Improvement Authority
SAI	Serious Adverse Incident

Executive Summary

Introduction

1. Health and social care services affect every member of society at some stage in their lives. Each year, there are in excess of 15 million key interactions between health and social care staff and healthcare patients and social care clients. The public expects, and deserves, that services are delivered safely. However, one guarantee that the health and social care services cannot give patients and clients is that they will not be harmed by the system meant to look after them. The challenge for the health and social care services is to ensure their patient safety systems minimise the risk of harm and to take steps to maximise the competence, knowledge and skills of health and social care professionals.

2. Two recent reports[1] on unsafe care at Mid Staffordshire NHS Foundation Trust in England bring into particularly sharp relief just how crucial it is that the health and social care system treats patients as human beings and is open, transparent and accountable when things do go wrong. It is important that Trusts here learn from what happened in Mid-Staffordshire to ensure nothing like the events there could possibly happen here.

3. Adverse incidents are incidents that occur in a health or social care setting that could have resulted, or do result in the harm, or even death, of the patient or client. Around 83,000 incidents are reported by the Health and Social Care Trusts each year – around 250 of these are classified as serious adverse incidents. The Department told the Committee that of the 2,084 serious adverse incidents reported between July 2004 and March 2012, 813 individuals died in circumstances related to these incidents. The Committee acknowledges that deaths reported may not be a reflection of issues with the care delivered by health and social care services: for instance 488 of the fatalities reported relate to suicides, whether proven or suspected. However, while recognising such caveats, the Committee considers that the number of deaths still suggests that the standard of care being delivered by health and social care bodies requires continued close scrutiny.

4. Patient harm arising from adverse incidents is both a systemic and a human problem. While individual responsibility for adverse incidents should not be played down, systemic solutions to the problem are needed. Patient safety systems should include effective reporting and learning systems, effective remedial mechanisms and the active dissemination and implementation of evidence-based knowledge aimed at reducing adverse incidents.

5. Some, probably a very small proportion of, patients and clients who are dissatisfied with the care or treatment they receive, seek redress either by lodging a complaint or taking legal action against the provider. The latter can have significant financial implications — in the past five years, settling health and social care negligence cases has cost the Department of Health, Social Services and Public Safety (Department) £116 million. A significant proportion of this (around 35 per cent) related to legal and administrative costs.

Overall Conclusions

6. The Committee's overall conclusion is that, despite the introduction of a number of safety policies and initiatives, there is no reliable evidence to show that people receiving health and social care are any safer today than they were a decade ago. The Department still lacks a reliable means of tracking the progress of the health and social care services in improving

1 The Mid Staffordshire NHS Foundation Trust Inquiry, Chaired by Robert Francis, 24 February 2010, HC 375, London: The Stationery Office; Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Chaired by Robert Francis QC, February 2013, HC 947, London: The Stationery Office

the safety of those receiving care or in holding service providers accountable for minimising preventable harm.

7. The Committee was disappointed by the Department's reluctance to undertake research to estimate the potential level of harm caused to patients and clients. In the absence of a robust measure of the level of patient and client harm, it will be difficult for the Department to demonstrate improvement over a period of time. The Committee considers that evidence of progress is a vital step in spurring Trusts to improve safety levels across both the health and social care sectors.

8. The Committee also considers that patients and clients must be provided with much more detail on the performance of individual Trusts. In practical terms, this will involve notifying those individuals involved in adverse incidents and routinely making sufficient information publicly available to enable comparisons of safety levels across Trusts and to create external pressure for improvement.

9. The Committee recognises that the year-on-year increases in the number of reported incidents indicate some progress in developing a more open and fair reporting culture. However, on the basis of evidence given by the Department, it considers that organisational culture does not always support reporting, while fear of the consequences in terms of job security and personal repercussions still exist. The Department told the Committee that under-reporting continues to be a widespread issue, particularly in the acute sector. On the basis of this, the Committee concludes that Trusts are not maximising the potential to learn when things go wrong. As a direct consequence of this, public trust in the extent to which Trusts are providing safe and effective care can be seriously undermined.

10. The Committee is extremely concerned that nurses within the health and social care sector have reservations about raising patient safety concerns. While the Department acknowledged that staff must feel empowered to speak up, challenge and share in the responsibility for patient safety, it confirmed that, to date, it has not actively engaged with nursing representative bodies to devise a methodology for reassuring nurses. The Committee considers that there is a strong link between the culture of an organisation and the willingness and capability of staff at all levels to report and learn from adverse incidents. The Department and Trusts must do more to embed a widespread culture of safety in which honest reporting is encouraged and genuine learning can take place.

11. The quality of treatment and care provided will, to an extent, depend on the competence of staff in post. Regularly appraising the performance of staff can identify gaps in knowledge or experience and identify potential training needs. The Committee is astounded that the lack of appraisal in some areas within the sector, which was identified in 2010, has yet to be addressed. While the Committee acknowledges that appraisal exists to help health and social care professional consolidate and improve on good performance, it is also its expectation that it will provide a formal system for identifying poor performance.

12. It is important that patients and clients with valid claims against the health and social care services understand their rights and have access to a range of timely remedies including an explanation, an apology, remedial treatment and, where justified, financial compensation. In the Committee's view patients find the complaints and claims procedures confusing and difficult to navigate and can too easily and too quickly find themselves in a position where they have to seek legal remedies.

13. The Committee concluded that the absence of formal dispute resolution procedures which offer a viable alternative to litigation causes additional stress and expense for those dissatisfied with their care and treatment. Alternative dispute resolution, including mediation, can assist both Trusts and patients in reaching the non-financial remedies which patients often say they seek. The Committee urges the Department to consider how best to channel compensation to eligible patients and clients and has determined that the Northern Ireland Ombudsman is well-placed to offer advice in this area.

Summary of Recommendations

Recommendation 1

The Committee recommends that the Department undertakes research to produce robust estimates of the extent and cost of patient harm which includes both commissioning errors (where patients receive poor quality, unsafe care) and errors of omission, where the harm is attributable to a lack of access to care. The Committee also considers that the Department should develop a range of safety-related indicators to routinely evaluate the safety performance of Trusts and to use this information to set challenging safety targets. The Committee considers that, based on experiences in other high risk industries such as aviation, targeted improvements in the rate of adverse incidents can be achieved. The Committee expects the Department, in six months' time, to provide it with: an action plan which sets out how it intends to establish a baseline measure of the incidence of harm caused to patients within the health and social care services; and how it intends to use this information for setting priorities for harm reduction efforts throughout the system.

Recommendation 2

All health and social care adverse incidents have the potential to generate learning across the sector. The Department should ensure that its data systems have the capability to identify the underlying causes of adverse incidents, with a view to preventing their repetition. In particular, it is important that the Department establishes an effective reporting and learning system for near misses (where the patient or client was unharmed) in an attempt to avoid more serious incidents in the future.

Recommendation 3

The Committee welcomes the Department's commitment to improving its management information through the RAIL system but is concerned with the timescales involved. The Committee recommends that interim arrangements are put in place as a matter of urgency to ensure regional collection of relevant information and calls on the Department to provide it with a progress report in six months' time.

Recommendation 4

The Committee notes the Department's preference to develop a regional management information system rather than join with England and Wales in the NRLS. Given the obvious risks involved in such IT projects, the Committee recommends that the Department's business case gives full consideration to all other options, particularly the NRLS option, and clearly explains why each of these is unacceptable.

Recommendation 5

The public has a right to sufficient information on individual Trusts in order to assess relative quality across service providers. The Committee recommends that the current reports produced by the HSC Board are enhanced by providing data on all adverse incidents, that they are made publicly available on a timely basis, and that they are sufficiently detailed to allow the public to get a regional and local picture of the safety of the treatment and care provided.

Recommendation 6

In the Committee's view, the open and fair culture to which the Department aspires must extend to the increased participation of patients in their treatment. The Committee recommends that health and social care providers are advised of the need to inform those involved in any adverse incidents. Information provided should include the nature of the incident, the circumstances giving rise to the incident, the possible impact for the patient or client and details of learning arising from the incident.

Recommendation 7

The Committee sees considerable merit in learning lessons from health care experiences elsewhere. It therefore expects the Department to independently verify the extent of compliance with NRLS safety alerts across the health and social care sector. Further, the Committee considers that sanctions should be imposed where health and social care bodies fail to implement action on a timely basis.

Recommendation 8

In terms of learning lessons, the Committee welcomes the recommendations of the Francis Reports on Mid Staffordshire Hospitals NHS Trust, many of which have implications that could apply to any health and social care trust here. The Committee calls on the Department to work closely with the HSC Board and the Trusts to consider the full implications of the Francis Reports and recommends that it reports back to the Committee in six months' time outlining what actions have been taken, or need to be taken, to address the concerns raised.

Recommendation 9

In the Committee's view the reluctance of nurses to report safety concerns indicates there is a real need to challenge the existing culture in which errors are concealed. Failure to report incidents prevents learning. A positive culture would result in improvements in safety practices through better communication, teamwork and knowledge. The Committee recommends that the Department engages with all staff groups within the sector and takes urgent steps to ensure a more open and proactive reporting culture.

Recommendation 10

The recipients of health and social care services must be assured that their views on the safety and quality of the services they receive are important. The Committee recommends that Trusts become more proactive in obtaining feedback on the services they provide, encouraging patients and clients to identify areas for potential improvement or to highlight good practice. Improving links between data on complaints with other safety data, such as risk and incident reporting data, can lead to complaints being taken more seriously as a source of information and feedback on the standard of service or care being provided.

Recommendation 11

Ensuring the competence of staff is crucial in creating a safe environment for patients receiving treatment and care from the health and social care services. The Committee finds it unacceptable that so little regard has been given to assessing, maintaining and improving the competency of staff – particularly among medical staff in the Northern Trust. While the Department's reminder to Trusts of their requirements in this area is encouraging, the Committee considers that action should have been taken as soon as

weaknesses were identified. The Committee recommends that the Department follows up on its reminder to Trusts by carrying out annual verification checks on staff appraisal and development plans. The Committee also asks that the Department provides it with an update, in six months' time, on the progress of Trusts in completing staff appraisals.

Recommendation 12

The Committee recommends that the Department continues to track the outcome of initiatives to speed up claims handling and that it provides the Committee with an update on the performance of long running cases up to September 2012.

Recommendation 13

The Committee considers that the current "fault-based" approach adopted across health and social care services can place additional, unnecessary stress and expense on those who suffer injury and on health and social care providers. The Committee recommends that the Department gives serious consideration to the feasibility of developing robust formal dispute resolution procedures which could offer a real alternative to litigation. The Committee considers that the Department should consult with the Northern Ireland Ombudsman in determining an appropriate way forward.

Recommendation 14

The Committee recommends that the Department assesses the relative merits of continuing to meet the compensation costs of clinical negligence settlements rather than requiring HSC bodies to assess their relative risks and contribute, on the basis of these risks, to a central pool from which compensation costs are met.

Introduction

14. The Public Accounts Committee (the Committee) met on 14 November 2012 to consider the Comptroller and Auditor General's report "The Safety of Services Provided by Health and Social Care Trusts". The main witnesses were:

- **Dr Andrew McCormick**, Accounting Officer, Department of Health, Social Services and Public Safety;
- **Dr Paddy Woods**, Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety;
- **Ms Julie Thompson**, Senior Finance Director, Department of Health, Social Services and Public Safety;
- **Mr Kieran Donnelly**, Comptroller and Auditor General; and
- **Ms Fiona Hamill**, Treasury Officer of Accounts.

15. Health and social care services are available to all people in Northern Ireland in a range of settings, such as hospitals and care homes. It is estimated that each year, there are in excess of 15 million interactions between health and social care providers and patient or clients. The vast majority of these patients and clients receive care or treatment which is effective and safe. Errors, which can and do cause harm, occur. In each year, around 83,000 incidents which caused, or could have caused, harm are reported by health and social care staff. Around 250 of these incidents are classified as serious. In the period from July 2004 to March 2012, 2,084 serious adverse incidents (SAIs) were reported. (Appendix 1 provides definitions of adverse/serious adverse incidents.) Although it can be difficult to determine the exact cause (or responsibility) for death, the Department told the Committee that 813 individuals died in circumstances related to these SAIs.

16. Where an individual considers that the care or treatment they received was not appropriate, they may seek redress. Redress may take the form of a complaint or, in more serious cases, may result in a claim for negligence. Around 60,000 complaints are lodged each year against health and social care providers. Around 600 new negligence claims are taken each year.

17. Negligence cases in the past five years have cost the taxpayer £116 million. The Department estimates that it could cost taxpayers a further £140 million to settle cases currently being processed. Other, less visible costs, such as the cost of providing care and treatment following an adverse incident, are not quantified but are likely to be substantial.

18. The Comptroller and Auditor General reported on the arrangements for settling clinical negligence claims in 2002. At that time, he recommended that action was required to ensure that cases were processed on a more timely basis. The Committee considered that this had the potential to minimise additional stress on injured patients and clients and to reduce the legal costs incurred in these cases. Progress in resolving negligence cases was unacceptably slow until the Assembly raised the issue again in 2010. The renewed interest resulted in initiation of an exercise to resolve long-standing cases which has seen a significant reduction in the number of cases running for over five years.

19. Despite a plethora of policy initiatives, there is little evidence that the Department or Trusts have made progress in making services safer. Recent cases, such as the pseudomonas outbreak in the Western Trust and subsequently the Belfast Trust and the death of a patient waiting on a trolley at the Accident and Emergency Department of the Royal Victoria Hospital, do little to provide assurance that safety is indeed a top priority.

20. In taking evidence, the Committee wished to explore how approaches to patient and client safety could help to reduce the burden of adverse incidents on heath and social care services. It focused on four key areas, as follows:

- The extent to which safety is measured;
- The culture within which care and treatment is provided;
- The competence of heath and social care professionals; and
- How the needs of those harmed as a result of receiving care can be fairly addressed.

The extent of harm caused by HSC providers must be measured and Information on the safety of Trust services made available to the public

There will always be risks in providing health and social care services. In order to mitigate against these risks, it is essential to have reliable estimates of the extent of harm caused to patients or clients

21. While no health and social care system will ever be risk free, adequate systems must be put in place to minimise the risk that patients or clients are harmed. As a first step in supporting efforts to make patient safety a standard of care in Trusts it is necessary to have reliable information on the extent and cost of harm caused. While it is difficult to estimate the extent and cost of harm accurately, available research suggests that, in England, around 10 per cent of patients admitted to hospital suffer some form of harm, much of which is avoidable.

22. The Committee is adamant that such a statistic should not be considered to be simply an unfortunate consequence of providing health and social care, particularly given the Department's evidence that adverse incidents have been linked to the deaths of hundreds of patients over the last eight years. In addition to the misery caused to patients and their families, adverse incidents negatively affect the health and social care system due to the increased costs of prolonged hospitalisation to treat complications. Currently these costs remain unmeasured. In the Committee's view, the Department's efforts to tackle patient safety effectively have to be based on a better understanding of the true extent of adverse incidents and the level of costs incurred in their treatment.

23. No research has been undertaken to estimate the likely level and cost of harm in Northern Ireland. The Department told the Committee that it sees little value in commissioning such research. Rather, in its view, efforts would be better focused towards making improvement. The Committee agrees that action is required to make improvements but considers that the vague notion that reducing patient harm should logically reduce costs and improve the outcomes of patient care is an unsound basis for developing a coherent approach to patient safety. Improvements cannot be measured unless a soundly based estimate of the extent of harm and the attendant financial costs is produced. The Department should set out clearly what it is trying to achieve and develop performance measures which can be used to assess its effectiveness in addressing patient safety issues.

Recommendation 1

24. **The Committee recommends that the Department undertakes research to produce robust estimates of the extent and cost of patient harm which includes both commissioning errors (where patients receive poor quality, unsafe care) and errors of omission, where the harm is attributable to a lack of access to care. The Committee also considers that the Department should develop a range of safety-related indicators to routinely evaluate the safety performance of Trusts and to use this information to set challenging safety targets. The Committee considers that, based on experiences in other high risk industries such as aviation, targeted improvements in the rate of adverse incidents can be achieved. The Committee expects the Department, in six months' time, to provide it with: an action plan which sets out how it intends to establish a baseline measure of the incidence of harm caused to patients within the health and social care services; and how it intends to use this information for setting priorities for harm reduction efforts throughout the system.**

Information on all adverse incidents must be collated and used to facilitate learning

25. Information on the circumstances leading to adverse incidents is extremely valuable, and learning lessons from individual incidents can prevent future harm. While the Committee recognises that the Belfast HSC Trust is one of the largest in the UK and provides various regional treatments, it does not agree with the Department that these factors should exempt it from comparison against other Trusts. The Committee considers that data on adverse incidents relating to regional (or specialist care) should be separately identified. As a result, the incidence of adverse incidents occurring in "routine" treatment or care could be fairly compared against the incidence in other Trusts.

26. In analysing data on adverse incidents, less attention has been focused on the detection and analysis of near misses, and the Committee believes that this neglect represents a missed opportunity. Near miss reports are a particularly good source of data for managing risk. Regionally, systems are in place to collate information on serious adverse incidents, but information on incidents deemed by Trusts to be less serious is retained within individual Trusts. Achieving substantial improvements in patient safety will require a management information system which captures data on all adverse incidents and near misses and uses this information to design care delivery systems.

27. A National Reporting and Learning System (NRLS) has been operating across England and Wales since 2003. The NRLS is a centralised database which supports development of improved patient safety solutions nationally. While, initially, the Department had considered the possibility of joining NRLS it told the Committee that it now plans to introduce a new Regional Adverse Incident Learning (RAIL) management information system. The Department informed the Committee that the outline business case for the RAIL system has not been finalised and, therefore, the anticipated full cost of the project is not yet known. However, to date, the system has cost just over £380,000. In the Department's view this system will provide comprehensive patient safety information which can be collated on a regional basis. Subject to approval of the business case, the Department expects that its RAIL system will be piloted in one health and social care organisation over a twelve-month period and, subject to the results of the pilot, will be rolled out across the sector.

28. The Committee notes that the RAIL pilot is not scheduled until 2014 and is concerned that prior to its full introduction, comprehensive information on adverse incidents will continue to be unavailable. Despite assurances by the Department, the Committee remains unconvinced of the need to embark on the development of a stand-alone Northern Ireland-specific management information system and expects the RAIL business case to fully explore all other available options.

Recommendation 2

29. **All health and social care adverse incidents have the potential to generate learning across the sector. The Department should ensure that its data systems have the capability to identify the underlying causes of adverse incidents, with a view to preventing their repetition. In particular, it is important that the Department establishes an effective reporting and learning system for near misses (where the patient or client was unharmed) in an attempt to avoid more serious incidents in the future.**

Recommendation 3

30. **The Committee welcomes the Department's commitment to improving its management information through the RAIL system but is concerned with the timescales involved. The Committee recommends that interim arrangements are put in place as a matter of urgency to ensure regional collection of relevant information and calls on the Department to provide it with a progress report in six months' time.**

Recommendation 4

31. **The Committee notes the Department's preference to develop a regional management information system rather than join with England and Wales in the NRLS. Given the obvious risks involved in such IT projects, the Committee recommends that the Department's business case gives full consideration to all other options, particularly the NRLS option, and clearly explains why each of these is unacceptable.**

The information provided to the public on the safety of care is inadequate and does not engender confidence in the health and social care services

32. Information on serious adverse incidents across the health and social care sector is collated by the Health and Social Care Board (HSC Board). The HSC Board considers the reported incidents and provides feedback to health and social care bodies. In addition, the HSC Board identifies lessons from individual incidents and communicates these across the sector. Information on all other adverse incidents is retained by individual Trusts.

33. The Committee acknowledges the work done by the HSC Board to ensure learning from serious adverse incidents. However, in the Committee's view, these reports must be extended to cover all adverse incidents and must be presented in a way that gives the public a clear picture of the safety of care available. Further, the Committee considers that, as the people who use health and social care services deserve to know about the risks they face on all aspects of safety, the reports should be sufficiently detailed to allow the public to compare safety performance across Trusts. The Committee expects that once the RAIL system is up and running this should go some way to ensuring that comprehensive information on patient safety is readily available so that the reporting needs of the public can be properly addressed.

Recommendation 5

34. **The public has a right to sufficient information on individual Trusts in order to assess relative quality across service providers. The Committee recommends that the current reports produced by the HSC Board are enhanced by providing data on all adverse incidents, that they are made publicly available on a timely basis, and that they are sufficiently detailed to allow the public to get a regional and local picture of the safety of the treatment and care provided.**

35. Individuals who suffer a serious adverse incident, or their representatives, are likely to be aware that they have suffered some form of harm. Even where this is not the case, procedures within Trusts dictate that, as part of the required investigation process, these individuals are informed.

36. The Committee was disappointed to learn that, in less serious cases, the individual will not always be informed. The public expects and deserves safe care, and those who do not receive this have a right to know.

Recommendation 6

37. **In the Committee's view, the open and fair culture to which the Department aspires must extend to the increased participation of patients in their treatment. The Committee recommends that health and social care providers are advised of the need to inform those involved in any adverse incidents. Information provided should include the nature of the incident, the circumstances giving rise to the incident, the possible impact for the patient or client and details of learning arising from the incident.**

38. Information on patient safety incidents is reported confidentially to the NRLS by healthcare staff across England and Wales. Clinicians and safety experts analyse submitted reports to identify any common patient risks and highlight opportunities to improve patient safety. Alerts

take the form of Rapid Response Reports, Patient Safety Alerts or Safer Practice Notices. Although Northern Ireland health and social care bodies do not provide incident data to the database, the Department told the Committee that arrangements are in place to ensure that NRLS messages are cascaded to all relevant organisations and clinical specialties for consideration and dissemination.

39. The Department told the Committee that individual Trusts are required to report on the extent to which they have implemented NRLS safety alerts. However, while the Department could provide evidence that safety information was provided to Trusts, it failed to convince the Committee that it routinely monitored the extent to which individual safety notices resulted in procedural improvements within Trusts. In the Committee's view, it is essential for the Department to independently verify the extent of Trust compliance with patient safety alerts and to impose sanction for failure (or unacceptable delay) in implementation.

Recommendation 7

40. **The Committee sees considerable merit in learning lessons from health care experiences elsewhere. It therefore expects the Department to independently verify the extent of compliance with NRLS safety alerts across the health and social care sector. Further, the Committee considers that sanctions should be imposed where health and social care bodies fail to implement action on a timely basis.**

Recommendation 8

41. **In terms of learning lessons, the Committee welcomes the recommendations of the Francis Reports on Mid Staffordshire Hospitals NHS Trust, many of which have implications that could apply to any health and social care trust here. The Committee calls on the Department to work closely with the HSC Board and the Trusts to consider the full implications of the Francis Reports and recommends that it reports back to the Committee in six months' time outlining what actions have been taken, or need to be taken, to address the concerns raised.**

Trusts must completely eliminate the blame culture if the reporting of incidents is to improve

Staff and those accessing care or treatment must be reassured that raising potential or actual patient safety concerns is welcomed

42. An open and fair culture encourages the willingness and capability of of staff to report and learn from adverse incidents. A failure to report incidents precludes learning across the sector and prevents identification of patterns and trends in causing harm. The Department acknowledges that there is likely to be significant under-reporting of incidents, particularly within the acute sector. In addition, the Committee highlighted that some cases of harm, for example those cases where the failure to provide treatment or care resulted in death, are unlikely ever to be captured. Against this background, the Committee was shocked to discover that nurses — or any medical staff who are well placed to advise on patient safety — should have reservations about raising concerns.

43. The Department acknowledged that an open and fair culture would ensure that individuals feel free to speak up and challenge the safety of treatment or care provided. It told the Committee that all health and social care staff have been reminded that the leadership within their organisation should promote a culture in which everyone can challenge everyone else.

44. Given the Department's views, the Committee was disappointed that it has not met with nursing representatives to discuss how the existing culture can be improved.

Recommendation 9

45. **In the Committee's view the reluctance of nurses to report safety concerns indicates there is a real need to challenge the existing culture in which errors are concealed. Failure to report incidents prevents learning. A positive culture would result in improvements in safety practices through better communication, teamwork and knowledge. The Committee recommends that the Department engages with all staff groups within the sector and takes urgent steps to ensure a more open and proactive reporting culture.**

46. Users of health and social care services are well placed to assess the quality and safe of the care or treatment they receive. Feedback from patients and clients can be useful in identifying good practice and highlighting areas where improvement in services is required.

47. Around 60,000 complaints are received about health and social care services each year, but with users fearing reprisal, it is likely that several others who are dissatisfied do not raise their concerns. Given the value of such information the Committee was disappointed that many health and social care patients and clients feel reluctant to complain about the quality or safety of the care they receive. The public must have confidence in the health and social care system and the attitude of staff responding to complaints is crucial to building this confidence.

Recommendation 10

48. **The recipients of health and social care services must be assured that their views on the safety and quality of the services they receive are important. The Committee recommends that Trusts become more proactive in obtaining feedback on the services they provide, encouraging patients and clients to identify areas for potential improvement or to highlight good practice. Improving links between data on complaints with other safety data, such as risk and incident reporting data, can lead to complaints being taken more seriously as a source of information and feedback on the standard of service or care being provided.**

The competence, performance and training needs of all staff must be regularly assessed

49. The Committee recognises that, whilst systems in place to support delivery of safe care make things happen, it is people that make systems work. Ensuring the competence of the staff and addressing training needs, therefore, are important steps in ensuring the safety of health and social care services. A survey in 2010 identified that a significant number of staff (over half of those who responded) had received no annual appraisal in the preceding twelve months and did not have a personal development plan in place. The Committee considers that the performance of all staff must be regularly assessed if poor performance is to be identified and addressed. Further, it considers that, in the absence of personal development plans, important training needs may be overlooked.

50. The Department agreed that the lack of compliance with appraisal practice is a major concern and informed the Committee that each Trust had been reminded of the need to ensure that the performance of staff is assessed regularly. Despite such an assurance statistics provided to the Committee by the Department following the evidence session indicate that there continues to be a problem in this area. The Table below sets out the percentage of staff who did not receive a formal appraisal in the latest performance period. This shows, for example, that in the South Eastern HSC Trust, an alarming 85 per cent of non-medical staff did not receive a formal appraisal in 2011-12. Similarly, in the last reporting period, 36% of medical staff within the Northern HSC Trust did not receive a formal appraisal.

HSC Trust	**Percentage of staff NOT appraised in latest performance period**	
	Medical	**Non-Medical**
Belfast	11%	14%
Northern	36%	53%
Southern	9%	65%
South Eastern	15%	85%
Western	48% (no breakdown provided)	

Recommendation 11

51. **Ensuring the competence of staff is crucial in creating a safe environment for patients receiving treatment and care from the health and social care services. The Committee finds it unacceptable that so little regard has been given to assessing, maintaining and improving the competence of staff – particularly among medical staff in the Northern Trust. While the Department's reminder to Trusts of their requirements in this area is encouraging, the Committee considers that action should have been taken as soon as weaknesses were identified. The Committee recommends that the Department follows up on its reminder to Trusts by carrying out annual verification checks on staff appraisal and development plans. The Committee also asks that the Department provides it with an update, in six months time, on the progress of Trusts in completing staff appraisals.**

Arrangements for addressing the needs of individuals who are dissatisfied with their care need to be improved

52. A small number of those who are dissatisfied with the treatment or care they received from a health and social body will take legal action in an attempt to obtain an explanation of, or an apology for, their experience or to seek financial compensation for injury suffered as a result of their experience. To be successful, these individuals must prove, in a court of law that a

practitioner or organisation failed to adhere to accepted standards of care or treatment. In other words, the individual must prove that no competent practitioner from the same specialty would support or endorse the care or treatment provided.

53. This "fault-based" approach has been the subject of criticism in England[2], because it places considerable additional stress on patients or clients, is time consuming, engenders a culture of secrecy across providers and results in substantial legal and administrative costs - which can often exceed the value of compensation awarded. For example, in 2011-12 across the Trusts, 139 closed cases resulted in the award of damages of less than £50,000. In 73 per cent of these settlements, total legal costs exceeded the level of damages.

54. Delay in clearing claims for clinical negligence causes uncertainty for all those involved, particularly those patients who have suffered and their families. The C&AG has reported that progress is being made and more claims are now being closed than opened. In particular he reported a decline in the number of long running cases between September 2010 and September 2011. While the Committee acknowledges this progress it considers that there are still unacceptable delays in clearing many negligence cases and further action is required.

Recommendation 12

55. **The Committee recommends that the Department continues to track the outcome of initiatives to speed up claims handling and that it provides the Committee with an update on the performance of long running cases up to September 2012.**

56. In 2002, in response to a report by the Northern Ireland Audit Office[3], the Department advised individual HSC bodies of the potential benefits of intervening early in cases where a clinical negligence case may arise. However, the Department has taken little action to measure the extent to which individual bodies have complied with the guidance.

57. The Committee considers that there are viable alternatives to litigation, such as conciliation, mediation and arbitration, which would ensure more satisfactory resolution in cases where patients or clients have suffered injury as a result of treatment or care. Such alternatives would ensure that compensation is provided to eligible patients and clients in an equitable and timely manner, would maximise learning across the sector and would incentivise HSC staff working towards improving the quality of treatment and care. Creating such an environment is essential to efficiency in an era of limited resources, and ultimately, in advancing patient safety and saving lives.

Recommendation 13

58. **The Committee considers that the current "fault-based" approach adopted across health and social care services can place additional, unnecessary stress and expense on those who suffer injury and on health and social care providers. The Committee recommends that the Department gives serious consideration to the feasibility of developing robust formal dispute resolution procedures which could offer a real alternative to litigation. The Committee considers that the Department should consult with the Northern Ireland Ombudsman in determining an appropriate way forward.**

59. In Northern Ireland, the cost of settled clinical and social care negligence claims falls to the Department rather than to the Trust or HSC body which provided the treatment or care. By contrast, in England and Wales, NHS bodies contribute to a central compensation pool on the basis of the assessed risk of the services they provide. The Committee considers that

2 Criticisms were expressed by the National Audit Office Report in May 2001 in its report , *Handling Clinical Negligence Claims in England HC 403* and subsequently by the House of Commons Public Accounts Committee who took evidence on that report.

3 *Compensation Payments for Clinical Negligence,* Northern Ireland Audit Office, July 2002, NIA 112/02.

the arrangements in England and Wales provide NHS bodies with some financial incentive to improving the safety of treatment or care.

Recommendation 14

60. **The Committee recommends that the Department assesses the relative merits of continuing to meet the compensation costs of clinical negligence settlements rather than requiring HSC bodies to assess their relative risks and contribute, on the basis of these risks, to a central pool from which compensation costs are met.**

Appendix 1

Adverse/Serious Adverse Incidents

Any event or circumstance that could have, or did, lead to harm, loss or damage to people, property, environment or reputation" is defined as an adverse incident. This definition acknowledges that not all incidents result in harm, but some do. Where an incident is prevented or avoided, resulting in no harm, this is called a 'near miss'. Adverse incidents can be, but are not always, related to individual human error. Often they are linked to system faults, work environments, technological failures or the complex characteristics of the individual patient's or client's condition or circumstance. Serious adverse incidents are a subset of adverse incidents.

A serious adverse incident, rather than an adverse incident, has occurred where there is:

- serious injury to, or the unexpected/unexplained death (including suspected suicides and serious self–harm) of: a service user; a service user known to Mental Health Services (including Child and Adolescent Mental Health Services or Learning Disability) within the last two years;
- serious injury to a staff member in the course of their work; or a member of the public whilst visiting a HSC facility;
- unexpected serious risk to a service user and/or staff member and/or member of the public; unexpected or significant threat to the provision of services and/or the maintenance of business continuity;
- a serious assault (including homicide and sexual assaults) by a service user on other users/staff/members of the public occurring within a healthcare facility or in the community care setting; or
- a serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

Northern Ireland Assembly

Appendix 1

Minutes of Proceedings of the Committee Relating to the Report

Wednesday, 7 November 2012
The Senate Chamber, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Daithí McKay
Mr Mitchel McLaughlin
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mr Darren Weir (Clerical Officer)
Ms Antoinette Bowen (Clerical Officer)

Apologies: Mr Ross Hussey
Mr Adrian McQuillan

2:00 pm The meeting opened in public session.

4. Briefing on Northern Ireland Audit Office Reports on 'The Safety of Services Provided by Health and Social Care Trusts'

The Committee considered the above report on 'The Safety of Services provided by Health and Social Care Trusts'.

Mr Kieran Donnelly Comptroller and Auditor General; Mr Sean McKay, Director; Ms Claire Dornan, Audit Manager; and Joe Campbell, Audit Manager briefed the Committee on the report.

2:18 pm The meeting went into closed session after the C&AG's initial remarks.

2:31 pm Mr Girvan declared an interest stating that he has family members in the medical profession and nursing.

3:09 pm Mr Copeland left the meeting.

3:10 pm Mr Anderson declared an interest stating that he has family members who are employed by Social Services.

3:15 pm Mr Dallat left the meeting.

3:17 pm Mr Copeland entered the meeting.

3:18 pm Mr Dallat entered the meeting.

3:24 pm Mr Girvan left the meeting.

3:26 pm Mr Copeland left the meeting.

3:27 pm Mr Clarke left the meeting.

3:27 pm Mr Girvan entered the meeting.

3:46 pm Mr Clarke entered the meeting.

The witnesses answered a number of questions put by members.

[EXTRACT]

Wednesday, 14 November 2012
The Senate Chamber, Parliament Buildings

Present: Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Mitchel McLaughlin
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mr Darren Weir (Clerical Officer)
Ms Andrienne Magee (Clerical Officer)

Apologies: Ms Michaela Boyle (Chairperson)
Mr Ross Hussey
Mr Daithí McKay
Mr Adrian McQuillan

2:04 pm The meeting opened in public session.

4. Evidence on the Northern Ireland Audit Office Report 'The Safety of Services provided by Health and Social Care Trusts'.

2:08 pm Mr Anderson declared an interest stating that he has family members who are employed by Social Services.

The Committee took oral evidence on the above report from:

- Dr Andrew McCormick, Accounting Officer, Department of Health, Social Services and Public Safety (DHSSPS);
- Dr Paddy Woods, Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety (DHSSPS); and
- Ms Julie Thompson, Deputy Secretary, Resource and Performance Management Group, Department of Health, Social Services and Public Safety (DHSSPS).

Agreed: The Committee agreed to request further information from the witnesses.

2:14 pm Mr Girvan entered the meeting.

2:19 pm Mr Girvan left the meeting.

2:28 pm Mr Girvan entered the meeting.

3:13 pm Mr Clarke left the meeting.

3:15 pm Mr Girvan left the meeting.

3:16 pm Mr Clarke and Mr Girvan entered the meeting.

3:19 pm Mr Copeland left the meeting.

3:21 pm Mr Rogers left the meeting.

3:22 pm Mr Anderson left the meeting.

3:24 pm Mr Copeland entered the meeting.

3:26 pm Mr Rogers entered the meeting.

3:44 pm Mr McLaughlin left the meeting.

3:52 pm Mr McLaughlin entered the meeting.

3:59 pm Mr Copeland left the meeting.

4:11 pm Mr Copeland entered the meeting.

4:26 pm Mr Copeland left the meeting.

4:28 pm Mr Clarke left the meeting.

4:39 pm Mr Clarke entered the meeting.

4:49 pm Mr Copeland left the meeting.

The witnesses answered a number of questions put by the Committee.

[EXTRACT]

Wednesday, 21 November 2012
Room 29, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Ross Hussey
Mr Daithí McKay
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Mr Darren Weir (Clerical Officer)
Ms Andrienne Magee (Clerical Officer)

2:00 pm The meeting opened in public session.

3:22 pm The meeting went into closed session after the C&AG's initial remarks.

8. Issues Arising from the Oral Evidence Session on 'The Safety of Services provided by Health and Social Care Trusts'

The Committee considered an issues paper relating to the previous week's evidence session.

[EXTRACT]

Wednesday, 30 January 2013
Room 144, Parliament Buildings

Present: Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Ross Hussey
Mr Daithí McKay
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Miss Maria Magennis (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Ms Michaela Boyle (Chairperson)

2:03 pm The meeting opened in public session.

2:07 pm The meeting went into closed session.

2:07 pm Mr McKay left the meeting.

4. Issues Paper on 'The Safety of Services Provided by Health and Social Care Trusts'

Correspondence from the Department of Health, Social Services and Public Safety

The Committee noted correspondence from Dr Andrew McCormick, Accounting Officer, Department of Health, Social Services and Public Safety providing the information sought by it following its evidence session on 14 November.

2:15 pm Mr McKay entered the meeting.

Agreed: Following consideration of an issues paper reflecting the additional information the Committee agreed the outline of its draft report.

[EXTRACT]

Wednesday, 27 February 2013
Room 29, Parliament Buildings

Present: Ms Michaela Boyle (Chairperson)
Mr John Dallat (Deputy Chairperson)
Mr Paul Girvan
Mr Daithí McKay
Mr Mitchel McLaughlin
Mr Adrian McQuillan
Mr Seán Rogers

In Attendance: Miss Aoibhinn Treanor (Assembly Clerk)
Mr Phil Pateman (Assistant Assembly Clerk)
Miss Maria Magennis (Clerical Supervisor)
Mr Darren Weir (Clerical Officer)

Apologies: Mr Trevor Clarke
Mr Michael Copeland
Mr Sammy Douglas
Mr Ross Hussey

2:04 pm The meeting opened in public session.

2:25 pm The meeting went into closed session after the C&AG's initial remarks.

6. Consideration of Draft Committee Report on 'The Safety of Services Provided by Health and Social Care Trusts'

The Committee considered its draft report on 'The Safety of Services Provided by Health and Social Care Trusts'.

Paragraphs 1 - 34 read and agreed.

Paragraph 35 - 36 read, amended and agreed.

Paragraphs 37 – 41 read and agreed.

Paragraph 42 read, amended and agreed.

Paragraphs 43 – 52 read and agreed.

Paragraphs 53 read, amended and agreed.

Insertion of a recommendation agreed.

Paragraphs 54 – 58 read and agreed.

Appendix 1 read, and agreed.

Consideration of the Executive Summary

Paragraph 1 – 13 read and agreed as per the main report.

Agreed: The Committee agreed the correspondence to be included within the report.

Agreed: The Committee ordered the report to be printed.

[EXTRACT]

Appendix 2

Minutes of Evidence

14 November 2012

Members present for all or part of the proceedings:

Mr John Dallat (Deputy Chairperson)
Mr Sydney Anderson
Mr Trevor Clarke
Mr Michael Copeland
Mr Paul Girvan
Mr Mitchel McLaughlin
Mr Sean Rogers

Witnesses:

Dr Andrew McCormick	*Department of Health, Social Services and Public Safety*
Ms Julie Thompson	
Dr Paddy Woods	

In attendance:

Mr Kieran Donnelly	*Comptroller and Auditor General*
Ms Fiona Hamill	*Treasury Officer of Accounts*

1. **The Deputy Chairperson**: Today we are considering the Comptroller and Auditor General's report on the safety of services provided by health and social care trusts. Does any member wish to express an interest?

2. **Mr Anderson**: I have a family member who works in Health and Social Care (HSC).

3. **The Deputy Chairperson**: Dr Andrew McCormick, accounting officer for the Department of Health, Social Services and Public Safety (DHSSPS), is here to respond to the Committee today. Dr McCormick, you are very welcome. Please introduce your team.

4. **Dr Andrew McCormick (Department of Health, Social Services and Public Safety)**: Thank you, Chairman. With me this afternoon are Paddy Woods, deputy chief medical officer, and Julie Thompson, senior finance director.

5. **The Deputy Chairperson**: Thank you. Given that the Audit Office report covers a wide area, I would be grateful if the witnesses could ensure that any responses are succinct. I repeat: succinct. Dr McCormick, I understand that you wish to make some introductory comments.

6. **Dr McCormick**: Thank you for the opportunity, Chairman. This is a very interesting and important topic, and we give top priority and attention to it all the time. If I may, I will just make one or two comments to set the scene and draw out the context.

7. The oversight of safety is a fundamental responsibility for me as accounting officer and for the accountable officers in each of the organisations, primarily the trusts, and it is the top issue on which we engage. We expect to be able to provide, and patients readily expect that they will get, the best possible care, and that that will be safe. However, as I have said before in this room in evidence sessions to the Health Committee, the best health systems, the best hospitals and the best doctors in the world have avoidable deaths, and the health service in Northern Ireland is not an exception. The key question for us all is how to minimise and manage risk to patients while still providing risky treatments.

8. Professor Cyril Chantler said:

"Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous."

9. That is a very good thing, because medicine is much more effective than it used to be. However, it involves expecting professionals to undertake procedures, to carry out activities and to manage a whole range of things that are inherently risky. The question then is how to minimise and manage that risk. We need to make sure that we have the best possible organisational leadership, strong governance systems, good policies and processes, a good work environment and good communication.

We need to measure and handle the complexity of work. We need to do all those things while ensuring that we maximise the knowledge, skills and motivation of staff. Clinical governance is the top corporate responsibility of each and every HSC organisation, and each chief executive is personally responsible to me for clinical governance.

10. We have a range of research on how unintended harm and unnecessary death arise in the worst cases. Most of the time, it is a result of a combination of circumstances in a system rather than the failings of an individual. Patient safety demands that we design effective systems. We need to minimise the risk of a single mistake or error — we are all human — leading to a bad outcome. We have undertaken a range of initiatives, going back to Best Practice, Best Care in 2002. In 2006, there was a framework for sustainable improvement in health and personal social services called Safety First. We have had a regular series of reports on the learning arising from serious adverse incidents (SAIs). Most recently, and very importantly, in November 2011, there was the publication of 'Quality 2020', which is a strategy designed to ensure that we do everything possible to promote quality and safety across the system.

11. However, we are not complacent, and we cannot possibly afford to be. What we have to do is create and nurture a learning culture and a systems approach. We need to ensure that our accountability is fair but not punitive. So, balancing the culture is very important. We need proper individual accountability, so that if an individual is not performing or does something that is outside the standard of professional practice, their professional regulator will act on that. That has to be part of what happens. However, the wider context is more complex and subtle, as I am sure will come out more fully in the questioning.

12. I hope that that was helpful by way of setting the scene.

13. **The Deputy Chairperson**: Thank you, Dr McCormick. I am sure that members will want to develop those themes. In turn, members will be putting their own questions, and I am sure they will want to pick up on some of the things you said.

14. I will begin along the lines of your introductory remarks. High-profile cases of patient harm strongly influence our views of the health and safety and social care services, but the report shows that the problem goes far beyond the headlines. Paragraph 1.5 of the report refers to the fact that 83,000 adverse incidents are reported each year. The truth is that we still know far too little about how often patients are being harmed by hospital treatment. Would you like to comment on that?

15. **Dr McCormick**: I understand and accept that we need to do further work to improve the information systems. To put that number of 83,000 in context, there are 2·8 million interactions a year between the service and individual patients, so the vast majority of what happens in the service is safe and effective. We are clear that we have a good information base that we have developed in relation to the more serious aspects of the things that go wrong. So the process for serious adverse incidents is clear and good. We are developing, and will introduce next year, the fully fledged system for bringing together, at regional level, all the information on learning from all adverse incidents. To complete that into 2014 will be a very important step, and that will place us, as a small, relatively simple region, ahead of other jurisdictions in the information that we will have. We accept that there is more to be done, and that will improve the handling and understanding of information. The whole essence of this is to learn from what goes wrong and make sure that we act to minimise recurrence. The hardest thing to defend is the same thing going wrong again, so we have to learn from the things that go wrong. We have a good system for learning from the serious incidents, and we are working further to improve that. That is part of the priority that we are giving to the issue.

16. **The Deputy Chairperson**: Dr McCormick, in your introductory remarks, you made reference to Safety First, from 2006. The Department was before the Public Accounts Committee 10 years ago, and we had loads of promises. Today, you have an opportunity to demonstrate that patients in Health and Social Care are safer than they were when you previously reported 10 years ago. How can you do that?

17. **Dr McCormick**: It is important to say that we have made a range of particular interventions to improve safety. It needs to be put in the context of the fact that medicine has changed in that period, so there are things that are done now that would not have been possible 10 years ago. They are well worth doing because they can extend life or improve quality of life in a very significant way, but that may mean that there are more things going wrong because more risky things are being undertaken. The key point far beyond any increase in such incidents is the increase in benefit. I would focus on the increase in the benefit of a better and improving healthcare system to patients, clients and the public in Northern Ireland. That is worldwide, of course. We are following through with applying innovations that are developed across the world, including here, and making sure that those are available, so that we have an improving standard of care and significant research-based interventions that improve safety. I can give details on that. However, we are still seeing a level of adverse and serious adverse incidents. At one level, it is inevitable that there will be some. Our job is to minimise them and to make sure that we learn from them.

18. **The Deputy Chairperson**: At this stage, two members, Trevor Clarke and Michael Copeland, have indicated their intention to ask questions.

19. **Mr Clarke**: You covered my question, sorry. That is OK.

20. **Mr Copeland**: You are very welcome, Andrew. I would like clarification. Are the 83,000 adverse incidents that the Chair referred to only adverse incidents that occurred within health service facilities, involving health service staff? A tremendous number of procedures are carried out in private clinics, paid for by the health service and, in some cases, using health service staff. Is the 83,000 the total number of adverse incidents concerning anyone receiving medical treatment? Or is there another figure paid for by the public, but outside that remit?

21. **Dr McCormick**: It embraces all activities that are the responsibility of the public sector. Even if it is carried out on behalf of the public sector by an independent sector provider, if it is contracted in that way, it will be covered by the statistics and will be required to be reported. Certainly, a significant proportion of the 83,000 come from the independent care home sector, and those are reported through the Regulation and Quality Improvement Authority (RQIA) as part of its functions. We would not pick up incidents in which an individual has sought private service, without that being within the governance of the public sector.

22. **Mr Copeland**: Is the public purse indemnified from claims arising from a procedure that has been carried out on behalf of, but not by, the health service?

23. **Dr McCormick**: The contracts that are drawn up with independent sector providers include provision to ensure that there is a proper handling of risk. Julie has the details in front of her. The model contract that we have with independent sector providers who are, say, undertaking a waiting list initiative or whatever, provides for the proper handling of the risk.

24. **Ms Julie Thompson (Department of Health, Social Services and Public Safety)**: They have to ensure that they cover the cost of that within their own arrangements. That is part of the standard contract arrangements that we have with the independent sector for clinical negligence claims, for example.

25. **Mr Copeland**: That is the potential cost of settlement of claims.

26. **Ms Thompson**: Yes, that it has to cover effectively.

27. **Mr Copeland**: That is not included in the figures that we have for those that are settled by the health service.

28. **Dr McCormick**: By definition, that will be excluded.

29. **Mr Clarke**: Dr McCormick, you said that a big proportion of the 83,000 relate to the independent sector. It is easy for us to accept that, but we have no evidence of it. Can you give us the figures that indicate that?

30. **Dr McCormick**: We can provide a breakdown of the figures per trust.

31. **Mr Clarke**: Proportionally, then, in the numbers that were referred in the independent sector versus the number that turned into actual negligence claims, as opposed to the number that you process yourselves versus actual claims. Even without looking at those figures, the proportion probably suggests that there is a bigger possibility of a claim against you than against an independent. I will stand corrected if you can provide me with evidence that proves otherwise.

32. **Dr McCormick**: I am not sure how much detail is available. We will give the Committee a breakdown of what is available. Of the 83,000, nearly 13,000 were reported by RQIA. My understanding is that the majority of those are from the independent care home sector. There are very limited independent hospital services in Northern Ireland. The majority of independent sector activity is in social care, nursing homes and residential care.

33. **Mr Clarke**: You referred to Northern Ireland. We are all aware of the pressures here in Northern Ireland, but some of this carries outside Northern Ireland. Let us not exclude that from the figures that you present to us. We are all aware that people travel to Dublin, Cardiff and other places for specialist surgery. Let us look at the broader picture. That is all part of the work that you have contracted out and part of the statistics. You made what I thought was a bit of a loose comment in your first response to Michael when, without coming armed with the evidence, you suggested that the figures might be higher proportionately.

34. **Dr McCormick**: I did not intend to imply that. I am sorry. I did not mean to convey that.

35. **The Deputy Chairperson**: Let us develop the theme a little bit. Members may be keen to ask about their own individual cases, but please do not do that.

36. Paragraph 3.5 mentions arrangements for promoting regional learning from serious adverse incidents through various patient safety reports. Dr McCormick, you will know that people are much more interested in how their local trust is performing. I am sure that you would agree with that. I am sure that you would also agree with the Committee that the public have a right to know how their local trust compares to other trusts in respect of patient safety. Do you accept that?

37. **Dr McCormick**: Yes.

38. **The Deputy Chairperson**: What steps have you taken to ensure that someone reading HSC patient safety reports can easily compare performance across different trusts and specialities?

39. **Dr McCormick**: It is important that there is an understanding of the context facing each individual organisation. That will vary between the organisations because of their different functions. We have available, and can provide for the Committee, a fuller breakdown of the incidence of serious adverse incidents by trust.

40. It is important to recognise that the trusts are unified organisations. Although they provide services on individual sites, they are coherent and unified organisations with medical staffing organised in networks. There is a mutual dependency between, for example, a larger hospital and a smaller hospital. Look at the relationship between, for example, Craigavon

hospital and Daisy Hill. They both have their particular staff present on site, but they also have an inherent and well-planned mutual dependency. It is important to focus only on information at trust level, and we can provide that. We have details of, and can answer questions on, the incidence of adverse incidents across the six trusts, if you include the Ambulance Service as a regional organisation. We can talk about that.

41. It is important to recognise that there are also important differences in context and the mix of services that are provided. By no means all, but many of the regional specialities are provided in the Belfast Trust. Those are often higher risk. It is important to recognise that if a hospital is providing higher-risk services, there might be a larger incidence of adverse incidents. That does not mean that the standard of care is lower. On the contrary, it might well be evidence that the standard of care is higher because that is where the specialist staff are available to take on the more difficult, more serious cases.

42. So, it is very important to look at this in context. However, I accept entirely that there is great local interest. It is important that there is confidence throughout the community that all services are as safe as they can be. I am very clear from all my dealings with the trusts that they accept the statutory obligation to provide safe services and that where there is a risk to that, we hear about it and act on it.

43. **The Deputy Chairperson**: Dr McCormick, I could not agree more. Indeed, you have encouraged me to ask a question that is not in the script. You will be aware that, recently, one man died in the A&E department of one of the Belfast hospitals. When a so-called independent team was set up to inquire into that, it was made up of members of the other trusts. Is that something that you would want to look at in the future when trying to rebuild confidence among members of the public?

44. **Dr McCormick**: It is very important for confidence that every part of the service is subject to scrutiny and accountability that is open and transparent. Good practice says that it is very important that an investigation of something that has gone wrong involves peers in Northern Ireland or, in more complex cases, experts from outside this jurisdiction. That shows a clear attitude among the leadership teams that people are in this business to learn from what goes wrong, identify the learning points and apply those conscientiously and systematically. I agree entirely with you that there should be that independent scrutiny.

45. **The Deputy Chairperson**: That is very important for the record. We appreciate your honesty on that.

46. **Mr Clarke**: Thanks for your indulgence again, Deputy Chairperson. In response to one of your earlier points, Dr McCormick, a bit like the Comptroller and Auditor General last week, was fairly defensive of the Belfast Trust, given it is accepted that it deals with more complex cases.

47. Dr McCormick, what information did you provide to the Audit Office on the level of these cases and the nature of the complaints? It is easy to lift this report and suggest that the Belfast Trust looks the worst. It is easy to make a defence that they deal with the most complex cases. However, there is nothing in here to convince me that these may not have been routine operations or procedures. There is nothing here to convince me that we are talking about complex cases. What information did you offer the Audit Office in relation to the nature of the cases that are referred to in the report?

48. **Dr McCormick**: That is an inherently complex point. I am very willing to engage further if there is further information that we can provide. We sought to bring to the Audit Office, as part of its development of the report, the relevant and available information. There is plenty of detail available on each of the individual cases. There is a record

in relation to each SAI, for example. Going through those exhaustively and undertaking an analytical scrutiny of the context in which they arose is at the heart of your point, and it is a very important point. Is more going wrong in complex areas of work, or are there too many things going wrong in relatively straightforward and routine contexts? We do need to get to that.

49. **Mr Clarke**: I appreciate that the Audit Office can work on the information only in numbers but not in detail. If you are taking this seriously, as you said you were in your opening remarks, you are bound to appreciate how difficult it is for us to accept this, even with respect to your answer, as did the Audit Office last week, when it suggested — possibly in your defence — that the Belfast Trust deals with the complex cases. However, there is nothing here that is evidence of that.

50. We listened to the media last week — thankfully it was not in Northern Ireland — and heard about a practitioner who was involved in many cases. If there are numbers of opportunities to do something when there have been complaints against an individual or individuals, something should be done. We should not just rest on the fact that they are working in a complex area or on complex cases, and that that is acceptable. To my mind, it is not acceptable. We saw evidence last week in the media, when someone was disciplined on the mainland.

51. I think that we need to have more drilling down on the figures. We see 35% in the Belfast Trust, but that is all it is telling us. It does not actually tell us what areas are involved. Indeed, reading the report regarding any of the trust areas, it does not tell me whether there are repeat cases or whether the same individuals are involved, and it does not tell me whether there is a pattern. I think we need to get more information in order to drill down into this in further detail.

52. **Dr McCormick**: I am happy to engage in that. It is a very important line of thinking. What I can point to is that we are seeking to learn from each case, and that many cases lead to particular follow-up by way of learning letters. An overview is then taken by the HSC Board, which is the manager of the SAI process. It looks for common themes coming out of the series of incidents that it is looking at.

53. We have details of the learning communications that have been issued in relation to safety and quality, which I can provide to the Committee. Several times a year, messages are sent out as issues arise, either within this jurisdiction or elsewhere, when something needs to be communicated. It is hard to use statistics to generalise.

54. The most important thing is to understand what has happened on a case-by-case basis, what underlay that, and, where we can, take corrective attention and draw it to the attention of those working in the particular field affected. Some themes are very general. For example, we have intervened in relation to how to assess a patient who might be deteriorating. If someone is deteriorating, and that is not noticed quickly enough, intervention might not be made in time to save them. We have had a number of cases of that nature in the past. So, we have early warning systems and systematic ways in which vital signs are monitored to ensure that intervention happens in time. Those are ways of learning lessons, and that draws out the point.

55. **Mr Clarke**: The only difficulty I have is that although that is a good sound bite as regards what you are trying to do, statistics — and statistics are all that we have here — show that over the past number of years, there has been no evidence of improvement. Although the sound bite concerns what you want to do to improve the service, the statistics do not back up what you are saying. I stand to be convinced about what your Department is doing to improve things because, statistically, there is no improvement.

56. **Dr McCormick**: Indeed. I have to acknowledge that. We have not yet touched on the level of reporting, although I am sure the point is coming. Several variables affect the total number of incidents reported. There is the actual level of harm happening and then there is the propensity to report, which varies. We know that this is a cause for concern and we cannot be complacent about it. We have to encourage a context in which every member of staff, families and individuals can feel free to challenge. That has to be the culture. In that context, some rise in the number of incidents could include some improvement in reporting, which would be a good thing. It is possible that we could have a steady or improving level of actual patient safety but with more incidents coming through. I am speaking hypothetically. I am not saying that that is the case. Our focus has to be on prevention. Once an incident has happened, it is vital to learn from it. The really important thing to do is maximise prevention.

57. **Mr Clarke**: The danger with that is that we have all been involved with the district policing partnerships, and we know how incidents are reported. In the past, when we saw a rise in crime, the police told us that it was due to more people reporting crimes. I am afraid of coming back here in a couple of years time and the health trusts saying that the reason there has been an increase is because they made it easier for people to report the problems. That is not drilling down to find the root of the problems. From sitting on the district policing partnerships, we all know that when there is a spike in crime the standard response from the senior civil servants involved is that it is because more people are reporting crimes.

58. **Dr McCormick**: I am not going to argue with that. It is a potential point; I will not make it more strongly.

59. **The Deputy Chairperson**: At this stage, I feel the need to remind myself, the witnesses and members of my opening remarks. We have to be succinct. It is a long report, and we have to get through it in reasonable time.

60. Moving on conveniently, the Audit Office approached the Royal College of Nursing (RCN) about its views. That was very important, because all of us agree that nursing staff are the backbone of any hospital or institution and that their views are very important. Turning to paragraph 3.14 of the report, I was shocked at the response from the RCN. The report states:

"While it assured us that Northern Ireland nurses are fully aware of their professional responsibility to raise concerns about patient safety and standards of care, it told us that, in its view, there remains a certain level of reluctance about raising concerns among nursing staff."

61. This is very serious, coming as it does from a prestigious organisation, the RCN. How do you intend to address that, Dr McCormick?

62. **Dr McCormick**: I share the concern about those remarks and I recognise that they are very serious. We will do all that is possible to promote a culture in which every individual feels free to raise concerns, and is protected and supported. Clinical governance is all about empowering every individual to speak up, challenge and share in the responsibility for patient safety. The Minister issued a circular to all staff throughout the health and social care system earlier this year. The substance of the letter was about whistle-blowing, but the first section said that whistle-blowing should not be necessary if the leadership in every organisation creates and promotes a culture in which everyone can challenge everyone else.

63. I react with considerable concern to what has been reported. It is important to emphasise the professional responsibility that everyone has to act in a way that promotes patient safety. I undertake to continue to convey the message to my chief executive colleagues that that has to be the culture that we promote.

64. **The Deputy Chairperson**: Dr McCormick, I am glad that you mentioned the word "culture" because there is a culture that does not encourage such behaviour. The general public and those who use the health service will judge you by your actions. Have you met representatives of the RCN?

65. **Dr McCormick**: I meet them regularly. I have not had —

66. **The Deputy Chairperson**: I am sorry, my question was very specific. Have you met representatives of the RCN in relation to the reluctance of their staff to assist you in identifying the serious problems in the health service, namely the 83,000 adverse incidents that we talked about earlier?

67. **Dr McCormick**: I have not had that specific meeting but I will do so. My colleagues in the Department have discussed the issue with RCN representatives. I need to follow through on that and I undertake to do so.

68. **The Deputy Chairperson**: Appendix 2 of the report provides a summary of the action taken by the Department on the recommendations in its 2002 report. The fourth recommendation refers to the need to be proactive to reduce the projected future costs of negligence cases. The Department responded by advising HSC bodies that patients affected by an adverse incident are less likely to sue when they are provided with an expression of sympathy and a full and factual explanation and, if appropriate, offered early corrective treatment. That is, in fact, good practice globally. Dr McCormick, did the Department follow up with the HSC bodies to establish whether the policy had been adopted?

69. **Dr McCormick**: We have regular engagement with the service on that. We probably need to do further follow-up as a result of this hearing to ensure that further evidence is produced of fulfilment of the undertakings given by the Department to the Committee and, in turn, by the trusts to us. They have responded acknowledging that it is the right thing to do, but we recognise and understand that further assurance is required regularly. It is not sufficient for this to be a one-off exercise following 2002. It has to be regular and consistent on a daily basis to pursue that point.

70. **The Deputy Chairperson**: Which HSC bodies did not adopt the policy?

71. **Dr McCormick**: I am not aware of any of them not adopting the policy as such. Undoubtedly, there will be some variation in performance against it and the extent to which it has been fully delivered, but I need to pursue that further and secure some further evidence for you on that point.

72. **The Deputy Chairperson**: We may return to that. No doubt, members will be aware from their constituency work of individual cases in which the standards of care have not lived up to what was expected.

73. **I repeat what I said earlier**: I ask members to keep their supplementary questions brief and clear. I will be keeping an eye on the time today, and I want everyone to remain focused. I have no doubt that they will. The first member is Paul Girvan.

74. **Mr Girvan**: I will let Mr Anderson ask his question.

75. **Mr Anderson**: I thank my colleague for allowing me to ask my question at this stage as I have another meeting to attend. Thank you for coming along. There are many very important issues, and some of them have been drawn out and debated in the initial questioning. My colleague Trevor touched on reporting. In paragraph 3.10, attention is drawn to the low level of adverse incidents reported in the acute sector. However, paragraph 4.5 states that 60% of complaints each year relate to the acute sector, most of which concern poor quality of care or treatment, staff attitude or the quality of communication. Typically, what redress is offered to a patient or client whose complaint is upheld?

76. **Dr McCormick**: There is a very clear procedure for handling complaints, and as the Venn diagram in the report draws out, not every complaint turns into a claim for compensation. The approach that we have taken in revising the complaints procedure over the past few years is to promote the maximum effort by each organisation to engage with the person who feels aggrieved and feels that they have not been provided with the appropriate standard of care at an early stage, to offer discussion, explanation and, where appropriate, an apology and to do those things straightforwardly and easily at local level. There should not be any reluctance or defensiveness, and the system should be very human in facing up to the fact that people will be in distress for one reason or another. They should receive a compassionate and caring response. The complaints procedure talks about local resolution being the first and best way forward.

77. We then have, as a second stage, the availability of access to the ombudsman. The ombudsman takes us to task firmly and fairly on a range of issues and will, at times, require action to be taken, including some financial redress on his recommendation. That is certainly part and parcel of how things work, and it is entirely appropriate. It is also fully provided for in our complaints procedure. Should the person affected still feel that they have further issues to pursue, they are not precluded from taking forward a claim for compensation through the courts. We want those procedures to be applied fairly and humanely, with genuine humanity and compassion throughout the process. That is vital, because we recognise that the system can appear intimidating. It is an enormous and complex system, and it can be forbiddingly technical. So it is very important that it is reduced to a straightforward engagement at a human level.

78. **Mr Anderson**: You kept saying "should" throughout your answer. I think that it should be "must". I do not know whether that is the case, so perhaps you can tell us.

79. **Dr McCormick**: It is what is expected. It is the only right thing that can be done. I regularly meet the chief executive of the Patient and Client Council (PCC) and the chief executive of the RQIA and I listen to what they are saying, because their job is to understand what is going in the system and bring to light what should be and must be applied that is not being applied.

80. If there is a consistent pattern of complaints or evidence emerging from inspections or reviews undertaken by the RQIA, I need to understand that and speak, as appropriate, to the chief executives of the organisations, be they the trusts or whoever else, and say, "I am hearing that things are not going as they should. That needs to change." We have regular accountability discussions with all the organisations that are accountable to the Department. That is routine, and we make sure that that agenda provides for any appropriate or necessary challenge to the patient experience and the quality and standard of care. I accept what you say: these things must be applied. If there is a departure from the acceptable standard, we need to draw together the evidence and intervene and act on that. That is part of our responsibility, and it is what we do.

81. **Mr Anderson**: So why are there 60%? Do you agree that the standards are not being applied, given the high level of 60% in acute cases?

82. **Dr McCormick**: It is understandable that acute services have a higher incidence of complex and risky activities and there is, therefore, more risk of something going wrong. Also, there is the risk that, in the heat of that context, something inappropriate might be said or done. So I would not say that I am surprised that 60% of the complaints are in the acute sector. That is reasonably understandable. It means that we need to make sure that the attitudes and standards of care in that sector

are given particular and consistent attention.

83. **Mr Anderson**: That being so, if 60% is understandable, what percentage do you think is — for want of a better word — acceptable? We are trying to get to zero, but what, to your mind, is acceptable?

84. **Dr McCormick**: I think that the objective is to get to a place in which the number of complaints, in absolute terms, is reduced. If the proportion from the acute sector were lower, that would imply that the proportion from some other sector was increasing, which would be no more acceptable. What we have to focus on is seeking to improve the standard of care that is being provided and reduce the risk or probability of something happening that gives rise to a complaint. So, we have to bear down on the issues. Therefore, the focus of our attention is on raising standards, promoting good practice and sharing evidence of how to do things effectively in order to ensure that time is available for the kind of explanation that helps people to have confidence that they are receiving the best possible care. So, there is a range of things that we can do. However, it is difficult to get at that percentage, to be honest.

85. **Mr Anderson**: What is that range of things?

86. **Dr McCormick**: It is promoting the application of good professional standards, ensuring that people are trained regularly in both the specifics of their clinical responsibilities and with regard to patient experience, and every other aspect of care. So, promoting good practice is the best thing that we can do in this context.

87. **Mr Anderson**: The Chair referred to something 10 years ago, before my time, which, probably, has not been acted upon. So, we are still looking for action in many areas and on many points in order to make inroads into this matter and reduce the number of complaints.

88. **Dr McCormick**: We always will be. In a service provided by 60,000 to 70,000 individuals, there is a continual turnover of staff. We know the right message to get across and the right leadership to apply. However, it has to be applied continuously. Realistically, we can never expect to reach the stage where the problem is solved. It requires continuous attention, refreshing of training and drawing out of new good practice as it emerges.

89. **Mr Anderson**: Are we getting that? Are we doing that?

90. **Dr McCormick**: Sorry: an immense effort goes into that. Generally, a very high standard of service is being provided. We are looking at a number of complaints and adverse incidents. Those are to be regretted. We are not at all complacent about the fact that they happen. To eliminate them completely would be unrealistic because there is an element of human error that arises. We have to simply ensure that there is consistent and steady leadership, so that —

91. **Mr Anderson**: So, how long has that been going on? You say that it is continuous. Has that procedure been continuous since 10, five or two years ago or is it beginning now?

92. **Dr McCormick**: The general effort to provide a high standard of care has been inherent in the health service since its inception. Part of what is happening is that there is more systematic awareness of the issues and, therefore, more responsibility on us as a leadership team to apply and promote good practice. Many features of that would have come to light in the past 10 years. There is no doubt that, in the next 10 years, there will be further things that could and should be done. We will have to pursue that. That will be an ongoing responsibility. I do not think that we can expect it ever to be solved completely unless we could have care provided by perfect people.

93. **Mr Anderson**: It could get a lot better.

94. **Dr McCormick**: Yes. I agree. That is our aspiration and determination.

95. **The Deputy Chairperson**: I will bring in Trevor Clarke in a second. Sydney Anderson, it is interesting that you said that it was before your time. It was not before my time, sadly.

96. Dr McCormick, we have heard all of this before. We have had all the promises before. Is there a monitoring system in place that quickly identifies where the clusters of complaints come from? What kind of early action can you promise the Committee that you will take to ensure that we do not have 83,000 complaints in 10 years' time, when I certainly will not be here? I think that anyone who listens to this today will be looking for answers. We have had the standard-issue promises. We get them from other accounting officers as well. The Health Department has been here before, 10 years ago. You had your own report in 2006. Really, you have failed. Today, you need to put on record what has changed because the media has not been good to you in the past year. There have been too many front-page stories, and we really need to know what system is in place to identify the problem hospitals and institutions and what action you can take to stop this immediately and not when the next Audit Office report comes out.

97. **Dr McCormick**: The things that are happening continuously include the clear monitoring of complaints and adverse incidents in each trust. So, there is a significant role for the board and the non-executive directors. Most trusts have a committee, which is chaired by a non-executive director, and which draws together information, challenges the leadership team in the organisation and asks why certain things are happening. The committee will have information along the lines you are describing; that is, where the clusters and patterns are. Individuals in each organisation are responsible for drawing that information together, understanding it and interpreting it. So, that is the first line of defence. The first responsibility has to be within each organisation, and they are accountable to me in fulfilling that responsibility.

98. The second line of defence is through the PCC, which is an individual organisation responsible, as the name suggests, for assisting patients and clients. If they are not getting satisfaction from a trust or a provider organisation, they can seek and receive assistance. Part of that facilitates the joining together of information by the PCC about the pattern of complaints or things that are causing problems or are going wrong. The PCC has direct access to the Department, which is why I meet its chief executive regularly to hear and understand what is going on. I can then use my authority, which comes from you, of course, as I am accountable to you. Therefore, I am accountable to you, and they are accountable to me: that is how it works. As I am vulnerable to criticism and challenge from you, I then say to the trusts, as accountable officer, that they must answer to me to secure improvement.

99. We have a process of accountability that is being developed and refined continuously to make sure that we are delivering. However, I am not going to promise that I can eliminate adverse incidents. That would be an unfair and unrealistic promise to make. What I can promise is that we will do everything in our power to promote patient safety, good practice, and improvement.

100. However, it needs to be accepted and recognised that there is inherent risk: medicine is risky. The only way to reduce the number of incidents of this nature is to stop intervening and let people die of their conditions. If someone dies without medical intervention, it would not be deemed to be an adverse incident, but it would be a very wrong thing to happen. We have a responsibility to intervene and to take risks. I recognise that we have a challenge in the context of the media reporting what we do, but I have no complaint about that. We need to make sure that there is support for people in the clinical teams who say to themselves, "If I do this, I am taking a risk and it might go wrong, but I am going to do it." We need people who are prepared to do that. I was talking

to a team this morning, and they know that in one in 100 cases, one of their patients will die. However, I need them to keep doing what they are doing, because we need the 99 other patients to do better than they would otherwise. That is a risk that society has to live with. There will always be adverse incidents; there will always be serious adverse incidents, and there will always be avoidable deaths. It would be wrong of me to promise otherwise.

101. **The Deputy Chairperson**: You referred to the media. In recent times, we have learned that even the media cannot escape responsibility, which we have seen in the case of the BBC. People are asking at what stage those in the health service will take responsibility. When will the heads roll when things systematically fail?

102. **Dr McCormick**: As you say, it would be if and when things systematically fail. It is clear that if there is a pattern in which the same thing goes wrong time and again, that would require a more serious level of intervention and accountability, and there are clear responses to that.

103. **Mr Clarke**: This is probably a good time for me to come in. You have left me a nice opening. In response to what you said, Dr McCormick, about us holding you to account, I am actually the new boy here — I am the youngest. We talked about a couple of dinosaurs a few minutes ago.

104. **The Deputy Chairperson**: Youngest?

105. **Mr Clarke**: I am the youngest here, and probably have the least experience, but when I read about you, I found out that you have been in post for seven years. I think I have a job to do to hold you to account, and I think that, in seven years, you have failed. To my colleague, you used the words "defensive" and "intimidating", and the phrase "show compassion". During the five years I have been in this job, I have had many people coming in — and I am sure that my colleagues have had individuals coming in — referring to complaints about the health trusts. I suggest that every word you have used is continuing practice. I have always found the Department to be "defensive". I have seldom seen it "show compassion", but it is certainly "intimidating". Those were your words, and I think they were well chosen. I accept that there can be human error.

106. As regards the length of time that you have been in post, I would like to be back here in the future, but I would not like to be back with you sitting there and with no change made. If it has taken you seven years, and we are reading the report that the Audit Office has for us today, dear help us.

107. **Dr McCormick**: I am convinced that many things are safer now than they were seven years ago. Many things are being done that could not have been done seven years ago because medical science has advanced. I think that the statistic that is invisible is the improving benefit of the interventions throughout the health and social care system. To me, that vastly outweighs the level of harm. There is a level of harm that is inherently unavoidable, because we provide services through human beings. We can show a series of interventions on —

108. **Mr Clarke**: I think that that point is acceptable, but there are cases when it is not. To go back to your use of the word "defensive"; in many cases, if the Department put its hand up and said that it made a mistake, that would prevent complaints, but you continue to defend your position right up until the matter goes to court, which does not convince me that this is not leading to statistics increasing, and it will not correct the mistakes that have been made. We all accept that there is human error, but there is no excuse for defending something over a period of years, getting to court and then settling, with an admission that you were wrong. There is a culture of defensiveness in your Department, which has to change. There has to be an acceptance that you can make mistakes and you have to be more upfront in that acceptance to the

general public. Then, I do not think we would be talking about 83,000 cases.

109. **Dr McCormick**: I accept and agree entirely that the right approach we should be taking is to be open and transparent, to be responsive and to engage in a way that says that something has happened here, it should not have happened, we want to acknowledge mistakes and apologise upfront. That is there.

110. In preparation for this hearing, I have seen internal documents in one of the trusts that say exactly that. It is not always easy to promote the application of that behaviour throughout a big system, and I acknowledge that there have been strong degrees of defensiveness in the past, including up to the present. We need to continually work at that.

111. My undertaking to the Committee is that my message to the service is that it should be open, transparent, responsive and human. I have been seeking to do that over the past number of years. That is the consistent approach taken by the chief executive group that I lead. We have more to do. I recognise and accept that, but I am determined to go forward and continue to do it.

112. **The Deputy Chairperson**: Can we go back briefly to Sydney Anderson? Apologies. We all make mistakes. I forgot that you were asking the questions, Sydney.

113. **Mr Anderson**: This is an area in which many questions can be asked and should be asked. Paragraph 4.7 refers to patients' fear of reprisal if they complain, which is similar to the views expressed by some health and social care workers about reporting errors. We have heard many things here today about clinical governance, best possible patient care, minimising risk in a culture of making services as safe as can be achieved. We have had all the fancy words and phrases. However, the situation is not good when you have patients and staff in fear of making a complaint. How will you persuade individuals that health and social care organisations see complaints not as something to run away from but an opportunity to learn from?

114. **Dr McCormick**: The scenario that you described is totally unacceptable to me. Having a situation in which a patient or member of staff is afraid to speak up or to complain can never be tolerated and must be rooted out. I am convinced that no chief executive in Northern Ireland would tolerate such an attitude. We need to continue to reinforce that message persistently and to point to and publicise the fact that there is a complaints procedure that is designed to open the access door to trust management and, if needs be, to the ombudsman. There must be a welcoming and positive response throughout the culture of the organisations. I am happy to use your expressions of concern in this hearing to take that message to some speaking opportunities at health service management conferences next week, and I undertake to speak out. This issue matters immensely in ensuring that we learn from things that go wrong rather than suppress or oppose, which are completely wrong and unacceptable responses.

115. **Ms Thompson**: The report points out that the regional board reviewed the complaints process, and one of its recommendations was about how to deal with cultural issues across the service and, equally, how to increase user satisfaction. Those recommendations that have come through will need to be implemented, and it is planned to do so as we move forward. So, the two issues that you drew out were picked up as part of that regional learning on the complaints process and are to be improved on as we look forward.

116. **Mr Anderson**: I will be brief, Chair, because I know that there is a lot of work to be done here today. Would you say that the situation is improving? It was, or may still be, that management did, or does, not always listen to staff. If there was a fear culture; why? If there was a fear culture, it must have been

triggered by something that may go back to management. Is there a fear of reprisals? Was or is there something going on? Do you agree that such a culture was there and may still be there in places?

117. **Dr McCormick**: I detect the features of it. At times, organisations can tend to regard reputational damage as a bad thing. Part of our consistent engagement with the trusts at present is to say that the interest of the patient, the safety of the service provided and the patient's experience and human interaction come first and foremost, and well ahead of an organisation's reputation. Somebody can get very good care but have a bad experience, and we need to fix and sort out both aspects. I think that there is a commitment across the leadership team to achieve that.

118. However, at times, there has been a view that organisational reputation is important, which is unsurprising in that we create, and give responsibilities to, organisations that, at some time and on some level, inherently compete with one another. They want to be seen as being the best, and, therefore, bad news or negative stories can take away from that. So, there is a human element there, but the message from me to them has to be, and is, that it is the patient first. Nobody is reluctant to take that message on board. The leadership teams get that point.

119. **Mr Anderson**: The clear message going out from here today is that the culture needs to change. It is good to hear from Julie that in a few weeks' time, you will speak at a conference. So, the message must go out that things need to change.

120. **The Deputy Chairperson**: We are an hour into the meeting, and only one member has asked questions. I will move on to Mitchel McLaughlin, but before that Sean Rogers and Michael Copeland have supplementary questions to ask. I ask you to be brief.

121. **Mr Rogers**: In response to what the Deputy Chair said earlier, you said that there was clear monitoring of adverse incidents. However, looking at the report, a wide category of adverse incidents are not collected or analysed. There is a conflict between what you are saying and what is in the report.

122. **Dr McCormick**: We have an established and systematic approach to serious adverse incidents. They are compiled, handled and managed, and there is then appropriate follow-up to lessons learned at that level. Also, each organisation will look at the full range of adverse incidents and draw information together. That way of doing things is broadly in line with the practice in other parts of the UK. So, we are not out of line in that approach to handling the issue.

123. We have the plan to develop and introduce the regional adverse incident learning (RAIL) system to provide a more comprehensive regional and systematic drawing together of all kinds of adverse incidents. That is on track, it is planned and it is being worked through. That will complete the process of information handling in the best possible way.

124. **Mr Rogers**: You mention RAIL, which came out of recommendation 5 in the 2002 report. That was to facilitate improved learning and sharing of lessons for all adverse incidents, including near misses. Granted, it was for criminal negligence, but, like my colleagues across the table, I question the promise you are making now, because in 2002, an action was recommended, yet 10 years later we are still talking about it.

125. **Dr McCormick**: The direct follow-up to the 2002 report included the creation and implementation of the system to deal with serious adverse incidents. That way of doing things began in July 2004, so there was a period of scrutiny and consideration of how to do it, but there was direct action following the 2002 report. That was a very important step. As I said, our practice is broadly in line with that in other parts of the UK, so we are not behind the game in that sense.

126. When the RAIL system is introduced, we will have a smoother and more systematic handling of that information than anywhere else. So, at that stage, we will be better off. There was definitely an effective response when it came to drawing together information directly on the issue of clinical negligence, which is where the report and hearing in 2002 focused. However, we have undertaken systematic work to develop and apply handling and learning from serious adverse incidents. That system came into being in July 2004.

127. **Mr Rogers**: The 2002 report talks about all adverse incidents, including near misses. We still do not have a situation in which information on all adverse incidents is collected or analysed. I am looking at the bottom of page 47 of the report.

128. **Dr McCormick**: As regards the summary of the recommendation, mechanisms have been introduced to facilitate learning and the sharing of lessons learned. The term used in 2002 was, "adverse clinical incidents". The definition of "serious adverse incidents" was only introduced in our response of July 2004. So, we did make a genuine response.

129. I acknowledge that we had hoped that the RAIL system would have moved more quickly. We had certainly set in train the action to introduce it from around 2010. It is on track to come into being and to provide the full and complete response. We also have a genuine ability in each organisation to draw together the information from all incidents, including near misses.

130. **Dr Paddy Woods (Department of Health, Social Services and Public Safety)**: It is fair to say that there has been an incremental exercise, arising from 2002, mainly focused on clinical negligence cases. Some, all, or a limited number of them may result from serious adverse incidents. With the RAIL project, we will go beyond serious adverse incidents and include all adverse incidents, which will take us beyond arrangements in any other jurisdiction in the developed world. The preparation for that has been quite extensive, because we are breaking new ground.

131. As well as that, there were attempts in the mid-2000s to link up with the National Patient Safety Agency's (NPSA) national reporting and learning system, which ultimately proved fruitless and introduced delay. At that time, it was felt that that might be the optimal way of dealing with the problem.

132. **The Deputy Chairperson**: I have misled members. The supplementary questions were only supposed to relate to the issues arising from Sydney Anderson's questions. You will get your turn to ask your own questions.

133. **Mr Rogers**: My question was a direct result of the response to the question about the closer monitoring of adverse incidents.

134. **The Deputy Chairperson**: I accept that.

135. **Mr Copeland**: To the best of my memory, my supplementary question relates to Sydney's questions. You will probably want to reply to this in writing because it is a bit convoluted. You said that the processes that you are employing are "under continual improvement and review", which I accept. However, as the Deputy Chairperson said, the process goes back over 10 years. Would it be possible to get a chronology of the process of continual improvement and review so that we can assess how it is relevant to where we are now? There seem to be some quite serious questions around this issue. We are charged with asking those questions, but it is not fair to ask you to give that information off the top of your head, so I am quite happy to take a reply in writing, if that is satisfactory.

136. **Dr McCormick**: I am happy to do that, and I can give a brief summary of some of the main points, which we will develop more fully in writing.

137. Best Practice, Best Care was in 2002. In 2003, there was a major piece of legislation taken through the Health and Personal Social Services (Quality,

Improvement and Regulation) (Northern Ireland) Order 2003, which led to the creation of the RQIA as a statutory regulator and included a statutory duty of quality. So, entrenched in legislation is the obligation on every organisation to provide quality services; and, believe me, chief executives take that obligation very seriously.

138. The reporting system for SAIs came in 2004, Safety First was in 2006, as were the quality standards. In 2006, we developed links with various UK-wide organisations, including NPSA. We had the creation of the HSC safety forum in 2007. The further piece of legislation that took forward the RPA further entrenched the obligations on the promotion of health and well-being. We revised the complaints procedure in 2009. The initiation of the RAIL process kicked-off in 2010, and we had a quality strategy in 2011.

139. So, almost every year, there has been some specific initiative designed to improve the system and secure a focus and attention on patient safety. We can elaborate on that in writing.

140. **The Deputy Chairperson**: For the record, I accept that Sean Rogers' question did relate to that of Sydney Anderson.

141. **Mr Mitchel McLaughlin**: Good afternoon. It has almost been like waiting for an appointment to see —

142. **Dr McCormick**: Oh dear.

143. **Mr Mitchel McLaughlin**: Turning to paragraphs 1.11 and 1.12 of the report, they are very interesting in that they discuss 'Safety First: A Framework for Sustainable Improvement in the HPSS'. They set out how we can create an informed safety culture in our hospitals and identify four main components. I will not read out the paragraphs — I am sure you have read them — but the four main components of an informed safety culture they identify are a reporting culture, a just culture, a flexible culture and a learning culture.

144. The paragraphs go on to discuss separating the actions of individuals involved in adverse incidents by examining the systems approach and recognising that there might be a chain of events that leads to particular circumstances. As far as it goes, that seems to be a fair approach, expect that does not really discuss the role, if any, of the clients or patients. Do you accept that this approach, as described, is inward looking?

145. **Dr McCormick**: I take the point. Part of what we have focused on more recently is the recognition that engagement with individuals is a vital part of how we go forward. Our 2009 legislation and our further interventions since then have emphasised the responsibility of organisations to secure patient and public involvement. They need to have schemes that provide for engagement, consultation and an open and transparent context of working. It is a point that we accept and recognise —

146. **Mr Mitchel McLaughlin**: We are describing a seamless regional approach across all trust areas. They all take the same approach. When an adverse incident is reported, are clients or patients notified automatically? Is it possible that a patient or client could be involved in an adverse incident and never know?

147. **Dr Woods**: By definition, it is possible. It is certainly the case that in serious adverse incidents, there is a requirement to undertake a root-cause analysis of what gave rise to the incident. Intrinsic to that is the involvement of patients and their carers. That is a critical perspective in determining what happened and the course of events from all the perspectives relevant to the incident.

148. **Mr Mitchel McLaughlin**: That is quite interesting. It seems to indicate that there is a very conscious policy in other circumstances not to tell patients. Is that what you just told us?

149. **Dr McCormick**: No.

150. **Dr Woods**: No. I am saying that it is very conscious. First, there is a requirement

to undertake a root-cause analysis when there is a serious adverse incident, and —

151. **Mr Mitchel McLaughlin**: Yes, the informing and involvement of patients and clients in an investigation into a serious adverse incident is de rigueur. That seems to make it clear that a distinction is made, and as a matter of conscious policy, you would not always automatically inform patients or clients who were involved in an adverse incident that is not regarded as a serious adverse incident. In those cases, it seems that the policy is that it is not necessary to inform patients or clients. Who makes that judgement call?

152. **Dr McCormick**: The attitude and responsibility has to be to engage with patients. The reason why the answer is not black and white is because the range of things that are classified as adverse incidents is very wide. It includes aspects that would affect individuals, but it could also include aspects of the management and organisation of the trust, and so on. It may not be essential to communicate with patients in each and every case. It depends on the context and effect of what has happened, and something could happen that would not have any major consequence for an individual.

153. I think that it is fair enough to look at this in a sensible way. However, if there is any doubt or there could be any effect on an individual, the attitude and the culture has to be that there should be communication with patients as a matter of principle.

154. The 83,000 incidents are very diverse. There may be some evidence from internal trust documentation that shows the kind of message that is given by trusts to their staff on how to do those things. Julie may have that to hand.

155. **Ms Thompson**: That is picked up in our guidance to trusts, particularly on how they should deal with apologies and explanations. It advises that each trust should consider how and when to express sympathy, and if things go wrong, that they should provide as full and as factual an explanation as possible. That goes alongside looking at the correct treatments. It is then picked up in individual trust policies and is recommended and endorsed to staff that they should carry that through. The guidance is not prescriptive about the standard, style or level of an incident. It is a wide-ranging response to deal with patients and users appropriately.

156. **Mr Mitchel McLaughlin**: Thank you for that. Dr McCormick, you did not address the question of who makes the judgement call. I am trying to understand — I do not understand — the difference between a serious adverse incident and an adverse incident. Is there a written code or specification?

157. **Dr McCormick**: Yes.

158. **Mr Mitchel McLaughlin**: In this fair and just culture we are talking about, you are trying to encourage staff to report issues that go wrong so that you can learn lessons and address the level of incidents that occur.

159. Paragraph 1.12 describes the circumstances in which disciplinary action could follow. Clearly, that would be a disincentive for staff to report incidents. You have a policy that, as far as it goes, seems to be an acceptable approach, but I am concerned that if there are obvious shortcomings in it, why those have not been recognised and picked up. A patient could be involved in an adverse incident, and someone else will decide whether it is a serious adverse incident and whether the patient will be informed if they were unaware of it. That does not seem to follow through on the principles that underlie the Safety First policy.

160. **Dr McCormick**: I understand what you are saying. When a patient has been affected by something like that, the principle should be to inform as the norm. In many cases, patients will be very well aware of the incident, but if they are not aware that something nearly went wrong that might have hurt them, an open and transparent culture would mean sharing that with them. In many

cases, and if there were no serious impact, it may just involve telling them that no harm was done.

161. The decision about what an adverse incident is as opposed to a serious adverse incident is a matter of frequent and live debate at senior level. However, clear criteria are used and we can share those with the Committee. There is a clear responsibility on each organisation to deal with those incidents transparently, and if there is a pattern of reluctance to record incidents in the proper way in an organisation, we will take action. We have a lot of reporting and scrutiny, and incidents will emerge. There is no point in anyone trying to hold back and not classify something that meets the criteria, because, thankfully, we have a context in which there is a lot of openness and scrutiny. Again, I acknowledge the positive benefit from whistle-blowing and from some media reporting. That can be beneficial, and it should ensure that nobody can say, "I will not report that as a serious adverse incident because I will get away with it and nobody will ever know". Thankfully, most times, people do know, and, specifically, we will take action against an organisation if a pattern of under-reporting emerges. We require organisations to be transparent, and that includes, as we have drawn out, the principle and obligation to be direct and frank with individuals. I am not saying that we are at a place where that is fully achieved, but our determination is that this is the right culture and the only culture that we will promote and tolerate.

162. **Mr Mitchel McLaughlin**: We will move on to paragraphs 1.16 and 1.17. They tell us that the actual scale of harm caused to patients and the true cost of that harm are unknown and talk about research in England that demonstrates that around 10% of patients treated are likely to suffer harm and that half of those incidents should have been avoidable. That rate of damage or harm would not be tolerated in the nuclear industry, and we are talking about the health service. If we cannot get the accurate data, and you tell me that there is a reporting culture and lots of information is gathered, how will we manage to deliver on the safety programme?

163. **Dr McCormick**: The correct response to that is to identify evidence-based understanding of scope to make improvement and to require organisations to apply evidence-based good practice. That is part of the general approach that we take to working with the organisations, and a lot of that comes from within them because the reason why doctors, nurses and the other professionals who work in the health service get up every morning is to provide a safe service. Many times, the ideas to promote safety come from them, and we need to make sure that evidence-based good practice is being applied.

164. I would focus on seeking to ensure a culture of service improvement, and that is why we follow, for example, the evidence that we obtained from the Institute for Healthcare Improvement in the US, which has a very good system to quickly identify where a change in practice can lead to saving lives. There was a 100,000 Lives campaign in the US. The leader of that was challenged, within his family, on the point that some improvement is not a number and soon is not a time, and the objective of securing actual numbers of lives saved within a number of years was undertaken. We seek to follow that pattern and ensure interventions that will actually save lives, such as reducing surgical site infections and dealing with ventilator-associated pneumonia. A range of evidence-based interventions will save lives, and the focus should be on that. Requiring organisations to apply evidence-based good practice is, to me, the right thing to do to bear down on the risk that is inherent in modern medicine.

165. **Mr Mitchel McLaughlin**: You will have read the report and maybe even the original research that demonstrated the level of casualty or adverse incident that could affect patients. The statistic of 10% prompts a question. If 10% of

people who get on an aeroplane get hurt, you would not get on a plane.

166. **Dr McCormick**: I am aware of the research from 2001. It was derived from two hospitals in the London area and based on a study of about 1,000 records over a period of about six months. So, it is quite a limited evidence base, and the authors of the paper acknowledged that there were real difficulties in extrapolating. I absolutely acknowledge that adverse incidents happening in the health service is a serious problem. In questioning the figure of one in 10, I am pointing out that it was from one context and at one time over 10 years ago. It is not the figure that is important but the recognition that there is a real issue that we have to address systematically and continuously. I do not advocate taking time to research exactly what is happening. I would rather research what we can do to improve patient safety and focus leadership attention and professional engagement on that, because that is how we make the best possible difference.

167. **Mr Mitchel McLaughlin**: Would you see no benefit in having a local or regional retrospective?

168. **Dr McCormick**: I question the value of it. There is lots of knowledge about how to make improvements. The problem is applying that knowledge systematically and achieving the change in culture on which I was challenged earlier. That is the difficult bit that it is well worth focusing our leadership energy on. Further research is likely to confirm that we have a problem. I am saying that we know that we have a problem, so I would rather not undertake research to confirm something that we are sure of already. I would rather focus on how to make improvement.

169. **Mr Mitchel McLaughlin**: On the next page, figure 2 shows us that the number of new clinical and social care negligence claims has increased in each of the past three years. What does that say about the priority given to safety?

170. **Dr McCormick**: It is important to see the clinical negligence numbers in figure 2 and throughout the report in the context of what has been happening. There is a fairly steady level of claims and significant expenditure in that area. However, as the report acknowledges, we have undertaken a lot of work to seek to accelerate the process. Good work has been done by the directorate of legal services to deal with old cases. Indeed, the number of old cases was challenged in an Assembly debate, and it is not right for justice to be delayed. That is wrong in principle. So, considerable effort has gone into bringing forward the rate of addressing claims in the courts. A significant number of those are listed to seek resolution in the courts well into next year. That led to higher expenditure this and last year and in recent years than would reflect the steady state. We are partly dealing with expenditure related to old cases because of the determined effort to clear old cases. That is an important point of context that the report fully acknowledges.

171. **Mr Mitchel McLaughlin**: Are you saying that that is the reason for the increase?

172. **Dr McCormick**: A significant part of the increase is down to clearing the backlog.

173. **Ms Thompson**: You are quite right to point out that the number of new cases is increasing each year. That trend is ongoing across the UK. For example, into 2011-12, we had a 4% increase in our new claims. England experienced a 6% increase and Wales, the previous year, a 10% increase in levels of new claims. The increase in the number of claims lodged is happening across the UK, and it goes back to the issues around the increasing complexity of what is happening in the health service and the work being performed. So, in the broader context, claims are increasing right across the UK on an ongoing basis and our level is slightly lower than those experienced across the rest of the UK.

174. **Mr Clarke**: Again, we have complacency from the Department. It is as if we should be giving it a gold star because

we are doing better than the rest of the UK and we have only a 4% increase in our claims. Honestly, I do not really care what is happening on the mainland; I am concerned with what is going on here in Northern Ireland. I think that it was a very complacent answer to suggest that we have only a 4% increase when others have 10%. That is not acceptable. I would rather you were telling us today that we had a 4% decrease. It is very defensive.

175. I also think that Dr McCormick's response to my colleague about why they did not want to drill down and did not think that there was any worth in doing so was a terrible indictment on your Department, because if you drill down into that, you might find out where some of the failings in your own Department are.

176. **Dr McCormick**: I think that we acknowledge the need to understand better where things are going wrong.

177. **Mr Clarke**: I do not think that you do appreciate that there is a need for an understanding because you said that the time would be better spent looking at ways of improving things as opposed to accepting that there has been wrongdoing in your Department. I am going back to when Mitchel asked the question initially. I do not think that Mitchel touched on the total cost of the claims; I think that he clearly stayed away from that. It was clearly the rise. However, you wanted to draw a parallel with the cost of the claims, which was fair enough. The total cases closed will bring rise to the overall cost. I think that you failed to answer the question, albeit Julie did not do any justification by trying to suggest that a 4% increase was very good in comparison with the mainland.

178. **Dr McCormick**: Sorry, I would not say that.

179. **Mr Clarke**: Well, that is how it came across.

180. **Dr McCormick**: If that is the case, I want to withdraw it.

181. **Mr Clarke**: We sit here today with 83,000 cases on the books, as it stands, and that is the attitude of the Department. You are drawing a comparison between yourselves and your counterparts in GB. You are suggesting that you are doing a good job, just because they have 10% and you have a 4% increase. I would say that you are doing a very bad job.

182. **Dr McCormick**: I am not claiming that; I do not want to claim that.

183. **The Deputy Chairperson**: For the sake of justice, I should give Dr McCormick one brief opportunity to clarify the position for Trevor Clarke and for anyone else.

184. **Dr McCormick**: We need to make sure that we are doing everything possible to bear down on claims. To me, the important thing to do is to promote patient safety and a culture in which people feel free to claim. It is possible that improving the culture could mean more claims. That would be an indictment in itself, but it would be a good thing to happen. We are also prepared to undertake any analysis that the Committee might recommend in relation to investigate why things are going wrong. We are entirely open to that. Ultimately, we are subject to your authority; we are accountable to you. We are offering our views in good faith, but we are subject to what you recommend. We are prepared to look at the balance between action to apply what we know will make a difference in improving patient safety and understanding root causes. Understanding root causes is vital. I think that we need to look at that very carefully and seriously.

185. **The Deputy Chairperson**: I call Mr Paul Girvan, who has shown remarkable patience.

186. **Mr Girvan**: Dr McCormick, thank you very much for coming along. I want to go back to the point that Mitchel raised about severe adverse incidents. Each and every one of us sitting round the table deals with constituents, day and daily. We hear about cases, some of which would make your hair stand on end. There are people who have no one to voice their complaint and, therefore,

no mechanism for bringing it forward. Some of those people may be senile, and many are buried. Sometimes, a case can be buried and never comes to light. Sometimes, the cases involving people who have passed away, due to something that went wrong, never come to light.

187. Of the 83,000 cases that are mentioned, how many are taken for inaction because nothing was done and the person never even got to hospital? By that, I mean that, in a number of cases, people never actually had treatment but were waiting to have treatment. I am talking about the likes of people who, perhaps, were on a waiting list for cardiac surgery but died. Some of the families have said that they died simply because they were kept on a waiting list and were delayed and became another one off the list. It is not that they were ever off the list, because the person, having passed away, is no longer a statistic. Are any of those included in the 83,000 complaints, or would some of those never have made it to the complaint list?

188. **Dr McCormick**: I will need to come back to you on the specific point that you have raised on the inclusion of non-events or things that should have happened. I follow and accept, clearly, the point that you are making. It is one reason why, from my point of view, ensuring timely access to service is a fundamental obligation. That is why our position on waiting times in a number of specialties is not defensible at present. Considerable effort is being made to improve, but we have to do better on access times. Thankfully, there is a clear clinical prioritisation so that waiting times for treatment to deal with life-threatening conditions is prioritised. We need to research on the point that you have made and come back. We need to make sure that, whatever about the fact at present, going forwards, there is a recognition that action that should have happened needs to be identified and recorded and be seen as part of our system, if it is not already. I need to check the facts on that.

189. **Mr Girvan**: Maybe you can respond to the Committee on that. Some of the patients have no voice, so no complaint would ever be lodged. I do not know whether it is because of the culture in it. Trevor talked about the need to hold the hands up and say that something went wrong and this is what happened. In a lot of the cases, some of the people who I spoke to said that all that they required was a sympathetic apology. Because they never got that, they hardened their position, so it went on and progressed to ending up in court. Instead of, in the early stages, hearing one sympathetic word from staff, they came up against what they deemed to be stonewalling in a system that was designed to restrict them from hearing what happened to their relative or their loved one. As a result, they decided that they were not going to let it drop and pursued the issue. That has added to the workload that you as a Department have had as well as probably lining the coffers of many expensive lawyers in the legal system in Northern Ireland.

190. **Dr McCormick**: I accept the point that you make entirely.

191. **Mr Girvan**: That leads me on to my main question. Paragraph 2.4 refers to the tracking process. The final bullet point in that paragraph refers to the systems that have been established by the trusts to track progress and action taken in response to patient safety alerts. Based on the information from those systems, how effective are the trusts at complying with safety alerts? What steps have been taken to validate the systems? What sanctions are placed on trusts where they fail to comply with safety alerts in the implementation of good practice? I appreciate that that is quite a convoluted series of questions, but there are very clear examples. The pseudomonas outbreak that we had in early 2012 had already been identified in Altnagelvin. I do not know what was going on — perhaps someone was living in a silo. Because they did not want to make this publicly aware, it was kept there. We had another outbreak in a Belfast Trust hospital, and, as

a result, the pair were not linked up. There seems to be a definite culture of trying to suppress what had been identified as a problem. We could maybe — I do not say definitely — have saved lives because of an intervention on something that had happened in another trust area where a problem and what had caused it had been identified. So, by taking on board some of the recommendations of that, they could have probably implemented changes throughout the whole organisation.

192. **Dr McCormick**: I am happy to respond both to the general point that you make about the handling of safety alerts and the specifics. We learned some very important lessons from pseudomonas and from the very penetrating insights in the two reports that RQIA, led by Pat Troop as an independent leader, brought together and brought to the Assembly and the Health Committee in the spring.

193. On the general point, we follow up safety alerts, and we require trusts to tell us whether they have complied with them or not. We have recently recognised the need to specify. If compliance is complete, that is fine. We had a requirement for them to refer to partial compliance, but that is too broad. We need to be specific and ask whether they have substantially complied, so that most of the important things are in place even if it is not total and complete. That is the place we want them to get to as a minimum. That is policed and monitored by the team that Paddy leads in our safety, quality and standards directorate. That is then brought to the twice-yearly accountability meetings, where we ask whether they have complied. If we have information in relation to non-compliance on any important safety alert, that is specifically discussed. What is going on and why? Those questions are asked. Trusts are well aware that if there is a safety incident in an area where they have been the recipient of a safety alert, that is bad for them. It is not quite as bad as the same thing recurring in the same organisation, but it is a bad point. It would lead to criticism and challenge, privately in my accountability meetings with them, and they know that there is a risk of that being very serious in the public domain as well.

194. On pseudomonas in particular, the Minister and I both said, in evidence sessions to the Health Committee in this very room, that we expected every safety alert to be taken seriously and every circular to be read, understood, channelled and handled. We know, and Pat Troop's report confirmed, that every organisation has a system for receiving, interpreting and disseminating the various alerts that come from the Department and from other sources. One of our penetrating points was to be more formal and official in our communications and to recognise that it is not sufficient to say that everybody knows because Northern Ireland is a small place and everybody talks to each other. Yes, people do talk a lot, and there was a level of awareness between the Belfast Trust and Western Trust about what had happened, but there was also a series of circumstances in relation to the taps especially. What came out scientifically about the taps was very unfortunate. People had introduced new taps that they thought would be safer, but it turned out that, scientifically, they were less safe. That was ironic and very unfortunate. People had been trying to improve things, but the very step taken to improve things had turned out to create a risk. We discovered that and acted on it. There was a problem with communication and with responsiveness, which came out very clearly in Pat Troop's report. We need to police it and see it through.

195. **Mr Girvan**: It just brings you back to the point of when something is identified as causing a major problem, such as pseudomonas. I know that comments have been made in relation to the nuclear industry and how a problem would be identified. I think back to something that happened with Boeing, when the board and the director of Boeing were going to be charged with manslaughter simply because a memo from a junior engineer who

saw a problem had not been adhered to. The director of Boeing was up on a manslaughter charge in, I think, the Italian courts. The same thing happened with a Formula 1 motor racing team, where certain people were held responsible because they had not paid attention to something. That did not even involve a serious incident in which people lost their life; rather, a potential risk was identified that senior officials had not acted on. When a major problem was identified at Altnagelvin, sufficient action was not taken to ensure that that came to the fore immediately. The Minister, therefore, had to stand in front of the House and answer questions, as did you, along with John Compton, in front of the Health Committee. I think that we have now identified a mechanism, but I want to ensure that that is in place, so that we will not have to revisit this in years to come.

196. That leads me nicely on to my next one. Paragraph 2.15 is to do with routine staff appraisals across the health service. It seems that there is a fairly low rate of reappraisal — 5% in some cases — and that staff development needs are not often assessed. Do those figures concern you? How do you intend to improve upon the situation? How can you have confidence that the care provided to patients and clients is safe when so little regard is given to assessing, maintaining and improving the competency of staff?

197. Some staff are very competent but their people skills are sadly lacking. Look at the number of complaints received about A&E. I am not necessarily blaming front line staff for that. Sometimes, management fail front line staff, because they give inadequate attention to the stress and strain that those staff are under. I know of one case — I do not want to go into any detail on it — where there was a major complaint about the blasé attitude of staff, which was, "There are a lot of sick people in here, so tough". That is not the way to deal with something. Those who complained were not being abusive or nasty, but they came back thinking that perhaps that was the right way to get action, because the people who were abusive got all the attention. It ended up that their family member passed away two or three days later. The first line at A&E was the problem, as was the attitude to patient safety and the way that staff responded to that. I am not one to blame front line staff, because sometimes they are under such pressure, and management sometimes cause that pressure. I am just wondering about paragraph 2.15 and how you feel that some of those areas can be dealt with.

198. **Dr McCormick**: I understand that that is a major concern arising from the report. I wrote to the trusts specifically on that point seeking a response before this hearing. I took very seriously the evidence presented on staff appraisal. Before coming to that specifically, I can give an important level of assurance on this aspect of work, in that appraisal is an essential part of good management, but continuous supervision and assessment are part of what is happening day and daily. So, the Committee can have confidence that, on a day-to-day basis, professional staff are being supervised and assessed. We should not wait until an annual appraisal to challenge someone. Annual appraisals are important, but more important, if things are going wrong or someone is not quite up to the mark, is challenging that person in the context of their normal work. If we have a supportive and learning culture, a supervisor can say, "You did the following things well, but you could improve on this". If that is happening all the time — and it is happening all the time — it provides assurance. The clinical staff take safety issues very seriously. If there is a risk, they will nip it in the bud. Nipping it in the bud and dealing with things in a daily context is the right thing to do.

199. Appraisal is also important. We have good information in relation to medical and dental staff. As we move towards revalidation, that will be cemented and secure. There will be a continuous

refreshment and revalidation. Paddy can talk about the detail of this if you wish.

200. The lower numbers, the more concerning numbers, are in the wider groups of staff. The context is that the Agenda for Change terms and conditions of service require the application of the knowledge and skills framework. That requires an assessment of individuals' training requirements on a regular basis; that is an inherent part of the system. We are looking to improve. Some of the percentages are unacceptably low. We are engaging with the Ambulance Service, in particular. The staff groups referred to in the report involve relatively small numbers, but they are still very important staff. It is important that there is both regular supervision and the application of the knowledge and skills framework approach in Agenda for Change to secure the right outcomes. The letter that I sent highlighted to the service the need for organisations to ensure that the performance of all staff is assessed regularly. I said that; I did not qualify it or put any subordinate clauses around it. That is a requirement on the organisations that we will pursue. We have had accountability meetings with two trusts in the past two days. We raised that point at those meetings and have had assurances that improvement is being made.

201. **Mr Girvan**: Does the Department ever engage in something that goes on in the private sector day and daily, namely a mystery shopper going in to carry out an assessment? The family that I am talking about were in A&E with their loved one, with the same condition, on two Friday afternoons. It was similarly busy on both occasions, but there was a sea change in the level of service from one occasion to the other. It could be identified that there were definitely staff who were creating a problem on a specific shift, and that needs to be focused on. That should be done. Does the Department go in as a fly on the wall to assess and observe what is going on?

202. **Dr McCormick**: We do not do that systematically. It has been done occasionally, and some quite important points have been made as a result. It is not done systematically, but we are certainly open to looking at it. It is important not to undermine confidence by giving the appearance of trying to catch people out. However, some unannounced inspections are carried out. For example, some of the RQIA hygiene inspections were planned on the basis of being unannounced, surprise visits. That is also part of what we talked about with the Committee in relation to the inspection of the independent sector homes. It is important to follow up that point and assess the value and effect that this would have. Getting an honest recognition of genuine problems is important. We need to find ways to make sure that there is good and effective challenge of — I am sure that it is not systematic bad intention — any pattern of behaviour that is not within the culture that we seek to promote. We need to take your suggestion seriously.

203. **Mr Girvan**: I think back to a problem that we had some time ago involving a number of ladies who had been brought in for mammograms. A problem was identified with how some of those mammograms were carried out. It seemed that a large number of cases had been missed. Why did it take so long for some of those things to be picked up? So many cases went through before a problem was flagged up. This is about the flagging up of issues, retraining and ensuring that the reporting comes back. The next thing that we heard was a headline on the Radio Ulster morning news that 1,400 women were being called back. The fear that that sort of thing causes in the community is horrendous. What happened that it took so long for some of those issues to be picked up? It is the sort of thing that does not give the public much confidence. Some of them will read a report like this and say, "I am safer not bothering going. I will just stay at home and take my chances." I am not saying that that is the case, but a lot of people will highlight that point.

204. **Dr McCormick**: If I recall correctly, the breast radiology case that you describe was in a difficult context. The vulnerability is where a service is being carried out by a single-handed practitioner, as was the case there. There are a number of areas in Northern Ireland where we have to provide services on that kind of basis. The important thing is to ensure that there is systematic peer involvement and that if someone is trying to keep something going but working in isolation, all the more attention is given to double-checking. That should be done without judging or making people feel that they are under unfair scrutiny. However, there should be a degree of peer challenge and a supportive network to maximise the safety services. We had an RQIA report on that case. It drew out some very important learning points in respect of timeliness of intervention and how to secure safety. It is a very important learning case for us.

205. **The Deputy Chairperson**: For the record, members and witnesses, we are now past the two-hour stage. Paul mentioned Formula One, although I am not trying to influence you. Sean Rogers has kindly given way to Mitchel McLaughlin, who has to leave shortly.

206. **Mr Mitchel McLaughlin**: I will remember your stricture about Formula One when I go to my next appointment.

207. At paragraph 4.13, figure 4 sets out the costs of settling claims. It is quite a stupendous figure really: £116 million. On a ratio of 2:1, the legal costs were £39 million. I just wonder how many hospitals you could build for that kind of money or how other Departments could use that kind of money if it were available. Will you talk to us about the changes that have been introduced in the past number of years — that five-year period, say — to reduce the costs of defending negligence claims and to reduce the time that it takes to process them?

208. **Dr McCormick**: A lot of important work has been done in the past number of years — the past five years, as you say — to seek to bear down on those costs. Lead responsibility for that lies with the director of legal services in the Business Services Organisation, which provides support to the health service bodies on this issue. So, action has been taken to seek to reduce the defence costs. We have looked at the way in which we contract for counsel and the way that that works. There has been significant work to standardise and put caps on that kind of cost. We look at what is necessary to benchmark and minimise our defence costs. Plaintiff costs fall to us as well, and it is important to challenge, without being unreasonable, the bills that come in and make sure that they are fair and acceptable given that we are responsible for public money in that context. We are seeking to do what is possible. It is quite a complex field, and quite a lot of factors go into the make-up of it. There are some important differences with elsewhere, but we are seeking to apply what we can to bear down on the legal costs and, as you said, increase timeliness and accelerate the process.

209. We welcome the view taken by the courts that procedures should be more timely and that we should seek to find alternatives to going to court, where possible. Given that harm has happened in the service, we cannot prevent or deny the right of access of a complainant to the courts, so we have to do what we can to minimise their need to go there. A range of things are being done to accelerate the process and bring forward and resolve some of the longer claims that are outstanding. That has been quite systematic. For example, in the financial year 2010-11, there was a significant drive to bear down on costs. The table shows a trend that, towards the end of financial year 2010-11, a significant number of cases were settled. Some of the plaintiff legal costs may have fallen into 2011-12, and you can see that it is not the most natural time series; 2010-11 looks a bit low, and 2011-12 looks a bit high. We have looked at that and think that there is probably some distortion of that trend. However, all that is about our

efforts to accelerate the processing of claims to meet our obligations and to try to contain cost where we can.

210. **Mr Mitchel McLaughlin**: I am slightly confused, looking at that, about the difference between 2009-2010 and 2010-11. Are you saying that 2010-11 was a blip?

211. **Dr McCormick**: It is probably most helpful to look at the trend and the percentages. The key point is that in 2010-11 and 2011-12, there was a concerted drive to clear old cases. So, some of the increase in compensation paid relates to old cases being cleared as well as the ongoing normal business. That partly explains the increase in expenditure in 2010-11 and 2011-12. The pattern across the years is that plaintiff costs run on average at 20% and defence costs on average at 10%. Most of the years are consistent with that. The 2010-11 figure shows a plaintiff cost of 13%, and that is probably a bit low against the normal trend. We think, perhaps, that some of that is because some of the plaintiff costs related to claims settled in 2010-11, because quite a few claims were settled late in the financial year. The claim may have been settled in January, February or March, but the plaintiff costs may not have been paid until 2011-12.

212. **Mr Mitchel McLaughlin**: What is the impact of the involvement of those in the directorate of legal services (DLS)? Do they arrange the defence for the Department, help in the assessment process or both?

213. **Dr McCormick**: They give advice and deal with the processing of the case through the court. They draw together the evidence on behalf of the trust and then secure counsel services in processing through the court. Part of their job is to seek to secure a fair outcome from the point of view of fulfilling our obligations to people who have suffered harm while also protecting the public purse. Their job is to find that balance and to be fair to both sides.

214. **Mr Mitchel McLaughlin**: Has the involvement of the directorate of legal services impacted on the percentage of cases that actually go to court, as opposed to, for example, negotiation between claimants' legal representatives and the Department that results in agreed settlements?

215. **Dr McCormick**: Some of that is down to earlier stages in the process whereby trusts are encouraged to seek to resolve issues without the need to go to court. Again, that is where the kinds of behaviours that we talked about earlier are so important, and we must do better on that.

216. **Mr Mitchel McLaughlin**: OK. I may just have presented that question in a misleading way. I did not intend to do so. I assume that a judgement call is always made somewhere. The decision was that you really needed to defend that case because you believed that you could defend it. That resulted in going to court. Obviously, you cannot guarantee the outcome. I am interested in how the involvement of the directorate of legal services has materially improved the process, because once you are committed to court, you lose control of the timetable. Lawyers and barristers will take their own sweet time in working their way through that process. Is there a material impact? What is the benefit of using the directorate of legal services if you still have to get external legal expertise to help you to defend your case?

217. **Dr McCormick**: They will provide essential expertise in processing responses and identifying when it is right to settle out of court and when it is right to let the process go through to the final stages. So, they have expertise and consistency in processing those cases.

218. **Mr Mitchel McLaughlin**: Does that not mean in practice that you will actually continue with that factor of 2:1 with regard to settlement awards and the cost of legal services, both for the complainant and yourselves?

219. **Dr McCormick**: There is some degree to which the process is not within our —

220. **Mr Mitchel McLaughlin**: I am trying to give you the opportunity to explain how you have improved, but I have to say that I am not getting it.

221. **Dr McCormick**: We are seeking to make sure that we process things smoothly in timing and that we do all that we can. DLS is doing what is possible to bear down on costs. So, improvement has been made. The underlying numbers are still as they are because a large number of claims have to be settled, including some very old ones. Some of the old high-cost cases would be in the realms of damages for birth injuries, and things like that, where you are talking about compensation, care and loss of earnings. There are lots of things that amount to large amounts of money. The right thing to do is to be responsible and handle those issues properly and fairly, and to seek to make maximum improvement. We are doing what we can to improve.

222. **Mr Mitchel McLaughlin**: Have you detected any impact from the review of legal aid?

223. **Dr McCormick**: Not directly.

224. **Mr Mitchel McLaughlin**: So, we are still dealing with high-cost cases?

225. **Dr McCormick**: Some aspects of cost are outside our control, as the report draws out. With the historic trend, courts locally are likely to make higher awards for personal injury than courts across the water. That is just a difference of fact. It is not within our sphere of influence. That is a matter for the courts.

226. **Mr Mitchel McLaughlin**: Paragraph 4.17 and figure 7 show that the majority of settlements result in compensation of £50,000 or less. Is that mainly as a result of court judgements or of negotiated settlements?

227. **Ms Thompson**: As the report points out, around 24% of claims result in compensation being paid, but you are quite right; that is not necessarily paid through the courts system. It can be agreed outwith the courts system. The report also points out that we need to look more at the smaller-value claims and maybe do something in a more cost-effective manner with them.

228. The court is actively advocating the use of mediation and alternative dispute resolution. We need to provide evidence on an ongoing basis of how that happens in cases. That is something that DLS will be working on with the Courts and Tribunals Service. So, we have acknowledged that we need to look at that recommendation, particularly as regards the smaller-value cases, to see whether there is a more cost-effective way of managing the legal side.

229. **Mr Mitchel McLaughlin**: There is an underlying issue. If the majority of settlements are £50,000 or less, are any statistics being thrown up on cases in which the legal costs exceed the amount awarded?

230. **Dr McCormick**: That is a genuine issue that needs to be looked at. Therefore, as Julie said, we accept the need to look hard for alternative means of resolution. We are aware of the approach being taken in other parts of the UK. I would not say that anywhere has this problem totally resolved. It is possible that some of the approaches taken might produce almost a perverse incentive to make low-value payments, which might then create a culture of wanting to make claims as there would be an automatic, or a semi-automatic, payment. We need to watch out for that, particularly given our responsibility to protect the public purse.

231. **Mr Mitchel McLaughlin**: Are you indicating that, at the moment, you do not monitor that?

232. **Dr McCormick**: We monitor things in the context of the way in which our system works, and we are satisfied that there is scrutiny of, and attention paid to, each settlement. So, each one is individually justifiable. What I am saying is that my understanding of what is being proposed in other jurisdictions is that if we were to follow that pattern, there could be some value in accelerating the process

but there would also be some risk of an unintended consequence.

233. **Mr Mitchel McLaughlin**: I understand that.

234. **Dr McCormick**: We need to watch out for that.

235. **Mr Mitchel McLaughlin**: There are probably more examples, but it occurs to me that there are three obvious examples: a negotiated settlement; the classic on-the-steps-of-the-court arrangement; and the outcome of a full court process. Do you have a statistical breakdown of that?

236. **Dr McCormick**: We will get some more details on that for the Committee.

237. **Mr Mitchel McLaughlin**: I accept that there may be other classes of compensation claims or settlements, but I would have thought that an analysis of those categories would inform your consideration of where the value-for-money aspect can be addressed.

238. Finally, I presume that the directorate of legal service's costs are just costed into the overall figures for legal services, compensation claims and settlements.

239. **Dr McCormick**: Yes, the figures that show the costs will include the relevant attribution of costs from DLS.

240. **Mr Clarke**: Following on from Mitchel's last point, I take it that we are going to get a paper detailing the cases that you won and the ones that you lost.

241. I am wee bit unclear about the legal costs. In figure 7, it is quite clear that legal costs are not included.

242. **Dr McCormick**: That was intended to present the scale of the compensation paid, but the figure —

243. **Mr Clarke**: Can you furnish us with a copy of the statistics for the legal costs in each of those categories?

244. **Ms Thompson**: Yes, we can; absolutely.

245. **Mr Clarke**: That would bear some weight and would help to answer some of Mitchel's questions.

246. **Mr Rogers**: I want to take you back to figure 3, "Reported Serious Adverse Incidents". Surely, valuable patient safety lessons are to be learned from an evaluation of all adverse incidents, and even the near misses. Focusing on just the serious adverse incidents could create a tolerance of near misses and low-grade harm. Why are we not maximising the potential to learn by collating all the information?

247. **Dr McCormick**: The intention is to do exactly that. We have drawn significant value from the existing reporting system, and we will continue to do so because there are very significant lessons to be drawn from serious adverse incidents. Once the RAIL system is in place, it is intended that it will provide exactly what you are asking for, namely a comprehensive pulling together of information, systematically and analytically, so that patterns can be more clearly identified and acted on. Paddy will provide more detail on the benefits that will result from the completion of the RAIL system.

248. **Dr Woods**: Even at this point in time, trusts will draw together all their adverse incidents, draw lessons from them and produce reports on adverse incidents in their organisations. As part of the accountability process, we will ask them to assure us that that is happening and that, very importantly, they are sharing more widely in the system any lessons that they have learned that are applicable elsewhere.

249. The expectation with the RAIL process is that all adverse incidents will be drawn together and analysed and that the lessons learned from the totality of adverse incidents will be drawn together and disseminated for learning across the piece. The expectation is also that, in addition, there will be learning from issues that arise from clinical negligence cases and complaints. As the Venn diagram in the report shows, they are separate but interrelated: they overlap in some respects, but they all present the opportunity for learning and the avoidance of repetition.

250. That is a fundamental element of the RAIL project. It also points to the complexity involved in pulling all those things together, because, when we do that, we will be the first jurisdiction in the developed world to pull those things together across a jurisdiction. There are states in the United States and parts of Australia that do it, but nowhere else in the world has done it for health and social care, which is a further factor. All the other systems in the world confine themselves to healthcare adverse incidents.

251. **Mr Rogers**: Mitchel made a point earlier about a systems approach. There has really been a breakdown in the systems approach up to now.

252. **Dr Woods**: There has been an incremental build in the systems approach in that we have concentrated on regional learning arising from serious adverse incidents. We have not neglected adverse incidents, although they are not collated on a region-wide basis. However, we expect trusts to aggregate their adverse incidents to learn the lessons from them and share them where wider learning opportunities arise.

253. **Mr Rogers**: Figure 3 shows that over 2,000 serious adverse incidents have been reported. Obviously, the ultimate price that patients pay when they are harmed is losing their life. Can you give us the number of cases from those 2,000 that involved fatalities?

254. **Dr Woods**: I do not have that figure to hand. We can produce them for you.

255. **Mr Rogers**: My other point is about paragraphs 4.35 and 4.36. You answered the question about paragraph 4.36 with regard to the level of damages. You said that it was a matter of fact that the English system awards more money. Will you comment on paragraph 4.35, which states that trusts here do not contribute to compensation claims? How do you feel about that, given that so much money comes from trusts in England?

256. **Dr McCormick**: This is partly a factor of different stages of the system's evolution. It also links to the fact that we have had within the process some delayed cases. So when the new trusts came into being in 2007, and we went from 17 to 5, it would have been potentially destabilising to have given the new trusts delegated responsibility for managing a volatile and significant level of expenditure. We have tried to form a balanced judgement. There is a case, as is drawn out in the report, for aligning responsibility for this cost with all the causal factors. In principle, that is the right thing to do, and, in looking at it a couple of times, our financial review groups have said that we should move in that direction. We did not do so in 2007 because it would have burdened new organisations with the legacy of past failings from other sources, so we thought that it was not the right thing to do at that time. We are keeping it under review, and we can see the arguments of principle. There are some advantages to us at present in that it is simpler and smoother to manage the budget centrally. That is not without some advantage, but we are very open to changing that. We can look at that again to see what is the best thing to do.

257. **Ms Thompson**: It is partly related to the number of outstanding cases. As that number falls, as one of the figures in the report shows, you then come down to a less volatile way of dealing with cases. That means that we should be able to reach a point with the trusts at which it is understood how much each should pay into a pool, which is how the system operates across other elements of the UK. So you have to have some understanding and an ability to forecast to enable you to put the costs through to the trusts in that way. We would be happy to look at that to see whether the time is now right, or would be right in the near future, to look towards doing that.

258. **Mr Rogers**: Finally, paragraphs 4.42 to 4.45 relate to alternative dispute resolution. Rather than facing court proceedings, patients and their families have a right to expect a full explanation, an apology and an undertaking that if harm has been done, it will not be

repeated. Keeping that in mind, do you think that it would be prudent to develop some alternative to legal action, which could reduce the costs and stress and perhaps result in a more positive outcome for the patient?

259. **Dr McCormick**: As the report states, we have accepted that recommendation from the Audit Office. We are looking at finding an alternative way forward and looking carefully at what is being applied elsewhere. Other parts of the UK are at different stages. There is also some potential learning from other jurisdictions. We have not yet identified a model from any other jurisdiction where this is a solved problem. Everyone is still learning, but the reason for seeking alternatives is very strong. If it is possible to provide a better, more responsive system at a lower legal cost, that is devoutly to be pursued. We are committing to work on that to identify alternatives, and if that means finding a compromise among other models and applying it, that is what we will do. Therefore, I accept the point and the recommendation.

260. **The Deputy Chairperson**: We have come a long road since Brangam and Bagnall and those who ripped off the health service. However, as I listen to you this afternoon, despite improvements in technology, record keeping, and so on, you seem still to be discussing ways in which you can reduce clinical negligence and better link the whole service. Have some people been sitting on their hands?

261. **Dr McCormick**: I would not say so. Rather, there is a strong motivation to take forward initiatives on patient safety. There are two parts to what you said. On patient safety, Paddy and the team in the Department's safety, quality and standards directorate and Michael McBride as Chief Medical Officer have shown strong personal commitment and leadership in introducing patient safety initiatives and exploring, developing and applying good practice. So we have strong leadership there and from many across the trusts who contribute to the patient safety forum. John Compton chaired that for a while, and that position is now with the Public Health Agency. There has been strong input and leadership from many across the service. There is a strong commitment to patient safety.

262. In response to your question on cost, we had to address the damage that was done through what happened in the Brangam Bagnall episode, which had very serious consequences, including recommendations from the Committee on dealing with that issue. We learned major lessons. A highly motivated team in the directorate of legal services is dealing with and clearing a caseload backlog. That has been a priority, and if that has limited all of our capacity, including mine, to change the system, I accept that we have not done all that we possibly could, but that is not through complacency or an absence of motivation. We are not complacent about this area of work. We know how much could be saved and that bearing down on this cost, including legal costs, would provide money for front line care. The previous Minister made strong statements about that in the Assembly a couple of years ago, and the current Minister wants to secure as much money as possible for the front line, so the motivation is inherent. I appreciate that it is difficult to satisfy you. Rightly, you place high demands on us to improve, and we undertake to seek to respond as positively as we can.

263. **The Deputy Chairperson**: Dr McCormick, if it is any help to you when you are dealing with the health trusts, and I am sure that I speak for all the members, patience is totally exhausted. We do not and cannot tolerate people living in fear of going into hospital and the public then paying out to meet horrendous compensation bills with money that should be going into public services.

264. **Mr Copeland**: I have four questions, three of which I am happy to talk to the Committee Clerk about and have answered by letter in the interest of expediency. I will start with a question that is not in front of me. It is widely accepted that we now live in a society that is more litigious than it used to

be. Is that factored into your thinking anywhere along the line and, if it is, in what context? Does there automatically exist in the back of your mind the thought that you will be sued? If so, does that have an impact on the way in which services are provided? I ask because my son is at Queen's medical school, and I am considering telling him to think again. People are now more inclined to go to law. I am not saying that there is a claims industry exactly but is there some outside influence? That is not to suggest for one minute that people are not entitled to lodge claims when they feel that such incidents have happened. However, is there any suggestion of people being led to law by commercial interests that lie outside the service?

265. **Dr McCormick**: It is difficult to produce hard evidence of that. We are concerned that the tendency to go to law in Northern Ireland is greater than in other jurisdictions. I understand that there is some reluctance in the legal profession to move to more specialist panels, as is the case in England. There are also no win, no fee provisions in England. Together, they have some effect in limiting the propensity for smaller claims to go forward. There are probably some cultural factors involved but those are beyond our control. You asked us what we do about this, and the answer is that we need to anticipate the issue. You mentioned medical school, and I think that it is absolutely right for there to be a clear understanding of risk management. That is part of how life works. I go back to what I said at the very beginning. I think that, as a society, we need to support those prepared to take risks. If I am in need of medical treatment, I want someone who has the courage to do what needs to be done, even knowing that something may go wrong, unintentionally, and despite the best of efforts. Again, I think of people working in highly stressed contexts in emergency departments or highly specialist services. As a society, we need to be behind those prepared to take risks, not create the consequence of people saying that they better not do something in case they are sued. That would be a very bad outcome. We need to promote and handle that very carefully. From our point of view, anticipating things going wrong and determining how to manage risk in a systematic way is a clear part of our responsibilities and something that we need to address smartly. We must really apply ourselves to this.

266. **Mr Copeland**: Thinking back to a previous career, which involved military service, I know that, when under fire, if you can get the casualty out of the killing area and back to the hospital, the survival rate is extremely high. I just wonder whether there is a cultural difference in there somewhere.

267. **Dr Woods**: There is a bit, from the point of view of healthcare practitioners. Those in the military appreciate that the environment in which they work is high risk and dangerous. For many years, probably until the past decade, the expectation was the rather unrealistic one that the practice of healthcare did not entail risk or a propensity for harm. A realistic approach is a start, and a big part of that is acknowledging that and then, as we have been discussing for most of this afternoon, systematically recording, analysing and learning from it. That is a relatively new perspective for the healthcare professions. In that regard, I do not worry so much about your son; it is the older generation like me who came up in a different culture. Part of the ongoing day-to-day push towards openness is recognising and managing risk. The first element in dealing with risk adequately is appreciating that it exists in the first place. That is not always the case. It is certainly a common theme throughout much of the material that we have been discussing today.

268. **Mr Copeland**: Andrew, paragraph 3.26 states that the latest policy document, 'Quality 2020', contains an undertaking to:

"devise a set of outcome measures, with quality indicators focused on safety, effectiveness and patient/client experience."

269. I am slightly puzzled that such indicators were not already in use, or were they but their name has changed? I become concerned when I see passé phrases, because I see so many of them, and they all originate in the same sort of psyche. Without such benchmarking information — that is on the assumption that you have not been using it to date — how have the trusts and the Department been able to set explicit, challenging and measurable goals for improving safety performance year on year?

270. **Dr McCormick**: The background is that a systematic approach to quality and safety with the kind of metrics being developed is relatively new. It is consistent with the recognition, which I mentioned a short time ago, of the degrees of risk that apply. The Quality 2020 strategy systematically brings together thinking that has been evolving over the past few years to ensure that we apply ourselves to this in a very systematic way and that it is given a strong leadership message. If you look back to, say, 2006, 2007 and 2008, the only show in town, and the metric on which attention was entirely focused, was access times in elective care. We had been singled out as having the longest waiting times in the UK for elective care, and that was the only thing that mattered. Shifting the attention in a more balanced way to a mature view of quality is a very good thing. I do not claim originality, nor do I say that we dreamed this up, but we have sought to give it really strong leadership. I appreciate that some of the phraseology can appear broad-brush and bland, but not when applied in a systematic and rigorous way, and I assure you that the statutory duty of quality gets people's attention and that the risk of being charged with corporate manslaughter is a live topic of conversation among chief executives. We know that this matters, so applying ourselves to sorting out these issues is very important.

271. **Mr Copeland**: I would like to raise a further point of information for my and the Committee's consideration. If one of these incidents occurs, a set series of steps kicks into place. Are those set by the trusts independently, and are they fine as long as they conform to the broad set of departmental guidelines? Is there a standard method of reporting that is instantly identifiable and transferable from one trust to another so that, at the end of a given period, the information comes to you in the form in which you need it and can be put to the purpose for which it was collated?

272. **Dr McCormick**: There is a prescribed and standard format for the reporting of SAIs to the Health and Social Care Board (HSCB) and for early alerts to the Department. There are some basic requirements. However, some detail has to vary according to the context because quite a broad range of categories apply. Paddy, do you want to say something about that?

273. **Dr Woods**: In broad terms, it is fair to say that the manner in which these are reported and followed up on is consistent across the piece.

274. **Mr Copeland**: Is the manner in which they are interpreted the same?

275. **Dr McCormick**: That is one of the key advantages of their being dealt with at a regional level by the Health and Social Care Board, which has the responsibility for collating SAIs across Northern Ireland. The HSCB wants, seeks and secures consistent information that it can turn into learning letters that are sent out into the system. Such letters will state: "In light of the following SAIs, the HSCB has reached the following conclusions." The letters then advise which points need to be attended to. Again, we have significant advantages in being a relatively small system.

276. **The Deputy Chairperson**: Michael, will you let Paul in at this point?

277. **Mr Copeland**: Yes.

278. **Mr Girvan**: My question is really about information and how it is passed through the organisation. Problems sometimes occur when information is not passed through.

279. I appreciate that you said that you will put together the RAIL database mentioned in paragraph 3.24. My point links in exactly with what Michael said. There are other software systems in operation, and there are risks involved in introducing any new software. We saw that previously when we paid a lot of money for software. That software ended up being owned by another company, not the people who paid for it to be developed, and it was then sold to other governments to run their systems. Given the risks involved in developing any new IT system, why were options such as joining the national reporting and learning system or purchasing an off-the-shelf package not considered? They could have delivered the same results.

280. **Dr McCormick**: I understand what you are saying. Paddy, do you want to take that question?

281. **Dr Woods**: Quite some time was devoted to trying to establish a link with the national reporting and learning system. However, that system does not cover social care, which would have been an issue for us. Subsequent events and the dispersal of NPSA across various organisations in England would suggest that, unfortunately, a link with that system was never going to be a realistic prospect. The history of the production of all singing, all dancing IT systems in the public sector, particularly in the health service, is not a happy one. However, the aim with the RAIL system is to, first, pilot it in one organisation and then road test all the areas that we want to cover. We recognise that we will be breaking new ground and that this system is not replicated anywhere else in the developed world. On that basis, we will pilot the system in one organisation to mitigate the risk that you mentioned. Depending on the results of that pilot, we will then roll it out across Health and Social Care.

282. **Mr Girvan**: What is the time frame for that?

283. **Dr Woods**: Assuming that we get agreement for the Department's business case, the expectation is that the pilot will be completed by the end of 2013, with a view to the overall system being in place by the end of 2014.

284. **Mr Girvan**: What will the new system cost?

285. **Dr Woods**: I do not have that figure to hand. Apologies.

286. **Mr Girvan**: Could we get that? Sometimes, we see very expensive systems that are nothing more than databases that everyone in the health profession can access.

287. From the outside, it does not seem too complicated, but it might be very complicated. Sometimes, those who write such programmes want to make them seem complicated so that it appears as though they are the only people who can write them. Gone are the days when notes were put up on a noticeboard and passed around everybody that way. I would like you to come back to us with the projected cost of the system — by that, I mean realistic projections.

288. **The Deputy Chairperson**: Paul, you may have noticed that Mr Michael Copeland has now left the meeting. Do you have any further questions?

289. **Mr Girvan**: We could go on all night if you want.

290. **The Deputy Chairperson**: I have been trying desperately to persuade you not to do that. Are you finished?

291. **Mr Girvan**: OK, yes.

292. **The Deputy Chairperson**: This has been an extremely important session. Health and social care services affect every member of society at some stage in their lives, and patient safety, which we have focused on, must be at the heart of all health and social care provision. I welcome the Department's appreciation of that and look forward to future improvements in service delivery.

293. The Committee will consider the evidence and produce its report in due course. Of course, we may wish to write to you for further information. Thank you for your evidence today, and —

294. **Mr Clarke**: Chairperson, I do not have a question but I want to make a comment.

295. **The Deputy Chairperson**: I knew that I was not going to get off that easily.

296. **Mr Clarke**: It is a caveat to your closing embarks. There will be questions, and in the absence of satisfactory answers, I ask for your indulgence in reserving the right to call the witnesses back. Is that appropriate?

297. **The Deputy Chairperson**: Trevor, thank you for that. It was a very useful contribution. Of course there will be questions. I imagine that someone will look back at the 2002 recommendations, investigate why many of those have not been honoured and ask what can be done in future to ensure that there is not another case of déjà vu. The public must be assured that there should be no fear of health service provision and that the awful problem of compensation will be better handled. I thank the witnesses. I also thank Hansard for its coverage of today's discussion.

Northern Ireland Assembly

Appendix 3

Correspondence

Correspondence of 14 November 2012 from Ms Marie Anderson

Ombudsman Northern Ireland

Our reference: MMCA/NIAO

14 November 2012

Ms Michaela Boyle MLA
Chair, Public Accounts Committee
Room 371
Parliament Buildings
Ballymiscaw
Stormont
Belfast
BT4 3XX

Dear Ms Boyle

Northern Ireland Audit Report (NIAO): The Safety of Services Provided by Health and Social Care Trusts

I read with interest the above report produced by the NIAO and understand that the Public Accounts Committee (PAC) took evidence, on the report, last week. Given the comments made on the matter of 'alternative dispute resolution' I thought it may be useful to contribute to the Committee's enquiry by outlining the Northern Ireland Commissioner for Complaints[1]' statutory role in the handling of health and social care (HSC) complaints which operates as a means of alternative dispute resolution.

The Commissioner's role in Health and Social Care Complaints

The purpose of the Commissioner's office is to investigate complaints of maladministration. In doing so the Commissioner seeks to ensure the people of Northern Ireland are served by a fair and efficient public administration, including health and social care that is committed to accountability, openness and, quality of service. The service provided by his Office is independent, free and, confidential.

The governing legislation for the Commissioner for Complaints jurisdiction in health and social care matters is the Commissioner for Complaints (Northern Ireland) Order 1996. His jurisdiction which included complaints of maladministration about Health and Social Care Trusts was extended in 1997[2] to include matters of complaint which related to 'the merits of a decision taken in consequence of the exercise of clinical judgement'. As a result of this extension of jurisdiction, the Commissioner for Complaints was empowered to investigate complaints about the care and treatment of patients arising from the actions of General Health Service Providers, (these include General Practitioners, Dentists, and Pharmacists) as well as Independent Providers of Health Services, (eg Nursing Homes). Where an individual is dissatisfied with the outcome of their complaint to a Trust or other HSC body, having been investigated and responded to under the HSC complaints procedure, they are advised of their right to forward their complaint to the Commissioner.

1 The NI Commissioner for Complaints is also known to members of the public as the NI Ombudsman

2 The Commissioner for Complaints (Northern Ireland) Order 1996 as amended by article 7(10) of the Commissioner for Complaints (Amendment) (Northern Ireland) Order 1997

Legal Remedy

It should be noted that the Commissioner is an alternative to the courts and individuals who seek compensation arising from a claim for clinical negligence as referred to in the NIAO report will be directed by the Commissioner to pursue a legal route for the remedy they seek. Article 9 (3) (b) of the 1996 Order prevents the Commissioner from investigating any matter in which the person aggrieved has or had a remedy by way of proceedings in a court of law. This bar is not absolute, however, as a residual discretion is afforded to the Commissioner by virtue of Article (4) (a) which enables the Commissioner to investigate, where he is satisfied that in the particular circumstances it is not reasonable to expect the complainant to resort or have resorted to the legal remedy. The circumstances where such a discretion will be used is where the complainant may not have the financial resources to fund court proceedings.

The Commissioner's approach to deciding those complaints involving clinical care and treatment of a patient or deceased member of a complainant's family which he will investigate recognises that, in theory, every complainant could potentially have a legal remedy. The Commissioner, therefore, considers carefully the remedy being sought by the complainant in respect of their complaint. Often the complainant simply seeks an explanation of what happened and where failures in care or treatment have been identified an assurance that this will not happen again. In many instances a complainant seeks only an apology. These are remedies which a complainant will not obtain if he/she pursues the legal route. Although his evidence gathering powers are equivalent to those of a High Court judge, unlike the legal process, the Commissioner's investigations are conducted in private, are inquisitorial in nature and, are non adversarial.

Maladministration

The standard which is being tested is for 'maladministration'. Maladministration is not defined in the legislation in order to reflect the wide discretion afforded to the Commissioner for Complaints in determining whether maladministration has occurred based on the facts of the case. Maladministration is also the standard which is being tested in clinical cases; albeit that the term in itself may not, on the face of it, appear to the general public to have relevance to clinical judgement.

The Commissioner's approach is to assess whether the actions of a health professional are fair and reasonable and this is not the same as a finding by a Court that a duty of care has been breached.

Learning from HSC Complaints

Where maladministration is found to have caused an injustice to an individual the Commissioner can recommend a remedy which often includes a change in practice or service improvement. As a result the Commissioner's investigations will result in outcomes which are not only personal to the complainant but which also result in learning for the HSC sector and consequently improved service delivery. The Commissioner has a discretion to recommend a wide range of remedies in any case. These can include a fuller explanation of events leading to the injustice suffered by the complainant, an apology, service improvement recommendations and, in appropriate cases financial redress.

Health and Safety Risks in the HSC Sector

Given the extent of the Commissioner's jurisdiction in the HSC sector, he enjoys a unique and valuable insight into the experiences of individuals who may have been failed by the sector. Significantly, the Commissioner also has an express power to disclose information to any person or body where he considers that information should be disclosed in the interests of the health and safety of 'any person'. For example, this power of disclosure enables the Commissioner for Complaints to eg refer a concern about a particular General Practitioner to the General Medical Council, or to refer a nursing home to the RQIA where regulations or procedures, may on the face of it, appear to have been breached. To assist with this important

mechanism for sharing information in the interests of patient safety, the Commissioner is currently finalising a protocol with the Regulation, Quality and Improvement Authority (RQIA); the body charged with responsibility for monitoring and regulating the HSC Sector.

HSC Case Digest

By way of illustrating the nature of the cases that the Commissioner investigates in the HSC sector, I attach a link to a recent case digest which focused on the Commissioner's casework involving the HSC sector:

http://www.ni-ombudsman.org.uk/niombudsmanSite/files/1e/1e645890-7740-4039-8edb-c88cc1447ab6.pdf

Alternative Dispute Resolution

The Commissioner's office, along with the Law Centre (NI), and Queens University's School of Law, published a public information booklet in September 2011 entitled 'Alternatives to Court in Northern Ireland'. The booklet, which has been circulated widely to advice and advocacy bodies in Northern Ireland, outlines the range of alternative dispute mechanisms.' The booklet also makes clear that alternative dispute resolution schemes are not meant to replace the courts in all cases but that such schemes do have some clear advantages over litigation. The booklet can be accessed at http://www.lawcentreni.org/publications/other-publications/831.html

Further Information

I trust the Committee will find the above information of assistance in their consideration of the need to establish an alternative to legal proceedings for clinical negligence, as highlighted by the Comptroller and Auditor General in his report on the safety of services provided by HSC Trusts. I would, of course, be available to provide further clarification on the Commissioner's role if you would consider that this would assist the Committee's inquiry.

Yours sincerely

Marie Anderson

MARIE ANDERSON
Deputy Commissioner for Complaints

Chairperson's Letter of 26 November 2012 to Dr Andrew McCormick

Dr Andrew McCormick
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Department of Health, Social Services
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26 November 2012

Dear Andrew,

Evidence Session on the Safety of Services provided by Health and Social Care Trusts

Thank you for your participation in the Committee's evidence session in this inquiry.

As the Committee agreed I would be grateful if you could provide the following information.

1) A breakdown of figures into claims made against Trusts which relate to care provided by independent healthcare providers, including those undertaken at locations outside Northern Ireland.

2) A summary of the number of serious adverse incidents by specialty for each Trust.

3) A breakdown of live negligence cases in the Belfast Trust which would be attributed to complex cases and a summary of the information recorded and how it is used in order to mitigate the risk of repeated failures by individuals.

4) A summary of the individual processes to categorise and record adverse and serious adverse incidents.

5) A sample of the learning communications disseminated by the HSC Boards to staff in response to its review of serious adverse incidents.

6) In response to the 4th recommendation at Appendix 2 of the 2002 Audit Office report, having issued guidance recommending that individual HSC bodies consider how to adopt the policy to proactively reduce potential negligence claims by early intervention, please confirm what action the Department took to follow up with each of the HSC bodies to establish whether this policy was adopted – and the number of HSC bodies without such a policy in place.

7) A chronology from 2002 of the reviews and continuous progress measures implemented by the Department to improve the safety of services.

8) Paragraph 3.10 of the Audit Office report highlights that the acute sector here has an adverse incident rate half that reported in England and Wales (35 % compared with 75%). Notwithstanding the different health and social care structures here, you have accepted that this suggests that there is under-reporting in the Northern Ireland acute sector.

   What assurances can the department give to the public that open, honest reporting is part of the culture of health and social care services?

9) In terms of under-reporting, what assurances can you give that it is not the more serious type of adverse incident which is not reported given that cases of this nature would attract most public attention and possible litigation?

10) An analysis of the 83,000 adverse incidents that led to harm, loss or damage to people or property, environment or reputation and a summary detailing how many of the individuals were notified.

11) Your assessment of the number of adverse or serious adverse incidents that go unreported as a result of issues arising from senility/mental illness where the patient does not have an advocate to complain, or people having died due to having been deferred from a waiting list repeatedly.

12) A breakdown by Trust and specialty of the number of outstanding staff appraisals for each of the last 3 years.

13) A breakdown by specialty summarising the number and percentage of cases where the legal costs exceeded the agreed settlement of less than £50,000. Please also indicate the average legal costs for each specialty.

14) Confirmation of the number of fatalities that relate to the 2084 serious adverse incidents referred to at paragraph 3.5 of the Audit Office report.

15) A summary of the steps the Department is taking to drive improvements in the collation of information on all incidents across the entire sector prior to the implementation of any new management information system.

16) The Department's projected timeframe for the pilot and for the full implementation of the Regional Adverse Incidents and Learning System; a detailed summary of the realistic, projected costs of its design and build; and confirmation of whether the intellectual property rights to the system will be retained by the Department.

I would appreciate receipt of your reply by 10 December.

Yours sincerely,

Michaela Boyle
Chairperson
Public Accounts Committee

Correspondence of 8 January 2013 from Dr Andrew McCormick

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

From the Permanent Secretary
and HSC Chief Executive

Dr Andrew McCormick

Michaela Boyle
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Email:
andrew.mccormick[redacted]

Our Ref: AMCC 4217
SECCOR/387/2012
DH3-12-8582

Date: 8 January 2013

Dear Michaela,

Evidence Session on the Safety of Services provided by Health and Social Care Trusts

Further to your letter of 26 November 2012, please find attached supplementary information in relation to the Committee's additional queries in relation to the above report. Responses in relation to queries 3, 12 and 13 are currently being finalised and will be sent to you by the end of this week.

I trust this is helpful. If you have any further queries, please contact Paul Gibson on [redacted] in the first instance.

Yours sincerely

ANDREW McCORMICK

1) A breakdown of figures into claims made against Trusts which relate to care provided by independent healthcare providers, including those undertaken at locations outside Northern Ireland.

The following table sets out the total number of current live claims made against the HSC which relate to care provided by independent healthcare providers including those from outside Northern Ireland.

Private Provider		No of Current Claims
Classic/Spire Health	Eng	13
BMI Woodlands	Eng	2
352 Group	NI	4
North West Independent Hospital	NI	8
Balmoral Clinic	NI	2
Mater Private Hospital Dublin	RoI	1
Guys and St Thomas	Eng	2
Sports Surgery Clinic Ltd Dublin	RoI	1
Orthoderm	NI	1
Medinet	Wales	1
Vita Clinics	Eng	1
Medica Group	Eng	1
Birkdale	Eng	46
Total		**83**

2) A summary of the number of serious adverse incidents by specialty for each Trust.

For the period 1 May 2010 to 31 March 2012, the HSCB received 523 SAI **notifications** from HSC organisations / Special Agencies or commissioned service providers.

However, SAI report notifications can be based on limited information at the time of reporting and on further investigation the degree of severity may become clear. This can result in the incident no longer meeting the criteria of an SAI and it can subsequently be de-escalated. Transferred SAIs can also occur which relate to duplicate notifications being received from one or more organisation but relating to the same incident.

The actual number of SAI's for the period 1 May 2010 to 31 March 2012 is therefore **475**, as 46 were de-escalated and 2 were transferred.

The number of SAI's reported from HSC Trusts for this period was **457**. The difference of 18 relates to non HSC Trust organisations and is set out below.

SAIs by POC and Org for Non HSC Trust organisations 1 May 2010 - 31 March 2012

Programme of Care	BSO	HSCB	Primary Care	Voluntary Sector	Total
Mental Health	0	0	0	1	1
Primary Health and Adult Community (includes GP's)	0	0	13	0	13

Programme of Care	BSO	HSCB	Primary Care	Voluntary Sector	Total
POC - Corporate Business / Other	2	2	0	0	4
Totals:	**2**	**2**	**13**	**1**	**18**

The 457 SAIs reported by HSC Trusts are not categorised by specialty (as these relate only to hospital services) but by Programme of Care in line with DHSSPS Data Administration Bulletin Programme of Care definitions.

Period 1 May 2010 to 31 March 2012

Programme of Care	BHSCT	NHSCT	NIAS	SEHSCT	SHSCT	WHSCT	Total
Family and Childcare (inc CAMHS)	11	17	0	5	13	1	47
Acute Services	48	12	1	2	14	9	86
Maternity and Child Health	4	1	0	1	5	2	13
Elderly	3	10	0	2	3	7	25
Mental Health	58	44	0	61	46	32	241
Learning Disability	2	2	0	3	7	3	17
Physical Disability and Sensory Impairment	1	0	0	0	1	0	2
Health Promotion and Disease Prevention	2	0	0	0	4	0	6
Primary Health and Adult Community (includes GP's)	1	1	0	0	1	3	6
POC - Corporate Business / Other	7	3	0	1	1	2	14
Totals:	**137**	**90**	**1**	**75**	**95**	**59**	**457**

4) A summary of the individual processes to categorise and record adverse and serious adverse incidents.

All HSC Trusts have a suite of extant incident policies and procedures in place which set out arrangements for categorising, recording, investigation and management of incidents including Serious Adverse Incidents (SAIs). All incidents and SAIs are recorded on Datix (the Trusts Risk Management System) and are coded and categorised by the use of the Common Classification System (CCS) codes contained within Datix and adopted by all HSC Trusts. The system also allows for the addition of specific Trust codes, if required. Datix also provides for incidents/SAIs to be recorded according to categories set up by the Trust for eg, by Directorate, sub Directorate, Specialty and Ward/Department/Facility.

All incidents and SAIs are coded on a central basis for actual and potential risk in line with the Risk Management Controls Assurance Standard using the Trusts Risk Matrix; this is also used for the purposes of determining the level of investigation to be undertaken.

Set out below are two flowcharts which illustrate firstly, the procedure for recording and reporting incidents and secondly, the procedure for identifying and processing serious adverse incidents. The examples used have been taken from the Northern HSC Trust's Incident management Policy and Procedures but these will reflect the position across all Trusts.

In addition, SAIs are specifically recorded and categorised in accordance with the criteria for reporting SAIs as set out in the HSCB procedure for the reporting and follow up of Serious Adverse Incidents (April 2010).

http://www.hscboard.hscni.net/publications/Policies/101%20Serious%20Adverse%20Incident%20-%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010%20-%20PDF%20268KB%20.pdf

The Procedure for the Reporting and Follow up of SAIs outlines the criteria for reporting organisations to determine whether or not an adverse incident constitutes a SAI. The criteria used are as follows:

- serious injury to, or the unexpected/unexplained death (including suspected suicides and serious self harm) of :
  - a service user
  - a service user known to Mental Health services (including Child and Adolescent Mental Health Services, (CAMHS) and Learning Disability (LD) within the last two years
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility.
- unexpected serious risk to a service user and/or staff member and/or member of the public
- unexpected or significant threat to provide service and/or maintain business continuity
- serious assault (including homicide and sexual assaults) by a service user
  - on other service users,
  - on staff or
  - on members of the public

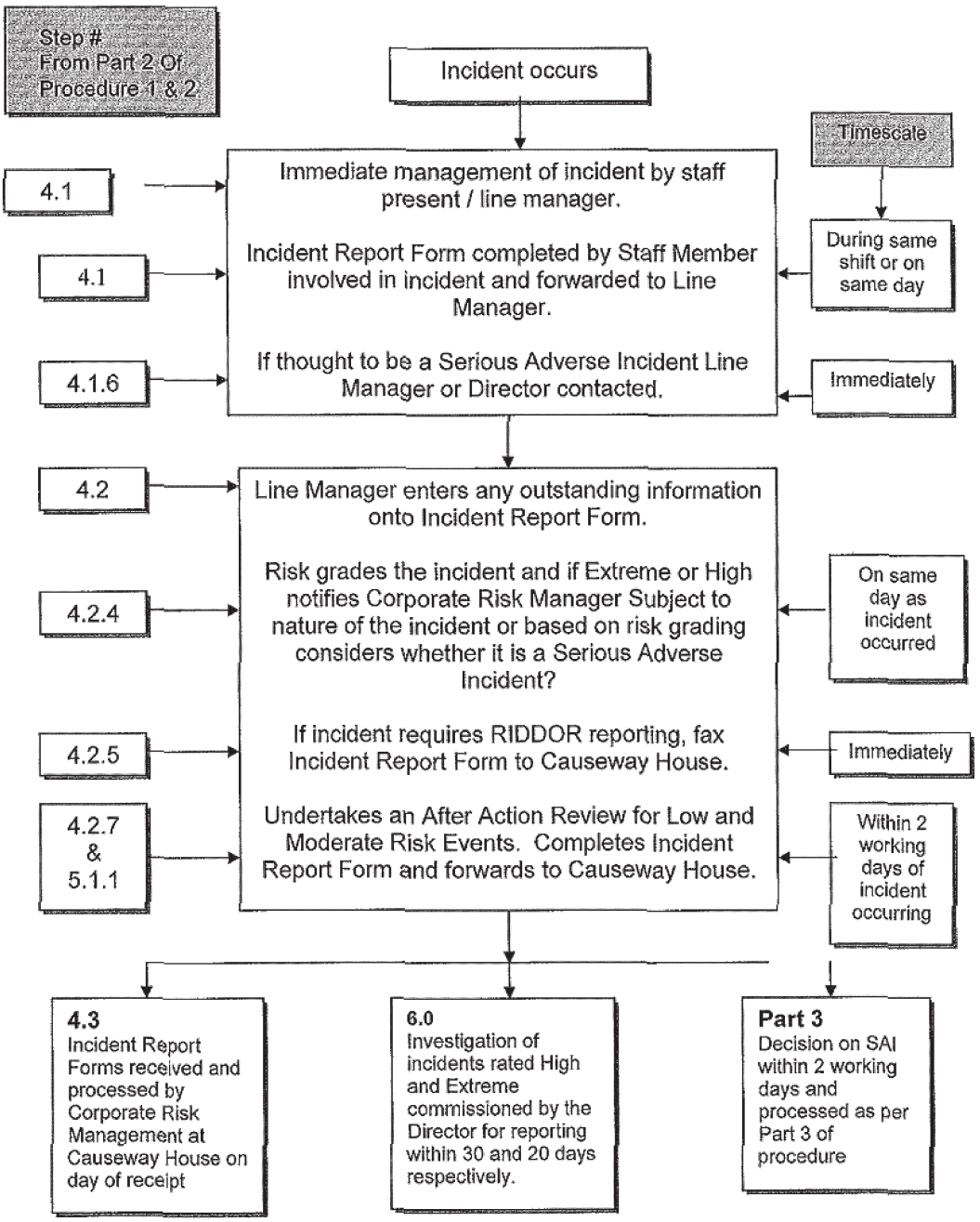
occurring within a healthcare facility or in the community (where the service user is known to mental health services (including CAMHS) or learning disability services within the last two years[1]).

- serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

When SAIs are received by the HSCB they are recorded on the DATIX risk management system; they are categorised under the nine programmes of care in line with DHSSPS Data Administration Bulletin (Programme of Care definitions) and also by a set of Common Classification System (CCS) codes. These codes are consistent with the DATIX risk management system which is used by all Trusts across the HSC.

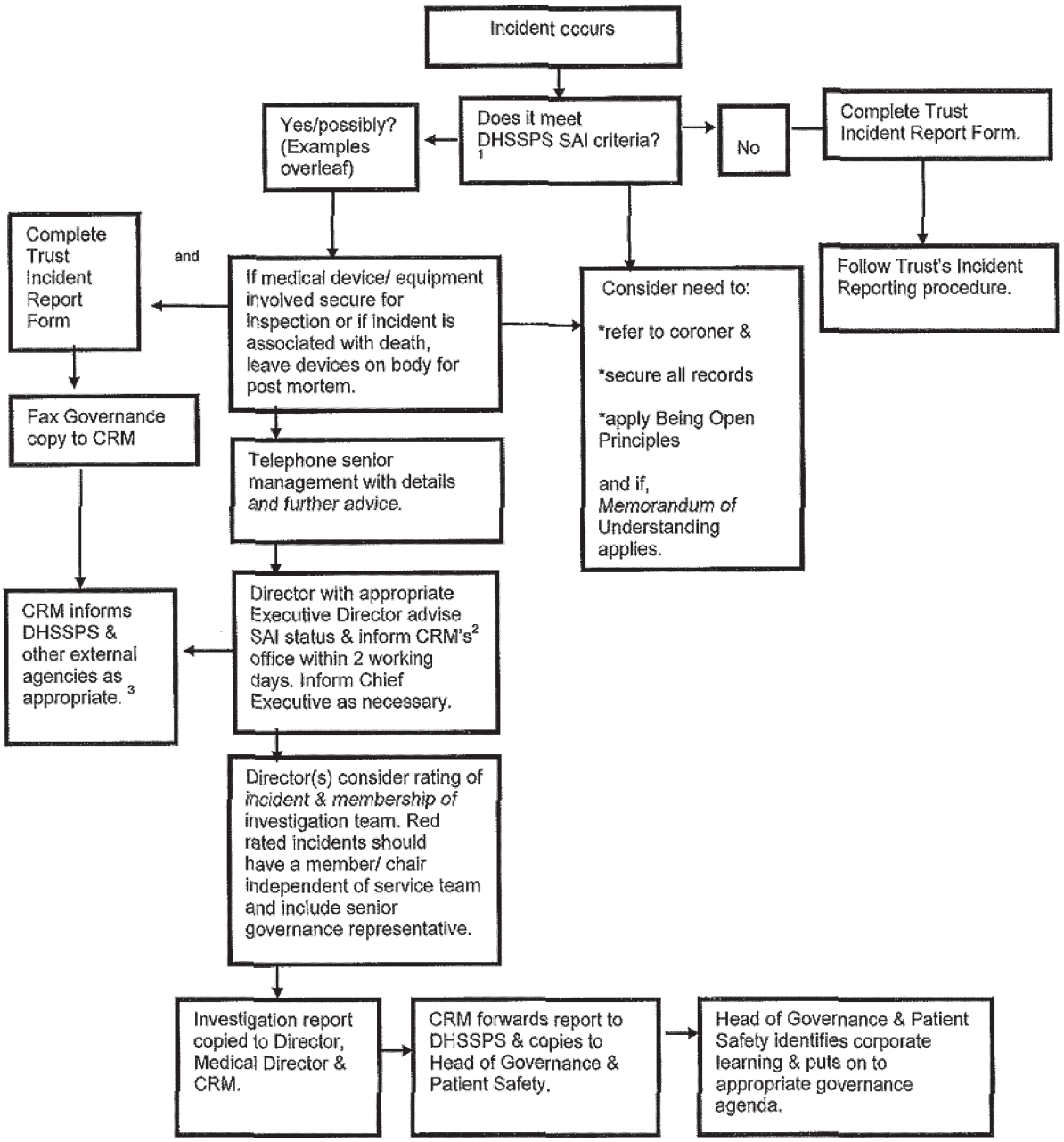
Appendix 1

Procedure for recording and reporting incidents



Appendix 2

PROCEDURE FOR IDENTIFYING & PROCESSING SERIOUS ADVERSE INCIDENTS



1.DHSSPS for SAI
* resulted in death
* regional learning
* media interest
ref to trigger list

2. CRM, Corporate Risk Manager, Alex Lynch
Tel: 028 9442 4635

3. Other agencies including:
MHC – Mental Health Commission
NIAC – re error using or in equipment/ medical devices
RQIA – regulated services other
NHSSB – Northern Health and Social Services Board

5) A sample of the learning communications disseminated by the HSC Boards to staff in response to its review of serious adverse incidents.

The two bi-annual learning reports produced by the HSC Board covering the periods 1 April 2011 – 30 September 2011 and 1 October 2011 – 31 March 2012 are attached below.

A third bi-annual learning report has been drafted and is pending approval. It will be forwarded to DHSSPS by the HSCB within the next few weeks.

In addition, the HSC Board also issues learning letters and recent examples are also attached.

- Letter dated 4 May 2012 - Learning from recent adverse incidents in maternity services
- Letter dated 22 May 2012 – Regional learning from a serious adverse incident (SAI) – Death following an accidental overdose of Warfarin
- Letter dated 22 May 2012 – Regional learning from a Serious Adverse Incident (SA) – Patients enrolled in a clinical trial
- Letter dated 28 June 2012 – Regional learning from a serious adverse incident (SAI) – flushing of a central line with the incorrect strength of heparin sodium injection

In addition to the HSC Board, the Department has also issued learning communications and examples of these are set as follows.

Supporting Safer Services Reports

Learning Communications - examples

Safety and Quality Learning Communication 02/11: Reducing the Risks Associated with Patients Taking Medication in Hospital Other Than That Prescribed as an Inpatient

http://www.dhsspsni.gov.uk/learning_communication_02_11

- issued following an incident involving the failure to recognise that a patient was taking medication
- linked to a Serious Adverse Incident
- to consider the best practice for their setting and take appropriate steps to minimise the risk to their patients of a similar incident occurring

Safety and Quality Learning Communication 01/09: Patients with Mental health Needs in the Acute Sector- Learning Lessons

http://www.dhsspsni.gov.uk/s___q_learning_communication_01_09.pdf

- issued (Jan 09) following the identification of a number of learning points arising from an investigation by a HSC Trust into the events surrounding the tragic death of a patient with mental health needs
- linked to a Serious Adverse Incident
- the recommendation from the investigation report related to: detaining & restraining patients under the Mental Health Order; staff training; communication among staff; and security access

Safety and Quality Learning Communication 05/09: Risk to patient safety of not using the H+C Number as the regional identifier for all patients and clients

http://www.dhsspsni.gov.uk/sqs_learning_communication_05_09_-_use_of_health_and_care_number_.pdf

- issued following NPSA highlighting the risk to patient safety of not using the NHS number as the national identifier for all patients. Reports to the NPSA about incidents arising from reliance on local hospital numbering systems demonstrate that there is real danger to patients of serious harm or death.
- linked to a Serious Adverse Incident
- with the introduction of the Health + Care Number (HCN) in Northern Ireland, similar patient/client safety considerations apply

National Learning Communications - examples

HSC (SQSD) 21/07: National Patient Safety Agency: Slips, trips and falls in hospital (PSO3)

http://www.dhsspsni.gov.uk/hsc__sqsd__21-07.pdf

- issued following the launch of NPSA's comprehensive report on patient falls in hospital
- to help assist in the practical implementation of falls prevention policies and to improve learning from falls

HSC (SQSD) 02/10: Preventing harm to children from parents with mental health needs

http://www.dhsspsni.gov.uk/hsc-sqsd02-10.pdf

- issued (March 2010) following a report undertaken by The National Confidential Inquiry into Suicides and Homicides (NCISH) – Filicide: A Literature Review.
- links with HSC (SQSD) 01/09 Patients with Mental health Needs in the Acute Sector-Learning Lessons(above)

HSC (SQSD) 28/07: NPSA Safe medication Alerts issued (June 2007) in response to NPSA's safer practice work programme (2007/2008)

http://www.dhsspsni.gov.uk/hsc__sqsd__28-07.pdf

- Actions that make anticoagulant therapy safer
- Promoting safer measurement and administration of liquid medicines via oral and other enteral routes
- Promoting safer use of injectable medicines
- Safer practice with epidural injections and infusions
- NPSA Alert 22 on reducing the risk of hyponatraemia when administering intravenous fluid therapy to children is highlighted in circular HSS(SQS)20-2007
- The NPSA Safe Medication Alerts have been designed to promote good practice and reduce the risk of harm. They are linked to the outcomes of the National Reporting and Learning System which has highlighted areas of high risk

HSS (MD) 17/2010: Physiological Early Warning Systems

HSS (MD) 39/2012: Physiological Early Warning Systems (PEWS) and the management of the deteriorating patient

http://www.dhsspsni.gov.uk/hss-md-17-2010.pdf

http://www.dhsspsni.gov.uk/hss-md-39-2012.pdf

- issued (April 2010) following a GAIN audit of the use of physiological early warning systems
- Consistent recording of physiological measurements (ie respiratory rate, pulse, blood pressure, temperature, alertness etc) being recorded as part of each set of observations.

- Escalation action to be performed and recorded when indicated by score.
- All observations for each patient to be recorded on an early warning system chart thus avoiding duplication.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

NCEPOD – A mixed bag report: An enquiry into the care of hospital patients receiving parenternal nutrition http://www.ncepod.org.uk/2010pn.htm

- Published by the National Confidential Enquiry into Patient Outcome and Death June 2010
- The enquiry reviewed the hospital care of 877 adult and 264 neonatal patients who were given parenternal nutrition (PN) and found good practice in less than a quarter of all cases
- Shared with HSC to note the report and its key findings and recommendations, to bring these to the relevant staff in your organisation & to consider the report and develop action plans to address the recommendations

National Confidential Inquiry into Suicides and Homicides (NCISH)

HSC (SQSD) 08/2007: National Confidential Inquiry: 5 year report into suicide and homicide by people with Mental Illness (NICISH)

http://www.dhsspsni.gov.uk/ncish-hss_sqsd_08_2007.pdf

- Issued (Jan 2007) following the publication of NCISH five year report into suicide and homicide by people with mental illness

HSC (SQSD) 51/2008: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Lessons for Mental Health Care in Scotland.

http://www.dhsspsni.gov.uk/hsc__sqsd__51-2008.pdf

- Issued (Oct 2008) Although specific to Scotland, the report's findings and recommendations will be of interest to those involved in the provision and delivery of mental health services in Northern Ireland.

Learning Communications (as a result of local intelligence)

Regulation and Quality Improvement Authority (RQIA) Reports

RQIA Report of Blood Safety Review – Issued February 2010.

http://www.rqia.org.uk/cms_resources/RQIA%20Blood%20Safety%20Report%2010%20Feb%202010.pdf

The RQIA was commissioned by the DHSSPS to carry out a review of the implementation in trusts and independent hospitals of DHSSPS Circular HSC (SQSD) 30/2007 dated 13 June 2007 and the addendum 02/08 dated 8 July 2008. These circulars relate to the National Patient Safety Agency (NPSA) Notice 14: Right Patient Right Blood.

Reducing the Risk of Hyponatraemia When Administering Intravenous Infusions to Children – Issued July 2010

http://www.rqia.org.uk/cms_resources/Hyponatraemia%20Report%207%20Jul%2010.pdf

The review team found there was evidence of improvement and commitment to achieving full compliance with the recommendations made in NPSA Safety Alert 22 and in the RQIA Hyponatraemia Review 2008.

6) **In response to the 4th recommendation at Appendix 2 of the 2002 Audit Office report, having issued guidance recommending that individual HSC bodies consider how to adopt the policy to proactively reduce potential negligence claims by early intervention, please confirm what action the Department took to follow up with each of the HSC bodies to establish whether this policy was adopted – and the number of HSC bodies without such a policy in place.**

Departmental circular HSS (F) 20/2002 entitled Clinical Negligence – Prevention of Claims and Claims Handling was issued in September 2002. The purpose of the circular was to advise HPSS Boards, Trusts and certain agencies of developments in the management of clinical negligence claims. HPSS bodies are asked: (i) to ensure that all claims managers and other relevant staff have access to the pre-action protocol; (ii) to examine their caseload to check the level of compliance with the time limits shown in it and rectify instances where the limits have been exceeded; and, (iii) to confirm in writing that their staff are actively taking its contents into account in processing cases. The circular contained an annual statement to be signed by Chief Executives confirming or otherwise that these and a number of other new obligations are being met. The statement was to be submitted by 30 June of each year.

A summary of returns received is set out below (2003 being the earliest year still held).

Year	Statements received
2003	15 out of 23 (4 Boards and 19 Trusts)
2004	16 out of 23 (4 Boards and 19 Trusts)
2005	17 out of 23 (4 Boards and 19 Trusts)
2006	15 out of 23 (4 Boards and 19 Trusts)
2007	6 out of 9 (4 Boards and 5 Trusts)
2008	9 out of 9 (4 Boards and 5 Trusts)
2009	4 out of 6 (4 Boards and 5 Trusts)

The requirement to provide this statement ceased with the issue of revised guidance on claims handling (HSS(SQSD) 05/10), as it was felt that equal assurance was already provided through Arms Length Bodies Governance Controls Assurance Standard and Risk Management Controls Assurance Standards. The handling of legal claims was also centralised in DLS who consider how and if early intervention would potentially reduce negligence claims, as part of ongoing case handling.

The Department's approach is to discharge its role in line with Managing Public Money NI reflecting that for 'Arms Length' Bodies it is the Board of the ALB and in particular the Chair and Non-Executive Directors who are charged with responsibility for ensuring that the ALB delivers on its statutory responsibilities and Ministers' priorities within the resource and policy framework set by the department

A significant component of any ALBs Governance arrangements connected to the safety of patients and clients will focus on how ALBs respond to and learn from instances where things have gone wrong and harm has occurred or could have occurred. However, overwhelmingly the main mechanism by which ALBs are required to ensure the safety of patients and clients is through ongoing good governance which provides assurances with regard to for example the estate e.g. the testing and safe handling of equipment and fire safety; Human Resources e.g.

regulation of the workforce, CPD, supervision, appraisal and revalidation; Quality of Services e.g. through regulation, audit and review

The Department is continuously seeking to strengthen the effectiveness of Governance within its ALBs and the Department's own role of sponsoring ALBs.

7) A chronology from 2002 of the reviews and continuous progress measures implemented by the Department to improve the safety of services.

The following sets out a chronology from 2002 of the reviews and continuous progress measures implemented by the Department to improve the safety of services

Best Practice Best Care (2002)

Published in May 2002, Best Practice Best Care (BPBC) aimed to put in place a framework to raise the quality of services and tackle issues of poor performance. BPBC has made an important contribution towards:

- Setting robust standards (through links with NICE and SCIE)
- Improving clinical and social care governance
- Improving regulation of the HSC workforce
- Introducing a Duty of Quality
- Establishing the Regulation and Quality Improvement Authority (RQIA)

Clinical and Social Care Governance (CSCG) (2003)

Guidelines to begin the process of developing and implementing clinical and social care governance (CSCG) arrangements across the HSC issued in January 2003. (HSS (PPM) 10/2002 refers)

The CSCG framework is intended to build on and strengthen existing activity relating to the delivery of high quality care and treatment. This includes: -

- continuing professional and personal development;
- audit;
- risk assessment and risk management;
- complaints management;
- evidence based practice;
- user involvement;
- identifying, promoting and sharing good practice, learning lessons from best practice as well as poor performance;
- significant event auditing; and
- professional regulation.

PSS (Quality, Improvement & Regulation) (Northern Ireland) Order 2003

Introduced a statutory duty of quality which placed a statutory requirement on the HSC Board and Trusts to put and keep in place arrangements for improving and monitoring the quality of HSC services they provide, that is, to put and keep in place a system of clinical and social care governance(CSCG).

The 2003 Order also established the Regulation and Quality Improvement Authority (RQIA). It has responsibility for regulating, inspecting and monitoring the standard and quality of HSC services provided by independent and statutory bodies in Northern Ireland.

Serious Adverse Incident Reporting System (2004)

The SAI Reporting System was introduced in 2004 – its purpose is to ensure an agreed approach to reporting, managing, analysing and learning from adverse incidents. (HSS (PPM) 06/2004 refers)

Service Level Agreement with the National Clinical Assessment Service (NCAS) (2004)

NCAS is a national service. It works to resolve concerns about the practice of doctors, dentists and pharmacists by providing case management services to health care organisations and to individual practitioners. It works with all parties to clarify the concerns, understand what is leading to them and make recommendations to help practitioners return to safe practice.

The Regulation and Quality Improvement Authority (RQIA) (2005)

RQIA took up its responsibilities on a phased basis from 1 April 2005.

Safety First: A Framework for Sustainable Improvement in the HPSS (2006)

Safety First was published in March 2006. It placed a particular focus on patient and client safety and led to further important developments which have ensured improved safety of services, such as the HSC Safety Forum and formal links with the National Patient Safety Agency in London

The Quality Standards for Health and Social Care (2006)

The Quality Standards for Health and Social Care was published in March 2006. The standards are designed to:

- give the HSC and other organisations a measure against which they can assess themselves and demonstrate improvement;
- help service users and carers to understand the quality of service to which they are entitled
- help to ensure implementation of the duty the HSC has in respect of human rights and equality of opportunity for the people of Northern Ireland; and
- enable formal assessment of the quality and safety of health and social care services.

External links established (2006)

On 1 July 2006, the Department established links with the National Institute for Health and Clinical Excellence (NICE) whereby all Clinical Guidelines and Technology Appraisals published by the Institute from that date are locally reviewed for their applicability in NI and, where appropriate, endorsed here. Under this arrangement, Northern Ireland also joined England, Scotland and Wales as full participants in the Interventional Procedures Programme.

Links were also established with the National Patient Safety Agency (NPSA) which issues regular safety alerts for action in the health service and which the DHSSPS communicates to HSC organisations for implementation. In addition, the DHSSPS participated along with the other countries in the UK in the Clinical Outcome Review Programme (which encompasses Confidential Enquiries) which conducts national confidential enquiries, and from which important learning is derived for application in Northern Ireland.

Memorandum of Understanding (MOU) between The DHSSPS (On behalf of the HSC) and the PSNI, HSENI and Coroner's Office on Investigation of Unexpected Death or Serious Harm (2006)

Developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations are required into a serious incident. (HSS (MD) 06/2006 refers)

Guidelines and Audit Implementation Network (GAIN) (2007)

GAIN was established in August 2007 as an amalgamation of the Clinical Resource Efficiency Support Team (CREST), Regional Multi-professional Audit Group (RMAG), and the Northern Ireland Regional Audit Advisory Committee (NIRAAC).

GAIN has an important safety and quality improvement role in HSC services throughout Northern Ireland through the commissioning of regional guidelines and audits as well as the promotion of good practice through the dissemination of audit results, and the publication and facilitation of implementation of regional guidelines.

HSC Safety Forum (2007)

The Forum was established in June 2007 to support organisations in their provision of safe, high quality care. The Forum has a number of aims:

- to be a regional resource for shared learning
- to proactively support the promotion of a safety culture
- to facilitate education and learning on improvement science and methodology
- to work to decide which interventions to implement in the future
- to promote collaborative working and facilitate shared learning
- to encourage the necessity of top table leadership
- to promote clinical and social care involvement
- to promote the involvement of patients.

Service Frameworks Programme (2007)

The Service Framework Programme began in 2007. The overall aim: to improve the health and well-being of the population, reduce inequalities and improve the quality of care. Service Frameworks set out the standards of care that patients, clients, their carers and wider family can expect to receive. The first round of Service Frameworks focused on the most significant causes for ill health and disability - cardiovascular health and wellbeing; respiratory health and wellbeing; cancer prevention, treatment and care; mental health and wellbeing; and learning disability. Work has also commenced to develop Service Frameworks for children and young people and older people.

Personal and Public Involvement (2007)

Guidance on strengthening Personal and Public Involvement (PPI) issued to assist HSC organisations improve the quality and effectiveness of user and public involvement as an integral part of good governance arrangements and to support the development of a more patient and user-centred HSC envisaged by the reform programme. (HSC (SQSD) 29/2007 refers)

Care Standards

The HPSS (Quality, Improvement and Regulation) (NI) Order 2003 allows for the regulation of a range of health and social care services, and for the development of minimum standards for these services. These standards focus on the safety, dignity, wellbeing and quality of life of service users. They are designed to address unacceptable variations in the standards of treatment, care and services and to raise the quality of services. To date the following standards have been developed:

- Nursing Homes Standards (2008),
- Residential Care Homes Standards (2008)
- Nursing Agencies Standards (date)
- Domiciliary Care Agencies Standards (2011)
- Residential Family Centres Standards (2011)
- Day Care Settings Standards (2012)
- Childminding and Day Care Standards (2012)

These will be used by RQIA, alongside the requirements of regulations, in making decisions on regulation of establishments and agencies.

The Health and Social Care (Reform) Act (NI) 2009

Introduced a specific duty on HSC Trusts to improve the health and social well-being of, and reduce health inequalities between those for whom it provides, or may provide, health and social care.

Complaints in HSC: Standards and Guidelines for Resolution and Learning (2009)

Effective from 1 April 2009 this introduced a new single-tier process for complaint handling (placing a renewed emphasis on the need for effective and robust local resolution). Complainants have access to the NI Commissioner for Complaints (the Ombudsman) where they remain dissatisfied with the outcome of the HSC Complaints Procedure. Complainants may also avail of independent help and advice from the Patient and Client Council (PCC).

Regional Adverse Incident Learning (RAIL) System (2010)

The development of a Northern Ireland wide, centralised database began in 2010. It is intended that the RAIL system will store, analyse and report on aggregated data emanating from all AIs (including SAIs and near misses) from across all HSC organisations so that the causal and contributory factors in patient and client safety can be assessed. RAIL will aim to address the gap in regional patient and client safety data by:

- maximising the reporting of adverse incidents (including near misses);

- ensuring that learning from all incidents and near misses, where relevant, is identified across the HSC;
- providing a mechanism to share learning from adverse incidents in a meaningful way within the HSC; and
- ensuring that learning from adverse incidents is put into practice in a timely manner.

The RAIL outline business case was passed to the Department in July 2012 and recommends a phased approach to implementation, with the first phase being a 12-18 month pilot to test and refine the system in practice, and determine the staffing, processes and system infrastructure required for RAIL to operate effectively in the longer term. The outline business case is revised following comment by Departmental advises. However, it is intended that the RAIL system will be fully operational by April 2014 subject to positive evaluation of the pilot phase, and approval of a future separate business case for the recurrent long term staffing and infrastructure.

Quality Strategy (2011)

Quality 2020 – A 10 Year Strategy to Protect and Improve Quality in health and Social Care in Northern Ireland was launched by Minister 17 November 2011. It defines quality for health and social care in terms of three key components: safety; effectiveness and patient/ client focus. It presents a clear Vision for the future, in which we aspire to be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care.

The implementation of Quality 2020 has commenced with the launch of the first tranche of projects in October 2012. These will focus on key areas for improvement and pave the way for further project work during the life of the strategy. It is intended that the implementation provide both a strategic 'agenda' and 'context' for quality improvement. It is not simply about a programme of new projects or strategic initiatives, important as they will be in driving forward necessary change and innovation. It is also about recognising and, where appropriate, endorsing the often self-initiated activity of HSC bodies across a multitude of quality improvement initiatives which they all undertake on an on-going basis in seeking to fulfil their Statutory Duty of Quality.

8) **Paragraph 3.10 of the Audit Office report highlights that the acute sector here has an adverse incident rate half that reported in England and Wales (35 % compared with 75%). Notwithstanding the different health and social care structures here, you have accepted that this suggests that there is under-reporting in the Northern Ireland acute sector.**

What assurances can the department give to the public that open, honest reporting is part of the culture of health and social care services?

The Department acknowledges that the data provided by the NRLS on reporting across England and Wales would suggest that there is under-reporting in the Northern Ireland acute sector.

However, comparisons between countries or healthcare systems are not straightforward as:

- the definitions of incident vary and therefore it is difficult to know if countries are reporting using similar definitions; e.g. suicides are reported under NI's SAI system
- the criteria for reporting may vary from country to country;
- Northern Ireland has an integrated Health and Social Care system which is unique. Throughout the UK, local councils are responsible for delivering components of Health and Social Care.

In relation to the NI Audit Office finding regarding the comparable rate of serious adverse incidents, acute SAIs account for approximately 20% of the total SAI activity reported from

across health and social care for the period 1 May 2010 – 31 March 2012. However, in attempting to draw a comparison with England and Wales, when social care SAIs are excluded from overall activity, the percentage of acute sector SAIs is in the region of 65%.

The Department is committed to the highest possible standards of conduct, openness, honesty and accountability in HSC services. The Department, HSC Board and Trusts will continue working to improve their safety culture and are encouraging the timely and open reporting of incidents at all levels - organisational and individual level through:

- The SAI Reporting System
- Whistle blowing policy
- HSC Complaints Procedure
- Clinical and social care governance and risk management arrangements

Reporting is promoted through the promotion of an informed safety culture across the HSC. The DHSSPS takes a "systems" approach to preventing incidents. Rather than blaming individuals, this approach seeks to indentify the underlying causes of incidents, learn from them, and take action to put things right. This approach promotes a culture of openness and transparency and encourages staff to acknowledge errors, investigate the events leading to the error and to disseminate any learning gained as a result of the investigation.

All Trusts are taking proactive steps to implement the web based datix adverse incident reporting system across their organisations. This means that all staff will be able to report incidents on a real time web based system from any Trust computer. The training that was rolled out with this implementation specifically focussed on appropriate reporting and feedback mechanisms to ensure learning. This requires on-going, targeted work to ensure confidence and participation by staff.

All staff are actively encouraged to report incidents and this practice is continuing to be promoted through corporate, directorate and divisional governance structures.

In addition, each Trust has a whistleblowing policy which encourages staff to report concerns, and provides a variety of options for staff to report outside line management arrangements if they feel their concerns are not being listened to.

The Department through the Trusts actively promotes an open culture, in which errors or service failures can be reported and discussed; and to ensure that, where lessons are identified, the necessary changes are put into practice. Staff are expected to, and must, make themselves fully aware of the relevant incident policy and procedures and the arrangements in place for the reporting, investigation and management of incidents.

9) In terms of under-reporting, what assurances can you give that it is not the more serious type of adverse incident which is not reported given that cases of this nature would attract most public attention and possible litigation?

The Department through Trusts actively encourages the reporting of all adverse incidents and SAIs. However, it is not possible to provide an absolute assurance in this regard but Trusts have confidence that systems are sufficiently robust to pick up on all or most cases. However, if a Trust becomes aware of an incident through other means rather than a formal notification of an adverse incident (eg, complaint, legal claim, coroners case or media enquiry) each case would be considered on an individual basis and investigated in accordance with the relevant policy. It would also be escalated and reported as an adverse incident/SAI or Early Alert, as appropriate and the reasons why it was not previously reported would be identified.

The Department requires all arm's-length bodies to have effective policies in place to deal with whistle-blowing at a local level. Recently, Minister wrote to all staff in the HSC to highlight the importance of their having the confidence to blow the whistle where they have genuine concerns, particularly around patient safety.

The aims and objectives of this policy are to promote a culture of openness, transparency and dialogue which at the same time should reassure staff that they will not be penalised for raising a genuine concern and gives them a process to follow that upholds patient confidentiality and should not unreasonably undermine confidence in the service. This policy enables the HSC to demonstrate to staff and the public that it is ensuring its affairs are carried out ethically, honestly and to high standards.

10) An analysis of the 83,000 adverse incidents that led to harm, loss or damage to people or property, environment or reputation and a summary detailing how many of the individuals were notified.

The following table provides a breakdown by organisation of the 83,000 adverse incidents reported in 2011/12.

Organisation	Number of adverse incidents
Belfast HSC Trust	22,682
Northern HSC Trust	10,771
South Eastern HSC Trust	15,574
Southern HSC Trust	8,422
Western HSC Trust	8,523
NI Ambulance Service HSC Trust	2,254
RQIA	14,742
Total	**82,968**

An analysis by each organisation of adverse incidents is provided in the attached spreadsheets.

Belfast HSC Trust

BHSCT Incidents by Sub Category and Category
Incident date: 1/4/11 to 31/3/12

Sub Category (CCS Level 2)	Category (CCS Level 1)																
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Abdominal organs other than digestive	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Placental abruption	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	5
Administration of assessment	0	0	0	0	37	0	0	0	0	0	0	0	0	0	0	0	0	37
Administration or supply of a medicine from a clinical area	0	0	0	0	0	0	0	0	0	0	0	0	903	0	0	0	0	903
Admission	103	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	103
Advice	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Anaesthetic problem connected with labour or delivery	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
Leaking abdominal aortic embolism	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Appointment	99	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	99
Arteries and veins	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	11

	Sub Category (CCS Level 2)	Category (CCS Level 1)																	
		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
	24-hour monitoring of "at risk" mental patients	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
	Born before arrival	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	6
	Transfusion of Blood related problem	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	276	276
	Bones or joints other than skull or spine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
	Breech presentation	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	5
	Abuse by the staff to the patient	0	54	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	54
	Cancer - Dx failed or delayed	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
	Communication between staff, teams or departments	0	0	0	0	0	396	0	0	0	0	0	0	0	1	0	0	0	397
	Communication with the patient (other than consent issues)	0	0	0	0	0	55	0	0	0	0	0	0	0	0	0	0	0	55
	Confidentiality of information	0	0	0	0	0	58	0	0	0	0	0	0	0	0	0	0	0	58
	Consent	0	0	0	0	0	31	0	0	0	0	0	0	0	0	0	0	0	31
	Cord prolapse	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3

Sub Category (CCS Level 2)	Category (CCS Level 1)																		
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Elective Caesarean Section	0	0	0	0	0	0	0	0	0	0	20	0	0	0	0	0	0	20
Emergency Caesarean Section	0	0	0	0	0	0	0	0	0	0	32	0	0	0	0	0	0	32
Upper Digestive tract	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Difficult delivery	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	7
Discharge	833	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	833
Patient's case notes or records	0	0	0	0	0	0	0	0	372	0	0	0	0	0	0	0	0	372
Patient's case notes or records	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Shoulder dystocia	0	0	0	0	0	0	0	0	0	0	33	0	0	0	0	0	0	33
Ectopic or other complications of pregnancy	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Environmental matters	0	0	0	0	0	0	0	0	0	150	0	0	0	0	0	0	0	150
Electronic Patient Record	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0	0	0	11
Equipment related	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Security issue related to Equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	46	0	46
Eye (OPCS4 - C01-C086)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2

		Category (CCS Level 1)																		
Sub Category (CCS Level 2)		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Lack of/delayed availability of facilities/equipment/supplies		0	0	0	0	0	0	0	0	0	314	0	0	0	0	0	0	0	314
Slips, trips, falls and collisions		0	0	5375	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5375
Lower female genital tract		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	7
Upper female genital tract		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Pathological or suspicious CTG or other fetal distress		0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	7
Financial Loss		0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Fires, fire alarms and fire risks		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	193	0	193
Inadequate maintenance of fluids		0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Labour assisted by forceps		0	0	0	0	0	0	0	0	0	0	16	0	0	0	0	0	0	16
Fracture - Dx failed or delayed		0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	3
Exposure to electricity, hazardous substance, infection etc		0	0	184	0	0	0	0	0	0	0	0	0	0	0	0	0	0	184
Operations on the Heart		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4
Unplanned homebirth		0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Staff records or information		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	3

Sub Category (CCS Level 2)	Category (CCS Level 1)																	
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Hysterectomy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Images for diagnosis (scan / x-ray)	0	0	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	14
Scans / X-ray images	0	0	0	0	0	0	0	0	12	0	0	0	0	0	0	0	0	12
Infection control	0	0	0	0	0	0	0	0	0	0	0	0	0	127	0	0	34	161
Injury or damage connected with Anaesthesia	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Delivery using more than one instrument	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Intrapartum haemorrhage	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Information Technology	0	0	0	0	0	0	0	0	0	120	0	0	0	0	0	0	0	120
IUGR or placental insufficiency	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Laboratory investigations	0	0	0	0	229	0	0	0	0	0	0	0	0	0	0	0	0	229
Lifting accidents	0	0	135	0	0	0	0	0	0	0	0	0	0	0	0	0	0	135
Prolonged first or second stage of labour	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Male genital organs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Medical device/equipment	0	0	0	0	0	0	0	0	0	0	0	926	0	0	0	0	0	926

	Sub Category (CCS Level 2)	Category (CCS Level 1)																	
		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
	Some other medical condition	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
	Possible delay or failure to Monitor	0	0	0	0	0	0	0	0	0	0	0	0	0	176	0	0	0	176
	Monitoring or follow up of medicine use	0	0	0	0	0	0	0	0	0	0	0	0	38	0	0	0	0	38
	Injury or poor outcome for the mother	0	0	0	0	0	0	0	0	0	0	113	0	0	0	0	0	0	113
	Mouth	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	8
	Neurological factor	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Abuse etc of Staff by patients	0	2860	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2860
	Public order, Protests, Bomb scares,Riot, Disorder	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	8
	Supply or use of Over The Counter medicines	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
	Abuse - other	0	1028	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1028
	Accident caused by some other means	0	0	813	0	0	0	0	0	0	0	0	0	0	0	0	0	0	813
	Appointment, Admission, Transfer, Discharge - other	14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14

Sub Category (CCS Level 2)	Category (CCS Level 1)																	
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Anaesthesia - other	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Assessment - other	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4
Consent, Confidentiality or Communication - other	0	0	0	0	0	8	0	0	0	0	0	0	0	0	0	0	0	8
Diagnosis - other	0	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	6
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	131	0	0	131
Infrastructure or resources - other	0	0	0	0	0	0	0	0	0	35	0	0	0	0	0	0	0	35
Information - other	0	0	0	0	0	0	0	0	29	0	0	0	0	0	0	0	0	29
Labour or delivery - other	0	0	0	0	0	0	0	0	0	0	136	0	0	0	0	0	0	136
Other medication error	0	0	0	0	0	0	0	0	0	0	0	0	20	0	0	0	0	20
Implementation of care or ongoing monitoring - other	0	0	0	0	0	0	0	0	0	0	0	0	0	137	0	0	0	137
Security - other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	61	0	61
Treatment, procedure - other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70	70
Patient complains of inadequate pain management	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Patient factor	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3

	Sub Category (CCS Level 2)	Category (CCS Level 1)																	
		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
	Patient's reaction to Medication	0	0	0	0	0	0	0	0	0	0	0	0	50	0	0	0	0	50
	Abuse etc of patient by patient	0	1502	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1502
	Post-partum haemorrhage > 1,000ml	0	0	0	0	0	0	0	0	0	0	29	0	0	0	0	0	0	29
	Security incident related to Premises, Land or Real Estate	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	120	0	120
	Preoperative factor	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	Preparation of medicines / dispensing in pharmacy	0	0	0	0	0	0	0	0	1	0	0	0	233	0	0	0	0	234
	Medication error during the prescription process	0	0	0	0	0	0	0	0	0	0	0	0	492	0	0	0	0	492
	Placenta praevia	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	4
	Security incident related to Personal property	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	264	0	264
	Pulmonary embolism postoperatively	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	4
	Problems following radiation therapy	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1

Sub Category (CCS Level 2)	Category (CCS Level 1)																
	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Patient's case notes or records	0	0	0	0	9	0	0	0	0	0	0	0	0	0	0	0	0	9
Problem with the referral from primary to secondary care	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Respiratory factor	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Respiratory Tract	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	10
Ruptured uterus	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	4
Self-harm during 24-hour care	0	709	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	709
Self harm in primary care, or not during 24-hour care	0	165	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	165
Needlestick injury or other incident connected with Sharps	0	0	293	0	0	0	0	0	0	0	0	0	0	0	0	0	0	293
Skin	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35	35
Bones and joints of skull and spine	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Soft tissue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Adverse events that affect staffing levels	0	0	0	0	0	0	0	0	0	607	0	0	0	0	0	0	0	607
Abuse of staff by other staff	0	33	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	33

	Category (CCS Level 1)																					
Sub Category (CCS Level 2)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Injury caused by physical or mental strain	0	0	21	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21
Connected with the management of operations / treatment	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	447	448
Test results / reports	0	0	0	0	0	0	0	0	124	0	0	0	0	0	0	0	0	124
Transfer	125	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	125
Pressure sore / decubitus ulcer	0	0	0	0	0	0	0	0	0	0	0	0	0	358	0	0	0	358
Urinary	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Security issue related to Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	26	0	26
Delivery assisted by ventouse	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Totals:	**1181**	**6351**	**6821**	**12**	**293**	**548**	**13**	**2**	**549**	**1226**	**433**	**926**	**1741**	**810**	**131**	**721**	**924**	**22682**

Northern HSC Trust

NHSCT Incidents opened between 01/04/2011 and 31/03/2012

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Abdominal organs other than digestive	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Placental abruption	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Administration of assessment	0	0	0	15	0	0	0	0	0	0	0	0	0	0	15
Admission	31	0	0	0	0	0	0	0	0	0	0	0	0	0	31
Appointment	10	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Arteries and veins	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Born before arrival	0	0	0	0	0	0	0	7	0	0	0	0	0	0	7
Transfusion of Blood related problem	0	0	0	0	0	0	0	0	0	0	0	0	0	13	13
Breech presentation	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Abuse by the staff to the patient	0	5	0	0	0	0	0	0	0	0	0	0	0	0	5
Communication between staff, teams or departments	0	0	0	0	172	0	0	0	0	0	0	0	0	0	172
Communication with the patient (other than consent issues)	0	0	0	0	56	0	0	0	0	0	0	0	0	0	56
Confidentiality of information	0	0	0	0	19	0	0	0	0	0	0	0	0	0	19
Consent	0	0	0	0	3	0	0	0	0	0	0	0	0	0	3
Elective Caesarean Section	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Emergency Caesarean Section	0	0	0	0	0	0	0	21	0	0	0	0	0	1	22
Lower digestive tract	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Upper Digestive tract	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Difficult delivery	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Discharge	569	0	0	0	0	0	0	0	0	0	0	0	0	0	569
Patient's case notes or records	0	0	0	0	0	107	0	0	0	0	0	0	0	0	107
Shoulder dystocia	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Environmental matters	0	0	0	0	0	0	21	0	0	0	0	0	0	0	21
Electronic Patient Record	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Security issue related to Equipment	0	0	0	0	0	0	0	0	0	0	0	0	6	0	6
Lack of/delayed availability of facilities/equipment/supplies	0	0	0	0	0	0	41	0	0	0	0	0	0	0	41
Slips, trips, falls and collisions	1	0	3856	0	0	0	0	0	0	0	0	0	0	0	3857
Pathological or suspicious CTG or other fetal distress	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Fires, fire alarms and fire risks	0	0	0	0	0	0	0	0	0	0	0	0	45	0	45
Inadequate maintenance of fluids	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Labour assisted by forceps	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
Exposure to electricity, hazardous substance, infection etc	0	0	91	0	0	0	0	0	0	0	0	0	0	0	91
Images for diagnosis (scan / x-ray)	0	0	0	7	0	0	0	0	0	0	0	0	0	0	7
Scans / X-ray images	0	0	0	0	0	30	0	0	0	0	0	0	0	0	30
Infection control	0	0	0	0	0	0	0	0	0	0	8	0	0	2	10
Laboratory investigations	0	0	0	55	0	0	0	0	0	0	0	0	0	0	55

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Lifting accidents	0	0	105	0	0	0	0	0	0	0	0	0	0	0	105
Prolonged first or second stage of labour	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Medical device/equipment	0	0	0	0	0	0	0	0	218	0	0	0	0	0	218
Possible delay or failure to Monitor	0	0	0	0	0	0	0	0	0	0	17	0	0	0	17
Injury or poor outcome for the mother	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
Mouth	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Abuse etc of Staff by patients	0	1344	0	0	0	0	0	0	0	0	0	0	0	0	1344
Abuse - other	0	178	0	0	0	0	0	0	0	0	0	0	0	0	178
Accident caused by some other means	0	0	459	0	0	0	0	0	0	0	0	0	0	0	459
Appointment, Admission, Transfer, Discharge - other	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Assessment - other	0	0	0	4	0	0	0	0	0	0	0	0	0	0	4
Consent, Confidentiality or Communication - other	0	0	0	0	34	0	0	0	0	0	0	0	0	0	34
Other	0	0	0	0	0	0	0	0	0	0	0	1068	0	0	1068
Infrastructure or resources - other	0	0	0	0	0	0	10	0	0	0	0	0	0	0	10
Information - other	0	0	0	0	0	54	0	0	0	0	0	0	0	0	54
Labour or delivery - other	0	0	0	0	0	0	0	58	0	0	0	0	0	0	58
Other medication error	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2
Implementation of care or ongoing monitoring - other	0	0	0	0	0	0	0	0	0	0	50	0	0	0	50
Security - other	0	0	0	0	0	0	0	0	0	0	0	0	12	0	12

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Treatment, procedure - other	0	0	0	0	0	0	0	0	0	0	0	0	0	47	47
Patient's reaction to Medication	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2
Abuse etc of patient by patient	0	570	0	0	0	0	0	0	0	0	0	0	0	0	570
Post-partum haemorrhage > 1,000ml	0	0	0	0	0	0	0	4	0	0	0	0	0	0	4
Security incident related to Premises, Land or Real Estate	0	0	0	0	0	0	0	0	0	0	0	0	73	0	73
Security incident related to Personal property	0	0	0	0	0	0	0	0	0	0	0	0	66	0	66
Patient's case notes or records	0	0	0	4	0	0	0	0	0	0	0	0	0	0	4
Problem with the referral from primary to secondary care	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Ruptured uterus	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Self-harm during 24-hour care	0	265	0	0	0	0	0	0	0	0	0	0	0	0	265
Self harm in primary care, or not during 24-hour care	0	33	0	0	0	0	0	0	0	0	0	0	0	0	33
Needlestick injury or other incident connected with Sharps	0	0	106	0	0	0	0	0	0	0	0	0	0	0	106
Skin	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Adverse events that affect staffing levels	0	0	0	0	0	0	104	0	0	0	0	0	0	0	104
Abuse of staff by other staff	0	13	0	0	0	0	0	0	0	0	0	0	0	0	13
Connected with the management of operations / treatment	0	0	0	0	0	0	0	0	0	0	1	0	0	38	39
Test results / reports	0	0	0	0	0	39	0	0	0	0	0	0	0	0	39

	STAGE OF CARE (CCS LEVEL 1)														
DETAIL (CCS LEVEL 2)	**AATD**	**ABUSE**	**ACCID**	**ASSESS**	**CCCP**	**INFO**	**INFRA**	**LABOUR**	**MEDDEV**	**MEDIC**	**MONIT**	**OTHER**	**SECRTY**	**TMTPRO**	**Total**
Transfer	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Twin delivery or multiple birth	0	0	0	0	0	0	0	2	0	0	0	0	0	0	2
Pressure sore / decubitus ulcer	0	0	0	0	0	0	0	0	0	0	127	0	0	0	127
Security issue related to Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	10	0	10
Delivery assisted by ventouse	0	0	0	0	0	0	0	4	0	0	0	0	0	0	4
MEDICATION STAGE															
Administration/supply of a medicine from a clinical area	0	0	0	0	0	0	0	0	0	218	0	0	0	0	218
Advice	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Monitoring/follow-up of medicine use	0	0	0	0	0	0	0	0	0	7	0	0	0	0	7
Other	0	0	0	0	0	0	0	0	0	74	0	0	0	0	74
Preparation of medicines/dispensing in a pharmacy	0	0	0	0	0	0	0	0	0	28	0	0	0	0	28
Prescribing	0	0	0	0	0	0	0	0	0	78	0	0	0	0	78
Supply or use of over-the-counter (OTC) medicine	0	0	0	0	0	0	0	0	0	8	0	0	0	0	8
Totals:	**624**	**2408**	**4617**	**85**	**284**	**231**	**176**	**114**	**218**	**422**	**204**	**1068**	**212**	**108**	**10771**

South Eastern HSC Trust

South Eastern
Incidents by Sub category and Type
1 April 2011 to 31 March 2012

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Acute transfusion reaction	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Administration	404	0	0	0	0	0	0	0	0	0	0	0	0	404
Alleged assault/abuse by other	0	0	0	0	0	0	0	0	0	0	0	6	0	6
Alleged assault/abuse by pt/clt/res	0	0	0	0	0	0	0	0	0	0	0	13	0	13
Alleged assault/abuse by pt/clt/res (weapon)	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Actual Assault/abuse by other (weapon involved)	0	0	0	0	0	0	0	0	0	0	0	3	0	3
Actual Assault/abuse by pt/clt/res (weapon involved)	0	0	0	0	0	0	0	0	0	0	0	7	0	7
Assisted to floor	93	0	0	0	0	0	0	0	0	0	0	0	0	93
Actual Assault/abuse by other	0	0	0	0	0	0	0	0	0	0	0	24	0	24
Actual Assault/abuse by pt/clt/res	0	0	0	0	0	0	0	0	0	0	0	1210	0	1210
Awaited	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Bed Management	2	0	0	0	0	0	0	0	0	0	0	0	0	2

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Delay in obtaining bleep holder or on-call staff	36	0	0	0	0	0	0	0	0	0	0	0	0	36
Bruising noted (cause unknown)	15	0	0	0	0	0	1	0	0	0	0	0	0	16
CDI	9	0	0	0	0	0	0	0	0	0	0	0	0	9
Incorrect documentation - Consent details incorrect/omitted	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Contact with electricity	0	0	0	0	0	0	0	7	0	0	0	0	0	7
Choking/Potential to choke	21	0	0	0	0	0	0	0	0	0	0	0	0	21
Contact with hot or very cold surface, object or substance	0	0	0	0	0	0	0	64	0	0	0	0	0	64
Collection or Delivery of blood from/to wards/lab/blood bank	7	0	0	0	0	0	0	0	0	0	0	0	0	7
Community Acquired Pressure Ulcer (Trust Patient)	59	0	0	0	0	0	0	0	0	0	0	0	0	59
*Breach of Confidentiality	16	0	0	0	0	0	0	0	0	0	0	0	0	16
Item dirty/contaminated - foreign body	149	0	0	0	0	0	0	0	0	0	0	0	0	149
Cut/Contact with sharp material/object (not needlestick)	0	0	0	0	0	0	0	86	0	0	0	0	0	86
Item dirty/contaminated - tissue	28	0	0	0	0	0	0	0	0	0	0	0	0	28
Item dirty/contaminated - not specified	10	0	0	0	0	0	0	0	0	0	0	0	0	10

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Possible fall from bed (bedrails not specified)	142	0	0	0	0	0	0	0	0	0	0	0	0	142
Incorrect documentation - consent form not signed by pt/doctor	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Theatre list incorrectly typed by secretary	7	0	0	0	0	0	0	0	0	0	0	0	0	7
Arrival at theatre without correct consent documentation	6	0	0	0	0	0	0	0	0	0	0	0	0	6
Incorrect consent documentation - wrong body part/side listed	5	0	0	0	0	0	0	0	0	0	0	0	0	5
Incorrect consent form used	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Delayed Discharge/Transfer	24	0	0	0	0	0	0	0	0	0	0	0	0	24
*Delay in obtaining records	5	0	0	0	0	0	0	0	0	0	0	0	0	5
Delayed Sample	15	0	0	0	0	0	0	0	0	0	0	0	0	15
Disposal (sharps bin)	0	0	0	0	0	0	0	0	0	14	0	0	0	14
Disposal of sharps/biological agent (improper)	0	0	0	0	0	0	0	0	0	11	0	0	0	11
Dispensing	195	0	0	0	0	0	0	0	0	0	0	0	0	195
Damaged/wet packaging	9	0	0	0	0	0	0	0	0	0	0	0	0	9
Dog Bite	0	0	0	0	0	0	0	3	0	0	0	0	0	3

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
*Breach of DPA Legislation	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Failure to comply with EU Directive (eg traceability)	13	0	0	0	0	0	0	0	0	0	0	0	0	13
Exposed to infection	19	0	0	0	0	0	0	0	0	0	0	0	0	19
Expected death	6	0	0	0	0	0	0	0	0	0	0	0	0	6
Exposure to radiation	6	0	0	0	0	0	0	0	0	0	0	0	0	6
Fall from bed (bedrails up)	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Fall from bed (bedrails down)	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Possible fall from bed (bedrails down)	26	0	0	0	0	0	0	0	0	0	0	0	0	26
Possible fall from bed (bedrails up)	59	0	0	0	0	0	0	0	0	0	0	0	0	59
Possible fall from chair height	332	0	0	0	0	0	0	0	0	0	0	0	0	332
Fall from bed	27	0	0	0	0	0	0	0	0	0	0	0	0	27
Fall from height	0	0	0	0	0	0	0	17	0	0	0	0	0	17
Fall whilst mobilizing (assisted)	39	0	0	0	0	0	0	0	0	0	0	0	0	39
Possible fall while mobilizing	588	0	0	0	0	0	0	0	0	0	0	0	0	588
Fall whilst mobilizing (unassisted)	91	0	0	0	0	0	0	0	0	0	0	0	0	91
Item faulty/broken	7	0	0	0	0	0	0	0	0	0	0	0	0	7
Use of firearms	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Fall from chair/commode/toilet etc	62	0	0	0	0	0	0	0	0	0	0	0	0	62

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Failure to act on results	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Found on floor - cause unknown	888	0	0	0	0	0	0	0	0	0	0	0	0	888
Hanging	22	0	0	0	0	0	0	0	0	0	0	0	0	22
Hit by moving vehicle	0	0	0	0	0	0	0	3	0	0	0	0	0	3
Road Traffic Accident	0	0	0	0	0	0	0	0	0	0	55	0	0	55
Hospital Acquired Pressure Ulcer	143	0	0	0	0	0	0	0	0	0	0	0	0	143
Exposure to or contact with harmful substance	0	0	0	0	0	0	0	5	0	0	0	0	0	5
Incorrect blood/component transfused	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Insufficient Information to allow coding by Pharmacy	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Issue of blood or blood products from blood bank	7	0	0	0	0	0	0	0	0	0	0	0	0	7
Jumping/multiple injuries	1	0	0	0	0	0	0	0	0	0	0	0	0	1
*Documentation - incorrect patient labels used or in file	14	0	0	0	0	0	0	0	0	0	0	0	0	14
Lifting/lowering (general)	0	0	0	0	0	22	0	0	0	0	0	0	0	22
Lifting/lowering (waste handling)	0	0	0	0	0	3	0	0	0	0	0	0	0	3
Lost Sample	10	0	0	0	0	0	0	0	0	0	0	0	0	10
Manoeuvring equipment with pt/client	0	0	0	0	0	7	0	0	0	0	0	0	0	7

Sub-Category (Level 3)	Clinical Incidents	Environmental Incidents	Fire Incidents	Harrassment Incidents	Ill Health Incidents	Manual Handling Incidents	Other Incidents	Personal Accidents	Security Incidents	Sharps & Needlestick Incidents	Vehicle Incidents	Violence/ Abuse Incidents	Waste Incidents	Total
Possibly due to medical condition	61	0	0	0	0	0	0	0	0	0	0	0	0	61
Due to medical condition	19	0	0	0	0	0	0	0	0	0	0	0	0	19
For Medication	13	0	0	0	0	0	0	0	0	0	0	0	0	13
Document/Labels misfiled	45	0	0	0	0	0	0	0	0	0	0	0	0	45
Documentation - incorrect/missing/ inadequate/illegible records	76	0	0	0	0	0	0	0	0	0	0	0	0	76
Mislabelled or wrong patient ID	45	0	0	0	0	0	0	0	0	0	0	0	0	45
*Missing Records	18	0	0	0	0	0	0	0	0	0	0	0	0	18

Southern HSC Trust

Incidents by Adverse event and Stage of care

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Absconder/missing patient - detained	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Absconder/missing patient - voluntary	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Admission could not be arranged / failure to admit	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Adverse reaction when drug used as intended	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Affray, fights, disorderly behaviour	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
False fire or intruder alarm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47	0	47
Medication prescribed to which p. had a known allergy	0	0	0	0	0	0	0	0	0	0	0	12	0	0	0	0	12
Ambulance was late or failed to show up	14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14
Wrong quantity	0	0	0	0	0	0	0	0	0	0	0	17	0	0	0	0	17

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Appointment recording error	17	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	18
Cardiac arrest	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Actual or suspected Arson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	5
Inadequate assessment	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Delay / difficulty in obtaining clinical assistance	1	0	0	0	4	0	0	0	0	0	0	0	3	0	0	1	9
Awareness / dreaming / nightmare	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Lack of/delayed availability of beds (general)	4	0	0	0	0	0	0	0	12	0	0	0	0	0	0	0	16
Lack of/delayed availability of beds (high dependency/ICU)	0	0	0	0	0	0	0	0	9	0	0	0	0	0	0	0	9
Stretching or bending injury, other than lifting	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Exposure to biological hazard	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	15
Failure to answer bleep	0	0	0	0	0	9	0	0	0	0	0	0	0	0	0	0	9
Bomb threat/scare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0	5

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Breach of patient confidentiality	0	0	0	0	0	19	0	0	0	0	0	0	0	0	0	0	19
Other breach of security or public order	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0	10
Breathing system problem / failure	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Contact with very hot or very cold surface	0	0	35	0	0	0	0	0	25	0	0	0	0	0	0	0	60
Inadequate check on equipment	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	4
Exposure to chemical	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Injury from clean sharps	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	10
Collapse of a structure or fitting	0	0	34	0	0	0	0	0	0	0	0	0	0	0	0	0	34
Collision with an object	0	0	116	0	0	0	0	0	0	0	0	0	0	0	0	0	116
Delay/failure in acting on complication of treatment	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Simple complication of treatment	0	0	0	0	0	0	0	0	0	3	0	0	41	0	0	0	44

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Contra-indication to the use of the medication	0	0	0	0	0	0	0	0	0	0	0	11	0	0	0	0	11
Healthcare associated cross infection	0	0	0	0	0	0	0	0	0	0	0	0	12	0	0	42	54
Unintended injury in the course of an operation or clin task	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	18
Delay	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25	48
Delay in diagnosis for no specified reason	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	3
Delay in administering medicine	0	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	7
Failure/delay in collection/ delivery systems	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	7
Lack/unavailability of device	0	0	0	0	0	0	0	0	5	0	36	0	0	0	0	0	41
Wrong device/equipment used	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	3
Diathermy burn	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Injury from dirty sharps	0	0	64	0	0	0	0	0	0	0	0	0	0	0	0	0	64

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Equipment disconnection	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Absconder / missing patient	247	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	247
Patient does not attend appointment	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Documentation - delay in obtaining healthcare record / card	10	0	0	0	0	0	0	13	0	0	0	0	0	0	0	0	23
Healthcare record / card - mislabelled	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Documentation - no access to	5	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0	10
Dose or strength was wrong or unclear	0	0	0	0	0	0	0	0	0	0	0	152	0	0	0	0	152
Unsafe / inappropriate clinical environment	56	0	0	0	0	0	0	0	12	0	0	0	1	0	0	0	69
Unsafe environment (personal safety, light, temp, noise, air)	0	0	0	0	0	0	0	0	34	0	0	0	0	0	0	0	34
Expiry date wrong, omitted or passed	0	0	0	0	0	0	0	0	0	0	0	14	0	0	0	0	14

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Failure or overload of IT or telecommunications system	0	0	0	0	0	0	0	0	18	0	0	0	0	0	0	0	18
Fire - Accidental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	18
Failure to follow up	4	0	0	0	1	0	0	0	0	0	0	0	3	0	0	0	8
Formulation of medication was wrong	0	0	0	0	0	0	0	0	0	0	0	18	0	0	0	0	18
Sharps or needles found	0	0	62	0	0	0	0	0	0	0	0	0	0	0	0	0	62
Frequency for taking of medication was wrong	0	0	0	0	0	0	0	0	0	0	0	78	0	0	0	0	78
Haemorrhage / haematoma, anaes.	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Inadequate handover of care	0	0	0	0	0	12	0	0	0	0	0	0	0	0	0	0	12
Fall from a height, bed or chair	0	0	234	0	0	0	0	0	0	0	0	0	0	0	0	0	234
Breach of confidentiality of staff records or information	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	3
Slips on ice or snow	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Diagnostic images / specimens - inadequate / incomplete	0	0	0	0	14	0	0	0	0	0	0	0	0	0	0	0	14
Discharge - inappropriate	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Hazardous and avoidable exposure to infection	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Infusion injury (extravasation)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Injury caused by medical device	0	0	0	0	0	0	0	0	0	0	8	0	0	0	0	0	8
Injury - cause unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	194	0	0	194
Communication failure within the team	0	0	0	0	0	11	0	0	0	0	0	0	0	0	0	0	11
Intruders, Break-ins, Trespassers, Intruder alarms	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32	0	32
IT/telecommunications failure/ overload	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	0	7
Wrong / transposed / omitted medicine label	0	0	0	0	0	0	0	0	0	0	0	8	0	0	0	0	8

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Lifting in the course of moving a load	0	0	24	0	0	0	0	0	0	0	0	0	0	0	0	0	24
Records missing, believed lost, damaged or stolen	0	0	0	0	0	0	0	8	0	0	0	0	0	0	0	0	8
Moving machinery	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Other IT malfunction	0	0	0	0	0	0	0	0	13	0	0	0	0	0	0	0	13
Failure of a device or equipment	0	0	0	0	0	0	0	0	0	0	146	0	0	0	0	0	146
Failure to discontinue treatment	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
Refusal of medication	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Documentation - misfiled	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	7
Mismatch between patient and medicine	0	0	0	0	0	0	0	0	0	0	0	39	0	0	0	0	39
Missing, inadequate or illegible healthcare record	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3
Missing young person	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Methicillin Resistant Staphylococcus Aureus	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	4
Missing needle/swab/ instrument	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	3
Inadequate or no consent to treatment or procedure	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Supply failure (gas or power)	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4
Medicine not administered	0	0	0	0	0	0	0	0	0	0	0	95	0	0	0	0	95
Failure to note relevant information in patient's record	0	0	0	0	1	0	0	10	0	0	0	0	0	0	0	0	11
Omitted medicine or ingredient	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	6
Omitted medicine or ingredient	0	0	0	0	0	0	0	0	0	0	0	65	0	0	0	0	65
Operative site not marked	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Communication failure - outside of immediate team	0	0	0	0	0	44	0	0	0	0	0	0	0	0	0	0	44
Abuse - other	0	489	0	0	0	0	0	0	0	0	0	0	0	0	0	0	489
Accident of some other type or cause	0	0	284	0	0	0	0	0	0	0	0	0	0	0	0	0	284

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Access, admission, transfer, discharge other	23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23
Anaesthesia - other	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Other incident to do with assessment	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	3
Consent, Confidentiality or Communication - other	0	0	0	0	0	16	0	0	0	0	0	0	0	0	0	0	16
Medical device/equipment - other	0	0	0	0	0	0	0	0	0	0	17	0	0	0	0	0	17
Documentation (including records, identification) other	0	0	0	0	7	0	0	30	0	0	0	0	0	0	0	0	37
Other - please specify in description	0	0	0	0	0	0	0	0	0	0	0	0	0	104	0	0	104
Other incident related to the Infrastructure	0	0	0	0	0	0	0	0	23	0	0	0	0	0	0	0	23
Other - Infection control incident	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	5	6
Labour or delivery - other	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	3
Other medication incident	0	0	0	0	0	0	0	0	0	0	0	155	0	0	0	0	155

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Implementation & ongoing monitoring/review - other	0	0	0	0	0	0	0	0	0	0	0	0	26	0	0	0	26
Preoperative - other	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	2
Other incident related to Security	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50	0	50
Self-harming behaviour - other	0	43	0	0	0	0	0	0	0	0	0	0	0	0	0	0	43
Treatment, procedure - other adverse event	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50	50
Communication failure with patient, parent or carer	0	0	0	1	0	21	0	0	0	0	0	0	0	0	0	0	22
Patient incorrectly identified	0	0	0	0	35	2	0	20	0	0	0	1	0	0	0	6	64
Lifting or moving a patient or other person	0	0	37	0	0	0	0	0	0	0	0	0	0	0	0	0	37
Physical abuse, assault or violence	0	1160	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1160
Discharge - planning failure	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Transfusion policy error	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	128	128

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Postponed or cancelled surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	52	52
Racial	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Adverse reaction to blood product	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Unexpected re-admission or re-attendance	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15
Failure in referral process	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Patient refuses/fails to take/ discontinues medication or TMT	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Inappropriate use of control and restraint	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Retained needle/swab/ instrument	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5
Wrong route for administration of medication	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Road Traffic Accident in the course of employment or care	0	0	36	0	0	0	0	0	0	0	0	0	0	0	0	0	36

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Attempted suicide, whether proven or suspected	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12
Self discharge, or against medical advice	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Sexual	0	60	0	0	0	0	0	0	0	0	0	0	0	0	0	0	60
Operation or procedure wrongly sited	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Self harm	0	158	0	0	0	0	0	0	0	0	0	0	0	0	0	0	158
Fall on level ground	0	0	1354	0	0	0	0	0	0	0	0	0	0	0	0	0	1354
Smoking related	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	18
Hazardous exposure to smoke or fire	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Hazardous exposure to electricity or electric shock	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Wound or Surgical Site Infection	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5
Lack of suitably trained / skilled staff	0	0	0	0	0	0	0	0	86	0	0	0	0	0	0	0	86

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Failure of sterilisation or contamination of equipment	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	5	6
Medication incorrectly stored	0	0	0	0	0	0	0	0	0	0	0	23	0	0	0	0	23
Stress-related illness possibly arising from employment	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Person struck by a projectile	0	0	14	0	0	0	0	0	0	0	0	0	0	0	0	0	14
Suicide (completed), whether proven or suspected	0	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11
Wrong method of preparation or supply	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Suspected fall	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Proven, alleged or suspected theft	0	0	0	0	0	0	0	0	0	0	0	0	0	0	57	0	57
Treatment/procedure - inappropriate/wrong	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Treatment / procedure - failed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Transfer - delay/failure	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Trapped in lift, locked in a room, other traps	0	0	19	0	0	0	0	0	0	0	0	0	0	0	0	0	19
Tripped over an object	0	0	42	0	0	0	0	0	0	0	0	0	0	0	0	0	42
Test results / reports - failure / delay to receive	0	0	0	0	23	0	0	0	0	0	0	0	0	0	0	0	23
Test results / reports - missing	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	2
Test results / reports - mislabelled	0	0	0	0	8	0	0	1	0	0	0	0	0	0	0	0	9
Test request form - none/ incomplete	0	0	0	0	18	0	0	0	0	0	0	0	0	0	0	0	18
Unplanned admission / transfer to specialist care unit	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Urgent appointment not available when required	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
User error	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	7
Damage caused by vandalism (other than ARSON)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28	0	28
Verbal direction to patient was wrong or omitted	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Verbal abuse or disruption	0	685	0	0	0	0	0	0	0	0	0	0	0	0	0	0	685
Connected with clinical waste	0	0	0	0	0	0	0	0	6	0	0	0	1	0	0	0	10
Connected with domestic waste	0	0	0	0	0	0	0	0	15	0	0	0	0	0	0	0	15
Assault etc with a weapon	0	24	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24
Wrong drug / medicine	0	0	0	0	0	0	0	0	0	0	0	81	0	0	0	0	81
Test results/ images - available but inaccurate	0	0	0	0	8	0	0	1	0	0	0	0	0	0	0	0	9
Failure to act on adverse test results or images	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Accidental or malicious use of an Alarm System	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50	0	50
Diagnostic images or Lab tests not available when required	0	0	0	0	3	1	0	0	0	0	0	0	1	0	0	0	5
Blood product not available	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37	37
Diagnostic images / specimens missing	0	0	0	0	20	0	0	1	0	0	0	0	0	0	0	0	21

	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Diagnostic Images / specimens - mislabelled / unlabelled	0	0	0	0	34	0	0	0	0	0	0	0	0	0	0	0	34
Theatre list details incorrect	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	14	15
Cross-matching error	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Delay or failure to monitor	0	0	0	0	0	0	0	0	0	0	0	0	9	0	0	0	9
Failure/delay to order correct tests, image etc	0	0	0	0	14	0	0	0	0	0	0	0	0	0	0	0	14
Failure to act on adverse symptoms	0	0	0	0	2	0	1	0	0	0	0	0	1	0	0	0	4
Totals:	465	2648	2414	18	198	145	4	102	272	6	217	802	106	298	321	406	8422

Western HSC Trust

STAGE OF CARE (CCS LEVEL 1)																				
ADVERSE EVENT (CCS LEVEL 3)		Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Unauthorised access or use of password		0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Admission could not be arranged / failure to admit		8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Adverse reaction when drug used as intended		0	0	0	0	0	0	0	0	0	0	0	0	20	0	0	0	0	20
Affray, fights, disorderly behaviour		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	4
False fire or intruder alarm		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10	0	10
Medication prescribed to which p. had a known allergy		0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
Ambulance was late or failed to show up		2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Wrong quantity		0	0	0	0	0	0	0	0	0	0	0	0	41	0	0	0	0	41
Apgars <6 at 5 mins		0	0	0	0	0	0	0	0	0	0	11	0	0	0	0	0	0	11
Appointment recording error		4	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	5

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Cardiac arrest	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	6	8
Actual or suspected Arson	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	29	0	29
Delay / difficulty in obtaining clinical assistance	2	0	0	0	2	0	0	0	0	0	5	0	0	3	0	0	10	22
Lack of/delayed availability of beds (general)	2	0	0	0	0	0	0	0	0	19	0	0	0	0	0	0	0	21
Lack of/delayed availability of beds (high dependency/ICU)	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	4
Stretching or bending injury, other than lifting	0	0	16	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16
Exposure to biological hazard	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Failure to answer bleep	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	3
Bomb threat/scare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
Breach of patient confidentiality	0	0	0	0	0	13	0	0	0	0	0	0	0	0	0	0	0	13
Other breach of security or public order	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24	0	24
Breathing system problem / failure	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Contact with very hot or very cold surface	0	0	50	0	0	0	0	0	0	0	0	0	0	0	0	0	0	50
Catheter-related urinary tract infection	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Inadequate check on equipment	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	4
Injury from clean sharps	0	0	28	0	0	0	0	0	0	0	0	0	0	0	0	0	0	28
Collapse of a structure or fitting	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8
Collision with an object	0	0	144	0	0	0	0	0	0	0	0	0	0	0	0	0	0	144
Delay/failure in acting on complication of treatment	0	0	0	0	0	0	0	0	0	0	3	0	0	6	0	0	15	24
Simple complication of treatment	0	0	0	0	0	0	0	0	0	0	82	0	0	225	0	0	0	307
Contra-indication to the use of the medication	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	3
Cord PH < 7.15	0	0	0	0	0	0	0	0	0	0	20	0	0	0	0	0	0	20
Healthcare associated cross infection	0	0	0	0	0	0	0	0	0	0	0	0	0	21	0	0	2	23
Unintended injury in the course of an operation or clin task	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35	35

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Delay	4	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	18	23
Delay in diagnosis for no specified reason	0	0	0	0	0	0	4	0	0	0	3	0	0	0	0	0	0	7
Failure/delay in collection/delivery systems	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	7
Lack/unavailability of device	0	0	0	0	0	0	0	0	0	8	0	17	0	0	0	0	0	25
Wrong device/equipment used	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	4
Diagnosis - wrong	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Delayed diagnosis of infection	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Injury from dirty sharps	0	0	103	0	0	0	0	0	0	0	0	0	0	0	0	0	0	103
Absconder / missing patient	406	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	406
Patient does not attend appointment	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Documentation - delay in obtaining healthcare record / card	5	0	0	0	0	0	0	0	19	0	0	0	0	0	0	0	0	24
Healthcare record / card - mislabelled	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3
Documentation - no access to	3	0	0	0	1	0	0	0	16	0	0	0	0	0	0	0	1	21

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Dose or strength was wrong or unclear	0	0	0	0	0	0	0	0	0	0	0	0	31	0	0	0	0	31
Eclamptic fit	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Unsafe / inappropriate clinical environment	12	0	0	0	0	0	0	0	0	9	0	0	0	0	0	0	2	23
Unsafe environment (personal safety, light, temp, noise, air)	0	0	0	0	0	0	0	0	0	13	0	0	0	0	0	0	0	13
Expiry date wrong, omitted or passed	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Extended stay / episode of care	0	0	0	0	0	0	0	0	0	0	5	0	0	3	0	0	2	10
Failure or overload of IT or telecommunications system	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	6
Fetal abnormality detected at birth	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Financial Loss	0	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	0	7
Fire - Accidental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15	0	15
Failure to follow up	5	0	0	0	2	0	0	0	0	0	0	0	11	8	0	0	8	34
Formulation of medication was wrong	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
Sharps or needles found	0	0	87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	87

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Frequency for taking of medication was wrong	0	0	0	0	0	0	0	0	0	0	0	0	23	0	0	0	0	23
Inappropriate handling of the patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5
Inadequate handover of care	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	5
Unplanned homebirth with good outcome	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Fall from a height, bed or chair	0	0	202	0	0	0	0	0	0	0	0	0	0	0	0	0	0	202
History insufficient or symptoms unaccounted for	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Breach of confidentiality of staff records or information	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	4
Slips on ice or snow	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Diagnostic images / specimens - inadequate / incomplete	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	0	6
Discharge - inappropriate	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Hazardous and avoidable exposure to infection	0	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Patient information leaflet wrong or omitted	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Infusion injury (extravasation)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5	5
Injury caused by medical device	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	0	5
Communication failure within the team	0	0	0	0	0	13	0	0	0	0	0	0	0	0	0	0	0	13
Intruders, Break-ins, Trespassers, Intruder alarms	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	30	0	30
Wrong / transposed / omitted medicine label	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
Lack of clinical or risk assessment	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	3
Diagnosis not normally possible at the time of the incident	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2
Lifting in the course of moving a load	0	0	18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18
Records missing, believed lost, damaged or stolen	0	0	0	0	0	0	0	0	16	0	0	0	0	0	0	0	0	16
Equipment malfunction / failure	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Other IT malfunction	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	0	6

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Failure of a device or equipment	0	0	0	0	0	0	0	0	0	0	0	120	0	0	0	0	0	120
Failure to discontinue treatment	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	2
Cardiac ischaemia / infarction	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Documentation - misfiled	0	0	0	0	0	0	0	0	18	0	0	0	0	0	0	0	0	18
Mismatch between patient and medicine	0	0	0	0	0	0	0	0	0	0	0	0	22	0	0	0	0	22
Missing, inadequate or illegible healthcare record	0	0	0	0	1	0	0	0	2	0	0	0	0	0	0	0	0	3
Methicillin Resistant Staphylococcus Aureus	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	0	1	19
Missing needle/swab/instrument	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4
Neonatal death	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Unexpected admission to Neo-Natal Unit	0	0	0	0	0	0	0	0	0	0	56	0	0	0	0	0	0	56
Inadequate or no consent to treatment or procedure	0	0	0	0	0	6	0	0	0	0	0	0	0	0	0	0	0	6
Medicine not administered	0	0	0	0	0	0	0	0	0	0	0	0	49	0	0	0	0	49

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Failure to note relevant information in patient's record	0	0	0	0	4	0	0	0	11	0	0	0	0	0	0	0	0	15
Lifting or moving an object other than a load	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Omitted medicine or ingredient	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Communication failure - outside of immediate team	0	0	0	0	0	46	0	0	0	0	0	0	0	0	0	0	0	46
Abuse - other	0	213	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	213
Accident of some other type or cause	0	0	275	0	0	0	0	0	0	0	0	0	0	0	0	0	0	275
Access, admission, transfer, discharge other	32	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32
Disruptive, aggressive behaviour - other	0	52	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	52
Anaesthesia - other	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	5
Other incident to do with assessment	0	0	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	15
Consent, Confidentiality or Communication - other	0	0	0	0	0	36	0	0	0	0	0	0	0	0	0	0	0	36
Medical device/equipment - other	0	0	0	0	0	0	0	0	0	0	0	17	0	0	0	0	0	17

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Diagnosis - other	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Documentation (including records, identification) other	1	0	0	0	5	0	0	0	21	0	0	0	0	0	0	0	0	27
Other - Clinical Trials	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22	0	0	22
Other incident related to the Infrastructure	0	0	0	0	0	0	0	0	0	17	0	0	0	0	0	0	0	17
Other - Infection control incident	0	0	0	0	0	0	0	0	0	0	0	0	0	20	0	0	3	23
Labour or delivery - other	0	0	0	0	0	0	0	0	0	0	16	0	0	0	0	0	0	16
Other medication incident	0	0	0	0	0	0	0	0	0	0	0	0	52	0	0	0	0	52
Implementation & ongoing monitoring/ review - other	0	0	0	0	0	0	0	0	0	0	0	0	0	46	0	0	0	46
Other incident related to Security	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	49	0	49
Self-harming behaviour - other	0	92	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	92
Treatment, procedure - other adverse event	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	29	29
Communication failure with patient, parent or carer	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	0	5

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Patient incorrectly identified	0	0	0	0	13	1	0	0	11	0	0	0	0	0	0	0	5	30
Patient injury or damage	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Lifting or moving a patient or other person	0	0	29	0	0	0	0	0	0	0	0	0	0	0	0	0	0	29
Physical abuse, assault or violence	0	1054	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1054
Discharge - planning failure	27	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	27
Transfusion policy error	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70	70
Postponed or cancelled surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	4
Post-partum haemorrhage > 1,000ml	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	0	6
Racial	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Unintended exposure to radiation	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Respiratory arrest	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Adverse reaction to blood product	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	7
Unexpected re-admission or re-attendance	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7
Failure in referral process	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Missing, inadequate, illegible referral letter	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	2
Patient refuses/fails to take/ discontinues medication or TMT	0	0	0	0	0	1	0	0	0	0	0	0	4	0	0	0	3	8
Maternal resuscitation	0	0	0	0	0	0	0	0	0	0	12	0	0	0	0	0	0	12
Failure to return from authorised leave	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Wrong route for administration of medication	0	0	0	0	0	0	0	0	0	0	0	0	5	0	0	0	0	5
Road Traffic Accident in the course of employment or care	0	0	39	0	0	0	0	0	0	0	0	0	0	0	0	0	0	39
Attempted suicide, whether proven or suspected	0	44	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	44
Self discharge, or against medical advice	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
Sexual	0	58	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	58
Operation or procedure wrongly sited	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Self harm	0	212	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	212

STAGE OF CARE (CCS LEVEL 1)																			
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Fall on level ground	0	0	385	0	0	0	0	0	0	0	0	0	0	0	0	0	0	385
Hazardous exposure to smoke or fire	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Hazardous exposure to electricity or electric shock	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Wound or Surgical Site Infection	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	4	6
Lack of suitably trained /skilled staff	0	0	0	0	0	0	0	0	0	90	0	0	0	0	0	0	0	90
Failure of sterilisation or contamination of equipment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Stillbirth	0	0	0	0	0	0	0	0	0	0	14	0	0	0	0	0	0	14
Medication incorrectly stored	0	0	0	0	0	0	0	0	0	0	0	0	15	0	0	0	0	15
Person struck by a projectile	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Suicide (completed), whether proven or suspected	0	25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25
Wrong method of preparation or supply	0	0	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	6
Suspected fall	0	0	1645	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1645
Third or fourth degree tears	0	0	0	0	0	0	0	0	0	0	30	0	0	0	0	0	0	30

STAGE OF CARE (CCS LEVEL 1)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
ADVERSE EVENT (CCS LEVEL 3)																		
Proven, alleged or suspected theft	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70	0	70
Lack of/delayed availability of operating theatre	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Unplanned return to theatre	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	3	4
Treatment/procedure - inappropriate/ wrong	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	9	11
Treatment / procedure - failed	0	0	0	0	0	0	0	0	0	0	6	0	0	0	0	0	5	11
Transfer - delay/failure	16	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	17
Trapped in lift, locked in a room, other traps	0	0	47	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47
Tripped over an object	0	0	52	0	0	0	0	0	0	0	0	0	0	0	0	0	0	52
Test results / reports - failure / delay to receive	0	0	0	0	9	0	0	0	3	0	0	0	0	0	0	0	0	12
Test results / reports - missing	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	0	0	4
Test results / reports - mislabelled	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3
Test request form - none/incomplete	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1

STAGE OF CARE (CCS LEVEL 1)																		
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Unplanned admission / transfer to specialist care unit	59	0	0	0	0	0	0	0	0	0	8	0	0	0	0	0	1	68
User error	0	0	0	0	0	0	0	0	0	0	0	14	0	0	0	0	0	14
Damage caused by vandalism (other than ARSON)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	74	0	74
Verbal abuse or disruption	0	429	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	429
Connected with clinical waste	0	0	0	0	0	0	0	0	0	4	0	0	0	1	0	0	1	6
Connected with domestic waste	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	2
Assault etc with a weapon	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
Incorrect blood product given	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Wrong drug / medicine	0	0	0	0	0	0	0	0	0	0	0	0	69	0	0	0	0	69
Test results/ images - available but inaccurate	0	0	0	0	8	0	0	0	2	0	0	0	0	0	0	0	0	10
Failure to act on adverse test results or images	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	4
Accidental or malicious use of an Alarm System	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	0	11

STAGE OF CARE (CCS LEVEL 1)																				
ADVERSE EVENT (CCS LEVEL 3)	Access, Appointment, Admission, Transfer, Discharge	Abusive, violent, disruptive or self-harming behaviour	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Patient Information (records, documents, test results, scans)	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/equipment	Medication	Implementation of care or ongoing monitoring/review	Other - please specify in description	Security	Treatment, procedure	Total
Diagnostic images or Lab tests not available when required	0	0	0	0	5	0	0	0	4	0	0	0	0	0	0	0	0	9
Diagnostic images / specimens missing	0	0	0	0	11	0	0	0	0	0	0	0	0	0	0	0	0	11
Diagnostic Images / specimens - mislabelled / unlabelled	0	0	0	0	75	0	0	0	2	0	0	0	0	0	0	0	0	77
Theatre list details incorrect	0	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	9	14
Delay or failure to monitor	0	0	0	0	0	0	0	0	0	0	0	0	32	31	0	0	26	89
Treatment not clinically indicated	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	2	5
Failure/delay to order correct tests, image etc	0	0	0	0	4	0	1	0	0	0	0	0	0	1	0	0	0	6
Failure to act on adverse symptoms	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	2
Totals:	**615**	**2188**	**3160**	**9**	**171**	**133**	**11**	**7**	**139**	**192**	**286**	**177**	**402**	**394**	**22**	**317**	**300**	**8523**

NI Ambulance Service HSC Trust

Adverse Incidents by Category and Incident date grouped by Stage of care
NIAS

	2011 04	2011 05	2011 06	2011 07	2011 08	2011 09	2011 10	2011 11	2011 12	2012 01	2012 02	2012 03	Total
	139	104	106	125	97	91	114	133	259	199	153	122	1642
Assault	3	1	0	1	1	0	1	1	6	4	2	3	23
Asset loss, damage etc	0	0	0	0	0	4	2	3	0	6	5	0	20
Late Meal Break	30	14	24	35	32	17	26	56	119	100	69	57	579
Building-Land	0	2	4	4	3	1	2	2	4	2	3	1	28
Confidentiality	0	0	0	0	0	0	0	1	0	0	0	0	1
Contact with something	2	1	2	3	0	0	4	3	3	3	2	0	23
Hazardous Substance	0	0	0	0	1	0	0	5	1	1	2	0	10
Drug	22	27	13	12	18	13	14	11	16	12	7	6	171
Equipment	27	28	32	34	21	29	30	28	33	26	22	24	334
Ergonomic	1	1	0	1	0	1	0	0	0	0	2	0	6
Harrassment	1	1	3	0	0	0	1	0	1	3	1	0	11
Manual Handling	4	2	4	5	3	0	9	1	10	5	11	4	58
Organisational	12	13	8	5	6	6	7	6	20	14	5	8	110
Records Management	1	0	0	0	1	0	0	2	3	2	0	1	10
Sharp Object	2	0	1	1	0	1	2	1	1	0	1	2	12
Slip, trip or fall	3	1	0	2	2	1	2	1	6	2	3	1	24
Treatment	3	1	0	3	1	1	1	2	2	1	0	1	16
Vehicle	28	12	15	19	8	17	13	10	34	18	18	14	206

	2011 04	2011 05	2011 06	2011 07	2011 08	2011 09	2011 10	2011 11	2011 12	2012 01	2012 02	2012 03	Total
	139	**104**	**106**	**125**	**97**	**91**	**114**	**133**	**259**	**199**	**153**	**122**	**1642**
Access, Appointment, Admission, Transfer, Discharge	10	19	16	20	9	16	12	5	6	10	12	12	147
Assault	0	0	0	0	0	0	0	0	0	0	0	1	1
Asset loss, damage etc	0	0	0	0	0	0	1	0	0	0	0	0	1
Drug	2	1	1	0	1	2	0	0	0	0	0	0	7
Equipment	1	4	6	9	4	4	4	0	0	2	1	4	39
Manual Handling	1	1	0	0	1	0	2	0	0	0	1	0	6
Organisational	4	11	6	6	2	6	3	5	4	7	8	7	69
Slip, trip or fall	1	0	1	0	1	0	0	0	0	0	0	0	3
Treatment	0	0	1	4	0	2	0	0	1	1	1	0	10
Vehicle	1	2	1	1	0	2	2	0	1	0	1	0	11
Abusive, violent, disruptive or self-harming behaviour	18	20	26	31	22	16	17	19	26	18	18	20	251
Assault	18	17	26	30	21	16	15	19	26	18	18	20	244
Asset loss, damage etc	0	0	0	0	0	0	1	0	0	0	0	0	1
Equipment	0	2	0	0	0	0	0	0	0	0	0	0	2
Harrassment	0	1	0	1	0	0	0	0	0	0	0	0	2
Vehicle	0	0	0	0	1	0	1	0	0	0	0	0	2
Accident that may result in personal injury	15	10	16	19	25	22	13	16	17	10	18	28	209
Building-Land	0	0	0	0	0	0	0	0	0	1	0	0	1
Contact with something	5	0	3	2	4	3	2	1	0	3	2	5	30

	2011 04	2011 05	2011 06	2011 07	2011 08	2011 09	2011 10	2011 11	2011 12	2012 01	2012 02	2012 03	Total
	139	104	106	125	97	91	114	133	259	199	153	122	1642
Hazardous Substance	0	0	0	0	1	1	0	0	0	0	0	2	4
Equipment	0	0	0	0	0	0	0	0	0	0	0	2	2
Manual Handling	1	5	7	6	3	6	3	2	1	2	3	5	44
Sharp Object	2	0	0	0	1	0	1	0	0	0	0	2	6
Slip, trip or fall	1	1	4	2	6	7	4	4	1	2	3	5	40
Vehicle	6	4	2	9	10	5	3	9	15	2	10	7	82
Medication	0	0	0	1	1	0	0	0	0	0	0	0	2
Treatment	0	0	0	1	1	0	0	0	0	0	0	0	2
Other - please specify in description	0	0	0	0	0	0	0	0	0	0	1	1	2
Contact with something	0	0	0	0	0	0	0	0	0	0	0	1	1
Hazardous Substance	0	0	0	0	0	0	0	0	0	0	1	0	1
Security	0	0	0	0	0	1	0	0	0	0	0	0	1
Equipment	0	0	0	0	0	1	0	0	0	0	0	0	1
Totals:	**182**	**153**	**164**	**196**	**154**	**146**	**156**	**173**	**308**	**237**	**202**	**183**	**2254**

RQIA

Under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and associated regulations, regulated services are required to report certain adverse incidents to RQIA. These include: deaths; serious injury; accidents; outbreaks of infectious disease; allegations of misconduct; incidents involving the police; and a range of other incidents. During 2011-12, 14,551 such incidents were reported to RQIA. In addition, under The Mental Health (Northern Ireland) Order 1986 as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009, certain categories of serious adverse incidents must be reported to RQIA by HSC trusts. These include: actual or alleged assault; sexual assault or allegation; death; suspected suicide; other incidents. During 2011-12, 191 such incidents were reported to RQIA.

The following tables provide a breakdown of reportable incidents by category across all regulated services and mental health and learning disability services. It should be noted that these figures should be considered in light of the age and health profile of the care population.

All Regulated Services

Category	Number
Death	2,982
Accident	2,229
Serious injury	1,449
Serious illness	960
Allegation of misconduct	795
Incident involving the police	633
Outbreak of infectious disease	227
Other incidents	5,276
Total	**14,551**

Mental Health and Learning Disability Services

Category	Number
Suspected suicide	90
Death	59
Actual/alleged assault	9
Actual/alleged sexual assault	9
Other incidents	24
Total	**191**

While it is not possible to provide a composite regional analysis at this stage it is expected that the implementation of the RAIL project will allow the analysis and monitoring of adverse incidents on a regional basis similar to that which is applied to Serious Adverse Incidents.

All investigations within the HSC follow the principles of the NPSA's guidance: *Being Open – Communicating Patient Safety Incidents with Patients, their Families and Carers (Revised 2009)* http://www.nrls.npsa.nhs.uk/alerts/?entryid45=65077

HSS (SQSD) 34/2007 HSC Regional Template and Guidance for Incident Review Reports draws attention to the principles outlined in Being Open.

http://www.dhsspsni.gov.uk/hsc__sqsd__34-07.pdf

Criteria 5.3.2(d) of the Quality Standards for Health and Social Care (2006) requires the HSC to have "systems in place that promote ongoing communication with service users and carers when treatment or care goes wrong". The Quality Standards are used by RQIA to assess the quality of care provided by the HSC. http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf

Trust policies and procedures state that the patient/client should be notified at the earliest opportunity if a serious near miss or adverse incident occurs and a note documented in their medical/health and social care record. However, from the Trust's database it is not possible to identify how many individuals were actually notified that an adverse incident had occurred.

With regard to SAIs, it is Trust practice to involve the patient/client and/or family member in the investigation and the outcome of this is documented in a section of the report entitled 'Involvement/contact with patient/client and/or family member'. However, it must be recognised that not all patients/clients and/or family member/s wish to participate in investigations.

11) Your assessment of the number of adverse or serious adverse incidents that go unreported as a result of issues arising from senility/mental illness where the patient does not have an advocate to complain, or people having died due to having been deferred from a waiting list repeatedly.

Trust staff are encouraged to advocate for patients/clients and raise concerns on their behalf. Trusts also engage with a number of independent/voluntary organisations to provide advocacy services for clients/patients who do not have capacity, or who feel unable to raise concerns directly with HSC staff. Within Learning Disability services there are also a number of appointed advocates for individual clients who cannot represent themselves. In addition, Trusts have robust complaints system, which operate at local and corporate level. In addition, there are a number of systems in place throughout Trusts whereby patients/clients are given the opportunity raise concerns.

There are requirements within legislation which require regulated services and trusts to report certain categories of incidents to RQIA. It is not possible to quantify the number of incidents that go unreported. However, where there is an identified failure to report incidents in line with relevant legislation, RQIA may take enforcement action against a regulated service (see note below), or in the case of a trust RQIA may escalate its concerns to the relevant chief executive.

Note: Under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, the following health and social care services are required to register with RQIA, and are subject to regulation:

- Adult placement agencies
- Children's homes
- Day care settings
- Domiciliary care agencies
- Independent clinics
- Independent hospitals (including private dental practices) *Nursing agencies Nursing homes *Residential care homes *Residential family centres Voluntary adoption agencies

14) Confirmation of the number of fatalities that relate to the 2084 serious adverse incidents referred to at paragraph 3.5 of the Audit Office report.

A SAI notification that documents a death does not necessarily imply that the circumstances relating to the adverse incident contributed to the cause of the death. Information from SAI notifications are captured at the time of reporting and it is not possible to determine causes (or responsibility) until all investigatory processes are completed.

Death Related SAI's - Period July 2004 to 31 March 2012

Suicide (completed), whether proven or suspected	488
Other death related	325
Total	**813**

The figure of 813 - is death related SAI's for the total notification received and **not** individual deaths as a SAI may be received relating to one incident but may involve one or more deaths e.g. maternal / neonatal death.

Deaths are reported where the individual is known to HSC services e.g. mental health services, children's services, community care, etc. The table includes deaths reported as a result of road traffic accidents, homicide, filicide, drowning, etc.

It should be noted therefore that deaths reported may not be a reflection of issues with the care delivered by health and social care services.

15) A summary of the steps the Department is taking to drive improvements in the collation of information on all incidents across the entire sector prior to the implementation of any new management information system.

Departmental circular HSC (SQSD) 8/2010 Learning from Adverse Incidents and Near Misses reported by HSC organisations and Family Practitioner Services was issued following the transfer of reporting arrangements from DHSSPS to HSCB. This provides guidance to HSC bodies on revised reporting roles and responsibilities as a result of the transfer.

Section 2 sets out the roles, responsibilities and accountability arrangements for incident reporting pending the establishment of RAIL.

The Public Health Agency/HSC Board have also established a number of regional groups which include the following:

- Regional commissioning indicators
- Regional Key Performance Indicators for Nursing
- Regional Quality Improvement Groups e.g. Falls and Pressure Ulcers.
- Regional governance leads meeting.
- Regional Patient Safety Officer Meeting

All these groups take forward work which will include improvements in the collation of information on all incidents across the entire sector prior to the implementation of any new management information system.

The HSCB/PHA are in the process of carrying out a review of the SAI system with a view to improving reporting mechanisms. The review will involve meetings with individual Trusts. Following completion of the review, the HSCB/PHA intend to issue revised guidance on the SAI process.

PAC may wish to note that in addition to reporting on AIs there are other local and national reporting arrangements (with statutory or mandatory reporting obligations) that operate

in tandem with serious adverse incident reporting process. These include, for example, notifications to:

- Coroners Service for Northern Ireland – sudden or unexplained death (such as industrial diseases) should be referred to the coroner;
- Health and Safety Executive Northern Ireland (HSENI) – incidents are required to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR);
- Northern Ireland Adverse Incident Centre (NIAIC) – incidents involving medical devices, non-medical equipment, plant and building items used in HSC services;
- DHSSPS, Pharmaceutical Advice and Services - drug alerts; and
- Medicines & Healthcare Products Regulatory Agency (MHRA) – for safety problems with medicines, medical devices and blood.

In relation to the development of the RAIL system, all Trusts are actively represented on both the Project Team and the Project Board. However, in the interim period until the new system is approved and implemented at Trust level, work is continuing to further embed an open culture and philosophy for adverse incident reporting, investigation and management. Examples of this work include:

- Review and update of the extant Incident Policies and Procedures;
- Awareness and training sessions on Incident Reporting;
- Approved project mandate to roll-out Datix web; draft project plan to implement Datix Web on an organisational basis is currently under development;
- Provision of quarterly reports (and other ad hoc reports) to Assistant Directors and 4th line staff in respect of adverse incidents, claims and litigation;
- Newsletter published following each Lessons Learnt Sub Committee meeting containing articles generated from the reports provided to the subcommittee to ensure dissemination of organisational learning at Directorate level;
- Further embedding of Safety, Quality & Experience programme via the Corporate and Directorate Management plan which includes governance issues relating to incidents, complaints and litigation.
- Provision of information for the purposes of appraisals viz medical staff on adverse incidents, complaints and claims that they have been involved in, on a yearly basis;
- Regular monitoring of open incidents and lessons learnt from SAIs through Directorate Governance Fora meetings, Monthly Performance Improvement Meetings and the Chief's Executives Mid and End of Year Accountability Review meetings; Governance Assurance Meetings, Corporate Control and Safety & Quality Committee meetings (and sub committees aligned to each area).

16) The Department's projected timeframe for the pilot and for the full implementation of the Regional Adverse Incidents and Learning System; a detailed summary of the realistic, projected costs of its design and build; and confirmation of whether the intellectual property rights to the system will be retained by the Department.

The Regional Adverse Incident Learning System (RAIL) Outline Business Case (OBC) is going through the Department's assurance process. The Public Health Agency (PHA) has been asked to address several queries and we expect a revised OBC within the next few weeks.

The total estimated cost associated with the preferred option (a twelve month pilot) is £383,771 as set out in the original OBC. The pilot will then inform a full business case.

With regards to Intellectual Property Rights (IPR) it is anticipated that within the pilot, members of the RAIL team will be utilising software products with which they are already or will become familiar with e.g. DATIX, INFRA, MS Access, MS SQL etc.

Assuming RAIL proceeds beyond the pilot it is most likely that the PHA will select a software product(s), or link two or more software products and configure the product(s) to meet requirements. It will only be in the event of PHA developing a solution from scratch that IPR will be considered. It will not be an issue if PHA configure a procured software product, as the product would be used under licence and subject to its own terms and conditions.

The issue of IPR has been logged on the pilot's "Issues Register" and will be revisited during the latter stages of the pilot.

Correspondence of 21 January 2013 from Dr Andrew McCormick

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

From the Permanent Secretary
and HSC Chief Executive

Dr Andrew McCormick

Michaela Boyle
Chairperson
Public Accounts Committee
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BELFAST
BT4 3XX

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Tel: [redacted]
Fax:
Email:
andrew.mccormick[redacted]

Our Ref: AMCC 4226
SECCOR/387/2012
DH3-12-8582

Date: 21 January 2013

Dear Michaela

Evidence Session on the Safety of Services provided by Health and Social Care Trusts

Further to my letter of 8 January 2012, please find attached the remaining supplementary information in relation to the Committee's additional queries in relation to the above report.

I trust this is helpful. If you have any further queries, please contact Paul Gibson on [redacted] in the first instance.

Yours sincerely

AW McCord

ANDREW McCORMICK

3. **A breakdown of live negligence cases in the Belfast Trust which would be attributed to complex cases and a summary of the information recorded and how it is used in order to mitigate the risk of repeated failures by individuals.**

The Belfast Health and Social Care Trust advised that, as at November 2012, there were 931 live negligence cases. The table below sets out the number of cases where the estimated value of compensation would be in excess of £500,000 which would relate to the more complex cases.

Specialty	Number of Active Cases
Paediatrics/Cardiology	2
Obstetrics	5
Obstetrics/Midwifery	2
A&E/Orthopaedic Surgery/Vascular Surgery	3
Neurosurgery/Orthopaedic Surgery/Ophthalmics	3
Intensive Care/Nursing	2
Other (Anaesthetics/Psychiatric/Orthopaedics/General Medicine)	5
Total	**22**

Information as at 03/01/13

The process the Trust has developed to learn from claims and mitigate against risk is applied against all claims regardless of "complexity". The Trust uses a commercial risk management software system 'Datix' to record information for each case. Each case is logged onto Datix and a number of fields are completed. A screen shot to demonstrate the data that is held is set out below.

Summary reports are provided on a quarterly and ad hoc basis to the Assurance Committee of Trust Board, the Governance Steering Group and to the Directorates. The Assurance Committee, on behalf of Trust Board, is responsible for seeking assurance that a robust system of risk management, including claims management is in operation. The Assurance Group of Executive Team is required to review data on incidents, including claims, from which to extrapolate trends and areas of concerns, including evidence of emerging risks. These are then brought to the attention of the Assurance Committee to which it reports.

The Trust has a Claims Review Group to oversee the management of all claims and to provide assurance that any deficiencies identified in existing Trust policy, procedures, systems of work or control measures have been brought to the attention of the Directorates and any lessons learned disseminated and implemented. This group meets four times per year. In order to ensure that appropriate actions required and lessons learned are implemented, the Assurance Committee will receive timely summary progress reports on all

claims, in addition to which, the Legal Services Manager will ensure that relevant details of the assessment are shared across the Trust to achieve optimum learning; e.g. by the provision of post-case summary reports to Trust Governance Managers and discussion of same at Trust Case Review meetings. An Annual Report is also produced.

Datix Screen shots

Figure 1 – Showing typical fields for inputting general claim information

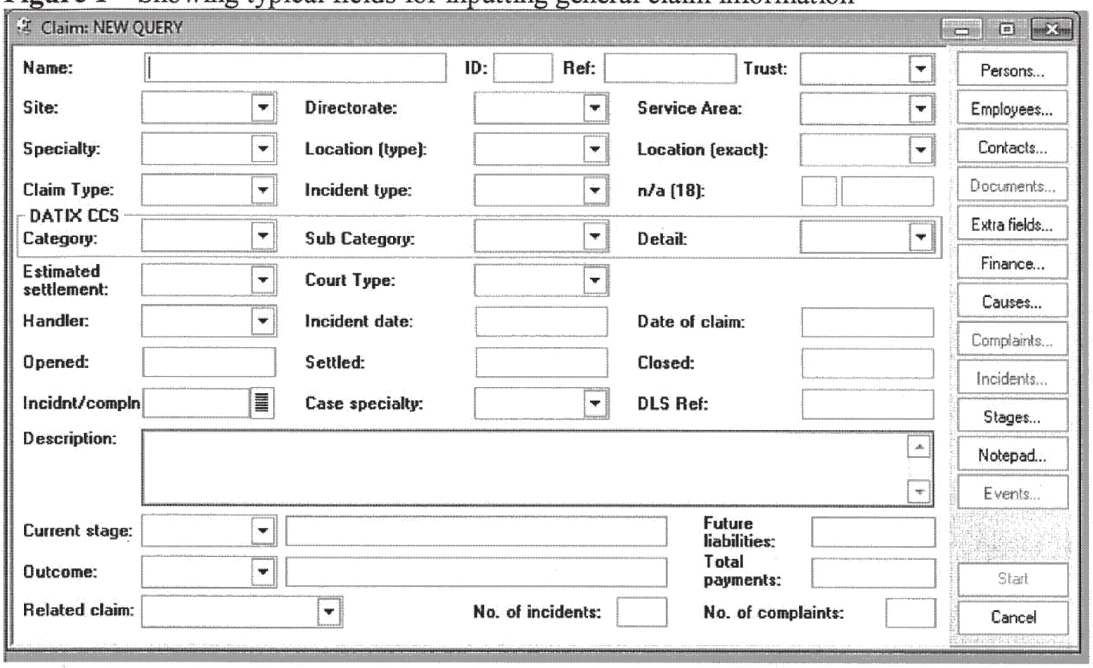
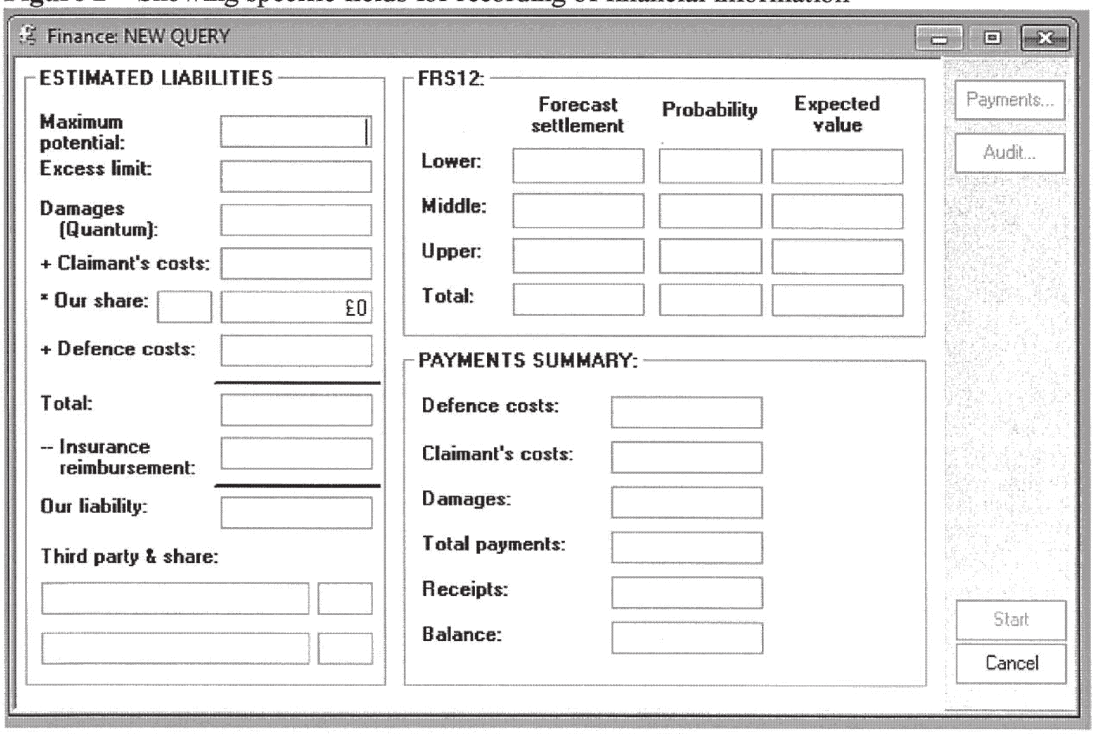


Figure 2 – Showing specific fields for recording of financial information



12. A breakdown by Trust and specialty of the number of outstanding staff appraisals for each of the last 3 years.

It is recognised that effective appraisals are good employment practice, leading to improved staff performance, higher staff satisfaction and better patient outcomes.

However, appraisal is only one element in a suite of management activities which are aimed at both improving the service and maintaining safety standards. To isolate appraisal in this context would not reflect the overall position. Appraisal itself is a formative process the outcome of which should be the development of a Personal Development Plan for the member of staff. If there were concerns about a member of staff it would be entirely inappropriate to wait until the next appraisal meeting to deal with these.

The key element in management which relates to the safety issues are on-going monitoring of all staff by their line managers and action taken quickly to resolve concerns when they arise. Concerns may be identified through managerial observation, complaints, legal cases or concerns reported to management by other members of staff. The Trusts have established Whistleblowing Policies to facilitate this. Good management techniques and close involvement with staff can identify issues early which in turn can allow action to be taken before anything serious develops. In the event a serious issue has been identified staff may be suspended from work or have their work restricted as a patient protection measure. In all cases of concern the issue is investigated and appropriate action taken, this can range from no action if the concern is unfounded to developmental training or through the use of disciplinary or capability procedures formal action, up to and including dismissal.

As part of the Agenda for Change Agreement, a Knowledge and Skills Framework was developed for non-medical staff as a tool for describing the knowledge and skills staff need to apply at work in order to deliver high quality services; it includes an annual review and development for staff. The output from the Knowledge and Skills Framework for an individual job is a list of descriptions and/or standards (KSF post outline) specifying the minimum applied knowledge and skills required for a job and how this should develop during a person's time in post.

As an integral part of the implementation of Agenda for Change KSF post outlines are being developed by individual employers. A KSF Organisational Leads group meets on a bi-monthly basis and is working in partnership to develop and disseminate guidance to ensure good practice and consistency of application of KSF post outlines across all HSC Organisations.
It is only when a post has a KSF outline that an effective review process of the skills attained by an individual can take place and where the skills fall short of the required standard for the post, a Personal Development Plan put in place.

During the last six years employers have been concentrating HR resources in delivering the pay and grading parts of the Agenda for Change Agreement to over 64,000 staff. Although work on KSF outlines has been ongoing as part of that implementation process, progress on this is varied across the HSC.

In relation to medical appraisal we should see a substantial improvement across all trusts over the next reporting period for the reasons outlined below:

1. Medical appraisal has been a long standing contractual requirement for doctors working in the HSC. While there have been historic variances in the uptake of appraisal for doctors, planning for the commencement of revalidation has had a significant impact in increasing participation, with the 2009 HSC Staff Survey reporting that 70% of medical and dental staff had been appraised in the preceding 12 months.

2. All doctors who wished to continue to practise medicine were issued with a Licence to Practise in November 2009. Medical revalidation, which commenced on the 3rd December 2012, is the process by which doctors will regularly renew their licence to practise, and will assure patients and the public that they are keeping up to date and continuing to practise to the appropriate professional standards. Doctors will be unable to revalidate if they do not to demonstrate that they have participated in a robust annual appraisal process that covers the totality of their practice.

The breakdown by each Trust setting out the percentage numbers of staff who did not receive a formal annual appraisal is set out below.

Belfast Health and Social Care Trust

Medical		Non-medical staff	
2008/2009	28%		
2009/2010	17%	**2009/2010**	23%
2010/2011	11%	**2010/2011**	Not available
		2011/2012	14%

Northern Health and Social Care Trust

Medical		Non-medical staff	
2009	5%		
2010	18%	**Sept 2010**	43%
2011	36%	**Sept 2011**	55%
		Sept 2012	53%

Southern Health and Social Care Trust

Medical		Non-medical staff	
2008/2009	2%		
2009/2010	1%	**Dec 2010**	77%
2010/2011	9%	**Dec 2011**	59%
		Nov 2012	65%

South Eastern Health and Social Care Trust

Medical		Non-medical staff	
2010	1%		
2011	Not available	**2010/2011**	83%
Sept 2012	15%	**2011/2012**	79%
		To Nov 2012	85%

Western Health and Social Care Trust

All Staff	
2009/2010	68%
2010/2011	60%
2011/2012	48%

Northern Ireland Ambulance Service

NIAS Paramedics undertake and must successfully complete the Trust's Paramedic-in-Training Programme which meets the Health Professions Council (HPC) Standards of Education and Training and Standards of Proficiency for Paramedics to enable them to apply for registration as a Paramedic with the HPC.

NIAS Ambulance Care Attendants undertake and must successfully complete a nationally accredited training programme (formally an Exexcel/IHCD qualification and now moved to an Edexcel/BTEC qualification).

Paramedics, by virtue of being a registered professional, are required to maintain Continuing Professional Development (CPD) portfolios of evidence. Furthermore, Paramedics, Emergency Medical Technicians and Ambulance Care Attendants are required to undertake mandatory annual reassessment of essential clinical skills. They are also required to undergo regular work-based observational assessments by Clinical Support Officers (CSOs). In addition, CSOs carry out audits on a regular basis, for example hand hygiene, patient experience, completion of PRFs. CSOs also hold regular CPD events for frontline staff.

KSF went 'live' within NIAS on 3 October 2012 and individual Directorates now have responsibility to roll-out Personal Development Reviews to staff within their area of responsibility. This is in line with the Regional KSF Action Plan.

Notwithstanding the above, it is important to note that the Trust has robust management procedures and policies in place to address any issues of concern that may arise with a member of staff, for example Capability, Disciplinary, Harassment and Attendance Management procedures and policies, with related performance management arrangements and reporting on each areas. The NIAS Assurance Framework includes details on all these areas and is presented at each Assurance Committee and Trust Board meeting.

The Trust had developed a Capability Procedure which is designed to deal with those cases where an employee is lacking in some area of knowledge, skill or ability, and is consequently unable to carry out some, or all of the duties required of them to an acceptable standard. The procedure is used where there is evidence of a genuine lack of capability rather than a deliberate failure on the part of the employee to perform to the standards of which he/she is capable.

The Trust also has a Disciplinary Procedure which is designed to help and encourage all employees to achieve and maintain appropriate standards of conduct, performance and behaviour.

13. A breakdown by specialty summarising the number and percentage of cases where the legal costs exceeded the agreed settlement of less than £50,000. Please also indicate the average legal costs for each specialty.

The tables below provides a breakdown of the number of clinical / social care negligence cases, which were closed during each year, and where the amount awarded in damages was less than £50,000. It excludes cases closed with no monies paid in damages or legal costs.

Table 1: Total number of cases closed during 2009/10, where the amount in damages was less than £50,000

Specialty	2009/10					
	Legal Costs Greater than Damages		Damages Greater than Legal Costs		Cases with Damages < £50k	Mean Legal Costs on Cases with damages < £50k
	No.	%	No.	%		
Obstetrics & Gynaecology	24	82.8%	5	17.2%	29	£6,340.69
Accident & Emergency	18	72.0%	7	28.0%	25	£7,542.01
General Surgery	9	75.0%	3	25.0%	12	£8,758.44
Trauma & Orthopaedics	5	100.0%	0	0.0%	5	£590.14
General Medicine	7	77.8%	2	22.2%	9	£9,453.92
Paediatrics	2	100.0%	0	0.0%	2	£159.25
Other Specialties	20	74.1%	7	25.9%	27	£14,865.64
Unknown	3	75.0%	1	25.0%	4	£8,135.01
Total	**88**	**77.9%**	**25**	**22.1%**	**113**	**£8,559.81**

Table 2: Total number of cases closed during 2010/11, where the amount in damages was less than £50,000

Specialty	2010/11					
	Legal Costs Greater than Damages		Damages Greater than Legal Costs		Cases with Damages < £50k	Mean Legal Costs on Cases with damages < £50k
	No.	%	No.	%		
Obstetrics & Gynaecology	21	80.8%	5	19.2%	26	£10,132.44
Accident & Emergency	16	66.7%	8	33.3%	24	£5,070.09
General Surgery	16	69.6%	7	30.4%	23	£9,490.98
Trauma & Orthopaedics	5	45.5%	6	54.5%	11	£15,154.51
General Medicine	7	77.8%	2	22.2%	9	£19,180.01
Paediatrics	4	80.0%	1	20.0%	5	£3,336.98
Other Specialties	20	57.1%	15	42.9%	35	£7,304.21
Unknown	2	66.7%	1	33.3%	3	£17,138.89
Total	**91**	**66.9%**	**45**	**33.1%**	**136**	**£9,312.40**

Table 3: Total number of cases closed during 2011/12, where the amount in damages was less than £50,000

Specialty	2011/12					
	Legal Costs Greater than Damages		Damages Greater than Legal Costs		Cases with Damages < £50k	Mean Legal Costs on Cases with damages < £50k
	No.	%	No.	%		
Obstetrics & Gynaecology	24	75.0%	8	25.0%	32	£19,937.15
Accident & Emergency	20	83.3%	4	16.7%	24	£8,902.80
General Surgery	10	62.5%	6	37.5%	16	£10,179.32
Trauma & Orthopaedics	6	60.0%	4	40.0%	10	£18,489.06
General Medicine	10	76.9%	3	23.1%	13	£13,919.04
Paediatrics	3	75.0%	1	25.0%	4	£16,600.84
Other Specialties	28	71.8%	11	28.2%	39	£8,158.55
Unknown	1	100.0%	0	0.0%	1	£1866.75
Total	**102**	**73.4%**	**37**	**26.6%**	**139**	**£12,710.91**

The information detailed in this response has been derived from the DHSSPS annual information collection on clinical / social negligence cases. The information refers to the number of cases which were closed during each of the financial years listed, with the financial information relating to the total amount paid during the period of time which the case had been open. For the purposes of the DHSSPS information collection, HSC Trusts are provided with clear definitive guidance on how to complete the return, i.e. a case is recorded as closed when the letter has been received by the HSC Trust that all monies (damages and legal costs) have been paid.

Appendix 4

Other Papers Submitted to the Committee but not included within the Report

Health and Social Care Board

Criteria for Reporting SAIs

http://www.hscboard.hscni.net/publications/Policies/101%20Serious%20Adverse%20Incident%20%20Procedure%20for%20the%20reporting%20and%20followup%20of%20SAI%20-%20April%202010%20-%20PDF%20268KB%20.pdf

Learning Communications

April 2011 – September 2011 - Learning Report

October 2011 – March 2012 - Learning Report

4 May 2012	Letter of Learning from Recent Adverse Incidents in Maternity Services
22 May 2012	Letter of Learning from a SAI Following an Accidental Overdose of Warfarin
22 May 2012	Letter of Learning from a SAI re Patients Enrolled in a Clinical Trial
28 June 2012	Regional Learning from a SAI re Flushing of a Central Line with the Incorrect Strength of Heparin Sodium Injection

http://www.dhsspsni.gov.uk/learning_communication_02_11
http://www.dhsspsni.gov.uk/hsc-sqsd02-10.pdf
http://www.dhsspsni.gov.uk/hsc__sqsd__28-07.pdf
http://www.dhsspsni.gov.uk/hss-md-17-2010.pdf
http://www.dhsspsni.gov.uk/hss-md-39-2012.pdf

Supporting Safer Services

June 2006	Report
December 2007	Report
September 2011	Report

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Report on Care of Hospital Patients Receiving Parenternal Nutrition
http://www.ncepod.org.uk/2010pn.htm

Report on 5 Year Report into Suicide and Homicide by People with Mental Illness
http://www.dhsspsni.gov.uk/ncish-hss_sqsd_08_2007.pdf

Report on Suicide and Homicide by People with Mental Illness: Lessons for Mental Healthcare in Scotland
http://www.dhsspsni.gov.uk/hsc__sqsd__51-2008.pdf

Regulation and Quality Improvement Authority (RQIA) Reports

February 2010 Report of Blood Safety Review

http://www.rqia.org.uk/cms_resources/RQIA%20Blood%20Safety%20Report%2010%20Feb%202010.pdf

July 2010	Reducing the Risk Hyponatraemia When Administering Intravenous Infusions to Children

http://www.rqia.org.uk/cms_resources/Hyponatraemia%20Report%207%20Jul%2010.pdf

National Patient Safety Agency Guidance

Being Open – Communicating Patient Safety Incidents with Patients, their Families and Carers
http://www.nrls.npsa.nhs.uk/alerts/?entryid45=65077

Regional Template and Guidance for Incident Review Reports
http://www.dhsspsni.gov.uk/hsc__sqsd__34-07.pdf

Quality Standards for Health and Social Care
http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health___social_care.pdf

Departmental Circular

Learning from Adverse Incidents and Near Misses Reported by HSC Organisations and Family Practitioner Services
HSC (SQSD) 8/2010

Northern Ireland Assembly

Appendix 5

List of Witnesses Who Gave Oral Evidence to the Committee

List of Witnesses Who Gave Oral Evidence to the Committee

1) Dr Andrew McCormick, Accounting Officer, Department of Health, Social Services and Public Safety (DHSSPS);

2) Dr Paddy Woods, Deputy Chief Medical Officer, Department of Health, Social Services and Public Safety (DHSSPS);

3) Ms Julie Thompson, Senior Finance Director, Department of Health, Social Services and Public Safety (DHSSPS);

4) Mr Kieran Donnelly, Comptroller and Auditor General; and

5) Ms Fiona Hamill, Treasury Officer of Accounts, Department of Finance and Personnel (DFP).

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Published by Authority of the Northern Ireland Assembly,
Belfast: The Stationery Office

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