HSCB/PHA

Annual Report on Safety and Quality Alerts

2012/13

1 April 2012 – 31 March 2013

Background

1. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. However, all health and social care comes with the risk of unintended harm, and on occasions, adverse events do occur.

2. A robust and comprehensive process for ensuring that care is safe and that adverse events and harm are minimised, involves identifying risks, managing those risks by responding appropriately, disseminating information effectively, and applying the learning from safety or quality related adverse events. As such, the Department of Health Social Services and Public Safety (DHSSPS) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to assure patient and client safety and best practice.

HSCB/PHA Process for the Management of Safety and Quality Alerts

3. In July 2009, DHSSPS transferred responsibility for performance managing implementation of Safety Alerts to the HSCB. Since then, Safety and Quality Alerts issued by DHSSPS and accompanied by an assurance template, were logged and recorded on the HSCB/PHA Safety Alerts Database.

4. A multidisciplinary group led by PHA professional advisers and supported by PMSI, oversaw the process and appropriate closure of Alerts.

5. In April 2012, taking account of comments from HSCB/PHA and Trust staff, the process for managing Safety Alerts was refined and new arrangements introduced. Challenges with the process included managing the range of safety alerts and guidance issued, ensuring a proportionate response to substantive issues that require a high level of

assurance, taking action as a region where appropriate, and managing the workload with finite staff resources.

6. The key changes included broadening the range of correspondence managed through this process, introducing a standard assessment of the assurance required taking account of complexity, likelihood, risks and other factors, and seeking more specific assurance from Trusts. The Medical Director/Director of Public Health was identified as the lead Director, and chair of the reconfigured Safety and Quality Alerts Team (SQA Team). The team includes representatives from the Health and Social Care Board (HSCB) and the Public Health Agency (PHA). A Central Coordinating Office (CCO) managed by the Governance Team within HSCB Corporate Services was established to manage and maintain a system to oversee the process, and track progress of safety and quality alerts.

7. During 2012/13, further refinements to the process were made which included enhancement of timely communication with DHSSPS and HSC Trusts to ensure specified timescales are met for implementation of alerts and circulars.

8. The SQA team continues to meet on a bi-weekly basis and membership is included within appendix 1. The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

Legacy Alerts [pre July 2009]

9. In 2011/12 and 2012/13, DHSSPS asked HSCB to follow-up on 11 legacy circulars. These were patient safety circulars which had been issued to Trusts prior to transfer of responsibility to the HSCB in July 2009.

10. Each was reviewed by the SQA Team and information on the current status of implementation was requested from the Health and Social Care Trusts.

11. As of end of April 2013, 9 of the 11 circulars have been closed.

    Two circulars remain open:

    - Reducing the risk of overdose with Midazolam injection in adults, which is expected to be closed in the near future.
    - Risk of Chest Drain Insertion, which requires a further final update on progress in August 2013.

Activity in 2011/12

12. During 2011/12 and up to 31 March 2013, 35 legacy Safety and Quality Alerts were reviewed by the multidisciplinary team. These comprised of 29 outstanding alerts issued in previous years (July 2009-March 2011) and 6 alerts issued in the financial year 2011/12.

13. Of the 35 alerts, 25 of these are closed. Of the 10 remaining alerts, four alerts have no material issues remaining, and Assurance Templates for three of these have been submitted to DHSSPS. For the remaining six alerts, further updates, or more detailed assurance information has been sought from HSC Trusts by HSCB/PHA. These Alerts will be finalised and closed during 2013/14.

Activity to date in 2012/13

14. From 1 April 2012 – 31 March 2013, 72 Category 1 Alerts or equivalent correspondence have been reviewed by the SQA Team. To date, 60 of these have been actioned and closed and 12 remain open with action plans in place.

15. In addition, 8 Category 2 Safety Alerts Broadcasts (SABs) have been reviewed by the SQA Team. One of these alerts remains open but is due to be closed in the near future.

Summary of Category 1 Alerts 1 April 2012 – 31 March 2013

Category 1	Closed	Open	Total
Safety and Quality Alerts / Circulars	49	4	**53**
Learning Letters	10	5	**15**
RQIA Reports	0	3	**3**
Medicines Safety Alerts	1	0	**1**
Total	**60**	**12**	**72**

As well as assuring implementation of Alerts, the SQA Team has also overseen a number of key safety/quality improvements including:

- Establishing regional training on chest drain insertion
- Sharing, and confirming adoption of good practice by all Trusts in use of intrathecal injections
- Development of a regional standard competency assessment framework for safe administration of intravenous fluids to reduce the risk of hyponatraemia
- Changes to the NIMATS information system to support screening for inborn errors of metabolism
- Trust action plans developed in response to Confidential Enquiries in Paediatric Surgery and in pre-op assessment of higher risk patients
- Early Warning Score systems revised and incorporating new National systems for children and maternity units

- Improvements to the training and supervision of staff providing newborn screening services.

The processes used by the Safety Quality Alerts Team have been welcomed by Trusts and continue to be refined in collaboration with Trust and DHSSPS colleagues.

Conclusion

16. During 2013/14, the CCO will provide a bi-annual report on activity to the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board and others as required.

Appendix 1

Safety and Quality Alerts Team Membership

Carolyn Harper [Chair]	Director of Public Health Research & Development
Brenda Bradley	Pharmacy Lead Medicines Governance and Public Health
Elaine Hamilton	Assistant Governance Manager
Gavin Lavery	Clinical Director Northern Ireland HSC Safety Forum
Jackie McCall	Consultant in Public Health
Janet Little	Assistant Director Service Development & Screening
Mary McElroy	Safety Quality and Patient Client Experience Lead
Michael Bloomfield	Director of Performance Management and Corporate Services
Oriel Brown	Senior Manager, Safety Quality Patient Experience
Zara Mayne	Medical Advisor