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SAFETY FIRST:
A Framework for Sustainable Improvement in the HPSS

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POLICY STATEMENT ON SAFETY

The Department of Health, Social Services and Public Safety, together with the Health and Personal Social Services (HPSS), is committed to the ongoing development of a safer service, as part of its drive to improve clinical and social care, service user experience and outcomes.

No health and social care environment will ever be absolutely safe and without risk; however, more can always be done to improve the safety and quality of care provided.

High safety standards are key indicators of a high quality service. Over the next few years, the policy focus will be on linking quality and safety. Particular attention will be on:

- Creating an informed, open and fair safety culture within the HPSS;
- Raising awareness of risk and promoting timely reporting of adverse incidents;
- Investigating serious incidents;
- Sharing the learning across HPSS environments;
- Implementing change;
- Developing skills, knowledge and expertise; and
- Involving and communicating with the public.

In support of the policy, an action plan has been developed, which places “Safety First” as the philosophy which all organisations, practitioners and staff should promote and adopt.

The action plan will be reviewed in 2007.

SECTION 1 – AIM OF FRAMEWORK

1.1 INTRODUCTION

Safety has to be the first concern of everyone who works in or manages the Health and Personal Social Services (HPSS) in Northern Ireland. It is an integral part of quality in health and social care - diminished standards of safety reflect poor quality of service for people. Effective care, therefore, has to place an emphasis on efforts to improve safety processes in order to prevent adverse outcomes, and to improve the service user and carer experience. Safety is, therefore, an integral part of clinical and social care governance.

This document aims to draw together key themes to promote service user safety in the HPSS. It intends to build on existing systems and good practice, to bring about a clear and consistent DHSSPS policy and action plan, which can be reviewed in light of advances and developments. It does not aim to identify or replace existing policies and procedures, particularly those relating to statutory health and safety functions, or staff or visitor safety, but rather focuses on safety in terms of improvement of quality of care through enhanced clinical and social care governance.

The major policy focus and action will be on:

- creating an informed, open and fair safety culture across HPSS organisations;
- raising awareness of risk and promoting timely reporting of adverse incidents;
- sharing the learning across HPSS environments;
- implementing change;
- investigating serious incidents; and
- involving and communicating with the public.

Appendix A sets out the Terms of Reference and scope of this safety document. The action plan (section 5) will be reviewed in 2007, to determine progress and map future priorities.

1.2 ERROR – A PART OF THE HUMAN CONDITION

No health and social care environment is one hundred percent safe. Some adverse incidents which occur may be the inevitable complication of treatment or care. Many treatment decisions are made in a busy working day, using a range of technologies and

activities (e.g. medicines, medical devices, equipment, procedures) and in different environments, which can, in themselves, be the subject of error. The factors which influence quality and safety of care, include:

- the context, e.g. HPSS, regulatory frameworks;
- the organisation and its management e.g. financial resources, priorities, policies, safety culture;
- the work environment e.g. staffing levels, skill mix, workload;
- the team e.g. structure, communication, supervision arrangements;
- the individual (staff) e.g. knowledge and skills, motivation, health;
- the task e.g. task design, use of protocols, accuracy of test results; and
- patient characteristics e.g. complexity of condition, language and communication, personality and social factors.[1]

Given the multiplicity of factors which influence the care of an individual, health and social services will never be totally error-free. But what can be achieved is the minimisation of risk, a greater knowledge and understanding of why human error and systems failures occur and the fostering of a culture which supports learning in order to prevent reoccurrence.

1.3 DEFINITION OF AN ERROR OR INCIDENT

It is important to have a common understanding of what constitutes an error or incident, regardless of the source. Errors can occur at all stages of the process of care, from diagnosis to treatment, to preventive care. Not all errors result in harm; these errors are often described as “near misses”. These too, represent an opportunity to identify systems improvements and have the potential to prevent adverse incidents in the future. All types of errors and incidents should be included in a common definition - social care, clinical, health and safety, fire, infection control etc., as they could potentially impact on the health and social care of service users, staff and visitors.

For the purposes of the Department and the HPSS, the regional definition of an error or incident is as follows:

[1] Adapted from; Vincent, Taylor-Adams and Stanhope 1998

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation".

The definition acts as a common working definition for HPSS organisations. It acknowledges that not all errors result in harm to patients and service users, but some do. Where the potential for harm/loss/damage is detected and the incident is prevented thus resulting in no harm to the individual, it is considered a "near miss" and can yield valuable learning.

The definition also supports the view that damage to property, environment or reputation can have both a direct and indirect impact and cost on health and social care. For example, faulty equipment may require tests to be repeated, potential for mis-diagnosis and concern for service users and staff. In addition, an incident may lead to loss of trust on behalf of the public and reduced satisfaction and morale among staff, with consequent negative impact on workforce recruitment and retention. More generally, employers and society may pay because of loss of worker productivity, school attendance, and a reduction in population health status. So, the human, social and economic costs resulting from adverse incidents are potentially high, but especially when a death occurs which may have been preventable.

1.4 THE HUMAN, SOCIAL AND ECONOMIC COSTS

The National Patient Safety Agency in England and Wales has produced its first report based on findings of the National Reporting and Learning System from November 2003 to March 2005. It shows a rate of five adverse incidents reported per 100 admissions in acute hospitals. In acute hospital settings, about three in every 1,000 reported incidents resulted in death[2].

Although many HSS Trusts and Boards have local incident reporting systems, the health and social services in Northern Ireland do not have a common reporting or data analysis system for adverse incidents; therefore, neither the number of adverse incidents in health and social care environments is known nor can the order of magnitude of untoward deaths be estimated. However, as with other developed healthcare systems, it can be reasonably assumed that the problem exists in our health and social care environment.

[2] Building a Memory: preventing harm, reducing risks and improving patient safety – The first report of the National Reporting and Learning System and the Patient Safety Observatory – July 2005 – www.npsa.nhs.uk

What is known is the fact that any adverse incident, whether or not it results in injury, harm or death, has the potential to cause considerable distress not just to service users and carers but also to health and social care staff. For the families of those who have suffered the loss of a loved one, that loss can be made worse by the knowledge that death may have been preventable and that past lessons may not have been learnt.

The human, social and economic costs to individuals and families, the Health and Social Services and society are enormous. For example, in the HPSS:

- in 2004, via the Northern Ireland Adverse Incident Centre[3], 166 adverse incidents reports were received with 4 relating to circumstances involving fatalities;

- in 2004/05, a total of 10,107 medication-related patient safety incidents[4] were reported by staff in eight of Northern Ireland hospitals alone, although 89% of these were considered not to have caused harm (i.e. a near miss);

- in 2004/05, the frequency of MRSA[5] among hospital patients has shown a first and significant annual downturn during four years of monitoring, 242 patients were recorded as having MRSA in 2004/05 a decrease of 21% when compared to the same period in 2003/04;

- 15 suspected suicides and 3 suspected homicides occurred involving people in or who had just been discharged from mental health settings in the HPSS and were reported to the Department in 2004/05[6]; and

- in 2003/04, £15 million was paid in settlement of clinical negligence claims (HSS Boards and Trusts) with a future potential liability of around £100 million for current claims[7].

[3] Northern Ireland Adverse Incident Centre records and investigates, as appropriate, reported adverse incidents involving medical devices, non medical equipment, plant and building items used in the HPSS

[4] Source – Northern Ireland Medicines Governance Team

[5] Source - Communicable Disease Surveillance Centre – Northern Ireland – www.cdscni.org.uk

[6] Source – DHSSPS – Circular HSS (PPM) 06/2004. Reporting and follow-up of serious adverse incidents

[7] Source - DHSSPS

1.5 LEADERSHIP AND ORGANISATIONAL CULTURE

The culture of an organisation is about "how we do things around here" and this is significantly influenced by the leadership of senior management. But for senior management to demonstrate leadership, it has to have the knowledge, skills and information to promote a safety culture.

An informed safety culture has four major sub-components[8]:

- *a reporting culture* - in which people are prepared to report their errors and near misses;
- *a just culture* – where an atmosphere of trust and fairness is created in which staff are encouraged to engage in safety related activities;
- *a flexible culture* - which respects the skills, abilities and limitations of frontline staff; and
- *a learning culture* – the willingness and competence to draw the appropriate conclusions from its safety information systems and to implement major reforms.

The DHSSPS endorses the approach that all organizations should have an informed safety culture, which should be given the highest priority at senior management level and promoted throughout as "everyone's business".

1.6 AN INFORMED SAFETY CULTURE

At present, there is no internationally accepted definition of patient safety incidents. Different definitions, information sources and methods of collection and analysis will affect findings. Appendix B provides examples of potential sources of information about the frequency of patient safety incidents and some of the strengths and weaknesses of each system. These include incident reporting systems, medical records review, surveys of patients and staff, and routine data collection. These illustrate the potential breadth of information sources, which contribute to knowledge of safety incident rates. However, for health and social care, the sources of reporting and data collection are even wider. What is needed is the systematic approach to data analysis and intelligence gathering from a range of sources, building on local, national and international capacity and capability, for example:

[8] Reason, J. Managing the risks of organisational accidents. Ashgate. Aldershot 1997

- published literature for health and social care environments e.g. NICE, SCIE and NPSA;
- National Inquiries - e.g. Confidential Inquiries: CEMACH, NCISH, NCEPOD;
- statutory and voluntary reporting systems - e.g. local medicines and devices reporting, MHRA, child protection, Mental Health Commission;
- hospital and social care episode statistics;
- health and social care complaints;
- local and national Inquiries, e.g., Lewis, Ombudsman, Hyponatraemia, Climbié, Shipman and Bristol Inquiry Reports;
- regional and local audit findings;
- Regulation and Quality Improvement Authority (RQIA) reviews and reports;
- Social Services Inspectorate reports;
- claims and litigation findings;
- coroner's findings; and
- death certification data.

Building a comprehensive picture on safety as part of improved quality of care can be complex. However, given the relatively small population size in Northern Ireland and the integrated nature of health and social care services, this provides us with a unique opportunity to draw together the different strands of learning and disseminate it in a positive way - to improve quality of health and social care, rather than in a punitive way to blame and shame individuals or organisations.

Yet being a small region also has its disadvantages in that incidents may occur relatively infrequently here to make their detection and monitoring meaningful. We must also learn from errors detected nationally; we cannot "reinvent the wheel" in terms of national and international expertise and resources when trying to draw together all the variety of sources of information to enhance learning. So, a balance has to be struck between the need for local intelligence mechanisms and expertise, and building on national and international capacity and capability. Hence the need for links with national organisations such as the National Patient Safety Agency (NPSA), Social Care Institute For Excellence (SCIE) and the National Institute for health and Clinical Excellence (NICE) - to enhance both quality and safety in health and social care.

KEY POINTS

- No health and social care service will ever be 100% error-free but what we can do is reduce the risk, enhance systems and expertise, and learn from adverse incidents and near misses.
- Strong leadership, a focus on systems and on organisational safety culture will reduce error.
- A regional definition of an adverse incident is identified covering health, social care, people, property, environment and reputation.
- A systematic approach to information gathering and data analysis is needed locally, which builds on national and international capacity and capability.
- No single source of information will provide all the data that is needed for safety analysis. For example, complaints, litigation, and death certification, together with adverse incidents reporting systems, audit and performance data need to be linked to enhance quality of care and be linked to evidence of effectiveness.

SECTION 2 – CURRENT SYSTEMS TO PROMOTE SUSTAINABLE IMPROVEMENT IN THE HPSS

2.1 INTRODUCTION

Sustainable improvement is at the forefront of the development of health and social care services in Northern Ireland. This is being undertaken through a multi-faceted approach to modernising and reforming organisational structures and delivery of care, together with a greater emphasis on quality, safety and accountability for the commissioning and delivery of that care.

Although healthcare systems from around the world vary considerably, many developed countries, such as the United States of America, Australia and the United Kingdom are leaders in the field of patient safety initiatives. Last year the UK European Union Presidency had a major focus on patient safety.

This section of the Safety Framework recognises that quality and safety are part of the continuum of local service improvement and are integral to good governance of an organisation. It sets out:

- the local commitment to quality and service improvement;
- safety and risk management systems underpinning good governance;
- local examples of organisational cultural change;
- links to national standard-setting bodies;
- examples of learning from local serious adverse incidents;
- changes to HPSS complaints procedures;
- serious adverse incident interim reporting arrangements; and
- the need for education, workforce development and regulation.

2.2 A COMMITMENT TO QUALITY AND SERVICE IMPROVEMENT

In 2001 the Northern Ireland Executive gave a commitment in the first Programme for Government to put in place a framework for raising the quality of services delivered and for tackling poor performance in the HPSS. Since then, much work has been undertaken to bring forward this programme.

The consultation document "Best Practice – Best Care"[9], issued in April 2001, was the first step towards fulfilling this commitment. It set out proposals to put in place a framework to raise the quality of services provided to the community and tackle issues of poor performance across the HPSS. The aim was to provide a high quality system of health and social care, which was easy and convenient to use, was responsive to people's needs and provided a service that instilled confidence in those who used it.

The quality improvements in "Best Practice – Best Care" are centred on five main areas:

- setting of standards: to improve services and practice;
- improving governance in the HPSS: in other words, the way in which organisations manage their business;
- improving the regulation of the workforce, and promoting staff development through life-long learning and continuous professional development;
- changing the way HPSS organisations are held to account for the services they commission and/or provide: the Duty of Quality; and
- establishing a new, independent body to assess the quality of health and social care - the Regulation and Quality Improvement Authority (RQIA).

From 1 April 2003, a statutory duty of quality was placed on HSS Boards and Trusts. Under this duty, each Board/Trust is required to[10] "*put and keep in place arrangements for the purpose of monitoring and improving the quality of the health and personal social services which it provides to individuals and the environment in which it provides them*". This requirement to deliver on the quality of services is similar to the requirements already placed on the HPSS to ensure financial probity.

RQIA came into operation from April 2005. RQIA's principal role includes the registration, regulation and inspection of a wide range of services delivered by the independent sector and the HPSS, and to report to the Department on the quality of care provided by the HPSS. In addition, it has a general role to promote and facilitate quality improvement in health and social care.

[9] Best Practice – Best Care: a framework for setting standards, delivering services and improving monitoring and regulation in the HPSS

[10] Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (S.I. 2003 No.431 (N.I.9))

In order to provide greater consistency and accountability in the quality of care provided, and to facilitate the RQIA in its role, a range of standards have been developed, including:

- controls assurance standards[11], to assist HPSS organisations to demonstrate that they are doing their reasonable best to manage risk effectively;
- minimum care standards[12], applicable to agencies and establishments in the independent, voluntary and statutory sectors and to certain HPSS services; and
- generic quality standards[13], applicable to primary, secondary and tertiary care in the HPSS.

The above developments all contribute to good governance within the HPSS.

2.3 SAFETY AND RISK MANAGEMENT AS PART OF GOOD GOVERNANCE

All HPSS organisations are required to have a system of internal control to help facilitate the flow of information about risk both up and down and across the organisation. Part of this system is the recording of risks on risk registers. These are held at key points within the organisation depending on its size and structure. When most effective, a system of risk management involves every member of staff, and the organisation as a whole being aware of the key risks that affect them.

The function of risk registers is to inform key decision-makers of the risks they need to know about in order to fulfill their role in the commissioning and delivery of care. The recently-produced "Establishing an Assurance Framework: a practical guide for management boards of HPSS organisations[14]" is written to help HPSS board members, directors and senior managers within the HPSS to further improve their systems of internal control and to embed the principles of whole-organisation risk management as an integral part of quality health and social care. It acknowledges

[11] Controls assurance standards available on: http://www.dhsspsni.gov.uk/index/health_and_social_services/governance/governance-controls.htm
[12] Draft care standards available on: http://www.dhsspsni.gov.uk/index/consultations/previous_consultations.htm
[13] The Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS available on: http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf
[14] Establishing an Assurance Framework: a practical guide for management boards of HPSS organisations – http://www.dhsspsni.gov.uk/publications/2006/assurance_framework.pdf

that decisions by individuals, managers and directors can positively or negatively affect the delivery of care to the individual.

Knowledge and skills in the assessment and appropriate management of risk in an often rapidly changing environment of care are essential to organisational health, to ensure safety and to improve outcomes in clinical and social care. Clear roles, policies, procedures and systems will help facilitate appropriate risk decisions and minimise inappropriate and potentially damaging decisions. This includes a system for assuring that each organisation has available information about key elements of risk:

- at the right time;
- in the right way; and
- to the right person(s).

This enables the most appropriate decisions to be made and facilitates the promotion and delivery of improvements in care.

2.4 SUPPORTING CULTURAL CHANGE

Having appropriate procedures to identify, assess and manage risk is central to organisational health, but this has to be complemented by cultural change in order to demonstrate a commitment to good practice, drive quality and enhance organisational performance. The following four initiatives are all examples which support cultural change:

The Clinical and Social Care Governance Support Team (CSCG) was established by the DHSSPS in 2004. In establishing the CSCG Support Team, the Department's aim was to promote the longer-term cultural change and organisational development that it considered necessary to ensure that the statutory duty of quality could be implemented successfully and consistently in the HPSS. In turn, this would lead to a continuous improvement in health and social care services in Northern Ireland. A decision to link with the NHS Clinical Governance Support Team in developing these local arrangements was taken on the basis that the HPSS would have access to the experience, knowledge and tools already developed in the NHS. The CSCG Team has developed an extensive work programme across primary, community and secondary care. This programme has included specific training initiatives and topic specific programmes, such as in elderly care, to facilitate a multidisciplinary approach to learning and to champion

quality improvement. It complements the many other local initiatives, some of which have been ongoing for a number of years, such as the Clinical Resource Efficiency Support Team (CREST) which aims to drive up standards in clinical practice by the production of specific guidance.

Regional Governance and Risk Management Adviser - The post of Regional Governance and Risk Management Adviser, sponsored by the Department from October 2003, was initially focused on supporting the HPSS in embedding the fundamental structures and processes of risk management. The post promotes a joined-up approach to governance arrangements in HPSS organisations. Integral to this is the involvement of the adviser in a range of safety, quality and risk management initiatives. A major project is underway relating to the standardisation of definitions and coding to enhance incident management (see Appendix D).

The Northern Ireland Medicines Governance Team aims to improve medication-related patient safety by a systematic regional approach to medication risk management through the deployment of six senior pharmacists dedicated to medicines risk management in Northern Ireland hospitals. Beginning in August 2002, the team has addressed three main areas: the development of the risk management process itself, including identification, analysis and evaluation of risk, the development of 'good practice' initiatives and risk education. In November 2004, the Team was awarded the Health Service Journal Award for Patient Safety. As part of the Pharmaceutical Services Improvement Projects currently underway, funding has been secured to extend the Medicines Governance Team, with the aim of enhancing medicines governance arrangements in the primary care sector of the HPSS.

The Safer Patient Initiative, promoted and funded by The Health Foundation Trust, in collaboration with the Institute for Healthcare Improvement (IHI) in the USA, aims at making hospitals safer for patients in the UK. Following rigorous assessment of applications, Down Lisburn Trust was one of four UK Trusts selected to start work on the safety initiative in October 2004. This provides the Trust with an opportunity to work with an expert team from IHI and world experts to promote safety and quality. The four UK Trusts were selected for this prestigious project on the basis of their exceptionally high level of commitment to improving patient

safety. The project will last for two years; the selected trusts are expected to become exemplars in patient safety so that other hospitals can learn from their success.

2.5 LINKING WITH NATIONAL BEST PRACTICE

Whilst HSS Boards and Trusts in Northern Ireland have the capacity to be leaders in the field of quality and safety, given our relatively small size and limited resources, we must draw on the wide range of skills, knowledge and expertise that is available at national and international level. The establishment of appropriate links with national best practice and standard setting bodies is a key element in the framework for raising the quality of health and social services in Northern Ireland. These links are necessary to secure access to independent evidence-based guidance to promote safe, effective and efficient care.

It is recognised that guidance developed in Great Britain should generally have universal application and that local duplication is unnecessary.

Current progress on the Department's links with national bodies is outlined below.

- **National Patients Safety Agency (NPSA)** - A formal agreement with NPSA to extend its services to Northern Ireland is planned from April 2006. This will provide access to the whole range of NPSA's training material, tools and guidance to promote and facilitate safety in the HPSS. This will include access to the NPSA's *Seven Steps to Safety* programme for both primary and secondary care, adapted to meet the need of our integrated health and social care environment. In addition, the HPSS will eventually join with the National Reporting and Learning System, to facilitate an integrated approach to reporting and learning from adverse events (see section 3). The NPSA's Patient Safety Observatory will bring together many sources of information and facilitate benchmarking on safety across the HPSS with other regions.

- **National Clinical Assessment Service (now part of NPSA but previously the autonomous National Clinical Assessment Authority)** - Since October 2004, NCAS provides advice, support, and assessment for HPSS organisations where a doctor's or dentist's performance is called into question (see section 3). This was one of the key

recommendations in *Confidence in the Future for Patients, and for Doctors*[15]. This document set out proposals for the prevention, recognition and management of poor performance of doctors.

- **Social Care Institute for Excellence (SCIE)** – SCIE was developed to identify and promote dissemination of knowledge about what works in social care. A service level agreement was established with SCIE in June 2004 extending the Institute's remit to cover Northern Ireland. Local social care practitioners and academics are now actively involved in SCIE projects and the development of best practice guidelines.

- **National Institute for health and Clinical Excellence (NICE)** - Whilst NICE guidance has no formal status in Northern Ireland, many parts of the HPSS draw on the material produced by the Institute. The Department has had negotiations with NICE on formal links and is represented, in observer capacity, on the committee that provides advice on the selection of topics for NICE appraisal and guidance programmes. A process for reviewing the applicability of NICE guidance to Northern Ireland and, where appropriate, endorsing it for uptake in the HPSS is being put in place. In addition, the HPSS will link with NICE new interventional procedures programme to ensure that new procedures used for diagnosis and treatment are safe enough and work well enough for routine use in the HPSS.

2.6 LEARNING FROM LOCAL ADVERSE INCIDENTS

The provision of health and social care will never be error free due to the complexity of factors which contribute to that care. It is acknowledged that the majority of errors do not lead to any harm for patients, staff or service users, but unfortunately some will. Recent examples of adverse incidents which continue to receive much attention, because of potential severity of outcome are:

- **The Independent Review of Endoscope Decontamination,** was established in June 2004, following concerns about the effectiveness of decontamination of endoscopes in some locations in Northern Ireland. This was chaired by Dame Deirdre Hine. It examined the systems and processes in Trusts to ensure the effective cleaning and

[15] www.dhsspsni.gov.uk/publications/archived/2000/confuture.pdf

high-level disinfection of flexible endoscopes before and after their use on patients, and found a number of areas in which procedures could be improved. Implementation of the recommendations is currently underway.

- **Inquiry into Hyponatraemia – Related Deaths[16].** In November 2004, the Department appointed Mr John O'Hara QC to hold an Inquiry into the events surrounding and following the deaths of three young children, with particular reference to their care and treatment in relation to fluid balance, and the role that individuals and organisations played following their deaths.

- **The Management of Hyperkalaemia in Adults.** Following recent serious adverse incidents relating to blood electrolyte abnormalities involving potassium, the Clinical Resource Efficiency Support Team (CREST) produced guidelines and wall charts for every local organisation to provide clear and concise information to enable clinicians to safely and effectively manage patients presenting with hyperkalaemia.

- **Post operative care following laparoscopic abdominal surgery.** An independent review team produced a report on lessons arising from the death of Mrs Janine Murtagh. It contained a number of recommendations covering consent, patient care, leadership and communication, and the implementation of policies and procedures.

2.7 ARRANGEMENTS FOR MONITORING AND LEARNING FROM SERIOUS ADVERSE INCIDENTS

In July 2004, interim guidance was issued to the HPSS, including family practitioner services, on the circumstances where particular serious adverse incidents or near misses must be reported to the DHSSPS (Circular HSS (PPM) 06/04). These are where the episode is considered:

- to be serious enough for regional action to be taken to ensure improved care or safety for patients, clients or staff;
- to be of such seriousness that it is likely to be of public concern; or
- to require independent review.

[16] www.ihrdni.org

The guidance complements existing local and national reporting systems, both mandatory and voluntary, which have been established over the years. These provide for specific incidents relating to, for example, medical devices, equipment, medicines, mental illness, child protection, communicable disease and the safety of staff to be reported to various points in the DHSSPS.

The new interim reporting arrangements on serious adverse incidents (SAI) were developed to try and ensure that lessons are learned across the HPSS and that serious local incidents are not repeated. The DHSSPS plans to collate learning from reported SAIs and produce an annual report. DHSSPS will also hold SAI briefings for the HPSS at regular intervals. HPSS directors and senior officers responsible for safety and quality will attend these meetings in order to gain information on the emerging current picture of SAIs across the HPSS. This will present an opportunity for the service to share learning and discuss possible improvements to the current reporting mechanisms in order to facilitate further sharing and learning.

It is recognised that different sources and types of data on adverse incidents all contribute to our knowledge of adverse incidents. Examples include “near misses”, complaints, social care inspections, litigation, audit, records review, confidential inquiries etc., together with information about relatively infrequent incidents, which occurred in other health and social care systems. Through the NPSA’s National Learning and Reporting System, and Patient Safety Observatory, the triangulation of data sources and analysis will be facilitated. However, there will remain a need to have some local reporting arrangements to ensure timely dissemination of local adverse incidents and near misses. Work will be done to clarify arrangements and avoid duplication.

2.8 EDUCATION, WORKFORCE DEVELOPMENT AND REGULATION

Staff and HPSS organisations must be able to justify the trust that the public places in them. For this to happen, the DHSSPS and the HPSS need to be able to demonstrate that good standards of practice and care are being maintained and that respect for service users is being shown. It is recognised that when safety and quality are introduced early into educational programmes, this has a positive impact on the future delivery of safe and effective care. Consequently, the content of this framework will be of use to educational providers.

The maintenance of good standards of practice and care requires individuals and organisations to have a learning culture, and one which supports training and development of staff. Training and development needs analyses, linked to regional, local, organisational and individuals' priorities and objectives, are essential for the ongoing enhancement of quality and safety within the HPSS. The introduction of quality assured appraisal systems which facilitate review of performance and the identification of development needs have the capacity to improve treatment and care and reduce error.

The regulation of the workforce has a major part to play in the promotion of quality and safety. Regulation and responsibility should take place at different levels[17], for example:

Personal level – based on a commitment to quality of care that puts the safety and care of the patient and service user first;

Team level – based on the concept of the importance of team working and the requirement to take responsibility for the performance of the team, and to act if an individual's conduct, performance or health is placing the public at risk;

Workplace level – which reflects the responsibility that HPSS organisations have for ensuring that staff, equipment and facilities are fit for purpose in the commissioning and provision of care. This is expressed through the Duty of Quality, clinical and social care governance, performance management systems and compliance with legislation; and

Professional level – which is undertaken by statutory regulators, for example, working through the development of standards, education, registration and licensing, and fitness to practise procedures.

Examples of professional regulators include the General Medical Council, General Dental Council, Nursing and Midwifery Council, Pharmaceutical Society of Northern Ireland, the Health Professions Council, General Optical Council and the Northern Ireland Social Care Council. All of these organisations have a major part to play in the promotion of quality of care and in the identification and management of fitness to practise. The Council for Healthcare Regulatory Excellence was formed in April 2003 to

[17] Adapted from Developing Medical Regulation: A Vision for the Future – April 2005 - GMC

ensure consistency of approach and good practice among nine "health" regulators. Several of the professional regulatory organisations identified above are undergoing development and change. Many of the drivers for change in the regulation of the workforce are as a consequence of national inquiries such as, the Bristol, Shipman, and Climbié Inquiry Reports.

Locally, a number of organisations also promote best practice and enhanced clinical and social care performance, including:

Northern Ireland Social Care Council (NISCC) – As part of the Northern Ireland Assembly's commitment to raising the status of the whole social care workforce, raising the standards of social care practice and ensuring proper protection of the public against persons who are unsuitable to carry out the work, NISCC was established in 2001 to regulate the social care workforce and to regulate the training of social workers.

Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) – In 2002, NIPEC was established to shape practice, education and performance within the professions of nursing and midwifery in Northern Ireland and to equip nurses and midwives in such a way as to enable them to provide better care for patients and service users.

KEY POINTS

- Sustainable improvement in health and social care requires a multifaceted approach, including service reorganisations and reform, and an emphasis on safety and quality as part of good governance.
- Systems and procedures for the identification, assessment and management of risk are important but have to be supported by organisational cultural change to promote sustainable quality improvements.
- Much work had already been undertaken locally to support quality and safety.
- National links are an important way of gaining access to knowledge, skills and best practice.
- Linkage with the National Patient Safety Agency, National Institute for health and Clinical Excellence, and the Social Care Institute for Excellence are pivotal to the promotion of quality and safety.
- Education, workforce development and regulation occur at individual, team, organisational, regional, and national levels; it is part of the drive to promote quality and protect the public.
- Recent local adverse incidents emphasise the need to put *safety first.*

SECTION 3 – PROMOTING SERVICE USER AND STAFF SAFETY

3.1 INTRODUCTION

Section 2 identified the progress that has been made to date to promote and embed quality and safety within HPSS environments. This section builds on this work and identifies other key elements to promote service user and staff safety. These include:

- creating an informed, open and fair safety culture across the HPSS;
- raising awareness of risk and promoting timely open reporting of adverse incidents;
- sharing the learning across HPSS environments and implementing solutions; and
- investigating serious incidents.

To facilitate implementation of these key elements requires co-ordinated action involving individuals, the HPSS including family practitioner services and the DHSSPS. Actions to promote and support a safer service are identified in section 5. This section is written for managers, educationalists and practitioners to clearly document high level work which needs to occur between 2006 and 2007. The action plan is outcome focused and attributes responsibilities.

3.2 CREATING AN INFORMED, OPEN AND FAIR SAFETY CULTURE ACROSS ORGANISATIONS

An informed organisational culture that promotes safety and quality should be at the centre of every stage of prevention, treatment and care. Section 1 identified four main components of an informed safety culture as:

- a reporting culture;
- a just culture;
- a flexible culture; and
- a learning culture.

A just culture is one that is seen to be open and fair to staff. Creating such a culture encourages the reporting of incidents, which is essential to the success of data collection and subsequent improvement in activity, systems, and care.

An “open and fair” organisation can be defined as a one where staff are not blamed, criticised or disciplined as a result of a

genuine slip or mistake that might have lead to an incident. Disciplinary action would, however, follow an incident that occurred as a result of misconduct, gross negligence or an act of deliberate harm. In determining 'blameworthiness', a 'fair' approach is one that separates the actions of individuals involved from the patient outcomes. A 'fair' culture advocates the systems approach, recognising that accidents may occur as a result of a series of system failures rather than through a deliberate malicious act on the part of an individual. Moving to the systems approach will be an important challenge. Research has shown that currently 85% of health care incidents are caused by systems failures yet, 98% of remedial action focuses on the person or people involved in the incident[18].

Organisations that operate a 'fair' culture are more likely to gather useful information about their organisation that can be used to further improve safe practice and pre-empt future incidents. In this way the organisation can acknowledge mistakes, learn from them and take action to put things right. This is an integral part of what the public wants the HPSS to achieve.

But being "open and fair" also means that the organisation should encourage staff to be open and fair when communicating with patients, service users and carers. This is a part of the redress that people can and should expect when things go wrong and where harm has been caused. This includes an organisational commitment to providing an explanation of what happened, an apology, a reassurance of speedy remedial treatment and, where appropriate, financial compensation.

Any change in culture requires sustained commitment at the most senior level in the organisation. Frank and open discussion needs to occur within senior management and agreement reached on what an open and fair culture will mean in practice for their organisation and this needs to be cascaded throughout the organisation as part of an overarching policy on safety. There are many tools which can assist HPSS organisations in assessing organisational safety culture in terms of underlying beliefs, attitudes and behaviours. In addition, tools such as root cause analysis and NPSA's Incident Decision Tree can assist in distinguishing between poor performance of the individual and a systems failure.

[18] Overveit J. Health Service Quality. Brunel University, 1998

3.3 RAISING AWARENESS OF RISK AND PROMOTING TIMELY REPORTING

Raising awareness of risk implies that all members of an organisation should have a good understanding of the factors that contribute to human and organisational error. In addition, there is a need for individuals to recognise that no-one is perfect; that there is always the capacity to reflect on one's work and to improve. Key tools to enhance this reflection are, for example, professional appraisal, audit and significant event analysis, and multidisciplinary team discussion and analysis.

Raising awareness of risk has to happen at all levels within an organisation. Whilst much work has been done to promote risk assessment and risk management within HPSS organisations within recent years, there remain opportunities which the HPSS will have, in the near future, including access to all NPSA material, tools and guidance.

Recent HPSS adverse incidents, highlighted through the coroner's service, have emphasised the need to pay particular attention to risk awareness and action within undergraduate and post graduate training programmes, newly appointed staff and at vulnerable interfaces such as the transfer of patients to different parts of the HPSS or at the interface between secondary, community and primary care. Specific action to raise awareness in these vulnerable areas needs to be undertaken. In particular, risk awareness should be incorporated into education and training programmes; there should be mandatory training for all newly recruited staff on basic organisational risk awareness, policies and procedures, risk within their specific areas of work, and on incident reporting systems. This should be seen by senior management as an integral part of a new recruit's induction into the organisation. In addition, all existing staff should have in-service education and training to support the continual awareness of risk. Appendix C provides an example of a training programme to promote risk awareness.

It must be explicit in all training and incident reporting and management policies that a staff member's responsibility for patient and service user safety comes before any responsibility to other staff, for example, in their own team or profession. This is supported by the codes of conduct for each profession and must be observed regardless of the severity of the incident(s) concerned.

Promoting a reporting culture is an important challenge for all sections of the HPSS and one which is essential if organisations and individuals are to learn from errors. Timely and open reporting is part of individual and organisational responsibility to quality improvement and learning. Whilst it is acknowledged that the majority of incidents do not lead to harm, valuable lessons can be learnt from these and "near misses" – where an error was detected and stopped before it resulted in harm. Research has shown that the more incidents and near misses that are reported then the more information there is about what is going wrong and the more action that can be taken to make health and social care safer both locally and nationally[19].

It is essential that commitment from senior management within the organisation is evident and that clear lines of accountability and communication are defined. It is equally important to ensure that policies and procedures are not simply 'for show' and that staff experiences reflect the ethos agreed by senior management. For example, the ways in which the reporting, investigation and subsequent management of medication incidents have been handled to date, indicates that cultural change is possible and, as a consequence, staff are willing to report incidents. But for staff, the benefits of reporting are not always made clear, particularly when there is a fear of blame, no noticeable change and no feedback. In addition, reporting can seem time-consuming and complicated.

The benefits of reporting need to be cascaded throughout the HPSS. These include:

- improvement in care of patients, clients, service users and staff;
- resources targeted more effectively;
- increased responsiveness;
- pre-empting complaints; and
- reducing costs.

3.4 REGIONAL REPORTING SYSTEMS PROJECT

In order to promote consistency of approach to reporting, in January 2005, the DHSSPS commissioned a project to be carried out across the HPSS to standardise definitions, reporting forms and the coding of incidents. A summary of the first phase of this project is included in Appendix D. This work should help facilitate

[19] Seven Steps to Patient Safety – NPSA - 2004

the sharing of learning between HPSS organisations as data can be shared and analysed more easily across Trusts, Boards and relevant Agencies that comprise Northern Ireland's HPSS. This project's remit encompasses all adverse incidents, inclusive of clinical incidents, social care, staff incidents and any other adverse event that may affect the operation of the HPSS, including the family practitioner services. The work will further facilitate a future link with the National Patient Safety Agency's National Reporting and Learning System.

Whilst local reporting mechanisms will always be important, there is some potential duplication in current reporting systems at local, regional and national level. This is because reporting systems serve different purposes and may have different specialist audiences. In order to provide a greater understanding of where the links are at local, regional and national level will require the Department to work with the HPSS and the NPSA to promote a consistent approach. Of particular importance is the incorporation of all health (both clinical and non clinical) and social care incidents.

The Regional Reporting Systems Project is part of the work to provide greater consistency of approach locally. This Project is part of the phased implementation plan to join with the NPSA's National Reporting and Learning System (NRLS). Joining the NRLS will mean that the HPSS will receive comprehensive reports on patient safety incidents, tailored to the needs of Northern Ireland, but it will also facilitate comparisons with other regions in England and Wales on the frequency of reporting and type of incident. In addition, through the Patient Safety Observatory, the Department and HPSS will have access to the learning that will emerge from other reporting systems and sources, such as, MHRA for medicines and medical devices, professional bodies and National Confidential Enquiries. Use of computerised data analysis tools will help identify potential clusters, patterns and trends across these reporting systems.

Comparisons between regions are important; however, there remains a need within each HPSS organisation to ensure that a reporting culture is fostered and that tools such as the Heinrich ratio are used to regularly assess the "health" of the organisation's reporting system and, where appropriate, ask area/sections which are not reporting for a "nil return" to confirm that incidents have not occurred.

3.5 SHARING THE LESSONS ACROSS THE HPSS

Section 1 provided examples of the many and varied data sources from which learning on safety and quality issues can occur - for example, audits reports, incidents reporting systems, complaints procedures and claims and litigation. When an incident occurs, a fundamental principle of a systems approach to error management is the understanding of how and why an incident occurred[19]. It is only then that learning can be shared and the lessons learnt used to prevent its reoccurrence. The sharing of learning can and should take place at different levels, for example:

- multidisciplinary team discussion within HPSS organisations;
- participation in personal and team education, training and development e.g. development of guidelines and solutions;
- training and participation in and use of investigative tools such as Root Cause Analysis;
- formal data collection and analysis procedures e.g. outcome statistics discussed at team, clinical and social care governance and senior management levels;
- formal communications pathways and networks e.g. urgent communications, newsletters, IT-based systems and discussion fora; and
- production and cascade of annual/ quarterly reports on adverse events.

Further consideration will be given to developing a single information gateway to bring together all departmental publications and guidance in an accessible format and on a monthly basis. In addition, the DHSSPS and the HPSS will consider how the extranet could be used to disseminate the results of all root cause analysis between organisations.

The accountability for patient, service user and staff safety rests with the Chief Executive of an organisation. To facilitate discussion, analysis and feedback, an integrated governance approach should be encouraged within HPSS organisations. There is a need to ensure that there are clearly delineated relationships and communication pathways within the organisation. This is necessary so that front line staff and, in particular, clinical and social care governance leads and risk managers have access to up to date information and that there is a feedback loop to ensure that safety information is received and acted upon within an appropriate timeframe.

The Safety Alert Broadcast System (SABS) is an electronic system developed by the Department of Health in England, with the MHRA, NHS Estates and the NPSA. The aim of this system is to bring different types of alerts together into one electronic system thus ensuring that all urgent communications are received and implemented. Nominated leads in each Trust and Primary Care Trust are asked to disseminate it to those who need to take action. This role is similar to the current MHRA medical device liaison officer role but with the additional responsibility of providing feedback on action to implement the alert using a simple electronic form. The development of a Service Level Agreement with NPSA will provide an opportunity for the Department to explore with the Department of Health in England if appropriate links to the SABS system can be established.

3.6 INVESTIGATING SERIOUS INCIDENTS

Obtaining incident reporting data is just the first step towards a comprehensive approach to safety. Significant investment has been made locally and nationally in root cause analysis training to promote proper understanding of the cause(s) of an adverse incident. There should be a consistent approach to deciding which incidents need to be followed up and further investigated; these should follow best practice in the use of tools for root cause analysis. There are two main criteria, which the HPSS should use in determining further investigation of an incident:

- ***the level of severity/grade of the incident*** - e.g. an untoward death or permanent injury; and
- ***the potential for learning*** e.g. frequency of incident or near miss.

The Chief Executive of the organisation is responsible for investigating the cause of a serious incident as part of his/her commitment to quality of care, which is underpinned by the Duty of Quality. The immediate priority in this case should be to take all the necessary steps to secure the safety of services users, staff and other people involved. All HPSS organisations should have clear policies on incident reporting including a standard approach to investigation of each level of severity of incident. This will be facilitated by the Regional Reporting Systems Project (see Appendix D) and links with the NPSA.

Incidents involving unexpected death or serious harm and requiring investigation by the police and/or the Health & Safety Executive (HSENI) are rare but have increased in number in the

past few years. There is a statutory duty placed on individuals and organisations to report such incidents. When they happen, incidents need to be handled correctly for public safety reasons as well as the maintenance of confidence in the HPSS, Police, Coroner and Health and Safety Executive. To achieve this, it is important that these four arms of the public sector communicate and work with one another in a consistent and ordered manner. The DHSSPS has finalised a Memorandum of Understanding[20] between these four organisations in order to better facilitate these complex interactions. The Memorandum complements existing joint procedures in relation to the protection of children and vulnerable adults.

Special action must be taken in the event of a public health hazard such as a major incident, chemical contamination, or biological, radiological or nuclear emergency. Specific regional guidance governs arrangements for dealing with major incidents.

Regional guidance should be followed where incidents involve suicides or other serious events involving people who have a mental disorder, child protection issues or when an incident fitting the criteria of a National Confidential Enquiry has occurred.

Where an incident involving a medicine has occurred, which falls within the remit of the Medicines Act and the Pharmacy Inspectorate of the DHSSPS, organisations should comply with regional reporting arrangements and co-operate with the investigation.

3.7 ENHANCED ASSESSMENT OF CLINICAL AND SOCIAL CARE PRACTICE

In countries that have promoted safety and quality in healthcare, there is a link between institutional assessment, reviews, accreditation and safety and quality initiatives; the assumption being that quality and safety, to some extent, can be assured by a review, inspection or an accreditation process. All of these processes take account of recognised standards of care.

This inspection, review or accreditation can take place at different levels, for example at:

- national level – through professional bodies and national accreditation schemes;

[20] http://www.dhsspsni.gov.uk/mou_investigating_patient_or_client_safety_incidents.pdf

- regional level – though statutory inspection procedures and clinical and social care governance reviews;
- local level – through commissioning arrangements with providers of care; and
- individual level – through the organisational assessment of individual performance.

The RQIA will be reviewing clinical and social care governance within the HPSS using the five themes contained within the Quality Standards, with particular emphasis on Safe and Effective Care. This approach will assist RQIA and the HPSS in the future development of methodologies and the refinement of self-assessment processes.

RQIA will report on the quality of care provided by the HPSS following its governance reviews. This developmental approach will promote quality improvement across organisations.

In addition to RQIA's inspection and review functions, it also has the power to investigate serious incidents at the request of the Minister, Department or the public. It will report to the Department on the quality of care within all HPSS services. As the work of RQIA progresses, it will provide a rich source of learning for the HPSS, the DHSSPS and the public.

At national level, the impact of major inquiries such as Shipman, Kerr/Haslam and Climbié, will continue to have a major impact on organisational and professional practice locally. In addition, reviews[21], such as those currently being undertaken by Sir Liam Donaldson and Mr Andrew Foster will impact on clinical and social care governance arrangements locally, including how an individual practitioner's fitness to practise is assessed.

A formal link with the National Clinical Assessment Service has already been established to provide advice, support and, where appropriate, full assessment for HPSS organisations, where a doctor's or dentist's performance is called into question. In addition, annual appraisal of individuals is now a reality for many HPSS staff. Where performance of an individual is considered to put patients or service users at risk, then the organisation must have processes in place to facilitate action and prevent harm.

[21] CMO Review of Medical Revalidation: A Call for Ideas, 3 March 2005 – www.dh.gov.uk; Review of Non-Medical Regulation – Call for Ideas, 29 June 2005, Mr Andrew Foster – www.dh.gov.uk

New disciplinary procedures for HPSS-employed doctors and dentists have been introduced to promote the early and active assessment and resolution of concerns regarding clinical practice. In addition, primary legislation is being drafted for the family practitioners services, to further extend the function of the Health Service Tribunal and the powers of HSS Boards where there is a concern about professional or personal conduct or practice.

A local response to Shipman Inquiry recommendations will be produced, to cover:

- Shipman 3 – Recommendations on new death certification pathways and investigation;
- Shipman 4 – Recommendations on enhanced monitoring and inspection of controlled drugs; and
- Shipman 5 – Recommendations on complaints, whistle-blowing, appraisal and professional performance.

3.8 DESIGNING AND IMPLEMENTING SOLUTIONS

The HPSS does not, as yet, have good mechanisms to facilitate the sharing of solutions on quality and safety problems. There is often excellent work in progress across the HPSS but no clear forum for sharing this work to others in similar situations. This may lead to duplication and wasted resources and the reoccurrence of adverse incidents. The measures identified in paragraph 3.4 will facilitate the cascade of effective solutions. So too will links with national bodies specifically involved with solutions development such as the NPSA, MHRA and the NHS Purchasing and Supply Agency.

Whilst reporting systems are a pivotal part of the identification of trends and themes requiring solutions, they are not the only source of information at local or national level. There is a need, therefore, to promote partnership working within the HPSS and at national level to share resources in solutions development. However, where a solution needs to be developed and implemented locally, it should be specifically commissioned by the DHSSPS with the scope of the project clearly defined and resourced.

To facilitate implementation, where appropriate, a solution should be designed in toolkit format in order to promote consistency of approach across the HPSS. As identified in the Safety Alert Broadcast System (SABS), there should be a feedback loop to confirm that implementation is completed. New arrangements for regional audit should be linked to the wider quality and safety

agenda and used to facilitate implementation of solutions, where appropriate.

The development of a Service Level Agreement with the NPSA opens up the possibility for the HPSS to be selected to pilot new approaches to the delivery of care/improvements in patient safety. This is particularly appropriate in areas where the HPSS has carried out innovative work e.g. Medicines Governance and in areas where the HPSS presents a unique challenge, for example, the large and complex area of social care. Participation in the development of innovative work will stimulate the further development of a safety culture across the HPSS and will engage both health and social care professionals.

Effective design of health and social care facilities remains an important aspect of quality of care. This is because effective design thinking can deliver products, services, processes and environments that are simple to understand, to use, comfortable and convenient, and consequently less likely to lead to accidental misuse, error and accidents. The report, *Design for Patient Safety* [22] identifies opportunities for improving patient and service user safety through the more effective use of design.

[22] Design for patient safety: A system-wide design-led approach to tackling patient safety in the NHS Department of Health and the Design Council. February 2004. Available at : http://www-edc.eng.cam.ac.uk/medical/reports.html

KEY POINTS

- An **informed** organisational culture, that builds on many data sources, is necessary to promote safety and quality. This culture requires endorsement and agreement by senior management in order to promote a **reporting** culture, and one, which is seen to be **just**, **flexible** and has the capacity to **learn** from errors.
- A systematic approach to raising awareness of risk of the factors that contribute to human and organisational failures is essential for staff, especially new recruits.
- Promoting timely open reporting is a major challenge for all HPSS organisations; the benefits of reporting should be highlighted to staff with clear feedback mechanisms identified.
- The first step to a comprehensive approach to safety, is obtaining and analysing **all** incident data. Clear policies and procedures for the reporting and investigation of serious incidents are the responsibility of senior management.
- The NPSA's National Reporting and Learning System will facilitate a cohesive approach to data collection in Northern Ireland and will facilitate benchmarking against other regions.
- Links to the NPSA, through its "Seven Steps" Programme together with use of tools and guidance will promote reporting and investigation of serious incidents in secondary and primary care, and build on existing work.
- Designing and sharing the solution, should draw on national and local work; where appropriate, local organisations should lead in the piloting of such solutions.
- Enhanced assessment of clinical and social care practice through HPSS Regulation and Quality Improvement Authority will promote learning.
- Where individual performance is called into question, the National Clinical Assessment Service will provide advice and support to organisations, and formal assessment of the individual, if required.

SECTION 4 – INVOLVING AND COMMUNICATING WITH THE PUBLIC

4.1 INTRODUCTION

There is now good evidence that trusting and respecting the patient/user at a number of levels (e.g. individual and community) in the health and social care system improves health and well-being significantly[23]. Patients, service users and the public have a major part to play in the prevention and detection of errors in health and social care.

4.2 PUBLIC INVOLVEMENT IN PROMOTING HEALTH, WELL-BEING AND SAFETY

People are ultimately responsible for their own health and well-being, and that of their dependants. However, it is acknowledged that health and well-being are influenced by many factors, such as poverty, crime, violence, education and unemployment. HPSS service provision plays but one part in the overall health of the population. The HPSS needs to work in partnership with other agencies, communities and the media to seek to influence and improve the health, social well-being and safety of the public and their staff. In this regard the media have an important public health and safety role in tandem with their duty to responsibly hold public bodies to account.

The Quality Standards for Health and Social Care set out the values and principles which all HPSS organisations and staff should adopt when engaging with the public and service users. These include the need to involve people in all stages of care and to provide timely and appropriate information to assist in decision-making.

Integration of service users, carers and local communities into all stages of planning, development, evaluation and review of health and social care services is an important part of continuous quality improvement and the open culture which should be promoted throughout the HPSS.

Through proactive involvement of the public in safety matters, it is hoped that:

[23] www.pickereurope.org

- risks will be identified;
- concerns and ideas for improvement will be shared; and
- solutions will be generated in partnership with service users and the public which will be more realistic and achievable.

4.3 PUBLIC EXPECTATION OF A QUALITY SERVICE

Understanding the expectations of the public, staff, media and an organisation can sometimes be difficult. But proactive involvement of the public and staff will lead to a mutual understanding of needs and drivers for change; for example, why certain HPSS services require development to ensure safe and effective care and others do not. In addition, it will promote an understanding of the complexity of factors which determine why health and social care services will never be error free, but minimisation of the risk of error is important for service improvement and health and social care outcomes. But when things go wrong, people have a right to feel let down by the Service, to make a complaint and to seek redress if harm has been caused. Some organisations and staff have a tendency to think of these actions in a negative light because of fear of litigation, adverse media coverage and potential for destruction of reputation and career pathway. Both service users and staff need open and fair processes to investigate and determine the cause of what went wrong. For this to happen means that there are special responsibilities placed on the media, the public, service users and staff. A system that does not support an open and fair process is to no-one's advantage in Northern Ireland, as it will not encourage open reporting, communication or learning.

4.4 CHANGING LOCAL COMPLAINTS PROCEDUES

The reporting and handling of complaints are also part of a learning culture. The public has a right to complain when concerned about their treatment or care. Complaints tend to be seen in a negative light, but nonetheless are a significant source of learning for individuals and organisations.

The Department is currently undertaking a review of the HPSS complaints procedures, with the aim of making complaints systems more effective for the public, staff and organisations. It is anticipated that a public consultation on the new procedures will commence in early 2006. This consultation will also incorporate some of the recommendations contained in the 5th Shipman Inquiry Report.

In reviewing the HPSS complaints procedures, the aim is to:

- make procedures easier to access;
- be fair to all parties;
- respond to complaints in a timely way;
- emphasise early resolution;
- ensure the process is aimed at satisfying the complainant's concerns; and
- promote learning across the HPSS.

4.5 A SYSTEM OF REDRESS

Errors will happen and although most do not lead to harm, some will. But what happens when things go wrong and a service user is harmed? Not all service users and carers are content with the current system and sometimes find it hard to engage with HPSS organisations to find out what happened to themselves or to their loved one.

Openness is fundamental to the partnership between the service user and those who provide care. In support of that openness, people should be given an explanation of what has happened, an apology, reassurance, remedial treatment and compensation, where appropriate. A unified approach to redress should be developed. Effective redress will be part of the regional and local goal to promote a timely response for the service user. It will also set "error" in the context of learning in order to promote quality improvements within the HPSS.

4.6 COMMUNICATING SERIOUS INCIDENTS

All organisations should have a clear policy on how to communicate a serious incident to individuals, families and carers, staff and to the media, where appropriate. This policy should comply with best practice relating to the confidentiality of information, human rights, and privacy for service users and staff. The six major parts of this policy should include:

- a unified approach to redress (as identified above) for the individual, their family and carers;
- support for service users and carers during the course of an investigation and/or further treatment;
- support for individuals within the organisation to cope with the physical and psychological impact of what has happened;
- a timely inter-organisational communication system;

- designated and trained key people within the organisation with responsibility for communication; and
- how and by whom the incident should be investigated.

KEY POINTS

- Individuals have responsibility for their own health, and that of their dependants.
- The HPSS, public and media need to work in partnership to promote public health and social well-being, and to enhance safety for service users and staff.
- Provision of information, in accessible format, to support decision-making in treatment and care, and to enhance safety, is essential for service users and carers.
- The public has a pivotal role in the prevention and detection of error.
- The public has a right to complain when concerned about their treatment or care. Complaints are a significant source of learning for HPSS organisations.
- The public and media have important responsibilities regarding the promotion of an open and fair culture, in order to prevent reoccurrence of incidents.
- Service users and staff need open and fair processes when a serious adverse incident is being investigated.
- Redress means having systems in place to offer an apology, reassurance, speedy remedial treatment, and compensation, if appropriate, when harm has been caused to an individual.
- All HPSS organisations should have an effective communication policy in place.

SECTION 5 – ACTION PLAN AND STEPS TOWARDS SUSTAINABLE IMPROVEMENT

5.1 INTRODUCTION

In this section, the action plan and steps underpinning sustainable improvement in the HPSS are brought together in five key themes:

- implementing evidence–based best practice and learning from adverse events;
- agreeing common systems for collection, analysis and management of adverse events;
- sharing the learning;
- building public confidence; and
- promoting education, training and support for health and social care staff.

The audience for this action plan is HPSS managers, staff, educationalists and practitioners, including those working within the family practitioner services. The plan also includes action which will be undertaken by the DHSSPS as part of its commitment to safe and effective care. Given the broad nature of the safety and quality agenda, the plan does not aim to be all-encompassing but rather to focus on high level actions which need to take place in order to prevent adverse outcomes, and to improve service user, carer and staff experiences. It is seen as complementary to the many other initiatives which are ongoing in the HPSS primary, secondary and community sectors to improve health and social care outcomes.

The vision for the future is a safer service, where there is a systematic and co-ordinated approach to safety and quality. This requires staff, organisations and the public to work in partnership to promote a culture of learning, which is open and fair to service users, carers and staff, and one which minimises errors.

The following action plan will be reviewed and updated in 2007 to take account of progress and local and national developments.

5.1.1 Implementing evidence based practice and learning from adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS	Links to the National Patient Safety Agency will be agreed and guidance issued to the HPSS	Access to training, tool and guidance for the HPSS and the Department	April 2006
DHSSPS	A phased implementation plan to support joining the National Reporting and Learning System (NRLS) will be put in place	Triangulation of data sources, benchmarking and cascade of learning	June 2006
DHSSPS	All HPSS organisations will be part of NRLS	Triangulation of data sources, benchmarking and cascade of learning	December 2007
DHSSPS	Guidance on the nature of links to NICE and local pathways will be cascaded to the HPSS	Promotion of evidence based best practice	February 2006
DHSSPS	Following links with NICE, specific guidance on the introduction of new interventional procedures into the HPSS will be produced	Safer introduction of new diagnostic equipment and treatments.	April 2006
DHSSPS, CREST	CREST together with the Department will agree and publish the process for development of its annual work programme	Better linkage of regional priorities and audit programmes	June 2006
DHSSPS, CREST, RMAG	The Review of Regional Audit Arrangements will be implemented. Regional audit programmes will be linked to the wider safety and quality agenda	Better linkage to regional priorities and audit programmes	April 2006 Ongoing
RQIA	Will commence evaluation of HPSS quality of care	Assessment quality of care	From April 2006 ongoing

5.1.2 Agreeing common systems for data collection, analysis and management of adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS, HPSS	All organisations will adopt the definition of an adverse incident as identified in Section 1	Standardisation of definition and local data collection in adverse incidents	March - 2006 ongoing
DHSSPS, HPSS	All organisations will recognise the need for an informed safety culture	Supports timely reporting and an open, fair, flexible and learning culture	March 2006
DHSSPS	Better linkage on quality and safety agenda within Departmental structures	Integration of quality and safety issues	April 2006
DHSSPS, HPSS	Safety and quality will be a standing agenda item at board meetings	Senior management commitment to quality and safety	February 2006 and ongoing
HPSS	Organisations will have incident reporting levels reviewed at least quarterly by senior management	Regular analysis of adverse incidents and near misses	March 2006 ongoing
HPSS	All organisations will have a designated lead to determine when a serious incident investigation should be instigated	Clarity and consistency in handing investigation of major incidents	April 2006
DHSSPS, HPSS	Algorithms on common and specific reporting systems will be designed and cascaded for use in HPSS	Avoidance of duplication and clarity of reporting arrangements	September 2006
DHSSPS	Develop and publish policy guidance to clarify the role and function of Interim Arrangements for the Reporting of Serious Adverse Incidents	Clarity for the HPSS and the Department in the Reporting of Serious Adverse Incidents	February 2006
DHSSPS	Review local Interim Arrangements for the Reporting of Serious Adverse Incidents, in light of links with the NPSA's Patient Safety Observatory	Clarification of purpose and avoidance of duplication	April 2007
DHSSPS, HPSS	Regional Reporting Systems Project for primary and secondary care will be completed, and linked to joining with NRLS	Standardisation of definitions, reporting forms and coding of incidents	April 2007

5.1.2 Agreeing common systems for data collection, analysis and management of adverse events			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS	A centralised database of clinical negligence claims will be developed	Enhanced data analysis and sharing the learning	December 2006
DHSSPS, in collaboration with PSNI, HSE, and Coroner's service	A Memorandum of Understanding will be published on the investigation of unexpected death or serious harm, which will complement existing procedures and processes for protection of children and vulnerable adults	Promoting communication and shared working between the public sector	March 2006
DHSSPS	Further guidance will be issued on how and when to investigate a serious adverse incident	Clarity and consistency in handling investigations	September 2006

5.1.3 Sharing the learning			
Responsibility	**Action**	**Purpose**	**Completion date**
HPSS, including FPS	Each organisation will have a policy on incident management which will be endorsed by senior management and will be regularly reviewed	Consistency of approach in incident management and learning throughout the organisation	March 2006
DHSSPS, HPSS including FPS	Each organisation will demonstrate a multidisciplinary team approach to reducing risk and improving reporting	Engagement with staff. Consistency of approach in incident management and learning throughout the organisation	April 2006
HPSS including FPS	Each organisation will have a feedback mechanism in place when an incident is reported by an individual or team	Facilitation of action, learning and service change	March 2006
DHSSPS, HPSS	Where a major incident has been identified locally, local solutions will be designed by convening a panel of experts and/or building into existing programmes e.g. CREST, NPSA	Facilitation of action, learning and service change	Ongoing
DHSSPS	An annual report on local serious adverse events will be issued to the HPSS	Sharing the learning and implementing change	March 2006 and Ongoing
RQIA	Following investigation of specific serious adverse incidents, RQIA will produce and cascade a report	Cascade of learning and prevention of reoccurrence of adverse incident	April 2006 and ongoing
DHSSPS, HPSS	A review of communication channels will be undertaken by the Department to include; - consideration of links with SABS, a gateway approach to provision of information, revision of departmental website “governance” pages and extranet access on the results of root cause analysis in the HPSS	Enhanced communication, timely distribution of urgent communications and sharing of learning	December 2006

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
DHSSPS, HPSS	Organisations will recognise that health and social care will never be error–free, but patients, clients, service users and carers have an important partnership role to play in identification and reduction of errors	Better information to service users and acknowledgement of their role as partners in care	February 2006 Ongoing
DHSSPS, HPSS	Organisations will have a policy on how to communicate a serious adverse incident to individuals/families/staff and the media	Better information and coordination of communication with stakeholders	April 2006
DHSSPS in collaboration with NISCC	A programme for roll-out of registration for the social care workforce will be agreed and commenced in April 2006	Enhanced regulation of the workforce	April 2006
DHSSPS	A public consultation will be undertaken on a new HPSS complaints system	Improved openness, transparency and learning	April 2006
DHSSPS, in collaboration with HPSS	Guidance on redress, where harm is caused to service users, will be developed and implemented in the HPSS	Supporting openness, an apology, an explanation, remedial treatment and compensation, where appropriate	December 2006
DHSSPS, in collaboration with HPSS	A composite set of safety/quality performance indicators will be developed encompassing clinical and non-clinical care, and social care	Enhanced accountability and performance management on safety and quality	July 2006
DHSSPS	New Primary Care legislation will be introduced to enhance the role and functions of the Health Service Tribunal and powers of the HSS Boards	Improved procedures for considering the conduct or performance of family practitioners	November 2006
DHSSPS, HPSS Boards and Trusts	A specific project will be convened to consider key elements to enhance safety and communication at the interface of primary and secondary care	Enhanced safety and quality of care at the interface of primary and secondary care	February 2007
DHSSPS, HPSS Boards, Primary care	Medicines Governance Team Programme will extend into primary care	Promotion of medicines risk management and improvement in quality of	January 2006 Ongoing

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
practitioners Medicines Governance Team		care	
DHSSPS	A Northern Ireland response to Shipman Inquiry Report Recommendations will be consulted upon and published	Improved professional practice and public protection	July 2006
DHSSPS	A review of existing appraisal systems (medical) will be undertaken	Improved professional practice and public protection	January 2006
DHSSPS	Following the outcome of Donaldson & Foster reviews on professional regulation, implementation of national recommendations will be implemented	Improved professional practice and public protection	Date to be determined
DHSSPS	The Department will publish guidance on Protecting Personal Information	Supports confidentiality and implementation of professional practice and legislation	January 2006
DHSSPS	Guidance on a new disciplinary framework for employed doctors and dentists will be published and implemented in the HPSS	Improved procedures for considering the conduct or performance of doctors/dentists in the HPSS	February 2006
CREST, DHSSPS, HPSS	All organisations will implement CREST guidance on Inter-hospital transfer of medical records	Reduction of risk to service user, when transferred in or between HPSS establishments	April 2006
HPSS	HPSS will complete implementation of the Hine Review on endoscope decontamination	Consistent approach to disinfection and decontamination of endoscopes	July 2006
DHSSPS, HPSS	A response to the O' Hara Inquiry Recommendations will be published and implemented	Safer care for sick children who require intravenous fluid	Date to be determined
DHSSPS, HPSS, in collaboration with Universities, CREST RMAG NIPEC,	The recommendations from the RQIA report on *Review of the lessons arising from the death of Mrs Janine Murtagh* will be implemented	Consistent and improved approach to consent, pre and post operative care, leadership and communication, and the implementation of policies and procedures	March 2007

5.1.4 Building public confidence			
Responsibility	**Action**	**Outcome**	**Completion date**
NIMDTA			
DHSSPS	A Regional Procurement Strategy, incorporating safety, will be published for the HPSS	Safer health service procurement, design and practice	January 2006

5.1.5 Promoting education, training and support for all health and social care staff			
Responsibility	**Action**	**Outcome**	**Completion date**
HPSS	All HPSS organisations will include risk awareness within induction programmes to the organisation, and in specific areas of care	Awareness of risk and of organisational reporting policies and procedures	April 2006 Ongoing
DHSSPS, in collaboration with NIMDTA	A project will be convened to consider the generic contents of an induction programme for new doctors, building on recent learning from adverse events	Standardisation of induction, for new doctors	February 2006
DHSSPS, in collaboration with Universities, NIPEC, NICPPET, NIMDTA NISCC NPSA	Discussion will be held with key stakeholders to incorporate risk awareness, and adverse incident policies and procedures into basic training modules, including specific high risk areas such as medicines, medical devices and child protection issues	Promotion of safety and quality and cascade of learning	December 2006

5.2 CONCLUSION

Safety First: A Framework for Sustainable Improvement in the HPSS sets out a clear policy direction to improve quality of care. This policy and action plan is part of the modernisation and reform agenda and places safety and quality at the heart of good governance.

It recognises that major steps are needed to promote partnership working and enhance public confidence in the services provided. Support, training and education of staff are vital to its success.

The action plan will be reviewed in 2007 to assess progress on implementation. Quality and safety are part of good governance and will be reported on by the HPSS Regulation and Quality Improvement Authority. In addition, the action plan will form part of the ongoing accountability review processes for HPSS organisations, including primary care practitioners. A number of quality and safety performance indicators will be developed as part of implementation of the action plan.

GLOSSARY

ACCREDITATION

Formal recognition or approval of a service or training programme from a recognised authority e.g. a royal college.

ADVERSE EVENT OR INCIDENT

Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.

CARER

A carer is an individual who looks after someone who is unwell and/or who requires special assistance to manage their complex needs or situation.

CLINICAL AUDIT

A quality assessment and improvement mechanism in which healthcare professionals peer review their practice, compare it to best practice and introduce improvement in line with their findings.

Clinical and social care audit is interpreted as multi-disciplinary or multi-professional audit, involving a wide range of clinical and social care professions, with inputs from all its constituent groups working together or in single disciplines.

CLINICAL AND SOCIAL CARE GOVERNANCE

A framework through which local organisations are accountable for the quality of service they provide.

CLINICAL NEGLIGENCE

Failure to exercise a reasonable standard of care appropriate to the circumstances, resulting in unintended injury, loss or death to another party.

CULTURE

The general customs and beliefs, of a particular organisation at a particular time. ‘How we do things around here.’

HEINRICH RATIO

A proactive check on a systems “vital signs”- The Heinrich ratio of one major injury to twenty nine minor injuries to three hundred no-injury incidents.

HOMICIDE

An act of murder.

HOSPITAL AND SOCIAL CARE EPISODE STATISTICS

Statistics on hospital and social care episodes of care, e.g. admissions, outpatients appointments, domiciliary care hours provided.

INTELLIGENCE MECHANISMS

The mechanisms for the collection and co-ordination of data.

MEDICINES GOVERNANCE

A focus on risk management involving the prescription, supply, dispensing administration and disposal of medicines. It aims to improve patient & client care through a programme of continuous improvement in medicines management.

NEAR MISS

An unexpected or unintended incident that was prevented, resulting in no harm.

RISK REGISTER

A record of residual risk which details the source, nature, existing controls, assessment of the consequences and likelihood of occurrence, action necessary to manage risk, person responsible for implementing action and timetable for completion.

SERVICE LEVEL AGREEMENT

A service level agreement is a document, which defines the relationship between two parties: the provider and the recipient.

SERVICE USER

Anyone who uses, requests, applies for, or benefits from health and social care services. They may also be referred to as clients, patients or consumers.

ABBREVIATIONS AND ACRONYMS

CEMACH

Confidential Enquiry on Maternal and Child Health.

CISH

Confidential Inquiry into Suicides and Homicides by people with mental illness.

CREST

Clinical Resource Efficiency Support Team.

CSCG

Clinical and Social Care Governance.

DHSSPS

Department of Health, Social Services and Public Safety (Northern Ireland).

DIS

Directorate of Information Systems (DHSSPS).

FPS

Family Practitioner Services- e.g. general medical practitioners, community pharmacists, general dental practitioners, and optometrists.

GB

Great Britain.

GDC

General Dental Council.

GMC

General Medical Council.

HPSS

Health and Personal Social Services commissioning and providing treatment and care in hospitals, communities and through family practitioner services.

HRD

Human Resources Directorate (DHSSPS).

HSENI

Health and Safety Executive Northern Ireland.

IHI

Institute for Healthcare Improvement in the United States of America.

MHRA

Medicines and Healthcare products Regulatory Agency.

MRSA

Methicillin-Resistant Staphylococcus Aureus.

NCAS

National Clinical Assessment Service now part of NPSA but previously the autonomous NCAA (National Clinical Assessment Authority)

NCEPOD

National Confidential Enquiry into Patient Outcome and Death.

NHS

National Health Service.

NI

Northern Ireland.

NIAIC

Northern Ireland Adverse Incident Centre.

NICE

National Institute for health and Clinical Excellence.

NIMDTA

Northern Ireland Medical and Dental Training Agency.

NIPEC

Northern Ireland Practice and Education Council for Nursing and Midwifery.

NICPPET

Northern Ireland Council for Pharmaceutical Postgraduate Education and Training.

NISCC

Northern Ireland Social Care Council.

NPSA

National Patient Safety Agency.

NRLS

National Reporting and Learning System.

PCD

Primary Care Directorate (DHSSPS).

PPMD

Planning and Performance Management Directorate (DHSSPS).

RMAG

Regional Multi-professional Audit Group.

RQIA

Health and Personal Social Services Regulation and Quality Improvement Authority.

SABS

Safety Alert Broadcast System.

SAI

Serious Adverse Incidents.

SCD

Secondary Care Directorate (DHSSPS).

SCIE

Social Care Institute for Excellence.

APPENDIX A - TERMS OF REFERENCE AND MEMBERSHIP OF GROUPS

The terms of reference for this project are as follows:

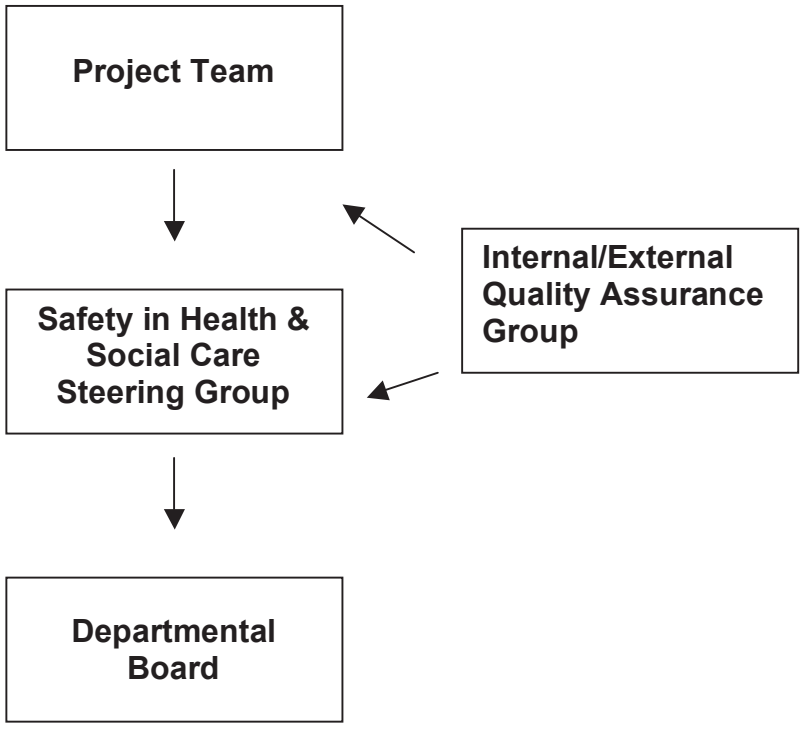
Service user and staff safety concerns everyone who uses or works in the HPSS. The safety policy framework will:

- identify the key components of a safety policy;
- consolidate good practice;
- promote and support an open and fair safety culture;
- link local objectives and priorities, with national developments;
- build capacity and capability at local level; and
- embed service user and staff safety in everyday practice, clinical and social care governance systems and health and social care environments.

The safety framework will be accompanied by an action plan, which will identify key tasks to be taken forward by the Department and the HPSS. This policy framework and action plan will be reviewed in early 2007.

Reporting arrangements

The Safety in Health and Social Care Steering Group will act as the steering group for this project. This Group will report to the Departmental Board by early September 2005.



Safety in Health and Social Care Steering Group

Chair: Dr Ian Carson – Deputy Chief Medical Officer, DHSSPS

Members: Mr Jonathan Bill, DHSSPS
Ms Tracey Boyce, RGH
Mr Brian Godfrey, DHSSPS
Dr Maura Briscoe, DHSSPS
Dr Glenda Mock, DHSSPS
Mr Don Hill, DHSSPS
Ms Irene Low, Ulster Community Hospitals Trust
Ms Nicola Kelly, Belfast City Hospital Trust
Ms Yvonne Kirkpatrick, Belfast City Hospital Trust
Mrs Nuala McArdle, DHSSPS
Dr Norman Morrow, DHSSPS
Mr Pat Newe, DHSSPS
Mrs Elizabeth Qua, DHSSPS
Mr Robert Sergeant, DHSSPS
Mrs Heather Shepherd, Regional Governance Adviser HPSS
Mrs Doreen Wilson, DHSSPS

The Project Team

The project team will comprise:

Mrs Heather Shepherd – Regional Governance Adviser, HPSS
Dr Maura Briscoe – Medical & Allied Group (lead), DHSSPS
Mr Jonathan Bill- Planning & Performance Management Directorate, DHSSPS
Ms Tracey Boyce – Medicines Governance Advisor, NI Medicine Governance Team, Royal Group Hospitals Trust
Mr Brian Godfrey – Health Estates Agency, DHSSPS
Mrs Liz Qua - Health Estates Agency, DHSSPS
Mr Pat Newe – Social Services Inspectorate, DHSSPS

Secretariat – Mr Jonathan Wright, Medical & Allied Group, DHSSPS

Quality Assurance Group

There will be a virtual QA Group comprising nominees from:

- Primary Care Directorate DHSSPS;
- Secondary Care Directorate DHSSPS;
- Community Care Directorate DHSSPS;
- Human Resources Directorate DHSSPS;
- Best Practice, Best Care Steering Group;
- Finance Management Directorate (Claims and Litigation) DHSSPS;
- Public Safety Unit DHSSPS;
- Planning and Performance Management Directorate DHSSPS;
- Professional Groups within the DHSSPS;
- Health and Personal Social Services Regulation and Quality Improvement Authority;
- Health Estates Agency DHSSPS;
- Northern Ireland Social Care Council;
- Mr Howard Arthur, CGST, Modernisation Agency
- HPSS Trusts & Boards; and
- HSS Councils.

APPENDIX B – EXAMPLES OF DATA SOURCES AND FINDINGS

Information Source	Examples of factors that will affect findings	Examples of findings
Incident reporting Systems	More likely to record near misses and errors which did not lead to harm. May be less likely to report known side effects and complications of treatment.	4.9 incidents reported for every 100 hospital admissions, and 1.2 incidents reported for every 100 bed days (England). 1.1 to 3.8 incidents for every 100 bed days (Regions, Pennsylvania, USA)[24]
Medical record review	The threshold that is used for including minor errors or deviations from standards of care. The threshold that is used for determining that harm to a patient was preventable.	Four to 17 adverse events in every 100 hospital admissions (studies in North America and Europe).
Routine data Collection	Recording of adverse events likely to be incomplete. Recording likely to improve with greater awareness of issues.	About two adverse events in every 100 hospital admissions in England[25]. 16 deaths from MRSA in every million men, and 8.5 deaths for every million women[26].
Surveys of patients and staff	Level of awareness of staff and patients. Patient's condition: for example, people with long-term conditions are more likely to be aware of errors than those receiving life-saving treatment.	35 in every 100 NHS staff reported seeing at least one error or near miss that could have harmed patients during the month before the survey[27]. 18 to 28 in every 100 patients with health problems from five countries believe a medical mistake or medication error affecting them had occurred in the two years before the survey[28].

Source:- *Building a memory: preventing harm, reducing risk and improving patient safety*. National Patient Safety Agency, July 2005.

[24] Department of Health. *Building a Safer NHS for Patients.* Available at www.doh.gov.uk/buildsafenhs (November 2003)
[25] Aylin P et al. How often are adverse events reported in English hospital statistics? *BMJ* 2004;329:369
[26] Office on National Statistics. *Health Statistics Quarterly.* Spring 2005:60-5
[27] Healthcare Commission. *NHS Staff Survey 2004: Summary Report.* March 2005
[28] Commonwealth Fund. *2002 International Health Policy Survey of Adults with Health Problems.* Available at: www.cmwf.org/surveys/surveys_show.htm?doc_id=228168

APPENDIX C

RAISING AWARENESS OF RISK, AS PART OF AN INDUCTION PROGRAMME FOR NEW RECRUITS, AND THE TRAINING OF IN-SERVICE STAFF

To improve patient and service user safety, the education and training of all HPSS staff must include risk awareness. Inclusion of "risk awareness" is an integral part of the risk management standard included in Controls Assurance Standards, the HPSS Quality Standards and the Care Standards.

Particular attention needs to be paid to the induction of temporary staff to ensure that key policies and procedures relevant to their level of competence are known prior to the commencement of practice.

Induction and in-service training programmes, should include:

- an overview on the organisation's safety culture, policies and procedures;
- basic awareness of the systems approach to patient and service user safety;
- awareness that health and social care is a high risk industry and the importance of being risk aware;
- awareness of their own personal responsibilities within their specific areas of work;
- the current incident statistics for health and social care within the organisation;
- examples of how things can go wrong;
- why incidents happen;
- how to report incidents;
- the importance of working within one's own ability; and,
- practical skills to practise safely.

APPENDIX D

How to Classify Adverse Incidents and Risk

Guidance for Senior Managers Responsible for Adverse Incidents Reporting and Management

Summary Version

The full version of this document will be subject to review and up-to-date versions will be available on the governance website.

http://www.dhsspsni.gov.uk/index/hss/governance.htm

Contents

1.0 Introduction

1.1 This is a shortened version of a document produced to assist Health and Personal Social Services organisations (HPSS) in developing or reviewing processes to assess incidents and their consequent risk implications. It has been written for senior managers responsible for reporting and overall management of adverse incidents and it is not intended as guidance for all staff. It does not provide detailed guidance for HPSS incident investigation, as this will be the subject of further work.

1.2 The following pages outline a tool to help managers classify incidents and risk, using the Australian / New Zealand Standard: Risk Management (AS/NZS 4360: 2004) and "Step 4 – Promote Reporting" from the National Patient Safety Agency (NPSA) publication "Seven Steps to Patient Safety" as primary sources.

1.3 The guidance should be used for all incidents not just those that involve patients / service users. This is in line with the current systems and processes that HPSS organisations use to manage incidents. The tool has been developed for use across the HPSS including the primary care sector and covers all incidents including clinical and social care incidents.

1.4 HPSS and primary care organisations should follow the principles of this guidance when developing, revising and implementing their own local policies and procedures. It is of key importance however that these principles are tailored to suit the objectives, nature and size of the particular organisation. The broad aim of this document is to facilitate better systems for sharing learning from adverse incidents across the HPSS and beyond. It provides a framework for appropriate and sufficient analysis of, and learning from events where there has been significant harm or potential harm to, and/or death of a patient, service user, staff member, visitor and/or significant damage to property or the environment.

1.5 One important principle is that all adverse incidents should be considered and recorded centrally within organisations so that any organisation-wide implications can be captured as early as possible. However, this must not negate the importance of local management responsibility for handling incidents in their area. All types of incidents should be included; for example; social care, clinical, health and safety, fire, infection control etc.

1.6 To help with capturing all incidents within similar processes an HPSS regional definition of an incident has been devised; an adverse incident within the HPSS context is therefore defined as;

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation"

1.7 Further associated work in this area will include a regional minimum dataset for recording incidents and a set of regional codes for the most prevalent types of incidents.

2.0 Stages of Adverse Incident Management (See Flowchart One)

Stage 1 – Incident occurs and is reported via the organisations' internal reporting mechanism to the organisations' central recording system. Incident details are communicated internally as necessary.

Stage 2 – Determine actual incident severity.

Stage 3 – Assess incident to determine immediate action required. Following initial assessment consider whether it is appropriate to report to external organisations (See flowchart for examples)

Stage 4 – Initiate incident investigation as appropriate. Consider whether it is appropriate to report to external organisations. (See examples of organisations requiring reports in Flowchart One)

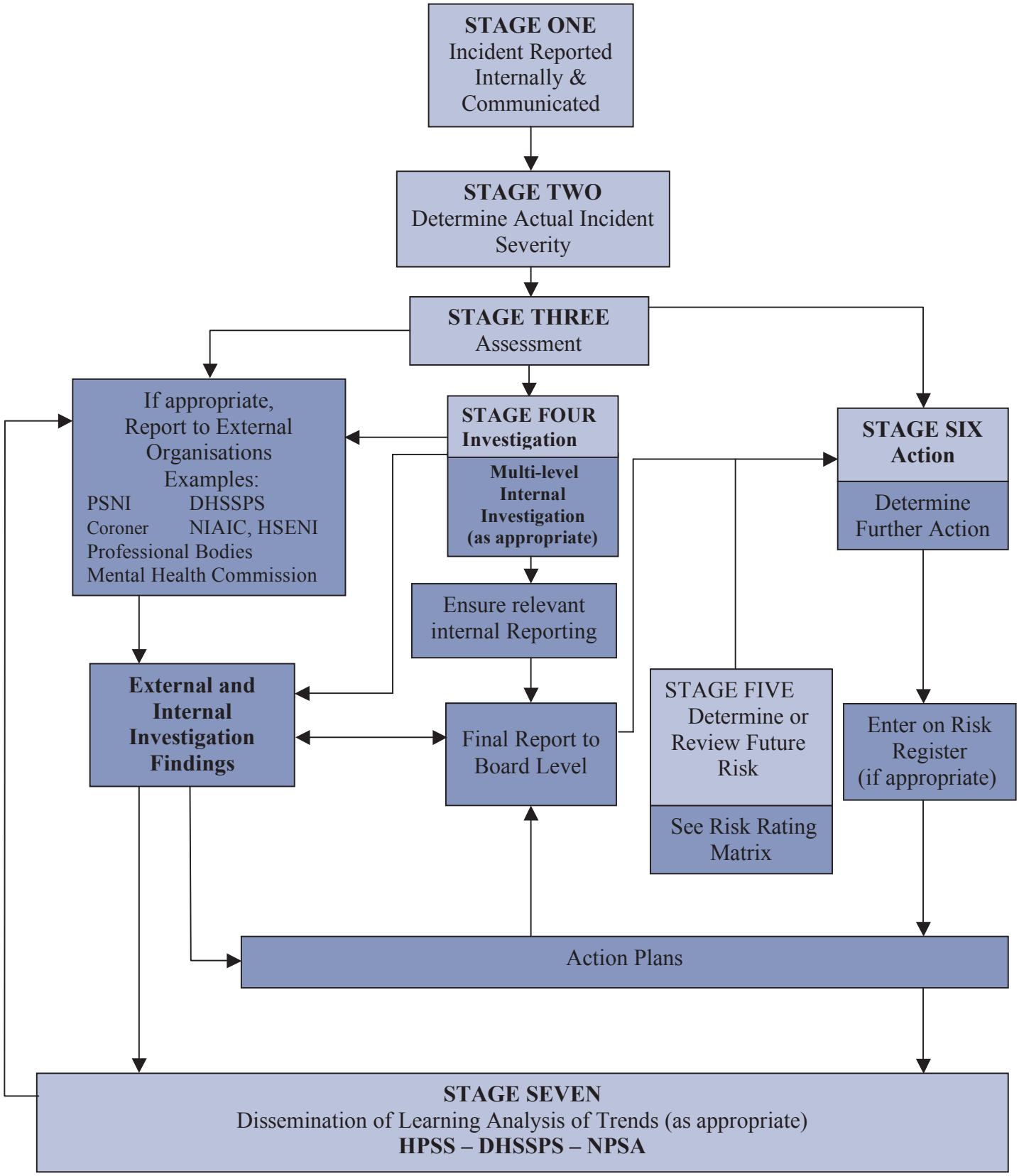
Stage 5 - This is a secondary classification mechanism for assessing ***potential future risks***. Use the following prompts:

(a) Think about the likely impact if the incident were to occur again without any intervening circumstances that made the incident less severe.
(b) Assess the likelihood of the incident occurring again.
(c) Use the Risk Rating Matrix (available in the full version of this document) to determine the risk severity.

Stage 6 – Use the Action Guidance to determine what further action should be taken. For example, consider whether this issue needs to be entered on the risk register.

Stage 7 – Determine any local and regional learning and communicate this within the organisation and with the appropriate regional / national bodies. Following the outcome and learning from investigations keep the future risk rating (Stage 5) under regular review.

STAGES OF ADVERSE INCIDENT MANAGEMENT FLOWCHART ONE



APPENDIX E

PROMOTING EQUALITY AND HUMAN RIGHTS

Section 75 of the Northern Ireland Act 1998 requires the Department, in carrying out its functions, powers and duties, to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

Members of the project team met to consider the equality and human rights implications of the safety framework and action plan. A screening exercise was undertaken, against four questions, which are identified below. The following text represents a summary of the discussion.

Is there any evidence of higher or lower participation or uptake by different groups?

The Group discussed the potential for greater integration of safety and quality policy development and action. It recognised that diminished standards on safety reflected a poor quality of treatment and care, for service users across the spectrum of care provided. Given the diverse nature of this framework, no one particular section 75 category would be disadvantaged. Indeed, the aim was to benefit all service users by promoting a safety culture, and a systematic approach to prevention, detection, reporting and management of adverse incidents. A part of this safety culture was the promotion of learning to prevent reoccurrence of incidents.

It was noted that whilst all people have the right to access HPSS services, greater use of these services are made by the very young, older people and those with complex needs and chronic conditions. The safety framework acknowledges the complexity of health and social care provision and environments. It advocates an open and fair culture which promotes involvement of all service users, particularly in relation to identification of risk and the part that service users, carers and the wider public have to play in the minimisation of that risk and in the development of solutions appropriate to their needs.

The safety framework links to the values and principles identified in the Quality Standards for the HPSS. These have been consulted upon;

these values include equality, diversity, choice, rights and respect for the individual.

Is there any evidence that different groups have different needs, experience, issues and priorities in relation to the particular policy?

No. It was considered that religion, political opinion, racial group, marital status, sexual orientation, gender or disability had no direct impact on this high level policy document or action plan. It was noted that there was a full section contained in the framework on involving and communicating with service users, carers and the public. This recognised that all people had a right to complain when concerned about their treatment or care, and that appropriate redress was an integral part of a quality system, when things go wrong. It was felt that the action plan was a relatively high level one which brought together many different strands of the quality and safety agenda. The action plan also attributed action to a number of organisations. In such circumstances, there would be a general need to consider equality and human rights implications when implementing specific actions.

Is there an opportunity to better promote equality of opportunity or good relations by altering policy or working with others in government or the community at large?

Equality of opportunity and good relations will be promoted through development of this policy. The policy and action plan recognise the need for:

- Enhanced promotion of health and safety for **all** service users, carers, staff, practitioners and visitors;
- Development of organisational communication policies and the training of staff to enhance engagement with service users and carers;
- Promotion of good relations through development and support of an informed safety culture;
- Increase in the reporting of adverse incidents and shared learning of experience;
- A more systematic approach to redress, when things go wrong;
- Enhanced communication across primary, secondary and community care, and with other agencies, for example, police, Health and Safety Executive and coroners;

- Increase in the availability of information and consultation on treatment and care with service users, carers and practitioners; and

- Enhanced education, training and development of staff.

How will this impact on complementary policy areas?

The safety framework and action plan complement other policy areas. It is part of the overall quality framework as set out in Best Practice Best Care (2001), which was subject to extensive consultation. Safety is an integral part of clinical and social care governance, care standards, controls assurance and quality standards. All of these developments are aimed at enhancing health and social care outcomes and the service user experience. The safety framework also supports other initiatives to promote continuous professional development, life-long learning and enhanced regulation of the workforce. The safety framework and action plan is underpinned by the Duty of Quality as outlined in the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

Conclusion

The safety framework is a high level document, which aims to bring together different strands of the wider safety and quality agenda. It draws on existing policy developments and identifies, in a single plan, actions which need to take place within the next two years to enhance safety within health and social care services. The project team concluded there was no adverse impact on equality or human rights arising from the safety framework. It was also noted that equality and human rights implications would be considered as part of the development and implementation of specific actions associated with the framework.

REFERENCES, CIRCULARS AND GUIDANCE

CIRCULARS

NIAIC Safety Notice MDEA (NI) 2004/01 Reporting Adverse Incidents and Disseminating Medical Device/Equipment Alerts. Health Estates, Northern Ireland Adverse Incident Centre.

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http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2002 – AS/NZS 4360:1999-Risk Management (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM)10/2002 – Governance in the HPSS: Clinical and Social Care Governance – Guidance on Implementation (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS(PPM)13/2002 – Governance in the HPSS – Risk Management (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (F) 20/2002 – Clinical Negligence: Prevention of Claims and Claims Handling (DHSSPS)

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (FAU) 19/2003 – Statement of Internal Control: Transitional Statement 2002/03(DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM)6/2004 – Reporting and follow-up on serious adverse incidents: Interim Guidance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM)8/2004 – Governance in the HPSS: Controls assurance standards – update
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (F) 2/2004 – Statement on Internal Control – Full Implementation for 2003/04 (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 5/2005 – Reporting of Serious Adverse Incidents within the HPSS
www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 2/2006 – Reporting and Follow-up on Serious Adverse Incidents
www.dhsspsni.gov.uk/hss/governance/guidance.asp

STANDARDS

Quality Standards – Consumer Involvement in Community Care Services (DHSSPS) 1999

Quality Standards for Health and Social Care: supporting good governance and best practice in the HPSS
http://www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf

GUIDANCE

Guidance on Implementation of the HPSS Complaints Procedure, (DHSSPS), March 1996

Guidance on Handling HPSS Complaints: Hospital, Community Health and Social Services, (DHSSPS) April 2000

Guidance to Trusts on reporting defective medicinal products (2001), DHSSPS

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http://www.niscc.info/

Co-operating to Safeguarding Children, (DHSSPS) 2003
http://www.dhsspsni.gov.uk/publications/2003/safeguard/safeguard.asp

Choosing to Protect – A Guide to Using the Protection of Children, Northern Ireland [POC (NI)] Service, DHSSPS 2005
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