Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

April – September 2016

November 2016

CONTENTS

SECTION 1

1.0 BACKGROUND AND INTRODUCTION

From 1 May 2010 the responsibility for the management and follow up of Serious Adverse Incidents (SAIs) transferred from Department of Health, Social Services and Public Safety (DHSSPS) to the Health and Social Care Board (HSCB) working jointly with Public Health Agency (PHA) and collaboratively with Regulation Quality Improvement Authority (RQIA). In response, the HSCB issued the Procedure for the Reporting and Follow up of SAIs (the Procedure) to all HSC organisations and Special Agencies.

During 2012/3 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013 for implementation on 1 October 2013 and with full operational implementation on 1 April 2014.

2.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The current arrangements for managing SAIs reported to the HSCB/PHA are:

- Regional reporting system for all SAIs;
- SAIs are reviewed by senior professional officers; in addition, the HSCB senior management team receives and considers all SAIs on a weekly basis;
- SAIs are allocated to a nominated professional officer, who is the Designated Review Officer (DRO) responsible for reviewing and scrutinising reports;
- SAI Review Sub Group (SAIRSG) meetings to consider reports, identify themes and learning;
- Overarching HSCB-PHA Quality Safety and Experience (QSE) Group to consider the issues identified by the SAIRSG and agree actions and assurance arrangements;
- The Safety and Quality Alerts (SQA) Team provide an assurance mechanism for any actions to be taken forward as a result of regional learning;
- Escalation if required in respect of:
    - timescales for receipt of SAI and review reports
    - assurances on action being taken forward by reporting organisations following the incident review.

3.0 WORK TAKEN FORWARD DURING THE REPORTING PERIOD

REVIEWS

Over recent months the HSCB and PHA have completed a review of the Procedure for the Reporting and Follow up of procedure, in consultation with DoH, HSCB/PHA DROs, Trust professionals and Governance leads. The main changes to the procedure are as follows:

- ***Quality Assurance of Level 1 SEA Review Reports***

  - The revised process requires reporting organisations to quality assure the robustness of level 1 SEA Reviews prior to submission to the HSCB.

  - Level 2 and 3 SAI Reviews will continue to be managed as per the current SAI process.

  - Additional guidance on the use of an 'incident debrief' for each level of SAI review has been developed in order to provide organisations with a mechanism to support staff and to identify any immediate service actions.

  - The role of HSCB/PHA DROs has been updated to reflect the above amendments.

- ***Never Events***

In line with DoH circular HSC(SQSD) 56/16 (Never Events), the current SAI notification form has been revised to enable reporting organisations to identify relevant SAIs as a Never Event and confirm that Service Users/Family/Carers have been informed.

A new field has also been set up on the HSCB DATIX reporting system which will allow all Never Events to be recorded in line with the current categories listed in the NHS England Never Event list.

- ***Engagement/Communication with Service Users/Family/Carers following a Serious Adverse Incident***

  - *Service User/Family/Carer Engagement Checklist*

The above checklist which forms part of all levels of review reports and the learning summary report, has been updated to reflect where relevant, the service user/family/carer has been advised:

- the SAI is a never event;
- the case has been referred to the Coroner, where the reporting organisation had a statutory duty to notify the Coroner.

- *A guide for Health and Social Care Staff*

The above guidance has been revised to reflect:

- the term 'SAI Review' (this has also been reflected throughout the revised procedure);

- a service user/family's right to contact the Northern Ireland Public Services Ombudsman (NIPSO) where they are dissatisfied with the HSC organisation's attempts to resolve their concerns following a SAI review.

- The engagement leaflet has been updated to reflect the organisation's responsibility to advise the service user/family/carer of a Never Event.

- ***Reporting of Falls***

The Report on Falls Resulting in Moderate to Service Harm was issued in March 2016. Reporting organisations will no longer be required to routinely report falls, which have resulted in harm in all Trust facilities, as SAIs. Instead a new process has been developed with phased implementation, which requires HSC Trusts to do a timely post fall review debrief to ensure local application of learning.

Local learning will be shared with the Regional Falls Group where trends and themes will be identified to ensure regional learning.

Reporting organisations will therefore manage falls resulting in moderate to severe harm as adverse incidents, unless there are particular issues or the subsequent internal review identifies contributory issues/concerns in treatment and/or care or service issues, or any identified learning that needs to be reviewed through the serious adverse incident process.

In addition to the above, all other changes to the process, previously communicated to ALBs since October 2013, are incorporated within the revised procedure.

- ***Implementation***

It is intended the procedure will be issued mid-November with the new process for level 1 SAI reviews being implemented from 1 January 2017 and all other aspects being implemented with immediate effect.

A further review of the procedure may be required following the completion of the two RQIA/GAIN strategic projects and subsequent publication of those reports.

DESIGNATED REVIEW OFFICER (DRO)

- ***DRO Protocol***

Work is already underway with regard to revising the internal HSCB/PHA DRO Protocol which will be aligned to the revised SAI Procedure. It is also the intention to run a series of DRO workshops, in each of the four HSCB/PHA localities, early 2017.

- ***DRO Professional Groups***

DRO professional groups for the following programmes have continued to meet on a monthly basis during the reporting period:

- Paediatrics and Child Health
- Maternity
- Mental Health (including Prison Health)
- Acute

These groups have contributed significantly to overall quality and safety structures within the HSCB/PHA in terms of:

- Multi-professional input / wider circle of experience,
- Group sign off , decisions not focused on one individual
- More complete understanding of the range of SAI issues within these service areas leading to the identification of regional trends

In light of the success of the above groups, it has decided to extend this process to other POCs i.e.:

- Integrated Care
- Adult Services
- Children's Services
- Corporate Services

It is intended the first meeting of the above groups will take place prior to Christmas 2016.

TRAINING

- ***Regional Governance Leads Workshop***

A regional governance leads workshop was held on 10 June 2016 in Clothworthy House, Antrim Castle Gardens and was attended by Governance Leads within the HSCB, PHA and the six HSC Trusts.

The workshop provided an opportunity to discuss:

- Reviewing the SAI Process
- taking forward recommendations from the Regional Learning System project
- Regional Risk Matrix
- Quality 2020 – Task for testing methods to learn from adverse incidents

A further workshop is planned in the same venue for 11 November 2016.

- ***RQIA/GAIN Event***

RQIA held an event Thursday 6 October 2016 in Riverside Tower, Belfast which focused on learning from adverse events and improving safety, and in particular, sharing approaches from Scotland and Northern Ireland.

Key focus points were:

- Overview of the approach to learning from adverse event in Northern Ireland HSC Trusts
- NI regional perspective on SAIs
- National Perspective on SAIs (Healthcare Improvement Scotland)
- Patient/Family perspective on SAIs

- ***HSC Trust SAI Workshops***

  - *Southern Health and Social Care Trust*

The SHSCT held an adverse incident workshop on 28 June 2016 in Trust Headquarters. This was attended by a wide variety of senior clinicians and specialists throughout the Trust along with representatives from DoH, HSCB and PHA. The workshop was facilitated by Maria Dineen from Consequence UK and the aims of the day were:

- To assess what extent the current service learns meaningful lessons from adverse event reviews

- To assess what extent the service can evidence and demonstrate learning from adverse event reviews

- To identify the biggest frustrations in the current system

- To identify what features should feature in a revised system

- Explore the Trusts Safety Culture and if this enables staff to engage wholeheartedly in adverse event reviews

  - *South Eastern Health and Social Care Trust*

The SEHSCT held 6 half day workshops during September 2016, targeting those professionals involved in the early investigative process of significant event audit. A total of circa 160 staff attended. The workshops were facilitated by Maria Dineen from Consequence UK and the professionals, from varied disciplines, including invitees from other HSC Trusts, focused on areas such as:

- What is a Significant Even audit (SEA)
- What incidents should SEA be applied to
- How to undertaken an SEA
- Constructing a worthwhile recommendation and local action plan
- Writing up the SEA

- Service User involvement and impending duty of Candour.

The sessions were well received and feedback was invaluable as we aim to organise further workshops in the future.

4.0 SAIs REPORTED DURING PERIOD APR – SEPT 2016

During the period 1 April to 30 September 2016, the HSCB received 200 SAI notifications. This represents an overall decrease on the previous six months (Oct 2015 – March 2016) when 272 SAI notifications were reported to the HSCB. This decrease in reporting can be largely attributed to revised reporting arrangements put in place, in year, for the reporting of child deaths and falls resulting in moderate to severe harm. These reductions are explained further in Appendix B - A breakdown of these SAIs by reporting organisation and programme of care.

5.0 DE-ESCALATION OF SAIs

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, it is recognised that SAI reports can be based on limited information at the time of reporting and further review may identify that the incident no longer meets the criteria of a SAI.

In such instances a request can be submitted, by the reporting organization, to de-escalate or withdraw the SAI, however, the decision to approve the de-escalation/withdrawal will be made by the HSCB/PHA Designated Review Officer.

During the reporting period one (1) SAI notification received was de-escalated/ withdrawn.

6.0 DUPLICATE SAI REPORTING

On occasions a notification may be received from one or more organisations relating to the same incident. In such instances, a lead organisation will be identified to take forward the incident review and follow up and the duplicate notification will be closed.

During the reporting period no duplicate SAI notifications were received.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

HSCB/PHA STRUCTURE FOR LEARNING FROM SAIs

It is important that when a serious event or incident occurs, that there is a systematic process for investigating and learning from incidents. The key aim from this process is to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole.

The HSCB, working closely with the PHA, is responsible for identifying and disseminating regional learning from its monitoring role in relation to SAIs, complaints and patient client and experience.

- **Quality Safety and Experience (QSE) Group**

The HSCB and PHA established a, jointly chaired, QSE Group to provide an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of Quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

A Regional SAI Review Subgroup reports to, and supports the work of the QSE Group.

- **Safety Quality and Alerts Team (SQAT)**

The SQAT group, which is closely aligned to the work of QSE, is responsible for performance managing the implementation and assurance of Regional Safety and Quality Alerts / Learning Letters / Guidance issued by HSCB/PHA in respect of SAIs.

The process is overseen by a joint PHA/HSCB SQAT which is a multidisciplinary group chaired by the PHA Medical Director/ Director of Public Health. The Group meet fortnightly to co-ordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DHSSPS, HSCB, PHA and other organisations. This provides a mechanism for gaining regional assurance that alerts guidance have been implemented or that there is an existing robust system in place to ensure implementation.

The HSCB/PHA SQAT issue a Bi-annual Report on Safety and Quality Alerts. This report provides an overview of the alerts reviewed by the SQAT in the reporting period and details key safety / quality improvements following the issue of alerts. The latest edition and previous issues of the PHA/HSCB Report on Safety and Quality Alerts are available to access using the following link:

http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html#TopOfPage

SAI LEARNING MECHANISMS

Possible **Learning actions** following the review of SEA / RCA review reports:

- **Local organisational actions**

- **Regional actions**

  - ***Disseminate***
    - Issue a urgent Learning Letter
    - Issue a Learning Letter / Alert
    - Include an article in the Learning Matters Newsletter or Medicines Safety Matters Newsletter or GMS Newsletter

  - ***Implement***
    - Through an existing work stream or established group
    - Through a Thematic Review
    - Establish a task and finish group

  - ***Inform others***
    - Refer to other regulatory body
    - Commission or organise training event/workshop

2.0 DISSEMINATION OF LEARNING INITIATIVES

Learning from SAIs is a significant element to improving practice. However the HSCB and PHA are cognisant that each and every SAI has an impact on individuals and families. Therefore, whilst for the purposes of this report patient identifiable information has been removed, this is not intended to diminish the personal impact that these incidents have had on the individuals involved.

The following initiatives were identified as part of the SAI review process and relate to learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in previous reports as part of on-going work.

THE FOLLOWING ITEMS ARE NEW LEARNING ISSUED SINCE LAST REPORT:

- **SQR/SAI/2016/020 (AS and PHC)** - Communication and reconciliation of combination antiplatelet and anticoagulation therapy

- **SQR-SAI-2016-021 (AS & MCH)** - Use of ventilator filters in the resuscitation of neonates

SAFETY AND QUALITY BEST PRACTICE REMINDER LETTERS RELATING TO THE ABOVE ARE AVAILABLE TO ACCESS USING THE FOLLOWING LINK:

http://intranet.hscb.hscni.net/documents/Learning_Letters/Safety%20and%20Quality%20Best%20Practice%20Reminder%20Letters/index.html

LEARNING FROM SAIs WITHIN FAMILY PRACTITIONER SERVICES (FPS)

There are a range of other initiatives across the HSC where learning from SAIs is shared with FPS practitioners to reduce the risk of recurrence. There have been a number of SAI related learning communications issued to FPS including the following:

- A professional letter has been issued to GPs reminding them of them of their responsibilities around private prescribing of CDs in relation to a Regulatory Investigation. http://primarycare.hscni.net/3817.htm The issue was also highlighted in an article in the GMS Newsletter (Spring 2016). http://primarycare.hscni.net/pdf/GMS_Update_Spring_2016(1).pdf

- A professional letter has also been issued to all Community Pharmacists regarding their responsibilities for the dispensing of controlled drugs. (5th April 2016) http://www.medicinesgovernance.hscni.net/primary-care/controlled-drugs/correspondence

- A professional letter has also been issued to all HSC Trusts Heads of Pharmacy relating to Opioid Substitute Therapy on discharge from secondary care.

- Medicines Safety Matter Newsletter for Primary Care Prescribers and Community Pharmacists featured an article relating to Z drugs on private prescription - June 2016

- Prescribing of Folic Acid - this case was presented at the regional SAI workshop in March 2016

Resources relating to the above are available at the following links:

http://www.medicinesgovernance.hscni.net

http://primarycare.hscni.net/gms_newsletter_main.htm

NEWSLETTER – "LEARNING MATTERS"

An essential element of improving services is the dissemination of information and a variety of methods are used to ensure learning is shared such as learning letters, alerts and reports. In addition the PHA/HSCB has developed a newsletter to compliment the other methods and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

Learning Matters Newsletter provides a method of sharing learning relating to SAIs, complaints, reviews and patient experience across Northern Ireland. The fifth edition was issued in April 2016 and covered the following topics:

- Residual Anaesthetic Drugs

- Consider the diagnosis of HIV
- Patients receiving prophylactic enoxaparin
- Magnetic Resonance Imaging (MRI) Referrals
- Prescription of IV Fluids
- National Patient Safety Alerts
- Reminder of Best Practice Guidance (SQR) Letters

Previous editions of the newsletter can be viewed at:

http://www.publichealthagency.org/publications/learning-matters-newsletters

A further edition will be issued in December 2016.

THEMATIC REVIEWS

Thematic Reviews are commissioned by the HSCB/PHA QSE Group, to review trends and patterns. These in-depth reviews ensure that local patterns are considered within the regional and national context and ensuing recommendations and key learning points are disseminated across the HSC.

There were no thematic reviews issued during this reporting period.

HSC SAFETY FORUM

In addition to facilitating the Annual Regional SAI Learning Event, the HSC Safety Forum welcomes information on key themes arising from SAIs to inform their improvement work. The Forum also provides assistance on specific SAIs on request.

Within the Safety Forum QI programmes, HSC Trust improvement teams are encouraged to present the learning from SAIs to inform change. Current areas of Safety Forum work influenced by specific SAIs, or themes from groups of SAIs, include communication and handover, sepsis, medication safety in paediatrics and recognition of the deteriorating patient (including early warning scores and escalation).

OTHER LEARNING ACTIONS

There are a range of other learning actions, which existing work streams or groups are taking forward or have been asked to consider by the HSCB/PHA, as a result of learning identified from SAIs. Examples include:

- Regional Falls Group
- Maternity Strategy Implementation Group
- Diabetic Network
- NICaN

- Pathology Network
- Regional Information Governance Advisory Group

SECTION 3

NEXT STEPS

1.0 THEMATIC REVIEWS

Following an in-depth review of SAI reports, the following thematic reviews were undertaken:

- ***REGIONAL REVIEW OF SAIs RELATING TO CHOKING ON FOOD***

A request was approved by the Quality Safety and Experience group to review and identify the numbers and types of SAIs and adverse incidents relating to choking on food.

This review will help to identify themes, consider any regional learning and determine if any further actions are required to reduce/prevent reoccurrence of these incidents.

2.0 SAI LEARNING EVENT S

- ***HSC SAFETY FORUM ANNUAL LEARNING EVENT***

The third Annual Regional SAI Learning Event will be held on Friday 19 May 2017 Mossley Mill. A call for examples of regional learning from SAIs will be issued shortly.

The event will continue to facilitate our ability to share and learn from SAIs in health and social care and progress a regional approach to reviews and learning.

It is intended to repeat the parallel workshop approach themed on programmes of care and also on specific issues, for example, sepsis, unrecognised deterioration, poor communication etc.

- ***LEARNING FROM CASES OF FINANCIAL ABUSE***

In the last 12 months, a number of SAIs have been reviewed which analysed situations where financial abuse occurred; this identified significant regional learning across service areas and organisational functions.

The learning identified is a complex area and it was determined that the most effective way to share this is through a Regional Learning Event. This Learning Event has been scheduled for Wednesday 5 October 2016 in the Seagoe Parish Centre, Craigavon.

In addition to sharing learning from SAIs, the event will:

- set the policy context for practice in this area;
- highlight actions already taken to address issues of financial abuse; and
- identify key actions required to implement the learning from these SAIs in each HSC Trust.

SECTION 4

CONCLUSION

Within the HSCB/PHA there is a continued commitment to learn from SAIs, to improve services and to reduce the risks of recurrence, both within the reporting organisations and across the HSC as a whole. The dissemination of learning following SAIs and ensuring that quality improvements are embedded into practice remains a key priority for the HSCB/PHA.

This report demonstrates actions planned and achieved in the period from April to September 2016. It also highlights the broad range of work that is routinely undertaken and reaffirms our commitment to safety, effectiveness and patient and client focus.

Since the last report, five learning letters/reminders of best practice have been disseminated to the relevant HSC organisations. The next "Learning Matters" newsletter will be issued in December 2016, to compliment the other methods of learning and to provide a forum where learning from SAIs, reviews and complaints is shared regionally and in a format that reaches all levels of staff across the wider HSC.

Quality, Safety and Patient Experience are a significant focus for the HSCB and PHA and both organisations will work in partnership with the HSC to improve the quality of care by learning from incidents and improving standards regionally.

APPENDIX A

REVISED CRITERIA FROM 1 FEBRUARY 2016

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI CRITERIA

- serious injury to, or the unexpected/unexplained death of:
  - a service user (*including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit*)
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility;

- unexpected serious risk to a service user and/or staff member and/or member of the public;

- unexpected or significant threat to provide service and/or maintain business continuity;

- serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

- serious self-harm or serious assault *(including homicide and sexual assaults*)
  - on other service users,
  - on staff or
  - on members of the public

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

- suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

- serious incidents of public interest or concern relating to:
  - any of the criteria above
  - theft, fraud, information breaches or data losses
  - a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

APPENDIX B

ANALYSIS OF SAI ACTIVITY APRIL - SEPTEMBER 2016

The HSCB has **received 200 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[2] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 and Chart 1 below provide an overview of all SAIs reported by organisation and includes **year on year comparison** of activity for the same **reporting period April to September.** This reduction can be largely attributed to revised reporting arrangements put in place, in year, for the reporting of child deaths and falls resulting in moderate to severe harm. These reductions are explained further below.

TOTAL ACTIVITY	Apr 15 - Sep 15	Apr 16 - Sep 16
BHSCT	91	53
BSO	2	0
NHSCT	54	40
NIAS	1	2
PCARE	5	7
SEHSCT	66	34
SHSCT	81	30
WHSCT	42	34
Totals:	**342**	**200**

Table 1

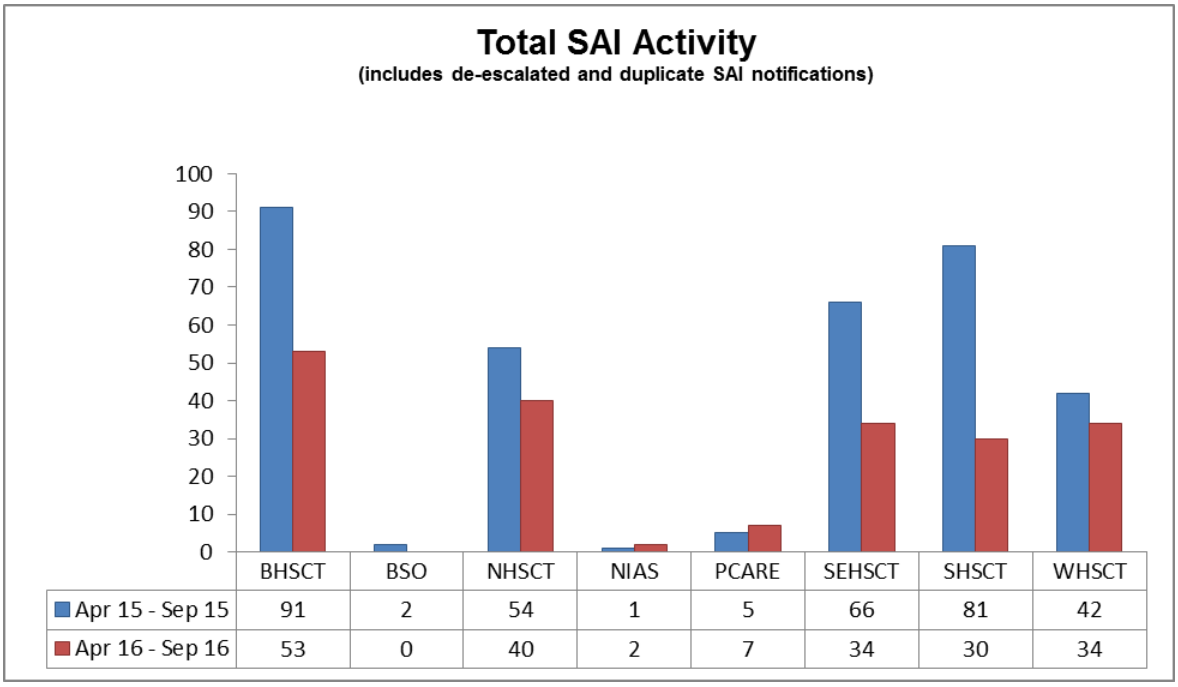


Chart 1

[2] Source- HSCB DATIX Information System

SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further review the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate or withdraw the SAI.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation can provide information on why the incident does not warrant further review under the SAI process. This information is considered by the HSCB/PHA DRO prior to approving any de-escalation.

During the reporting period **one (1) SAI notification** received was subsequently **de-escalated/withdrawn**.

TOTAL DE-ESCALATED/WITHDRAWN	Apr 15 - Sep 15	Apr 16 - Sep 16
BHSCT	3	0
NHSCT	2	0
SHSCT	5	0
WHSCT	1	1
Totals:	**11**	**1**

DUPLICATE SAI NOTIFICATIONS

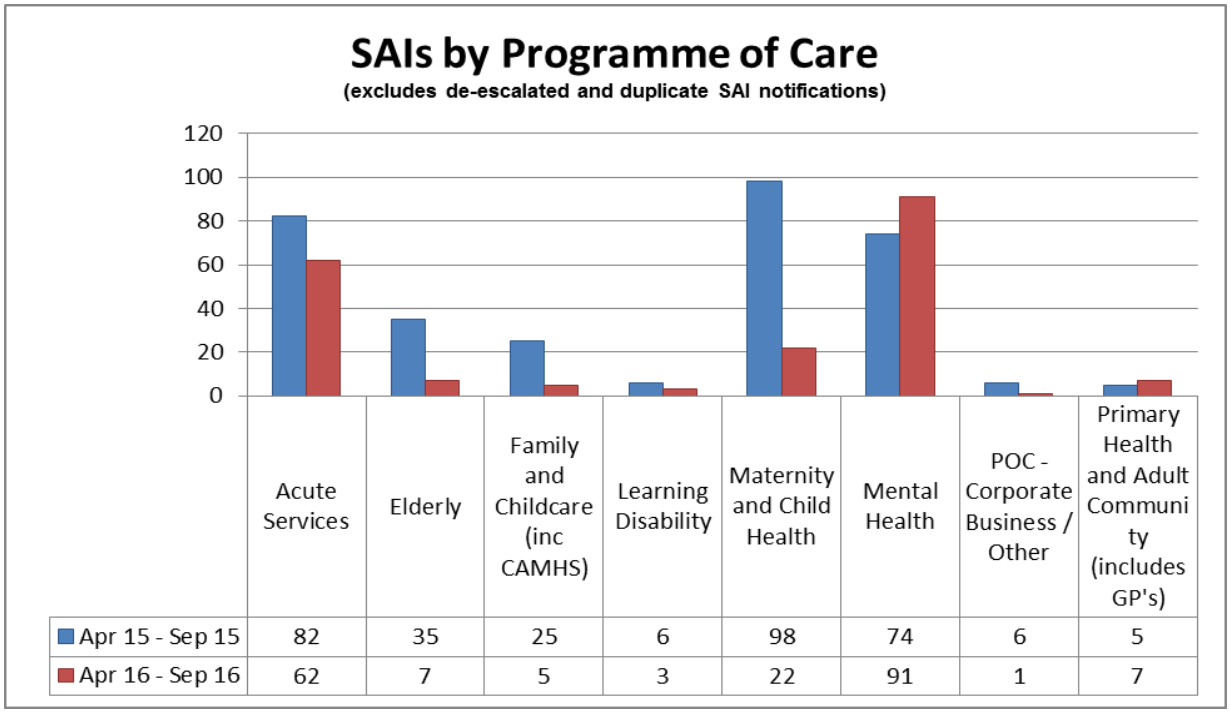
A notification may be received from one or more organisation but relating to the same incident. During the reporting period no duplicate SAI notifications were received.

SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

De-escalated and duplicate SAI notifications have been **excluded** from the analysis in the remainder of this report.



	Acute Services	Elderly	Family and Childcare (inc CAMHS)	Learning Disability	Maternity and Child Health	Mental Health	POC - Corporate Business / Other	Primary Health and Adult Community (includes GP's)
Apr 15 - Sep 15	82	35	25	6	98	74	6	5
Apr 16 - Sep 16	62	7	5	3	22	91	1	7

ACUTE SERVICES

ORGANISATION	Apr 15 - Sep 15	Apr 16 - Sep 16
BHSCT	19	20
NHSCT	6	11
NIAS	1	2
SEHSCT	12	4
SHSCT	28	7
WHSCT	16	18
Totals:	**82**	**62**

Current period: Sixty-two (62) SAIs were reported. The top four groups related to the following classifications/categories. Thirteen (13) incidents being the most reported in any one category.

Classification/category

- Diagnosis failed or delayed
- Implementation of care or ongoing monitoring/review
- Treatment, procedure
- Clinical assessment (investigations, images and lab tests)

MATERNITY & CHILD HEALTH

Organisation	Apr 15 - Sep 15	Apr 16 - Sep 16
BHSCT	45	15
HSCB	0	0
NHSCT	12	0
SEHSCT	12	2
SHSCT	14	2
WHSCT	15	3
Totals:	**98**	**22**

Current period: Twenty-two (22) SAIs relating to maternity and child health were reported. This represents a significant **decrease** in the number reported for this programme and is directly related to the revised child death review process which was effective from 1 February 2016.

Circular HSS(MD) 1/2016 (*Process for the Reporting of Child Deaths*) issued January 2016, advised that all child deaths will be recorded on a Child Death Notification form (CDNf) and reviewed at HSC Trust Mortality and Morbidity (M and M) meetings from 1 February 2016.

The aforementioned circular was issued simultaneously with notification from the HSCB of the change to the HSC SAI criteria (see Appendix A). Any incident involving the death of a child, which meets the redefined SAI criteria, will also continue to be reported and reviewed as a SAI. However, the death of other children, including those with a terminal illness where death was expected, will not to be automatically reported as SAIs. Instead they will be reported to the HSCB/PHA using the new CDNf, and reviewed at HSC Trusts M and M meetings.

These new reporting arrangements also allow for cases to be subsequently reported as SAIs following a HSC Trust M&M meeting, should that be necessary.

FAMILY & CHILD CARE

ORGANISATION	Apr 15 - Sep 15	Apr 16 - Sep 16
BHSCT	7	2
NHSCT	11	1
SEHSCT	2	1
SHSCT	5	1
WHSCT	0	0
Totals:	**25**	**5**

Current period: Five (5) SAIs relating to family and childcare were reported. The largest classification/category group (n=4) related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	Apr 15 - Sep 15	Apr 16 - Sep 16
BHSCT	0	0
NHSCT	1	2
SEHSCT	9	2
SHSCT	22	1
WHSCT	3	2
Totals:	**35**	**7**

Current period: Seven (7) SAIs reported related to older people services. The largest classification/category group (n=3) related to slips, trips, falls and collisions. This represents a significant **decrease** in the number reported for this programme; which can be associated to the revised reporting arrangements following the Report on Falls Resulting in Moderate to Service Harm issued in March 2016.

A new process has been put in place enabling HSC Trusts to undertake a timely local post falls review, and report the learning from these incidents to the Regional Falls Group, rather than being routinely reported as SAIs.

MENTAL HEALTH

ORGANISATION	Apr 15 - Sep 15	Apr 16 - Sep 16
BHSCT	14	16
NHSCT	18	25
SEHSCT	30	24
SHSCT	7	17
WHSCT	5	9
Totals:	**74**	**91**

Current period: Ninety-one (91) SAIs relating to adult mental health services were reported. 76% (n=69) related to suspected / attempted suicides* or unexpected deaths.

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

LEARNING DISABILITY SERVICES

ORGANISATION	Apr 15 - Sep 15	Apr 16 - Sep 16
BHSCT	1	0
NHSCT	4	0
SEHSCT	0	1
SHSCT	0	2
WHSCT	1	0
Totals:	**6**	**3**

Current period: Three (3) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

No reported incidents

PRIMARY HEALTH AND ADULT COMMUNITY (INC. GENERAL PRACTICE)

ORGANISATION	Apr 15 - Sep 15	Apr 16 - Sep 16
PCARE	5	7
Totals:	**5**	**7**

Current period: Seven (7) SAIs relating to Primary Health and Adult Community were reported. The largest classification/category group (n=6) was 'Medication'.

CORPORATE BUSINESS

ORGANISATION	Apr 15 - Sep 15	Apr 16 - Sep 16
BHSCT	2	0
BSO	2	0
SEHSCT	1	0
WHSCT	1	1
Totals:	**6**	**1**

Current period: One (1) SAI was reported relating to corporate business.

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents

This page is intentionally blank

APPENDIX C

Analysis of Checklists RECEIVED 1 April 2016 to 30 September 2016

Table 1a - Analysis of Engagement with patient/ family/carer	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**50**	**100.0%**	**41**	**100.0%**	**1**	**100.0%**	**40**	**100.0%**	**49**	**100.0%**	**37**	**100.0%**	**218**	**100.0%**
Patient/Service User/Family **not informed** incident was being reviewed as an SAI	12	24.0%	5	12.2%	0	0.0%	9	22.5%	4	8.2%	4	10.8%	**34**	**15.6%**
Patient/Service User/Family **informed** incident was being reviewed as an SAI	38	76.0%	36	87.8%	1	100.0%	31	77.5%	45	91.8%	33	89.2%	**184**	**84.4%**

Table 1b - Analysis of Rationale for patient/ family/carer not informed that incident was being reviewed as an SAI	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Not informed	**12**	**100.0%**	**5**	**100.0%**	**0**	**0.0%**	**9**	**100.0%**	**4**	**100.0%**	**4**	**100.0%**	**34**	**100.0%**
No NOK or contact details	7	58.3%	1	20.0%	0	0.0%	4	44.4%	1	25.0%	1	25.0%	**14**	**41.2%**
Other rationale provided	1	8.3%	2	40.0%	0	0.0%	5	55.6%	0	0.0%	0	0.0%	**8**	**23.5%**
Impact on health/safety /security and/or wellbeing	2	16.7%	2	40.0%	0	0.0%	0	0.0%	3	75.0%	2	50.0%	**9**	**26.5%**
Not applicable	1	8.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**1**	**2.9%**
Environ or infrastructure related with no harm	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	25.0%	**1**	**2.9%**
Case identified as a result of review exercise	1	8.3%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**1**	**2.9%**

Table 2a - Analysis of SEA/ RCA Reports shared/not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**50**	**100.0%**	**41**	**100.0%**	**1**	**100.0%**	**40**	**100.0%**	**49**	**100.0%**	**37**	**100.0%**	**218**	**100.0%**
SEA/RCA Report shared	14	28.0%	12	29.3%	0	0.0%	10	25.0%	12	24.5%	19	51.4%	**67**	**30.7%**
SEA/RCA Report **not** shared	36	72.0%	29	70.7%	1	100.0%	30	75.0%	37	75.5%	18	48.6%	**151**	**69.3%**

Table 2b - Analysis of SEA/RCA Reports not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Report not shared	**36**	**100.0%**	**29**	**100.0%**	**1**	**100.0%**	**30**	**100.0%**	**37**	**100.0%**	**18**	**100.0%**	**151**	**100.0%**
Final Review Report to be shared with SU/FAM	23	63.9%	16	55.2%	1	100.0%	10	33.3%	25	67.6%	1	5.6%	**76**	**50.3%**
Impact on health/safety/ security and/or wellbeing	2	5.6%	1	3.4%	0	0.0%	0	0.0%	2	5.4%	2	11.1%	**7**	**4.6%**
No NOK or contact details	7	19.4%	2	6.9%	0	0.0%	4	13.3%	1	2.7%	1	5.6%	**15**	**9.9%**
Other rationale provided	2	5.6%	4	13.8%	0	0.0%	7	23.3%	1	2.7%	3	16.7%	**17**	**11.3%**
No response to correspondence	0	0.0%	2	6.9%	0	0.0%	3	10.0%	6	16.2%	6	33.3%	**17**	**11.3%**
Review Report discussed with SU/FAM	1	2.8%	0	0.0%	0	0.0%	1	3.3%	0	0.0%	2	11.1%	**4**	**2.6%**
Draft Review Report shared with SU/FAM	0	0.0%	2	6.9%	0	0.0%	1	3.3%	1	2.7%	1	5.6%	**5**	**3.3%**
Declined Report	0	0.0%	0	0.0%	0	0.0%	3	10.0%	0	0.0%	1	5.6%	**4**	**2.6%**
Family withdrew	0	0.0%	2	6.9%	0	0.0%	1	3.3%	0	0.0%	0	0.0%	**3**	**2.0%**

Table 2b - Analysis of SEA/RCA Reports not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklist not completed	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	1	5.6%	**1**	**0.7%**
Case identified as a result of review exercise	1	2.8%	0	0.0%	0	0.0%	0	0.0%	1	2.7%	0	0.0%	**2**	**1.3%**

NOTE: The data recorded in the above tables are reported from a 'live' database and will be subject to change following planned/further engagement