Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

April – September 2015

November 2015

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 for action being taken forward by reporting organisations following the investigation.

3.0 WORK TAKEN FORWARD IN 2015- 2016

REVISIONS TO THE SAI PROCEDURE

It is expected that the HSCB/PHA will review the 'Procedure for the Reporting and Follow-up of SAIs issued in October 2013, for implementation on 1 April 2016.

Nonetheless, during the reporting period, there were a number of issues that were identified within the current process that required immediate implementation and were therefore issued to all ALBs in June 2015:

- A revised SAI service user/family/carer engagement checklist to enable easier data input and more meaningful information output, allowing for a systematic approach to monitor this information. (*APPENDIX C provides an analysis of HSC Trusts service user/family/carer engagement received for the period 1 April 2015 to 30 September 2015).*

- Minor revisions to both the Level 1 and Level 2/3 review templates and to also incorporate the above checklist.

In addition the HSCB and PHA issued flowcharts to all HSC organisations in order to assist both reporting organisations and HSCB/PHA staff when managing the following:

- SAIs that are also being reviewed as adult or children's safeguarding incidents
- Interface incidents that have been reported via the SAI process
- Early Alerts that have reported in line with DHSSPS process

INVOLVING LAYPERSONS IN THE SAI PROCESS

The panel of lay persons, (already involved in the HSC Complaints Procedure), availed of relevant SAI training including Root Cause Analysis, and are now available to be called upon to be a member of a SAI review team; particularly when a degree of independence to the team is required.

Profiles and relevant contact details for all available laypersons were circulated to all HSC organisations in conjunction with the above documents.

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

All groups benefit from:

- 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

Consideration to extending this process to other POCs remains under review.

TRUST GOVERNANCE LEADS MEETINGS

During the reporting period the Chair and Co-chair of the RSAIRG conducted a round of meetings with each of the HSC Trust Governance Leads to discuss regional arrangements for learning and sharing best practice, and also how best to address operational issues on a regional basis.

The outcome from these meetings was a consensus on the following:

- Regional Governance Leads meetings would continue to meet on a bi-annual basis, be workshop based and structured around learning and best practice.

- For any Business/Operational Issues, HSCB/PHA reps will join the end of Trust Governance Leads meetings

- Any issues/concerns /proposals, from either of the above two meetings, that require DHSSPS input, will be raised at the Department's Safety Health and Social Care Group, which is now attended by all Trust/HSCB/PHA Governance Leads.

TRAINING

- **SAI Learning Event**

  The HSC Safety Forum hosted a Regional SAI Learning Workshop on the 14 April 2015 at Mossley Mill, Newtownabbey.

  The aim of the event was to provide an opportunity to share learning from SAIs regionally. HSC Trusts and Integrated Care presented a number of case studies for discussion and a relative of a patient involved in a SAI shared their experience of the process and the impact it had on their family.

  Over 180 attended the event and 90% of feedback rated the event as very good or excellent. It is intended to hold another event on 11th March 2016 in Mossley Mill. A letter has already been issued to HSC Trusts with a call for submissions.

- **Designated Review Officer (DRO) Workshops**

  Workshops for DROs have been arranged during September and October 2015, across each of the four locations. The rationale for holding the workshops is to:

  - Provide DROs with a clear outline of the key stages of the:

    - SAI process taking account of any recent/imminent

- Service User/Family Engagement process
- Learning process
- Early Alert Process

- Provide an overview of key documentation

- **BHSCT RCA Forum for Chairs**

  Following the success of DROs attending the first BHSCT RCA Forum for Chairs in November 2014, DROs across a number of programmes of care, were invited to attend the third Forum in October 2015.

  This provided Trust RCA Chairs with a perspective on the role of a DRO within the SAI process. The meeting also provided an opportunity for DROs to share anonymised examples of well written review reports.

- **NHSCT SAI Review Group**

  The NHSCT SAI Review Group invited DROs across a number of programmes of care, to meet with this group which comprises of their Lead Directors to do a Question & Answer session on Monday 20th July 2015. The Trust welcomed this opportunity and the session was positively evaluated by all members present.

CHILD DEATH NOTIFICATIONS

In October 2013, the criteria for reporting a SAI were revised to include the death of every child in receipt of HSC services. The rationale behind this change was to provide clarity in terms of reporting all child deaths and to enhance the culture of learning and review.

The report "The Right Time, The Right Place" by Sir Liam Donaldson on governance arrangements across the HSC (January 2015) indicated that the current requirement for all child deaths to be reported and investigated as SAIs seemed to be having "*a detrimental effect on the system*". He also stated that "*the process itself was distressing for families, burdensome for staff, and was not producing any useful learning*". Hence, he recommended that, "*the deaths of children from natural causes should not be classified as Serious Adverse Incidents.*" This was an issue the HSCB/PHA had already identified and work had commenced on an alternative arrangement for child death notification.

During this reporting period, DHSSPS, working in partnership with HSCB/PHA and Trusts, have agreed a new process for recording, reviewing and reporting of all child deaths as part of a new Regional Mortality and Morbidity Review (MMR) System. This process will be introduced and regarded as a pilot with a review being performed after one year.

DHSSPS intend to issue the new child death notification process to the HSC in January 2016, for implementation on 1 February 2016. In conjunction with this new process, the HSCB will issue a set of revised SAI criteria to all Departmental ALBs.

4.0 SAIs REPORTED DURING PERIOD APR - SEP 2015

During the period 1 April to 30 September 2015, the HSCB received 342 SAI notifications. This represents a decrease on the previous six months (October 2014 – March 2015) when 366 SAI notifications were reported to HSCB.

A breakdown of these SAIs by reporting organisation and programme of care is detailed at Appendix B.

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 investigation 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 eleven (11) SAI notifications received were 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 investigation and follow 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 recently 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 overseeing the implementation and assurance of Regional Learning Letters/ Guidance issued by HSCB/PHA in respect of SAIs.

SAI LEARNING MECHANISMS

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

- **Local organisation 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 the previous report as part of on-going work.

UPDATES FROM PREVIOUS LEARNING REPORT:

- **SQR/SAI/2015/002 - Avoidance, recognition and management of anaphylaxis** *Reminder of best practice*

  As a result of the above learning reminder, the HSCB/PHA have worked with Trusts to ensure protocols are in place for anaphylaxis in both hospital and community settings and that staff are provided with regular training in the management and treatment of anaphylaxis.

- **SQR/SAI/2015/003 - Residual anaesthetic drugs in cannulae and intravenous lines –** *Reminder of best practice*

  Whilst all Trusts provided satisfactory responses that they are implementing the actions required, a further SAI was reported during this reporting period. This has resulted in a number of regional actions currently being taken forward, in order to ensure learning from both SAIs are embedded in practice.

- **SQR/SAI/2015/004 - Reduced fetal movements -** *Reminder of best practice*

  All Trusts have confirmed compliance with the required actions contained within the reminder of good practice letter.

THE FOLLOWING ITEMS ARE NEW LEARNING ISSUED SINCE LAST REPORT:

- **SQR/SAI/2015/005 -** Safe disposal of patients' drugs in the community - *Reminder of best practice*
- **SQR/SAI/2015/006 -** Assessment of a potential undisclosed/ unknown pregnancy – advice for emergency department staff - *Reminder of best practice*
- **SQR/SAI/2015/007 -** Assessment of domestic violence in pregnancy - *Reminder of best practice*
- **SQR/SAI/2015/008 -** Assessment and management of trauma in pregnancy – advice for emergency department and maternity staff - *Reminder of best practice*
- **SQR/SAI/2015/009 -** Prescribing and dispensing high risk drugs e.g. immunosuppressant's such as tacrolimus - *Reminder of best practice*
- **SQR/SAI/2015/011 -** Supervision in accordance with individual care plans - *Reminder of best practice*
- **SQR/SAI/2015/013 -** Alcohol based skin preparation solutions and the risk of fire in operating theatres - *Reminder of best practice*
- **SQR/SAI/2015/014 -** Identifying an acutely unwell child on arrival at an emergency department - *Reminder of best practice*

REMINDERS OF BEST PRACTICE ISSUED FOR AREAS NOT IDENTIFIED AS A RESULT OF SAIs

- **SQR/ADT/2015/010 -** Services for infants/young children with suspected hearing impairment - *Reminder of best practice*
- **SQR/CLNC/2015/012 -** Preventing shoulder dystocia and brachial plexus injury - *Reminder of best practice*

SAFETY AND QUALITY BEST PRACTICE REMINDER LETTERS RELATING TO ALLTHE 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#P-1_0

LEARNING FROM SAIs WITHIN FAMILY PRACTITIONER SERVICES (FPS)

There are a range of other initiatives across the HSC where learning from SAIs changes practice to reduce the risk of recurrence. There has been a number of SAI related learning communications issued to FPS including the following:

- Letter to GPs & community pharmacies - Communication between GPs and Community Pharmacies about patient clinical concerns

- Medicines Safety Matters Newsletter Community Pharmacy vol 3 issue 1 - Focus on the Community Pharmacist's Clinical Check – under-dosing

- Poster & Letter to community pharmacies - Poster: Reducing harm from high risk drugs in primary care and Letter: Reducing dosing errors– highlighting high-risk medications often seen in community pharmacy practice

- Letter to GPs & community pharmacies - Fraudulent attempts to Obtain Medicines for Patients Detained in Prison

- GMS Update Newsletter Spring 2015 - Learning arising from SAI – patients receiving medicines from Republic & Northern Ireland

- Letter & Guidance on how to delete prescriptions from GP system - In-house prescription fraud. Reduce the risk, reduce the temptation.

- Letter to community pharmacies - Further Dispensing Errors involving Beta Blockers

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

http://www.medicinesgovernance.hscni.net/primary-care/medicines-safety-advice-letters/

http://primarycare.hscni.net/3634.htm

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 serious adverse incidents, complaints, reviews and patient experience across Northern Ireland. The **fourth edition was issued in September 2015** and covers the following topics:

- NEWS on the National Early Warning Score

- The process for escalating clinical concerns – when time is important, speak directly by phone – do not text.

- Getting to know the new oral anticoagulant medicines

- Volvulus in people with a Learning Disability

- Informed Consent
- Reassessment of patient on Venous Thrombo Embolism (VTE) Prophylaxis
- Drug administration using prefilled glass syringes. Can you make the connection?
- National Patient Safety Alerts

This edition of the newsletter can be viewed at:

http://www.hscboard.hscni.net/publications/Learning%20Matters/12%20Learning_Matters_Issue_4-September_2015.pdf

http://www.publichealth.hscni.net/sites/default/files/Learning_Matters_issue4_final_version.pdf

A **'Special Maternity Edition'** of the Learning Matters Newsletter **was issued in June 2015,** and covers six articles on topics which have been recognised to be recurring themes in a number of SAIs.

- Care of Women who have had a Previous Caesarean Section
- Antenatal Fetal Growth Monitoring
- Obstetric Early Warning Scores
- Operative Vaginal Delivery
- Human Factors and Situational Awareness
- Inadequate Arrangements for Elective Caesarean Section

This edition of the newsletter can be viewed at:

http://www.hscboard.hscni.net/publications/Learning%20Matters/11%20Learning_matters_maternity_issue_LR_07_15.pdf

http://www.publichealth.hscni.net/sites/default/files/Learning_matters_maternity_issue_LR_07_15.pdf

THEMATIC REVIEWS

Thematic Reviews are commissioned by the HSCB/PHA Quality Safety and Experience (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.

Following an in-depth review of SAI reports, the following thematic review was issued during the reporting period:

- ***PATIENT MIS-IDENTIFICATION IN HOSPITALS***

‘Misidentification of Patients/ Clients’ in HSC services was identified as a theme through SAI analysis, following several reported incidents. The aim of this thematic review was to identify recurrent themes found within reported SAIs and to consider any regional actions that could be implemented to reduce the incidence of “Misidentification of Patients and Clients”.

This review was issued on 22 June 2015 to the HSC along with the regional poster (designed in partnership with the five HSC Trusts) for display throughout Trust wards and departments to raise staff awareness of the importance of patient verification processes at every stage of care.

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 CAMHS Service Manager Forum and Regional MARAC multi-agency forum
- Regional dissemination of the Ligature Policy by Children Services Improvement Board RIT 9 Working Group
- Regional Group for Endoscopy Services

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 PATIENTS WITH A FALL RESULTING IN MODERATE TO SEVERE HARM REPORTED AS A SAI***

A request was made by the SAI Regional Review Sub Group to review and identify the numbers and types of SAIs relating to patients with a fall resulting in moderate to severe harm and reported as an SAI, across all programmes of care.

The purpose of this report is to identify recurrent themes found within the reported SAIs, to consider any regional learning and whether any further actions are required to reduce/prevent reoccurrence of these incidents. This report will be presented to the Regional Quality, Safety and Patient Experience Group prior to dissemination to the relevant Health and Social Care (HSC) organisations.

To best understand the key challenges in relation to, where a patient with a fall resulting in moderate to severe harm and reported as an SAI, had occurred, a review of all the relevant SAI's reported, within HSC was carried out across all programmes of care for the period of 6 months, 1October 2013 to 31 March 2014.

This review has been completed and will be issued to relevant HSC organisations early 2016.

- ***REGIONAL REVIEW OF SAIs RELATING TO PATIENTS ON INSULIN***

A request was made by the Serious Adverse Incident (SAI) Regional Group to review and identify the numbers and types of SAIs relating to patients on Insulin, across all programmes of care.

The purpose of this review is to identify recurrent themes found within the reported SAIs, to consider any regional learning and whether any further actions are required to reduce/prevent reoccurrence of these incidents.

This review is progressing well and an update will be provided in the next learning report.

2.0 SAI LEARNING EVENT

To build on the success of the 2015 event, the HSC Safety Forum will be hosting its 2nd Regional SAI Learning Workshop on 11 March 2016 at Mossley Mill, Newtownabbey.

As before, this will provide an opportunity to share learning regarding SAIs in the Health and Social Care system and progress a regional approach to reviewing and learning.

It is hoped to repeat the parallel workshop approach themed on programmes of care e.g. acute, maternity, mental health, integrated care etc. or potentially on specific issues such as unrecognised deterioration, poor communication or sepsis care.

SECTION 4

CONCLUSION

The HSCB and PHA want patients, carers and their families to feel confident about the quality and safety of health and social care services in Northern Ireland. 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 2014 – September 2015. 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, ten learning letters/reminders of best practice have been disseminated to the relevant HSC organisations. The “Learning Matters” newsletter was published in September 2015, 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. In addition a ‘Special Maternity Edition’ of the Learning Matters Newsletter: was issued in June 2015, and covers six articles on topics which have been recognised to be recurring themes in a number of SAIs

HSCB/PHA has continued to work with HSC Trust colleagues in relation to enhancing service users/families involvement in the SAI process.

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 OCTOBER 2013

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 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;

- any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register;

- 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,*

[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

psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

- 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 2015

The HSCB has **received 342 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 1 April 2015 to 30 September 2015.**

TOTAL ACTIVITY	Apr 14 - Sep 14	Apr 15 - Sep 15
BHSCT	101	91
BSO	3	2
HSCB	1	0
NHSCT	118	54
NIAS	2	1
PCARE	12	5
PHA	1	0
SEHSCT	60	66
SHSCT	73	81
WHSCT	63	42
Totals:	**434**	**342**

Table 1

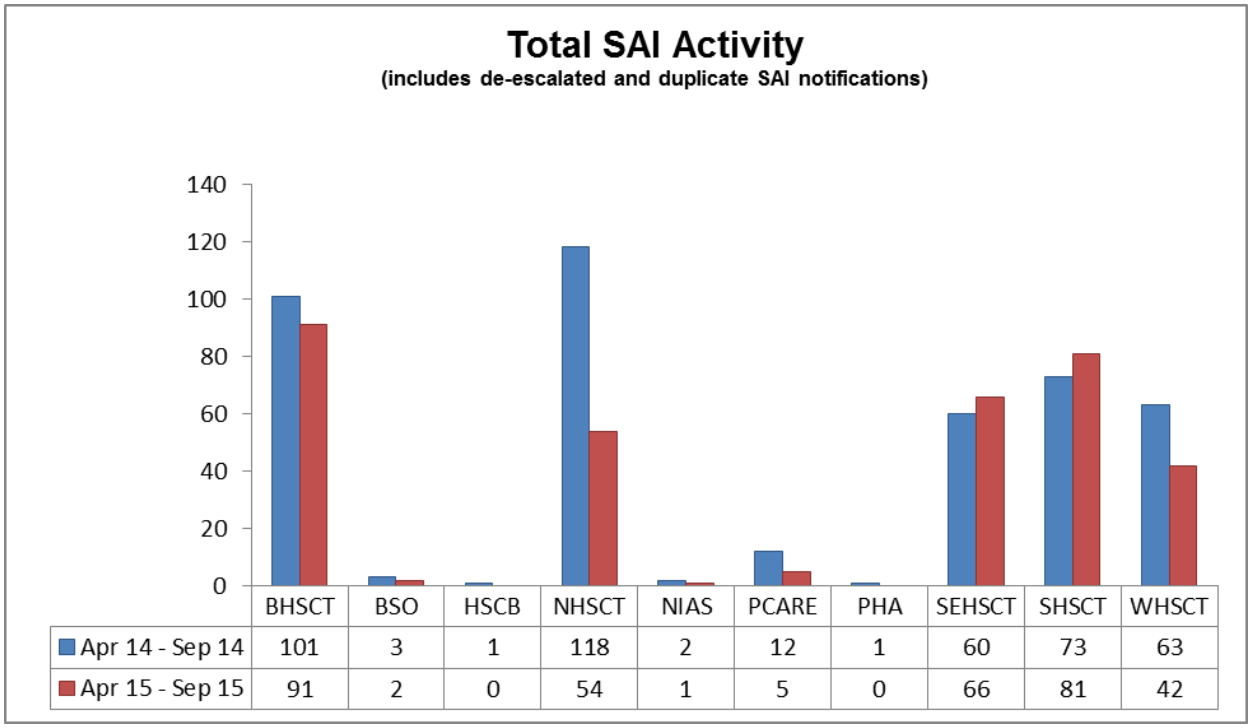


Chart 1

[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 investigation 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 provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period **eleven (11) SAI notifications** received were subsequently **de-escalated/withdrawn**.

TOTAL DE-ESCALATED/WITHDRAWN	Apr 14 - Sep 14	Apr 15 - Sep 15
BHSCT	1	3
NHSCT	1	2
SHSCT	0	5
WHSCT	2	1
Totals:	**4**	**11**

DUPLICATE SAI NOTIFICATIONS

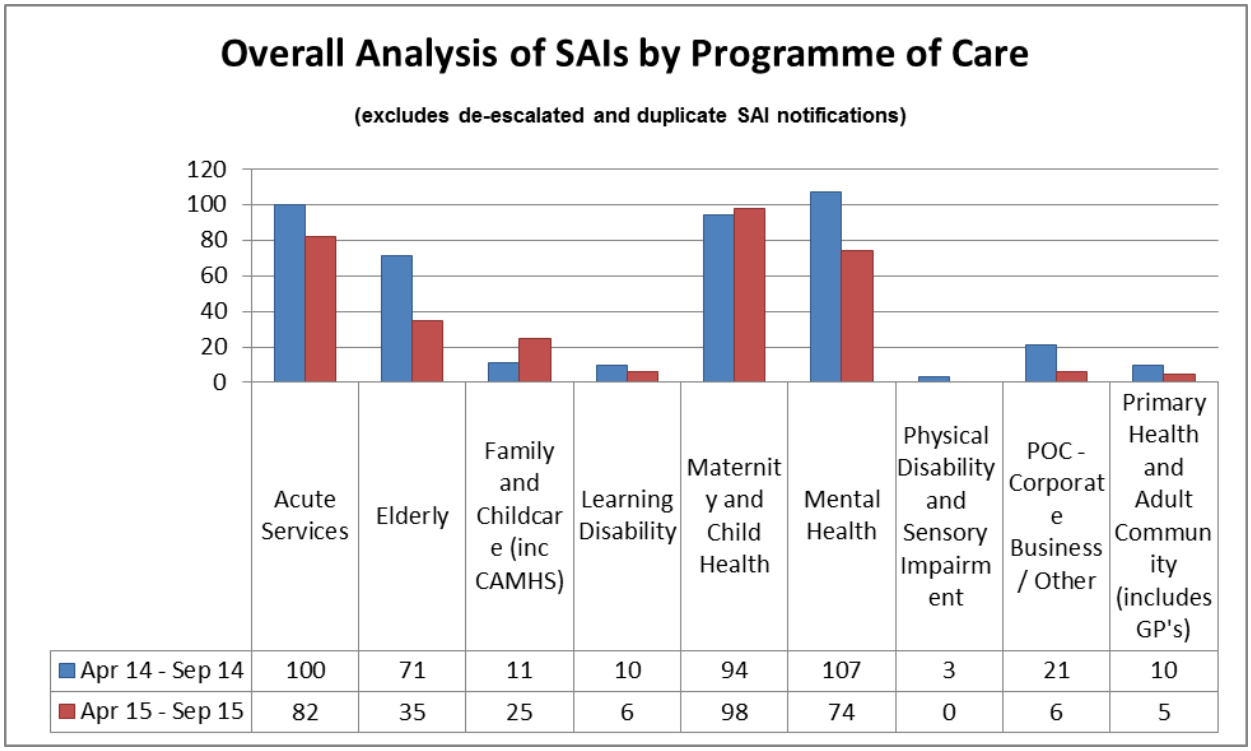
A notification may be received from one or more organisation but relating to the same incident. During the reporting period no duplicate SAI notifications were received.

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	Physical Disability and Sensory Impairment	POC - Corporate Business / Other	Primary Health and Adult Community (includes GP's)
Apr 14 - Sep 14	100	71	11	10	94	107	3	21	10
Apr 15 - Sep 15	82	35	25	6	98	74	0	6	5

ACUTE SERVICES

ORGANISATION	Apr 14 - Sep 14	Apr 15 - Sep 15
BHSCT	23	19
NHSCT	29	6
NIAS	0	1
SEHSCT	10	12
SHSCT	11	28
WHSCT	27	16
Totals:	**100**	**82**

Current period: Eighty-two (82) SAIs were reported. The top four groups related to the following classifications/categories. Eighteen (18) incidents being the most reported in any one category.

Classification/category

- Treatment, procedure
- Accident that may result in personal injury
- Diagnosis failed or delayed
- Implementation of care or on-going monitoring/review

Since the revised SAI criteria (see Appendix A) were introduced (October 2013), there has been an increase in the number of reported incidents relating to falls; within the above classification/ catergory: accident that may result in personal injury, 21% of the reported SAIs (n=17) for this programme of care relate to slip, trips, falls and collisions in an acute setting.

MATERNITY & CHILD HEALTH

ORGANISATION	Apr 14 - Sep 14	Apr 15 - Sep 15
BHSCT	57	45
HSCB	1	0
NHSCT	10	12
NIAS	2	0
PCARE	1	0
SEHSCT	5	12
SHSCT	6	14
WHSCT	12	15
Totals:	**94**	**98**

Current period: Ninety eight (98) SAIs relating to maternity and child health were reported. The revised criteria (Appendix A) included an additional requirement to report 'any death of a child in receipt of HSC services (up to eighteenth birthday)'. 84% of the reported SAIs (n=82) for this programme of care relate to HSC Child Death Notifications.

FAMILY & CHILD CARE

ORGANISATION	Apr 14 - Sep 14	Apr 15 - Sep 15
BHSCT	0	7
NHSCT	4	11
SEHSCT	1	2
SHSCT	4	5
WHSCT	2	0
Totals:	**11**	**25**

Current period: Twenty five (25) SAIs relating to family and childcare were reported. The largest classification/category group (n=19) related to 'Abusive, violent, disruptive or self-harming behaviour'.

OLDER PEOPLE SERVICES

ORGANISATION	Apr 14 - Sep 14	Apr 15 - Sep 15
BHSCT	1	0
NHSCT	37	1
SEHSCT	1	9
SHSCT	26	22
WHSCT	6	3
Totals:	**71**	**35**

Current period: Thirty five (35) SAIs reported related to older people services. The largest classification/category group (n=29) related to slips, trips, falls and collisions.

MENTAL HEALTH

ORGANISATION	Apr 14 - Sep 14	Apr 15 - Sep 15
BHSCT	9	14
NHSCT	22	18
PHA	1	0
SEHSCT	41	30
SHSCT	23	7
WHSCT	11	5
Totals:	**107**	**74**

Current period: Seventy four (74) SAIs relating to adult mental health services were reported. 61% (n=41) 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 14 - Sep 14	Apr 15 - Sep 15
BHSCT	6	1
NHSCT	3	4
WHSCT	1	1
Totals:	**10**	**6**

Current period: Six (6) SAIs relating to learning disability services were reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

Organisation	Apr 14 - Sep 14	Apr 15 - Sep 15
NHSCT	2	0
SHSCT	1	0
Totals:	**3**	**0**

Current period: No incidents relating to physical disability and sensory impairment services were reported.

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	Apr 14 - Sep 14	Apr 15 - Sep 15
NHSCT	2	0
PCARE	8	5
Totals:	**10**	**5**

Current period: Five (5) SAIs relating to Primary Health and Adult Community were reported. The classification/category group (n=5) was 'Medication'.

CORPORATE BUSINESS

ORGANISATION	Apr 14 - Sep 14	Apr 15 - Sep 15
BHSCT	2	2
BSO	3	2
NHSCT	8	0
PCARE	3	0
SEHSCT	2	1
SHSCT	1	0
WHSCT	2	1
Totals:	**21**	**6**

Current period: Six (6) SAIs were reported relating to corporate business. The largest classification/category group (n=3) related to 'Infrastructure or resources (staffing, facilities, environment)'

HEALTH PROMOTION AND DISEASE PREVENTION

No reported incidents

APPENDIX C

Analysis of Checklists RECEIVED 1 April 2015 to 30 September 2015

Table 1a - Analysis of Engagement with patient/family/carer	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**47**	**100%**	**42**	**100%**	**3**	**100%**	**38**	**100.0%**	**63**	**100.0%**	**23**	**100.0%**	**216**	**100.0%**
Patient/Service User/Family **not informed** incident was being investigated as an SAI	2	4.3%	6	14.3%	2	66.7%	5	13.2%	3	4.8%	2	8.7%	**20**	**9.3%**
Patient/Service User/Family **informed** incident was being investigated as an SAI	45	95.7%	36	85.7%	1	33.3%	33	86.8%	60	95.2%	21	91.3%	**196**	**90.7%**

Table 1b - Analysis of Rationale for patient/ family/carer not informed that incident was being investigated as an SAI	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Not informed	**2**	**100%**	**6**	**100%**	**2**	**100%**	**5**	**100%**	**3**	**100%**	**2**	**100%**	**20**	**100%**
Case identified as a result of review exercise	0	0.0%	1	16.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**1**	**5.0%**
Impact on health/safety /security and/or wellbeing	1	50.0%	0	0.0%	0	0.0%	2	40.0%	0	0.0%	1	50.0%	**4**	**20.0%**
No NOK or contact details	0	0.0%	2	33.3%	0	0.0%	1	20.0%	0	0.0%	0	0.0%	**3**	**15.0%**
Not applicable	0	0.0%	1	16.7%	0	0.0%	0	0.0%	1	33.3%	0	0.0%	**2**	**10.0%**
Other rationale provided	1	50.0%	2	33.3%	2	100.0%	2	40.0%	2	66.7%	1	50.0%	**10**	**50.0%**

Table 2a - Analysis of SEA/RCA Reports shared/not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Checklists received	**47**	**100%**	**42**	**100%**	**3**	**100%**	**38**	**100.0%**	**63**	**100.0%**	**23**	**100.0%**	**216**	**100.0%**
SEA/RCA Report shared	27	57.4%	22	52.4%	1	33.3%	9	23.7%	50	79.4%	18	78.3%	**127**	**58.8%**
SEA/RCA Report not shared	20	42.6%	20	47.6%	2	66.7%	29	76.3%	13	29.6%	5	21.7%	**89**	**41.2%**

Table 2b - Analysis of SEA/RCA Reports not shared	BHSCT		NHSCT		NIAS		SEHSCT		SHSCT		WHSCT		TOTAL	
Report not shared	**20**	**100%**	**20**	**100%**	**2**	**100%**	**29**	**100%**	**13**	**100%**	**5**	**100%**	**89**	**100%**
Case identified as a result of review exercise	0	0.0%	1	5.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**1**	**1.1%**
Draft Review Report shared with SU/FAM	1	5.0%	2	10.0%	0	0.0%	2	6.9%	1	7.7%	0	0.0%	**6**	**6.7%**
Family withdrew	0	0.0%	2	10.0%	0	0.0%	8	27.6%	1	7.7%	2	40.0%	**13**	**14.6%**
Declined report	1	5.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**1**	**1.1%**
Final Review Report to be shared with SU/FAM	15	75.0%	1	5.0%	1	50.0%	8	27.6%	6	46.2%	0	0.0%	**31**	**34.8%**
Impact on health/safety /security and/or wellbeing	0	0.0%	0	0.0%	0	0.0%	3	10.3%	0	0.0%	1	20.0%	**4**	**4.5%**
No NOK or contact details	0	0.0%	3	15.0%	0	0.0%	1	3.4%	0	0.0%	0	0.0%	**4**	**4.5%**
No response to correspondence	0	0.0%	4	20.0%	0	0.0%	3	10.3%	2	15.4%	1	20.0%	**10**	**11.2%**
Other rationale provided	2	10.0%	6	30.0%	1	50.0%	4	13.8%	3	23.1%	1	20.0%	**16**	**19.1%**
Review Report discussed with SU/FAM	1	5.0%	1	5.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	**2**	**2.2%**

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