



Department of  
**Health, Social Services  
and Public Safety**

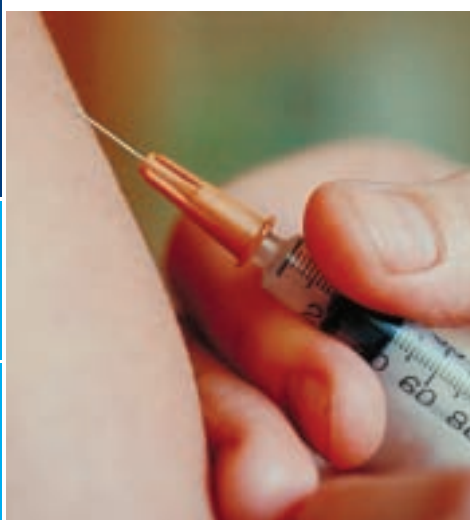
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AN ROINN

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydënter Heisin  
an Fowk Siccar**



# CMO'S UPDATE 32

IMPORTANT INFORMATION FOR DOCTORS FROM THE CHIEF MEDICAL OFFICER **JANUARY 2008**

## CMO's Foreword

As we move into 2008, doctors throughout Northern Ireland can look back on a year of significant change. Five new integrated Trusts were created in April. Devolution was restored in May and we now have a local Minister for Health, Health Committee and Assembly. We must take the opportunities these changes offer and use them to achieve demonstrable improvement in the health and well-being of the people of Northern Ireland.

"Never mind the quality, feel the width" – how often does it seem that the focus of health and social care is on "width" rather than quality? In 2008, I want to continue to increase our focus on the quality of care provided and this CMO's Update reflects that.

The principles from Best Practice Best Care remain – standards, delivery, measurement. Service Frameworks will set the standards that services should meet. Evidence-based guidelines will support clinical decision making, and two are highlighted in this Update. The new Safety Forum will help to build frontline staff skills in improvement science and multidisciplinary team working. Improving care also means recognising mistakes when they occur, and making sure that



learning is used to improve systems. Reporting and surveillance systems such as the National Patient Safety Agency, Serious Hazards of Transfusion, and the Communicable Disease Surveillance Centre can contribute to measuring improvement in practice.

Finally, I am pleased to welcome Dr Carolyn Harper as a new Deputy Chief Medical Officer. The safety and quality agenda is part of Carolyn's remit and complements the role of Dr Elizabeth Mitchell, Deputy CMO who leads on health improvement and health protection.

# contents

- 01 Foreword
- 02 Service Frameworks
- 03 The HSC Safety Forum - your place for improvement
- 04 Serious Hazards of Transfusion - SHOT
- 05 Communicable Disease Surveillance Centre Northern Ireland
- 06 Transmissible Spongiform Encephalopathy (TSE) Agents: Safe Working and the Prevention of Infection
- 07 Haemophilus Influenzae Type B Vaccine for younger children – catch-up-programme
- 08 Medication Patient Safety Observatory Report
- 08 GAIN created to focus work on regional guidelines and audit

For further details on any item in CMO's Update contact CMO's Team  
E-mail: [cmo@dhsspsni.gov.uk](mailto:cmo@dhsspsni.gov.uk) Tel: 028 9052 2359 or visit [CMO's webpage at:](http://www.dhsspsni.gov.uk)

<http://www.dhsspsni.gov.uk/index/phealth.htm>

## Service FRAMEWORKS

Work has commenced on the development of a range of service frameworks which will set out clear standards of service that patients and service users should expect within health and social care.

The development of service frameworks is a major element of the Service Reform Programme. Service frameworks will set clear quality requirements for care based on the best available evidence of what works. They will be used by the public, HSC commissioners, HSC organisations, other providers and inspection and regulatory bodies drive quality improvement.

Service frameworks will link to key policies and strategies already developed and will draw on evidence from established sources for example National Institute for Health and Clinical Excellence and Social Care Institute for Excellence. They will not seek to reinvent the wheel and, where appropriate, will include standards which have been developed elsewhere.

Each service framework will use a common template which will include the setting of standards for prevention, promotion, protection of health and wellbeing, to appropriate assessment, diagnosis, treatment, management and care provision, rehabilitation, discharge from services and end of life care.

The development of service frameworks is being undertaken in partnership with the HSC, service users and carers, and voluntary and community organisations. Where possible, development will be undertaken in collaboration with established networks and groups. Each service framework will use a multidisciplinary approach,

recognising that the majority of care is delivered in the primary/community sectors with active participation of individuals and carers. In addition, service frameworks will recognise that care can go beyond traditional HPSS boundaries and embrace interagency working as necessary.

Five areas have been identified as regional priorities for the development of service frameworks in the first instance. These are:

- Cardiovascular health and wellbeing;
- Respiratory health and wellbeing;
- Cancer Prevention, Treatment and Care;
- Mental Health; and,
- Learning Disability.

The next stage of the work programme is to identify further priority areas for service framework development, for commencement in early 2008. It is important that additional areas which are suitable for the service framework approach are identified and prioritised in an open and transparent manner. To this end the department has requested that Boards, in collaboration with Trusts and local stakeholders, work together to identify and prioritise areas in health and social care for service framework development, especially in areas where there is evidence of regional variation in terms of effectiveness, safety and/or

protection of patients, service users or the public.

It is important that all key stakeholders, including users and carers, and voluntary and community sector organisations, are provided the opportunity to inform and influence the prioritisation process. In support of this a workshop was held on 17 October 2007, and Boards were requested to submit their finalised proposals by 30 November 2007.



### Further Information

Further information on Service Frameworks can be accessed at <http://www.dhsspsni.gov.uk/index/phealth/sqs/sqsd-standards-service-frameworks.htm>



# THE HSC SAFETY FORUM

## your place for improvement

In a public, universally accessible service and given the size of our population, the potential is unlimited to continuously improve and provide extraordinary care. The HSC Safety Forum was officially announced on June 29, 2007 by the CMO Dr. Michael McBride to promote a safety culture within health and social care organisations by sharing learning regionally and supporting the implementation of national and international best practice on patient safety. It has members from a wide range of health and social care organisations.

The Forum will work in partnership with Northern Ireland's Health and Social Care to capitalise on the benefits of shared learning. The Forum will concentrate on building knowledge, developing leaders, supporting organisations, engaging clinicians and engaging patients.

Our aim is to consolidate a strong base of patient safety and improvement expertise throughout the region. In doing so, we will contribute to shape the present and future of our health and social care system towards a safe and effective service, making the experience of patients and clients the best possible one and optimising their health outcomes.

The Forum will act as a knowledge management centre. We will promote synergy between the many communities involved in health and social care to steadily improve the current level of safety, quality, effectiveness, and efficiency of healthcare.

Our aspiration is that continuous improvement and best practice in relation to patient safety will move towards professional mainstream in

our health and social care system, ultimately encouraging and developing executive and clinical leadership. All our Trusts will be learning organisations, be equipped with a high level of expertise in patient safety and improvement science and be engaged in evidence-based patient safety interventions. Measuring systems will be set up to follow the progress of safety and improvement. Patients and clients will be active partners in their care and receive outstanding service every time. Collaboration and synergy will be the norm of our service, without boundaries.

### Further Information

Pedro Delgado is the NI General Manager of the HSC Safety Forum. He can be contacted at [pedro.delgado@setrust.hscni.net](mailto:pedro.delgado@setrust.hscni.net).

**Dr Gill Hastings & Simona Area (The Health Foundation), Pedro Delgado (HSC Safety Forum Manager), Dr Carol Haraden (Vice President Institute of Healthcare Improvement, Boston, USA), John Compton (Chief Executive SE Trust)**





## Serious Hazards of Transfusion

# SHOT

SHOT collects reports of adverse incidents relating to blood and blood products across the UK. The SHOT (Serious Hazards of Transfusion) Annual Report for 2006 has recently been published.

- Over 3 million units of blood components were issued across the UK
- There were 531 reports of adverse incidents, including 4 deaths
- ABO incompatible transfusions were lower than ever previously recorded, with just 8 cases.
- There were 10 cases of transfusion-related acute lung injury, the lowest recorded since 1996
- 85 acute transfusion reactions and 34 haemolytic transfusion reactions were reported
- 125 reports involved junior doctor error in requesting or prescribing blood.
- Other reports included pre-transfusion testing errors, handling or storage errors, and patients receiving a wrong blood component

SHOT have made three recommendations for this year:

1. Inclusion of transfusion medicine in core curriculum for junior doctors.
2. Specialty accredited laboratory and clinical staff in all hospitals.
3. Comprehensive reporting to SHOT by all hospitals.

## Further Information

More information can be obtained from SHOT  
Tel: 0161 251 4208  
Email: [shot@nbs.nhs.uk](mailto:shot@nbs.nhs.uk)  
Website: <http://www.shot-uk.org>



# COMMUNICABLE DISEASE SURVEILLANCE CENTRE

## Northern Ireland

Established in 1999, CDSC (NI) is part of the national Health Protection Agency and is based at Belfast City Hospital. The primary objective of CDSC (NI) is to undertake surveillance of communicable disease in Northern Ireland.

This includes all major infections of public health importance, such as healthcare associated infections, *Staphylococcus aureus* and *Clostridium difficile*. Surveillance involves the timely collation of approximately 6,000 notifications of infectious disease from clinicians, 13,000 reports from laboratories, outbreak and enhanced surveillance information from Consultants in Communicable Disease Control and additional information from GUM clinics and sentinel GP practices.

Once this data is collected it is analysed, interpreted and distributed to DHSSPS, Boards, Trusts and primary care. The dissemination of this information is vital as surveillance is information for action.

Examples of a surveillance programme include a weekly report

which is produced during the 'flu season. This is based on 'flu activity' using data collected from sentinel GPs, Out-of-Hours Centres, the Regional Virus Laboratory and the Registrar General. In addition, every quarter there is a report on vaccine preventable diseases and uptake of the childhood vaccination programme. Similarly, there are regular updates on the main food poisoning pathogens, such as salmonella and *E. coli* 0157, meningococcal infection, sexually transmitted infections and TB.

CDSC (NI) also provides advice and support to DHSSPS, Boards and Trusts on communicable disease issues and as part of a national organisation can readily access expert advice when required.



## Further Information

For more information please visit our website [www.cdscni.org.uk](http://www.cdscni.org.uk) which features our latest weekly and monthly bulletins and relevant archives. This bulletin provides readers with the latest surveillance figures and information on communicable diseases. The website also contains links to other relevant health protection institutions and agencies within the UK and abroad.

If you would like to subscribe to the email version please email the editorial team at [cdscni@hpa.org.uk](mailto:cdscni@hpa.org.uk) or telephone **02890263765**.



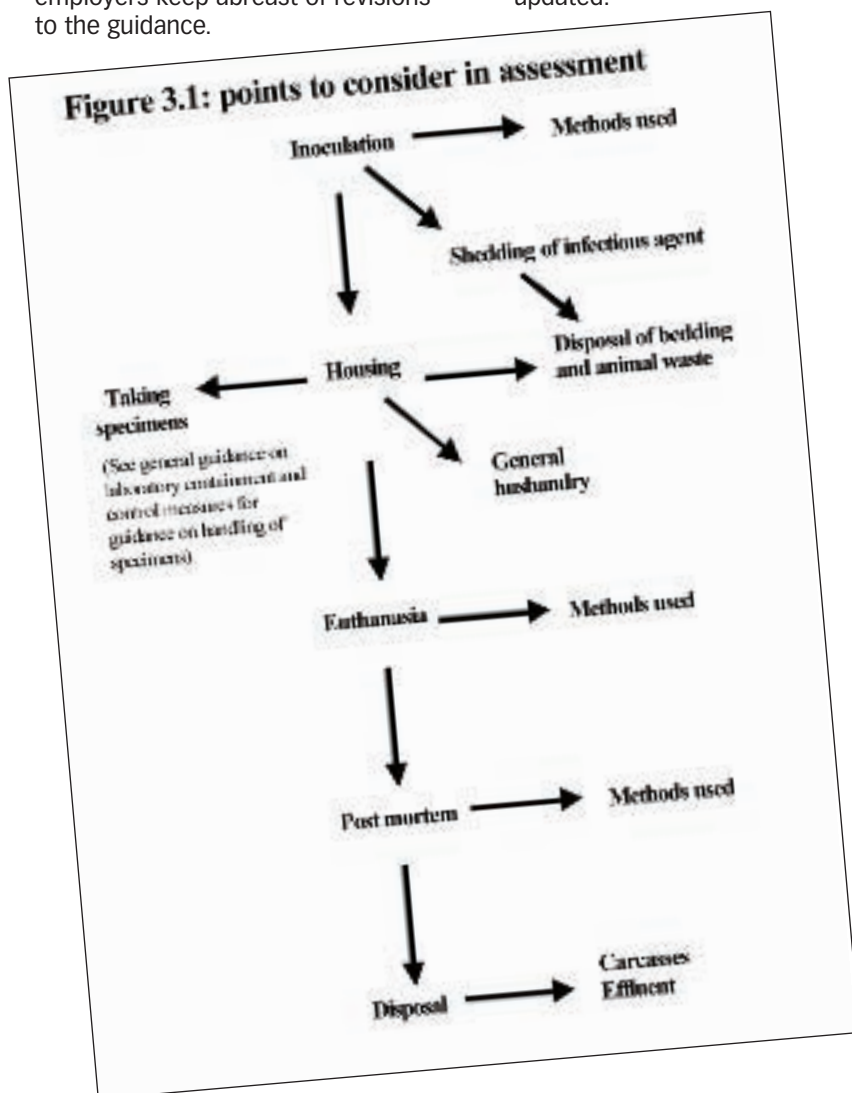
# TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHY (TSE) AGENTS:

## Safe Working and the Prevention of Infection

Guidance from the Advisory Committee on Dangerous Pathogens on TSEs: Safe Working and the Prevention of Infection is available on the website of the Department of Health. This guidance is divided into four parts and contains a series of Annexes. It is reviewed regularly and where necessary updated. It is important that people whose work could involve a risk of exposure to TSE agents as well as their employers keep abreast of revisions to the guidance.

Recent changes are as follows:

- Part 4 entitled "Infection Control of CJD and Related Disorders in the Healthcare Setting" was updated earlier in 2007 to include information on the four cases of probable human transmission of vCJD infection via blood transfusion. Formatting of the clinical algorithms has also been updated.
- Updates to Annexes A1 and A2 "Distribution of TSE Infectivity in Human Tissues and Body Fluids" and "Distribution of Infectivity in Animal Tissues and Body Fluids" were made in February 2007.
- In March 2007, Annex F entitled "Decontamination of Endoscopes" was revised. In addition a new paragraph has been added which outlines decontamination of endoscope cleaning equipment.
- In May 2007 an information sheet for funeral directors, relatives and others following the death of a patient with CJD was added to Annex H "After Death". This is in a Question and Answer format and is intended to address specific issues which may arise in these difficult circumstances. In addition Annex I "Outline Protocol for Management of Instruments and Tissues from Brain Biopsy Procedures on Patients with Progressive Neurological Disorders" was amended.
- Annex G Decontamination of Other Specialised Equipment is currently under revision and will shortly be available.



### Further Information

All information is contained in the following link  
<http://www.advisorybodies.doh.gov.uk/acdp/tseguidance/index.htm>



## HAEMOPHILUS INFLUENZAE Type B Vaccine for younger children – **CATCH-UP-PROGRAMME**

Following advice from the Joint Committee on Vaccination and Immunisation (JCVI), a Hib booster will to be offered to young children who have not previously received one, so that these children are protected in line with older and younger children.

The eligible group includes children born between 13 March 2003 and 3 September 2005. This cohort of children are too young to have had a booster as part of the 2003 Hib catch-up campaign, and too old to have received the new Hib/MenC booster vaccine at 15 months following its introduction in September 2006.

The *Haemophilus influenzae* type B (Hib) vaccination catch-up programme will run from 10 September 2007 and continue until 3 March 2009. Key features of this campaign are:

- During the course of this campaign, the age at which the pre-school immunisation is offered will be reduced. Further information on this will follow during the campaign.
- Some older children in the cohort, who may have already received their pre-school immunisation, will need to be offered an additional appointment to be offered a Hib containing vaccine.
- The Hib booster will be offered as part of the pre-school immunisation programme by temporarily changing the pre-school booster to one that contains an additional Hib component;

### Further Information

Further details are contained in the HSS(MD)17-2007 letter issued 24 July 2007, available at [http://www.dhsspsni.gov.uk/hss\\_md\\_17-2007.pdf](http://www.dhsspsni.gov.uk/hss_md_17-2007.pdf)





# MEDICATION PATIENT SAFETY

## Observatory Report

The National Patient Safety Agency has published "Safety in Doses: Medication Safety Incidents in the NHS" which includes nearly 60,000 safety incidents reported by staff up to June 2006.

The medication process consists of a series of stages:

- prescribing (ordering a given medicine and dose);
- dispensing (supplying medicines to individuals or to hospital wards)
- preparation (preparing a dose of medicine for administration);
- administration (administering the dose of medicine by the

appropriate route and method);

- monitoring (checking the administration and effect of a medicine).

The report gives examples of errors at each of these stages, and in both hospital and community settings. Importantly the report suggests how healthcare professionals can take practical measures to improve medication safety.

## Further Information

The report can be found at the NPSA website:  
<http://www.npsa.nhs.uk>



# GAIN CREATED TO FOCUS WORK ON regional guidelines and audit

In recognition for the important work that has been undertaken over the last 20 years for the Regional Multiprofessional Audit Group (RMAG), the Northern Ireland Audit Advisory Committee (NIRAAC) and CREST a dinner was sponsored by the Minister to acknowledge the efforts and commitment given by members past and present in the Long Gallery in Parliament Buildings on 20 September 2007.

A review of regional clinical and social care audit arrangements in Northern Ireland in 2005 found there was a need for a single regional audit focus in place of the two current committees NIRAAC and RMAG. The Department supported the recommendations for a single regional focus through their amalgamation and

asked that further consideration be given to how to integrate the work of CREST in developing local clinical guidelines with the proposed new arrangements.

In August 2007 RMAG, NIRAAC and CREST became the Guidelines and Audit Implementation Network (GAIN) and will keep regional audit and guidelines in the forefront of service improvement.

## Further Information

Further information:  
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or visit CMO's webpage at: <http://www.dhsspsni.gov.uk/index/phealth.htm>