ADDITIONAL ISSUES RAISED IN CORRESPONDENCE OF 2 JULY AND SUBSEQUENTLY AMENDED IN CORRESPONDENCE OF 8 AUGUST – PAPER 2

Responsibility for Quality of Care

(i) From the establishment of the different Trusts in the early to mid-1990's until 2003, who was responsible for the quality of care provided to patients? How was that responsibility fulfilled? (This will build on the evidence given already by, inter alia, Mr McKee, Dr Carson, Mr Mills, the witnesses from the Western Health and Social Services Board and Professor Scally)

The Health and Personal Social Services (Northern Ireland) Order 1991 introduced the concept of a 'Purchaser/Provider split' with Boards assuming the role of Service Commissioners (or Purchasers) and Trusts as Providers of services.

Article 3 (1) of the above Order amended Schedule 1 of the 1972 Order and outlined the new constitution of a Health and Social Services Board.

Article 10 of the same Order gave the Department of Health and Social Services (NI) the power to establish Health and Social Services Trusts, with a remit to provide local acute and community health services. The DHSS (NI) document "HSS Trusts: A Working Guide" (1991) states:-

"A key element of the changes is the introduction of HSS Trusts. They are hospitals and other units which are run by their own Boards of Directors; are independent of Health and Social Services Board Management; and have wide-ranging freedoms not available to units which remain under Health and Social Services Board control, i.e. directly managed units.

Whilst remaining fully within the health and personal social services, Trusts differ in one fundamental respect from directly managed units – they are operationally independent. Trusts have the power to make their own decisions – right or wrong – without being subject to bureaucratic procedures, processes or pressure from higher tiers of management."

In tandem with the development of structural change, the DHSS (NI) policy document "People First" (1990), introduced a division between the commissioning and provision of health and social services. The implementation of the major Community Care Reforms in 1993 established Boards as commissioners of services responsible for:

- Assessing the health and social care needs of their resident population;
- Strategic planning to meet need;
- And the development of purchasing plans.

(See responses of the WHSSB, NHSSB, SHSSB and EHSSB to the Inquiry dated 2005)

Within the legacy Board areas, 19 HSS Trusts were established between the period1993 and 1996. The Trusts were the providers established as a central part of the changes outlined within the 1991 Order and were placed in a direct reporting relationship with DHSS (NI).

The HSS Trusts were responsible for the quality of the services provided to the individual patients by their clinical professionals including doctors and nurses, and were accountable directly to the DHSS (NI).

(v) What have been and are the respective roles and contributions in this area (responsibility for Quality of Care) of: The Health and Social Care Board and; The Public Health Agency.

The respective roles and contributions of the HSCB/PHA in respect of Quality of Care has been covered by response to questions 1 (a) and (b) in Paper 1.

(vi) How are new guidelines/practices which are developed elsewhere in the United Kingdom considered and adapted for use in Northern Ireland? How do they find their way into the training of doctors, nurses and allied health professionals, whether under graduate or post graduate, and into clinical practice?

The HSCB/PHA have responded within Paper 1 questions 4 (a) 'How do new guidelines, practise and recommendations which are developed in Northern Ireland become embedded in practice, and 4 (b) how is adherence to them enforced/confirmed.
In relation to how new guidelines/practices developed elsewhere in the United Kingdom are considered and adapted within NI and how they find their way into the training of doctors, nurses and allied health professionals (AHPs), the following applies:-

The Department

- Departmental dissemination of National guidance.

HSC Trusts

- Post registration for clinical professionals including doctors, nurses and AHPs: HSC Trusts will implement regional guidance for clinical use (including training of staff), and in addition HSC Trusts will have pre-registration staff who will be updated on policies and procedures including new guidelines and practices
- HSC Trust policies and procedures will be reviewed and revised to reflect new guidelines/practices.

Nurses

- The Regional Educational Commissioning Group commission Nursing university courses, short courses, standalone modules and life support skills to fulfil clinical practice needs (these will include relevant national guidance)
- New guidelines will be included into the pre-registration training of nurses.

Doctors

- The recruitment and training of post registration doctors is undertaken by the Northern Ireland Medical and Dental Training Agency (NIMDTA)

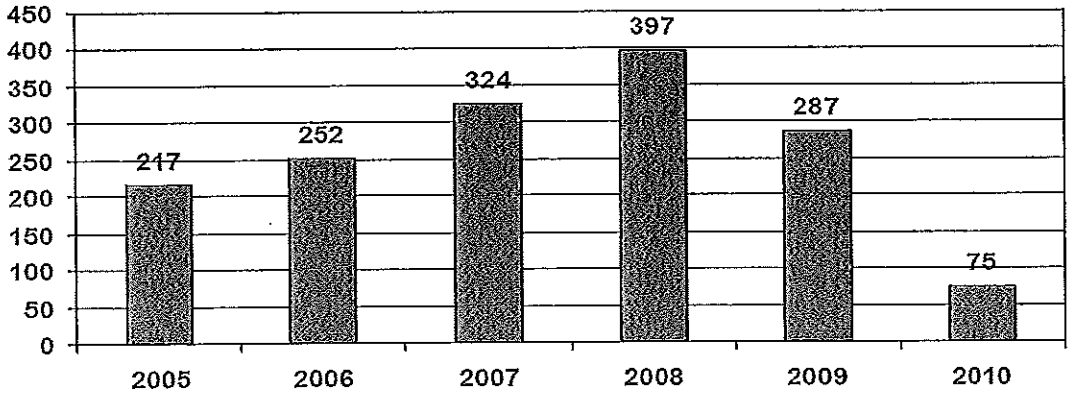
- Doctors undertake a structured training programme in their respective discipline, following a curriculum developed by their college
- NIMDTA oversees training through a series of visits which includes interviews with doctors in training. The quality of patient care is a component of the visit. Concerns regarding patient safety are raised with the Medical Director of the HSC Trust
- In circumstances where the NIMDTA visiting team has identified issues of concern and brought them to the attention of the Medical Director of the HSC Trust, it has been agreed with NIMDTA that commissioners would also be advised of the relevant issues
- Doctors in training have an annual review of competency progression (ARCP) through NIMDTA
- The GMC carries out an annual survey of doctors in training where trainees have the opportunity to raise safety concerns. Concerns raised are reviewed by the relevant HSC Trust.

Actions of Doctors, Nurses and Trusts

(i) Has there been an increase in reports of serious adverse incidents and other adverse clinical incidents within Trusts?

In 2004 DHSSPS Circular HSS (PPM) 06/04 introduced guidance for HPSS organisations and special agencies on the reporting and follow-up of SAI's. The number of SAIs reported annually since 2005 are shown in figures 1 and 2. From this date, reports of SAIs have increased annually (*with exception of the year 2009 and 2010*).

Figure 1: Annual SAI Reporting Rates

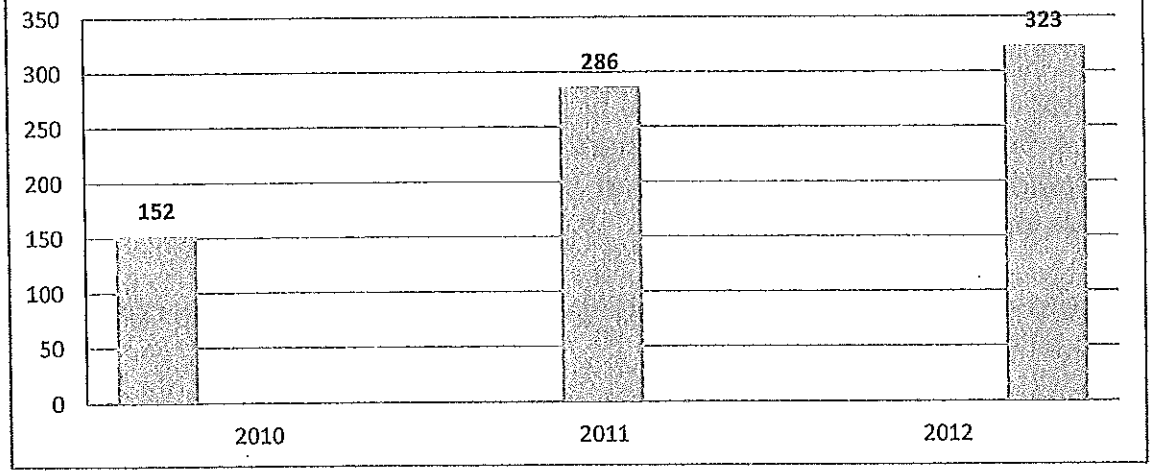


(A factor contributing to the decrease in reported incidents in 2009 is the change introduced by Circular HSC (SQSD) 22/09 in March 2009, which removed from SAI reporting certain categories of incident (suspected suicides and admissions of under-18s to adult mental health wards) from the DHSSPS SAI reporting system).

The requirement on HSC organisations to routinely report SAIs to the Department ceased on 1 May 2010 (figure 1 shows statistics reported to Department up until end April 2010). From this date revised arrangements for the reporting and follow up of SAIs transferred to the HSCB in conjunction with the PHA and RQIA.

Figure 2 shows the annual SAI reporting rates to the HSCB for the period 1 May 2010 to 31 December 2012, and highlights an increase in SAIs reported over the last three years.

Figure 2: HSCB Annual SAI Reporting Rates



(viii) If there is now more reporting of serious adverse incidents, or other adverse clinical incidents, and/or doctors and/or nurses, what has brought about this change? What has been the contribution of, respectively, Departmental and Trust policy to this change and what has been the impact on the culture surrounding the reporting of such incidents?

There are many factors which may have brought about increased reporting of SAIs across the HSC.

The HSCB Procedure for the reporting and follow up of SAIs (2010 revised 2013) encourages the reporting of SAIs to maximise the potential for learning to be shared and reducing the risk of recurrence. The approach adopted is, if in doubt report, and the focus of SAI investigation is on the general principles of "what has happened?" and "how can we improve?", rather than seeking to attribute individual blame, or "who made the error?"

There is a process for de-escalation of an SAI should it become apparent, as investigation of the incident commences, that it no longer meets the criteria of an SAI.

All HSC Trusts are required to ensure that their policies for dealing with adverse incidents are updated to reflect arrangements in line with the HSCB procedure.

(ix) What is the relationship between the management respectively, of litigation, complaints and incident reporting, arising from clinical incidents, and how are lessons learned from each?

See also response to question 3(a) in Paper 1.

The HSCB is responsible only for the management of clinical negligence cases which originated pre 1993 or relate to treatment and care provided by a Trust pre 1993. As such there is no direct relationship between the litigation cases of the nature that the HSCB has responsibility for, and SAIs and complaints.

There are occasions when a SAI is also the subject of a complaints investigation and vice versa.

In such instances, collaboration between the SAI investigation team within the HSC Trust and the Complaints Department at the HSC Trust is essential, to ensure a joined up approach in terms of investigation, involvement of the family in this process, and ensuring that the family is aware what issues are being investigated as part of the SAI process and what issues will remain to be investigated through the Complaints process. The revised SAI Procedure (October 2013) (Appendix IV Paper 1) makes reference to this refinement of process.

Learning identified from SAIs through the SAI procedure and the Regional SAI Group; and Complaints via the monitoring arrangements in place within the Board, and agreed by the Regional Complaints Group, are disseminated by the Board.

It should be acknowledged that there would be a greater opportunity within HSC Trusts to look at the three components.

Additional Issues relevant for PHA to consider - Actions of Doctors, Nurses and Trusts

(ii) How effectively are such incidents (SAIs) now reviewed? To what extent do they now involve families? How are the findings disseminated

Please see answers to questions 2, 3 and 4 in Paper 1, which include details of how SAIs are now reviewed, the involvement of families and how learning is disseminated.

(iii) Are there more reports to the GMC/NMC?

NMC statistics indicate that the number of new cases or referrals received by NMC has increased from 2,986 in 2009/10 to 4,211 in 2010/11 and 4,407 in 2011/12. Of the 4,211 referrals received in 2010/11, 2,215 were sent for investigation.

GMC statistics indicate that the number of referrals have increased from 7,153 in 2010, to 8,781 in 2011 and to 10,347 in 2012.

The trend in UK wide referrals to the GMC has increased over the last 5 years.