SUBMISSION FROM DHSSPS TO THE HYPONATREMIA INQUIRY – 20th SEPTEMBER 2013

Background

1. This submission is prepared for the Hyponatraemia inquiry by the Department of Health, Social Services and Public Safety. The submission is presented in three sections:

Section A: The NHS/HSC;
Section B: Overview of Quality and Safety; and
Section C: A number of additional focused submissions covering policy on:

C.1 Assurance and Accountability of Arms Length Bodies including HSC Trusts;

C.2 Clinical and Social Care Governance, Quality and Patient Safety

C.3 Guidance, Guidelines and Clinical Audit;

C.4 Guidance, Guidelines and Clinical Audit with specific reference to hyponatremia, presented as a timeline with regard to timing of children's deaths;

C.5 Medical Governance;

C.6 Nursing Governance;

C.7 Medicines Governance;

C.8 Information Governance

C.9 HSC complaints;

C.10 Death certification;

C.11 Investigating Hospital Deaths;

C.12 Role of RQIA and how it has evolved; and

C.13 Controls Assurance Standards; Governance and Risk Management.

Section A: The NHS/HSC

Introduction

2. The National Health Service (NHS) is the shared name of three of the four publicly funded health care systems in the United Kingdom. In reality, only the English NHS is officially called the National Health Service. There are separate entities entitled NHS Scotland and NHS Wales. The integrated system in Northern Ireland is unique and is officially called "Health and Social Care" rather than the NHS, reflecting the full integration of personal social services with healthcare, which has applied in Northern Ireland since 1973.

3. The four parts of the UK now have increasing divergence in the structure of the health service, based on inherent differences of scale and important differences of policy. Scotland and Wales have systems based on central planning, with no structural separation of roles between the planners and commissioners of services and the providers. England, having experimented with an internal market in the 1990s, moved under Labour to a more full market model with increasingly autonomous providers (Foundation Trusts) and clearly separate commissioners (originally called "purchasers" in the 1990s model), and a growing independent or private sector.

4. The structures in Northern Ireland as established in the legislation passed by the Assembly in 2009 retain commissioning like England, but also place specific emphasis on public health (a similar policy emphasis to Scotland and Wales in 2008 and to England as of now).

Integrated Health and Social Care Services in Northern Ireland

5. Health and social care services in Northern Ireland were integrated in 1973. Since then there have been numerous restructuring exercises, following broad patterns

established across the UK. The Review of Public Administration and the most recent legislation, the Health and Social Care Reform Act 2009, reinforces in statute the Department's responsibility to promote an integrated system of health and social care in Northern Ireland. The legislation re-enacted the Departments "General Duty" "...to provide, or secure the provision of, health and social care..." – the central point being that the statutory responsibility for the provision of services is placed on the Department, which in turn secures the provision of services through bodies with distinct delegated responsibilities – though the Department retains ultimate responsibility and accountability for all aspects of the service.

6. At the heart of the current system, a single Health and Social Care Board, working in conjunction with a Public Health Agency, commissions services to meet assessed need and promote general health and wellbeing. A full range of health and social care services are provided by five Health and Social Care Trusts, with a sixth Trust providing ambulance services for the region.

7. These structures are unique to Northern Ireland because, in England, Scotland and Wales, social services remain the responsibility of Local Authorities, although developments elsewhere in the UK over recent years are signalling a gradual but significant transition towards integrated health and social care services. This is particularly noticeable in the response to a growing elderly population.

8. Integration provides the opportunity for comprehensive assessment of both health and social care needs, and allows the Department and commissioners to plan services on the basis of programmes of care. Local Commissioning Groups, which are committees of the Health and Social Care Board, are able to establish local priorities and commission services to meet the spectrum of care needs within their areas. A single budget has also promoted the coherent development of objectives within a unified strategic planning process, which spans acute and community based care.

9. In more practical terms, integration is seen as facilitating strategic change such as the shift away from institutional to community based care. There are also benefits in terms of opportunities for multi-disciplinary working. Unlike other parts of the UK,

integrated packages of domiciliary care have always been provided free of charge in Northern Ireland. This is seen as an important contributor to supporting the maximum number of people to continue living in dignity and safety in their own homes.

Department of Health, Social Services & Public Safety

10. Section 2 of the Reform Act places on the Department a general duty to promote an integrated system of:

i health care designed to secure improvement:

1. in the physical and mental health of people in Northern Ireland, and
2. in the prevention, diagnosis and treatment of illness; and

ii social care designed to secure improvement in the social well-being of people in Northern Ireland.

11. In terms of service commissioning and provision, the Department discharges this duty primarily by devolving the exercise of its statutory functions to the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and to a number of other health and social care bodies created to exercise specific functions on its behalf. All these health and social care bodies are accountable to the Department, which in turn is accountable, through the Minister, to the Assembly for the manner in which this duty is performed.

12. In addition, the Department retains the normal authority and responsibilities of a parent department as regards direction and control of its arm's length bodies. The main principles, procedures etc are set out in the Department of Finance and Personnel (DFP) guidance *Managing Public Money Northern Ireland*[1] and are reflected in each body's management statement/financial memorandum, in the letter appointing its chief executive as accounting officer for the body, and in the letters appointing its chair and other non-executive board members.

[1] *Managing Public Money NI* replaced *Government Accounting NI*, which contained the same principles and definitions of accountability. The detailed content of the appointment letters for Accounting Officers have also been largely consistent throughout the period covered by the Inquiry.

Remit of the Departmental Board

13. Under the Minister, the Permanent Secretary, as Accounting Officer, is accountable to the Assembly for management and organisation of the Department, including use of public money and stewardship of its assets. The responsibilities of an Accounting Officer are set out in the DFP publication "Managing Public Money Northern Ireland" (June 2008).

14. The Permanent Secretary, as Accounting Officer, is supported in discharging his roles and responsibilities by the Departmental Board. The Departmental Board operates in line with best practice from HM Treasury on corporate governance. The Chief Medical officer, Chief Social Services Officer and Chief Nursing Officer are all Executive members of the Departmental Board.

15. The responsibilities of the Departmental Board are also set out in the Terms of Reference for the Departmental Board (June 2011) and include establishing policies, legislation, standards, priorities and targets aimed at ensuring high quality, value for money services for users and taxpayers alike through:

- Establishment of strategic priorities;
- Policy maintenance and support for Minister/Assembly;
- Securing resources and contributing to joined up government;
- Policy/legislation/standards - development and review;
- Professional leadership;
- Governance of ALBs – managing performance to ensure that policies and outcomes are delivered, ensuring good vfm; and
- Corporate capacity to fulfil statutory and other departmental responsibility.

16. The Board supports the Minister and Accounting Officer in directing the business of the Department as effectively as possible to achieve objectives and priorities. Within the overall policies and priorities established by the Minister, and subject to his approval, the remit of the Board is to:

- Set the Department's standards and values;

- Agree the Department's strategic aims and objectives as set out in the Corporate Business Plan;

- Oversee sound financial management and corporate governance of the Department in the context of the Corporate Business Plan;

- Oversee the allocation and monitoring of the Department's financial and human resources to achieve aims and objectives set out in the Corporate Business Plan;

- Monitor and steer the Department towards the achievement of agreed performance objectives as set out in the Corporate Business Plan;

- Scrutinise the governance and performance of ALB's; and

- Set the Department's 'risk appetite' and ensure appropriate risk management procedures are in place.

Matters Reserved for the Departmental Board

17. The range of matters reserved for consideration by the Departmental Board includes:
    - Approval, monitoring and amendment of the Corporate Business Plan and risk register;
    - Corporate governance, accountability and risk management;
    - Governance of ALBs;
    - Performance monitoring – Department and its ALBs;
    - Approval of Departmental legislative programme;
    - Approval of annual resource allocations (priorities and budget reviews);
    - Resource monitoring and financial control;
    - Resource accounts and annual report;
    - Corporate human resource monitoring;
    - Corporate communications; and
    - Establishment, dissolution and oversight of committees.

18. The Departmental Board is chaired by the Permanent Secretary. The role of the chair is to:

- Provide leadership to the Board;
- Facilitate Board meetings;
- Enable all members to make a full contribution to the Board's affairs;
- Ensure that systems are in place to provide the Board with accurate and timely, quality information to allow the board to properly consider all matters brought before it; and
- Ensure that a review of Board effectiveness is carried out in line with Treasury guidance.

Executive Board Members

19. The role of Executive Board members is to:

- Challenge and support other board members in a corporate way and not merely represent their own functions;
- Ensure appropriate information is being provided to the Board;

Chief Medical Officer

20. The Chief Medical Officer has a range of responsibilities which include providing advice to the Minister and the Department on public health policy development and legislation. This includes health improvement, health inequalities and underpinning strategies, health protection and emergency planning.

21. He provides professional and policy advice to the Minister and the Department on medical professional and practice issues as they relate to

- health-care provision (across primary/secondary/ mental health) and its commissioning;
- the quality of care;
- estate management; and
- the medical workforce (in terms of its development and regulation).

22. He also provides advice to other Departments in relation to matters which impact on the health and wellbeing or protection of the health of the population.

23. His area of policy responsibility covers cross-cutting quality issues in relation to safety and standards /effectiveness in the HSC. This includes responsibility for setting the Quality strategy and monitoring its implementation; sponsorship of the Regulation and Quality Improvement Authority (RQIA) and the Public Health Agency (PHA); Reform of Death Certification; Clinical Negligence and Redress; the HSC Complaints Procedures and developing, monitoring and reviewing Personal and Public Involvement policy both externally within HSC organisations and internally within the Department.

- In terms of safety his group's policy responsibilities include Departmental policy on Early Alerts, Serious Adverse Incidents (SAIs), Corporate Manslaughter and the Memorandum of Understanding for Investigating Patient and Clients Safety Incidents.
- In terms of standards /effectiveness his group is responsible for the development and review of all minimum care standards for regulated services and the associated regulations, the HSC Quality Standards, and policy for Service Frameworks. Also policy on the implementation of National best practice guidance and through sponsorship of the Guidelines and Audit Implementation Network (GAIN) facilitating development of local guidance and regional clinical audit.

24. The CMO is also the Departmental policy lead for Research & Development.

Chief Nursing Officer

25. The Chief Nursing Officer (as the head of the Nursing and Midwifery Professions), is responsible for the strategic direction, performance and development of these Professions in Northern Ireland, and provides professional leadership for nurses and midwives across all sectors in Northern Ireland.

26. The CNO is responsible for providing expert professional to the Minister and Permanent Secretary/HSC Chief Executive on policy, which impacts on nursing,

midwifery and public health nursing, education, research and practice and is the departmental policy lead for patient experience

27. The CNO's team of professionals including nursing and lead AHP s provide advice on acute and children's services, mental health, elderly care, learning and physical disabilities, public health, community nursing, primary care, midwifery, and international issues in nursing. They also advise on the regulations of professions, education policy, workforce planning and development.

28. The roles and responsibilities of the Department and its Arms Length Bodies as well as the relationship between the Department and its Arms Length Bodies are set out more fully in the framework Document published in September 2011. However, the inquiry may wish to note the roles of key bodies as set out below.

Health & Social Care Board

29. The HSCB, which is established as the Regional Health & Social Care Board, under Section 7(1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, has a range of functions that can be summarised under three broad headings.

30. Commissioning – this is the process of securing the provision of health and social care and other related interventions that is organised around a "commissioning cycle" from assessment of need, strategic planning, priority setting and resource acquisition, to addressing need by agreeing with providers the delivery of appropriate services, monitoring delivery to ensure that it meets established safety and quality standards, and evaluating the impact and feeding back into a new baseline position in terms of how needs have changed.

31. Performance management and service improvement – this is a process of securing continuous improvement in the interests of patients and clients by monitoring health and social care performance against relevant objectives, targets and standards, promptly and effectively addressing poor performance through appropriate interventions, service development and, where necessary, the application of sanctions and identifying and promulgating best practice. Working with the PHA, the HSCB has an important role to play in providing professional leadership to the HSC.

32. Resource management – this is a process of ensuring the best possible use of the resources of the health and social care system, both in terms of quality accessible services for users and value for money for the taxpayer.

33. Primary care in general and family practitioner services (FPS) in particular are central to the health and social care system. Family practitioners and those who work with them in extended primary care teams act as the first point of contact and as a gateway to a wider variety of services across the HSC. The HSCB has a key role to play in managing contracts with family practitioners, not only in terms of pay and performance monitoring but also in terms of quality improvement, adherence to standards and delivery of departmental policy. The HSCB is accountable to the Department for the proper management of FPS budgets.

Public Health Agency

34. The primary functions of the PHA, which is established as the Regional Agency for Public Health & Social Well-being under Section 12(1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, can be summarised under three broad headings.

35. Improvement in health and social well-being – with the aim of influencing wider service commissioning, securing the provision of specific programmes and supporting research and development initiatives designed to secure the improvement of the health and social well-being of, and reduce health inequalities between, people in Northern Ireland.

36. Health protection – with the aim of protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies.

37. Service development – working with the HSCB with the aim of providing professional input to the commissioning of health and social care services that meet established safety and quality standards and support innovation. Working with the HSCB, the PHA has an important role to play in providing professional leadership to the HSC.

Health and Social Care Trusts

38. HSC Trusts, which are established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991, are the main providers of health and social care services to the public, as commissioned by the HSCB.

39. The six HSC Trusts are established to provide goods and services for the purposes of health and social care and, with the exception of the Ambulance Trust, are also responsible for exercising on behalf of the HSCB certain statutory functions which are delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each HSC Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them (Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003).

40. Section 21 of the Reform Act places a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

Patient and Client Council

41. The Patient and Client Council (PCC), which is established under Section 16 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, is a regional body supported by five local offices operating within the same geographical areas covered by the five HSC Trusts and LCGs. The PCC replaced four separate Health and Social Care Councils (Eastern, Northern, Southern and Western) – one in each Health and Social Care Board Area. The main objective of the PCC is to act as a health and social care consumer organisation. It is responsible for ensuring a strong patient and client voice at both regional and local level, and for strengthening public involvement in decisions about health and social care services. By having locally elected representatives in the body, it also supports democratisation and facilitates local government involvement.

Regulation and Quality Improvement Authority (RQIA)

42. The RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. Although accountable to the Department, it is an independent health and social care regulatory body one of whose main functions is to keep the Department informed about the provision, availability and quality of health and social care services. The Reform Act transferred the responsibilities of the former Mental Health Commission to the RQIA with effect from 1 April 2009. The RQIA now has a specific responsibility for keeping under review the care and treatment of patients and clients with a mental disorder or learning disability.

43. The RQIA's other main function is to promote improvement in the quality of health and social care services. It does this by, for example, disseminating examples of good practice and giving advice to service providers on how to meet minimum standards, the requirements of clinical and social care governance guidelines and the requirements arising from any other standards, guidance or guidelines which the Department may endorse as applying to health and social care bodies and regulated services.

44. The RQIA is responsible for registering and inspecting a wide range of health and social care services. Inspections are based on a new set of minimum care standards which ensures that both the public and the service providers know what quality of services is expected. The RQIA inspectors visit nursing and residential care homes and children's homes to examine all aspects of the care provided, to gain assurance about the comfort and dignity of those using the facilities, and ensure legitimate public confidence in these services. It is also currently responsible for the regulation of independent hospitals and clinics and nursing agencies.

Northern Ireland Medical and Dental Training Agency (NIMDTA)

45. NIMDTA was established to ensure that doctors and dentists are effectively trained to provide the highest standards of patient care and, as a special Agency, is accountable to the Department. NIMDTA is responsible for funding, managing and supporting postgraduate medical and dental education. It provides a wide range of functions in the organisation, development and quality assurance of postgraduate

medical and dental education and in the delivery and quality assurance of continuing professional development for general, medical and dental practitioners. NIMDTA is also accountable to the General Medical Council (GMC) for ensuring that the standards set by the GMC for medical training, educational structures and processes are achieved. The Postgraduate Medical Dean, as the 'Responsible Officer' for doctors in training, has a statutory role in making recommendations to the GMC to support the revalidation of trainees.

The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC)

46. The NIPEC was established under the Health and Personal Social Services Act (Northern Ireland) 2002 as a non-departmental public body to support the development of nurses and midwives by promoting high standards of practice, education and professional development. The NIPEC also provides advice and guidance on best practice and matters relating to nursing and midwifery.

The Northern Ireland Social Care Council (NISCC)

47. The NISCC was established under the Health and Personal Social Services Act (Northern Ireland) 2001 as a non-departmental public body to protect the public, specifically those who use social care services, and to promote confidence and competence in the social care workforce. It achieves this aim by registering and regulating the social care workforce, setting and monitoring the standards for professional social work training and promoting training within the broader social care workforce.

Section B: Overview of Quality and Safety

Introduction

48. It will be evident to the Inquiry that health and social care is a complex area involving a number of bodies delivering a multitude of different services to the NI population as a whole and to subsets of the NI population through a range of different providers at different locations, including in the community.

49. It would be unwise of the Department to suggest that tragic deaths such as those

which are the subject of the Inquiry could never happen again. Indeed, it would not only be unwise and impossible to give such a definitive and absolute assurance but the complacency of such an assertion would reflect an incomplete understanding of the complexity and challenges **inherent** in providing modern health care. **Ideally, our aim is to prevent such incidents occurring in the first place and where this is not possible it must be to ensure that similar episodes do not occur again.** There is however, no acceptable level of harm to patients in a service that's fundamental objective is to provide treatment and care. Equally To fail to learn and effect change to seek to prevent harm occurring again is equally unacceptable; patient safety is paramount and requires **constant** vigilance. The health service can however always do better and, it must constantly strive to improve the systems and processes to protect patients. The Department believes that the steps which have been taken particularly over the past number of years significantly reduces the risk of harm to patients and where such incidents do occur that there are mechanisms to both identify, investigate and disseminate learning in order to seek to prevent similar episodes

"To Err Is Human"

50. The Inquiry should note that throughout the history of the NHS/HSC in Northern Ireland, the quality and safety of services has been a key component of the oversight and governance of the system. However, there is no doubt that the publication in 1999 in the United States of "**To err is human: Building a safer health system**" was a seminal moment in the Department's understanding of how organisations, systems and individuals must work in concert to promote safety within health and social care services. This report is as relevant today as it was in 1999 and had a significant impact in the United States and wider afield including in all parts of the UK. This document established that health care in the US was not as safe as it could be. It suggested that at least 44,000 people and perhaps as many as 98,000 people died each year in US hospitals as a result of medical errors that could have been prevented.

51. The report concluded that it was not acceptable to be harmed by the health system.

It concluded that the know-how already existed to prevent many of the mistakes. Furthermore, one of the report's main conclusions was that the majority of medical errors do not result from individual recklessness or the actions of a particular group – this is not a 'bad apple' issue. More commonly it concluded, errors are caused by faulty systems, processes and conditions that lead people to make mistakes or, more importantly, to fail to avoid them. Mistakes could be prevented by health systems at all levels to make them safer, to make it harder for people to do something wrong and make it easier for them to get it right. Whilst, it was not a new concept that healthcare professionals across the world were trying constantly to improve, 'To Err Is Human' gave voice in a coherent fashion to what needed to be improved.

52. The substantial body of work, arrangements, systems and improvements which we have in place today as the result of work undertaken by Government, Health and Social Care bodies and Professional bodies across the UK largely date from the publication of this report and through the learning arising from high profile failings in which these arrangements and systems have proven ineffective in protecting patient from harm.

53. Given the frequency and speed with which evidence on best practice, treatments and technology can evolve and change, the process of delivering safe, effective, patient and client focused health and social care is not simply a matter of maintaining the status quo. This is reflected in the following quotations :

"Advances in knowledge and technology have in recent decades immeasurably increased the power of health care to do good, to prevent or treat illnesses against which there was previously no defence. Yet they have also immeasurably increased the complexity of health care systems. Their unique combination of processes, technologies and human interactions means that modern health care systems are among the most complex in the world. With that complexity comes an inevitable risk that at times things will go wrong. And in health care when things go wrong the stakes are higher than in almost any other sphere of human activity." **(DoH London, "An organisation with a memory" (2000))**; and

"There was a Victorian aphorism that a good doctor was better than a bad doctor and almost as good as no doctor at all. That such a statement is no longer true is because of the advances in biomedical science. ***Medicine used to be simple, ineffective, and relatively safe. Now it is complex, effective, and potentially dangerous.****" (Prof Sir Cyril Chantler, 1999)*

54. Legislation, professional practice, treatments and drugs, guidance, guidelines, standards, research, lessons learned, Inquiry reports, Reviews and reports are all key drivers contributing to the increasing level of complexity. The origins in each case can be:

- International
- UK
- NI
- Department
- HSC Board/Representative Groups/Regulators/Training bodies/Professional Associations
- Trust
- Units/Communities
- Staff/Patients/Clients

55. The nature of the services provided by HSC and the vulnerabilities of the populations who receive its services mean that HSC bodies as organisations and individual practitioners within HSC bodies manage a variety of risks on an ongoing basis to the individuals and the populations we provide services to. Whilst there is no authoritative measure of the scale of avoidable harm, it is recognised internationally that health care is not as safe as it should or could be and unintended harm and unnecessary deaths are too frequent. The health service in NI is no exception in this regard. Given the multiplicity of factors, most unintended harm and unnecessary deaths are due to a combination of circumstances within a system rather than the failings of an individual. It is vital that learning is achieved when 'things go wrong' so as to minimise, if not eradicate, the risk of recurrence (Hansard, May 2012 p265 refers)

56. The expectations of people who are touched by the health and social care system has evolved over time and the behaviour/culture of health professionals and organisations has also needed to adapt continuously in response to those expectations. Departmental policy has sought to keep pace with and where possible keep ahead of these many changes in order to support the HSC in delivering high quality, safe and effective services.

57. In practice, there are a multiplicity of groups, documents and processes of interaction by which the healthcare system learns and improves. It would be difficult to provide a full taxonomy of those various means and even more difficult to adequately map out the links between the constituent parts of the system. However, what is clear is that a significant proportion of the time and energy of all HSC bodies and of individual health and social care professionals is devoted towards diligently working to improve the quality and safety of health and social care. This submission will seek to describe some of the processes broadly and, in some cases, by way of example. It will not seek to describe everything that is or was in place before the Inquiry rather it will seek to describe how things have evolved and continue to improve.

Clinical and Social Care Governance

58. Responsibility for the safety and quality of the services provided by the HSC in Northern Ireland was always inherent in the roles and responsibilities of front-line clinical staff from the inception of the NHS onwards. There was a long evolution which led to the development of the systems for governance, oversight and accountability for quality and safety including the development of general management through the Griffiths Report of 1983, which changed decision making from the traditional "consensus management" that had applied up to that time, to a system which gave explicit management responsibility to an administrative cadre.

59. The introduction of the internal market in the 1990s led to more explicit definition of these inherent responsibilities. METL 2/93, which has already been provided to the Inquiry, set the scene for governance and the clinical governance of the health and social care system. It places explicit responsibility on Trusts corporately for "..the quantity, quality and efficiency of the service they provide.." In the internal market,

this was to be specified and monitored through contracting – the central point being that quality would be a relevant criterion to be applied by purchasers in exercising their power of choice (if one provider's quality of service was poor, the purchasers could take their business elsewhere). Hence METL 2/93 makes providers accountable to purchasers for that aspect of governance.

60. The system created in the 1990s of Trusts as providers and separate purchasers/ commissioners has continued to evolve since that time. Much of the focus in terms of Clinical Governance in Northern Ireland in the late 1990s concentrated on dealing with poor clinical performance by doctors and resulted in papers such as *Supporting Doctors, Protecting Patients* and *Confidence in the Future*.

Best Practice - Best Care

61. A consultation on *Best Practice – Best Care* began in April 2001 and led to the publication of the framework in May 2002 for:

- Setting standards (including links with NICE and SCIE);
- Improving clinical governance;
- Improving regulation of the workforce;
- Introducing a Duty of Quality; and
- Establishing what became the Regulation and Quality Improvement Authority (RQIA).

62. The specific proposals set out in Best Practice Best Care are substantially reflected in the developments which have taken place since then and consequently in the content of this submission to the Inquiry.

Statutory Duty of Quality

63. Based on one of the key proposals in this framework, Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 created a statutory obligation on HSC Boards and HSC Trusts to "put and keep in place arrangements for the purpose of monitoring and improving the quality of health and personal services which it provided to individuals; and the

environment in which it provides them" i.e. a system of clinical and social care governance.

64. Clinical and social care governance is described as a framework within which HPSS organisations can demonstrate their accountability for continuous improvement in the quality of services and for safeguarding high standards of care and treatment. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.

65. In 2006/07, to establish the effectiveness of clinical health and social care governance, RQIA undertook a review of quality standards, examining in detail the themes of corporate leadership and accountability, and safe and effective care. In addition, recommendations from earlier, topic-specific reviews were followed up.

66. In total, RQIA conducted 25 Clinical and Social Care Governance reviews which were summarised in an RQIA overview report. This was largely positive and recognised that the reviews had been undertaken at a time when health & social organisations were undergoing significant change. Overall, the report indicated that the organisations were taking forward, and engaged with, the clinical social care governance agenda. The issues reported upon included:

- Controls assurance standards;
- Risk managements;
- Service user and public involvement;
- Training, staff appraisal and supervision;
- Safe and effective discharge of older people from the acute to the community setting ;
- Safe and effective post-operative care for patients in the acute hospital setting; and
- Safe and effective care relating to looked after children and young people in residential care settings.

67. Whilst these first reports constituted a significant examination of the clinical and health and social care arrangement, RQIA went on to carry out a second programme of governance reviews in 2008 with visits to the then recently established five Health & Social Care Trusts and the NI Ambulance Service Trust. It examined the following themes:

- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well being; and
- Effective communication and information.

68. The overview report based on the 2008 reviews noted a number of examples of good practice. It also made a number of recommendations including:

- The use of single sex accommodation;
- The prevention of shared accommodation between children and adults;
- The provision of dedicated advocacy services;
- The development of a single consent policy;
- Full implementation of the Departmental guidance on Promoting Personal Involvement; and
- The need for policies and procedures in relation to emergency planning.

Quality Standards

69. Published in March 2006, The *Quality Standards for Health and Social Care*, underpin the duty of quality on the HSC Board and HSC Trusts. They complement standards and other guidelines already in use by organisations and give a measure against which organisations can assess themselves and demonstrate improvement.

70. The five quality themes on which the standards have been developed were identified through consultation with service users, carers and HPSS staff and through a review of standards developed elsewhere at local, national and international level. The five quality themes are:

1. Corporate Leadership and Accountability of Organisations;

2. Safe and Effective Care;
3. Accessible, Flexible and Responsive Services;
4. Promoting, Protecting and Improving Health and Social Well- being; and
5. Effective Communication and Information.

Serious Adverse Incidents (SAIs)

No health and social care system is risk or error free and the vast majority of HSC patients and clients access services without incident. In health and social care "*any event or circumstance that could have, or did, lead to harm, loss or damage to people, property, environment or reputation*" is defined as an adverse incident. Where an incident is prevented or avoided, resulting in no harm, this is called a '*near miss'*. Approximately **83,000 adverse incidents** (AIs) are reported each year by HSC organisations in Northern Ireland. SAIs are a subset of AIs. Over the period from May 2010 to March 2012, a total of **528 serious adverse incidents** were reported to the HSC Board.

71. It is important that we create a culture were "near misses" are reported to possibly prevent a SAI from occurring in the first place and when SAIs occur that these *are reviewed to identify learning for dissemination. To this end it is important that an increase in "near miss" or SAI report*ing in a particular organisation or system is not taken to infer a less safe environment for patients, rather such repor*ting is an* indication of a **culture wherein organisa**tions and professionals are committed to realising opportunities to prevent harm and to identify shortcomings in care to ensure lessons are learned when SAIs occur.

RQIA – Independent scrutiny

72. Independent scrutiny of the system is an important aspect. The Health and Personal Social Services (Regulation, Quality and Improvement) RQIA conducts almost 3,000 inspections per year in accordance with its statutory obligations. These are a combination of announced and unannounced inspections by qualified and experienced personnel. Sanctions and enforcement action are applied to protect safety. The number of registered establishments has increased year on year since 2005/06 from under 700 to over 1,400 in 2012/13.

73. In addition the RQIA also carries out an annual Review Programme made up of:

- A regular programme of announced and unannounced inspections of hygiene and cleanliness;
- Reviews identified by RQIA; and
- Reviews commissioned by the Department.

74. The Minister may also ask RQIA to carry out an immediate review in relation to emerging concerns. An example of such a review was the independent review into the major outbreak of *Clostridium difficile* infection in the Northern Health and Social Care Trust in 2008. These are all means by which quality and safety may be regulated and improved. Furthermore, the independent nature of RQIA helps place it to ensure public confidence.

75. The recent media coverage in respect of the Care Quality Commission (CQC) in England indicates the importance of the effectiveness of the regulator. It is important to appreciate that the English legislation governing CQC is somewhat different to that which underpins the operation of RQIA. However, the effectiveness of either regulator is vital. To that end, RQIA's governance arrangements are closely monitored by the Department as part of its arrangements for the governance of arm's length bodies.

76. As part of the Management Statement between RQIA and the Department, a capacity and capability review is planned in 2013/14. The review will take a fundamental look at RQIA as it is now, how it has evolved since its inception, what it needs to do in the future and whether it is structured/resourced effectively for current and future purpose.

Governance of Arms Length Bodies (ALBs)

77. Governance of ALBs (which includes, by definition, Health and Social Care Trusts) remains a difficult and onerous task. There are many examples highlighted in the media of failures in governance.

78. Under the Review of Public Administration, the reduction in the number of Trusts from 19 to six created the opportunity for more effective mid-year and end year accountability meetings. Accountability is not confined to those formal meetings. Each ALB has a formal engagement with a sponsor within the Department and Policy and Professional leads across the Department engage regularly with ALBs individually or in groups to discuss issues relating to ongoing policy and professional matters. This provides a conduit for formal governance and escalation in both directions.

79. To further reinforce accountability, this year the Minister introduced an opportunity for public facing accountability review meetings. Although it is not proposed that such meetings will take place every year for every ALB, a targeted programme is already underway.

Other Initiatives

80. There were many initiatives launched aimed at strengthening clinical and social care governance and many of which are substantially reflected in the papers provided under Section C of this submission. Examples include:

- NI Adverse Incident Centre (1992)
- Whistle Blowing (2000)
- Best Practice Best Care (2001/2)
- Medicines Governance Team (2002)
- Safety in Health and Social Care Group (2003)
- HPSS (Quality, Improvement & Regulation) (NI) Order (2003)
- Clinical & Social Care Governance Support Team (2004)
- Serious Adverse Incident Reporting System (2004)
- Service Level Agreement with the National Clinical Assessment Service (NCAS) (2004)
- The Regulation & Quality Improvement Authority (RQIA) (2005)
- Safety, Quality & Standards Directorate (2006)
- Memorandum of Understanding (MOU) between DHSSPS (on behalf of the HSC) and the PSNI, HSENI & Coroners Office on Investigation of Unexpected Death or Serious Harm (2006)

- National Institute for Health and Care Excellence (NICE)(2006)
- Assurance Framework (2006)
- Quality Standards for Health and Social Care (Supporting Good Governance and Best Practice in the HSC) (2006)
- HSC Safety Forum (2007)
- Personal and Public Involvement (2007)
- Service Framework Programme (2007)
- Guideline and Audit Implementation Network (GAIN) (2007)
- Care Standards (2008)
- Review of Public Administration (2009)/The HSC (Reform) Act (NI) 2009
- Complaints in HSC: Standards & Guidelines for Resolution and Learning (2009)
- Early Alert System (2010)
- Physiological Early Warning Systems (PEWS) and the Management of the Deteriorating Patient. (2010)
- Quality 2020 - A 10 Year Strategy to Protect and Improve Quality in health and Social Care in Northern Ireland (November 2011)

Governance of Doctors

81. As described previously, governance of ALBs and clinical governance are important. However, governance is not simply confined to these domains. By way of example, there are also other systems in place to support good medical care. Submission paper C.5 describes the governance system for doctors. This is made up of:

- Undergraduate Training;
- Post graduate medical training;
- Appraisal for doctors;
- Induction processes;
- GMC requirements for professional practice and revalidation; and
- Identifying and responding to poor practice.

Clearly, the General Medical Council is the regulator for doctors and it has an ongoing programme of issuing guidance on the professional practice of doctors. It

also has the authority to limit a doctor's practice, suspend or remove a doctor from the register.

82. Doctors are amongst the most trusted of all professionals. However, the age of 'doctor know best' has passed and there is a less deferential culture in which patients are more questioning and where knowledge of what medicine can do increases expectations. Put plainly, there need to be systems in place to ensure that the trust in doctors continues to be justified.

83. In recognition of the need to maintain that trust and explicitly demonstrate to the public the continued fitness to practice of their registrants, The GMC has led, together with the four UK Health Departments, the development of medical revalidation. In its development, medical revalidation has sought to be embedded in and complementary to the wider quality assurance mechanisms within the health and social care system. The Bristol Royal Infirmary Inquiry was the primary stimulus for revalidation since it identified many issues relating to medical practice which resulted in harm to patients. The publication of Trust Assurance and Safety led to the establishment of the Confidence in Care Programme in NI in 2008 and that programme has led to the implementation of medical revalidation in Northern Ireland in 2012.

84. It is expected that all doctors will have revalidated for the first time by 2015 and it is expected to deliver the following benefits:

- A consistent approach to the regular evaluation of doctors' fitness to practise;
- A clearly defined framework for appraisal and a statutory requirement for all doctors to participate in appraisal annually ;
- A statutory requirement to respond to concerns about a doctor's fitness to practise; and
- Promoting patient and service user involvement through the requirement to provide patient feedback at appraisal.

85. The General Medical Council has always sought to provide assurance through the register of medical practitioners. The register is a historical record of examinations passed and qualifications earned. As such, it previously offered limited public assurance about how each doctor is maintaining the high standards expected of them throughout their careers and their continued fitness to practice. Revalidation is one element in the medical register evolving from a record of qualification to one of on-going fitness to practise

86. Revalidation aims to fill that gap. It will provide visible assurance of, and a focus for, every doctor to maintain and improve their practice. It will also provide a driver for the organisations in which they work to support them in fulfilling this professional obligation. In this way it should contribute to improvements in the quality of patient care.

87. Revalidation reaffirms what should already have been happening in every doctor's practice. More importantly, it should go beyond a simple assessment of a doctor's knowledge and skills at a point in time but will be based on a continuing evaluation of their practice in the context of their everyday working environment.

Complaints, Adverse incidence and Clinical negligence claims

88. The relationship between complaints, adverse incidence and clinical negligence claims is not straightforward. The occurrence of an adverse incident may lead to a complaint but the vast majority do not. Complaints and clinical and social care negligence claims may arise where no adverse incident has occurred. This is because complaints and clinical and social care negligence claims are perceptions of treatment from the perspective of claimants and may subsequently or may not be upheld. Even when an adverse incident has occurred it may not have come about as a result of negligence. Adverse outcomes which are consistent with '*normal*' risk of a procedure, intervention or treatment must be borne by the patient following an informed consent process which clearly articulates the risk and benefits to a particular patient.

Adverse incidents – approximately 83,000 reported annually

Complaints – approximately 6,000 complaints made every year

Negligence claims – approximately 600 claims made each year

Complaints

89. Notwithstanding the importance of: clinical and social care governance; governance of arms length bodies; independent regulation; Promoting Personal Involvement; research; evidence based practice; and, good policy making, the health and social care system cannot underestimate the valuable information which is received from both complaints and people who express their gratitude for positive experiences. Patients or clients dissatisfied with the quality of treatment or care received, may submit a complaint. Effective complaints handling is an important aspect of clinical and social care governance. Complaints are also seen as a significant source of learning and provide opportunities to improve outcomes for patients and clients, the quality of services and the patient and client experience. The top three subject areas for complaints against Trusts:
    - the quality of treatment and care;
    - staff attitude or behaviour; and
    - communication/ information to patients.

90. Complaints are a significant source of learning within health and social care and provide opportunities to improve:

    - Outcomes for services users;
    - The quality of services; and
    - Service user experiences.

91. Departmental policy on HSC complaints has been the subject of regular and consistent periods of review, policy implementation, further evaluation and review in the context of emerging best practice. The process of complaints handling has continued to be refined and the Regional Complaints Liaison Group provides a valuable forum for review. A revised complaints procedures was introduced in April 2009. Since then the HSC Board has published two annual reports on complaints

handling by HSC bodies. The HSC Complaints is currently undergoing a three stage evaluation process including:

- o A Project Evaluation – carried out by SQSD in consultation with HSC colleagues. Completed Nov 2010; (DH1/10/123391 refers)
- o A Process Evaluation – an evaluation of the implementation of the new Complaints Procedure arrangements carried out by the HSC Board, in consultation with HSC colleagues. Completed Feb 2012; and
- o An Outcomes Evaluation – an evaluation of the effectiveness of the new arrangements with a target completion date of March 2014 which SQSD leads. To include:
    - ▪ a commissioned review by RQIA of HSC governance arrangements (including complaints handling) during 2013/14; and
    - ▪ an assessment of the impact of the HSC complaints procedure on improving quality.

92. The HSCB published its Report on the Process Evaluation of the Complaints in HSC: Standards and Guidelines for Resolution and Learning (Nov 2011) and this led to a series of 14 recommendations which are now being moved forward. The evaluation recognised that communication, staff attitude and behaviour are among the highest categories of complaints received. The HSC Board found that:
    - o effort is still required to efficiently achieve more robust local resolution arrangements (links with recommendations 1 and 2); and
    - o there is evidence that organisations do learn from complaints, but there is a need to ensure that staff and service users are advised of this learning or changes that have been made to procedure or policy .

93. The Health & Social Care Board has carried out a series of complaints workshops with service users across NI with the aim of securing the best possible improvements.

94. The DHSSPS has commissioned RQIA to review HSC governance arrangements (to include complaints handling) and to review adverse incident management, reporting

& learning (taking account of arrangements for handling complaints) during 2013/14 and 2014/15 respectively.

Litigation

95. In order to successfully bring a case against the HSC sector, a claimant must prove that the practitioner or organisation failed to adhere to accepted standards of care and treatment. The cost of defending and settling clinical and social care negligence claims is substantial. Other UK countries have reported increased claims in recent years caused by a combination of reductions in legal aid and solicitors who are now allowed to offer to represent people on a "no win no fee" basis. This creates an upward pressure on clinical negligence expenditure, especially for small claims. A larger number of cases have been listed for Hearing over the last two years or so, i.e. since 2010, as a consequence of tighter judicial management. However, the number of outstanding negligence cases has decreased substantially over the last 10 years as in recent years, more negligence claims have been closed than opened – evidence of the success of the concerted effort which has been made to progress cases as quickly as possible. The closure of a claim does not necessarily imply a cost to the Department, as many negligence claims which have little chance of succeeding in court are closed without payment to the plaintiff. The level of compensation paid in settled cases varies considerably depending on the individual circumstances of each case.

96. In September 2002, the Department issued guidance (HSS(F) 20/2002) which advised health bodies that there was some evidence to suggest that patients who suffer an adverse incident may be diverted from making a claim for compensation where they are provided with an expression of sympathy, a full and factual explanation and, if appropriate, are offered early corrective treatment. The guidance recommended that individual HSC bodies consider how to adopt this policy.

97. Since 2004, three Supporting Safer Services Reports and two Learning Reports have been issued to support and promote learning from serious adverse incidents.

98. In 2010, DLS completed a review of all live cases which were active for more than 10 years. As a result of the exercise, 35 cases were closed. DLS is now proactive in monitoring the progression of cases. HSS(F) 20/2002 reminded HSC bodies that, in line with the pre-action protocol, medical records should be provided within 40 days from the date they are requested. DLS assures us that confidentiality clauses are only used in cases where they are specifically requested by the plaintiff (i.e. the injured party). DLS procedures now ensure that cases are actively managed and HSC bodies are encouraged to use a pre-action protocol to resolve disputes. Risk management procedures have been enhanced, and continue to be developed, across the HSC sector.

Redress

99. The UK's fault-based approach to compensation has received significant criticism for a number of years and has been accused of failing either to provide fair compensation or to create incentives for deterrence. The lack of alternatives to legal redress makes it difficult for those who suffer as a result of medical accidents or negligence to obtain explanations of what happened to them, and in particular to extract apologies. The Department considers that effective redress can include offering an apology, providing reassurance and speedy remedial treatment, in addition to offering compensation, if appropriate, when harm has been caused to a patient or client (Safety First 2006). In Guidance on Claims Handling in HSC Organisations (March 2010), the Department encourages (but does not compel) HSC organisations to comply with a 2009 GB protocol designed to resolve disputes about healthcare or medical treatment.

100. A redress scheme is a consensual process, not a judicial process; redress is offered not awarded. Proceedings under a redress scheme is voluntary. Proceedings under a redress scheme and civil legal proceedings are mutually exclusive: they cannot be conducted at the same time. Legal rights are suspended but remain intact during a redress process when legal liability is assessed; legal liability is not adjudicated upon by the scheme's procedure since it is not a tribunal. Legal rights are only determined if any offer is made and accepted as part of a compromise agreement. It may include investigations when things go wrong, remedial treatment,

rehabilitation and care when needed; explanations and apologies; and financial compensation in certain circumstances.

101. The Department has considered the feasability of developing formal dispute resolution procedures which could offer viable alternatives to litigation. It is currently considering the approaches adopted in other jurisdictions and will consult with, amongst others, the NI Ombudsman in establishing an appropriate way forward.

102. In view of the work required to fully consider the feasibility of developing formal resolution procedures which could offer real alternatives to litigation it is not possible to provide a planned date for completion at this stage although it is not likely to be completed before June 2015.

The importance of lessons learned from public inquiries and reviews

103. There have been a number of Inquiries and Reviews in NI. It is important that the recommendation from NI Inquiries and Reviews are considered, addressed and implemented. It is also important that lessons from inquiries and reviews in other jurisdictions are also incorporated into the business of delivering the highest quality possible health and social care in NI. By way of example, responses to a number of reviews and inquiries are described below.

Human Organs Inquiry

104. The Human Organs inquiry, chaired by John O'Hara, QC, was established by the Minister for Health, Social Services and Public Safety in March 2001. All 20 of the Inquiry's recommendations were accepted. Since then the Department has taken action in respect of **all** the recommendations. Key elements have included:

- A public information campaign, in conjunction with the Relatives' Reference Group, that included mailing leaflets to every household in Northern Ireland;
- A dedicated telephone enquiry line from November 2002 to March 2005 (and ongoing arrangements within individual Trusts to continue to respond to telephone enquiries as necessary);

- The Human Tissue Act 2004, in which Northern Ireland is enjoined with England and Wales;
- The Human Tissue Authority created under the new legislation as the regulating body for all matters concerning the removal, retention, use and disposal of human tissue (excluding gametes and whole blood) for specific purposes;
- A Code of Good Practice on Post Mortem Examinations; a Careplan for Women who experience a Miscarriage, Stillbirth or Neonatal Death; and new consent forms and guidance booklets to be used in respect of Hospital Post Mortem Examinations;
- Permanent memorials in Belfast City Hall and Ballyoan Cemetery dedicated to the memory of all those whose organs and tissue were removed without the knowledge or consent of families following post mortem examinations; and
- A regional network, comprising 5 area co-ordinators, for the development of bereavement care standards and training (launched in January 2006.).

C.Diff Inquiry

105. The C.Diff public inquiry was established in response to the outbreak of Clostridium difficile in Northern Trust Hospitals in 2007/2008. The final report contained twelve recommendations (http://www.cdiffinquiry.org/chapter-11.pdf), of which nine were addressed to the Northern Trust and the remaining three to the Department. The Inquiry Panel noted in the report that the recommendations would be of value in other Trusts, in Northern Ireland and further afield. The recommendations dealt in the larger part with infection control issues but several recommendations (such a those listed below) would have a degree of relevance to other setting and Inquires:

- Governance arrangements (Recommendation 3);
- Record keeping (Recommendation 3);
- Training and support (Recommendation 10); and
- Organisational change (Recommendation 12).

Pseudomonas Inquiry

106. In January 2012, the Minister commissioned the RQIA to carry out an expert-led inquiry into the incidents of pseudomonas infection and colonisation across hospital neo-natal units that arose in the closing weeks of 2011 and early 2012. The inquiry team produced an Interim Report in April 2012 and a Final Report in May 2012 containing a total of 32 recommendations.

107. Most of the 32 recommendations have been completed and all have been progressed. With regard to those recommendations for which there are actions outstanding, either substantial construction work is required and in train, or there is paperwork to be done to complete the Department's record of implementation. The status of the recommendations is as follows:

- Interim Report - 15 recommendations, 11 completed, 4 partially completed (2 requiring substantial building work)

- Final Report - 17 recommendations, 15 Completed, 2 partially completed

108. Themes in the Review recommendations which are relevant in other contexts include:

- Communication;
- Governance arrangements;
- Sharing documentation and Information;
- Plans for managing incidents; and
- Support for staff during incidents.

Dental Inquiry

109. 5 February 2011, the Belfast Health and Social Care Trust (BHSCT) recalled 117 Oral Medicine patients from the Dental Hospital for precautionary check-ups following a BHSCT review of the appropriateness and timing of patient referrals and treatment. An urgent independent inquiry into these matters was

set up. The Inquiry Panel initially reported in June 2011, making 45 recommendations under seven headings:

- Quality of Care
- Supervision of Appraisal
- Administrative Considerations
- HR/Training/Workload Planning
- Adverse Impacts on Patients
- Communications
- Other Recommendations.

110. The Inquiry Panel completed its work on preparation for publication of the final Dental Hospital Inquiry Report in June 2013. This included an addendum which highlighted that a further death in late 2011 gave rise to additional concerns regarding the late diagnosis of oral cancer. The full Inquiry Report and corresponding Action Plan are available at http://www.dhsspsni.gov.uk/dentalinquiryreport.pdf and http://www.dhsspsni.gov.uk/dentalactionplan.pdf .

111. A short-term Working Group was established in July 2011 to address the initial recommendations, so it is important to note that, although the full report was not published until July 2013, there had been a significant amount of work carried out, and progress made, over the previous 2 years. The DHSSPS has co-ordinated the development of an Action Plan in response to the Dental Inquiry Report and adopted a collaborative approach between the DHSSPS, the Health and Social Care Board (HSCB), the Public Health Agency (PHA), the BHSCT, Queen's University Belfast (QUB), and the Patient and Client Council. The Dental Hospital Inquiry Report acknowledged and supported the work that had already been undertaken. The main objectives of the Action Plan have been to promote patient safety, and to enhance both the patient experience and public confidence in the services provided by the Dental Hospital/School of Dentistry. The Action Plan sets out time-bound actions

relating to the recommendations and which organisation is responsible for delivery.

112. A number of regional learning points emerged from the findings of the Inquiry Report which are pertinent to policy and both HSC organisations and teams in primary care. It is also considered that much of this learning has commonality with other lessons learnt in UK health systems and wider beyond.

113. The closing recommendation of the report was that the Minister establishes an appropriate mechanism to ensure that the recommendations which he considers have merit are fully implemented. Each HSC organisation will be required to submit a full report to DHSSPS on progress towards implementation of its respective actions until full implementation is achieved in 2014. DHSSPS will seek independent assurance regarding implementation of the Action Plan and on improving the quality of dental care commissioned by HSCB and provided by the BHSCT. This will be led by the Regulation and Quality Improvement Authority, and carried out during 2015/16.

UK Inquiries

114. The Department and the HSC's approach also reflects the findings of Inquiry and other evidence emanating from other parts of the UK (and further afield). A current example is the Francis Public Inquiry Report into events at Mid Staffordshire Foundation Trust which was published in February 2013. The Department is giving due consideration to the findings of the inquiry and is aiming to publish its response in November.

Quality 2020 - A 10 Year Strategy to Protect and Improve Quality in health and Social Care in Northern Ireland (November 2011)

115. Quality 2020 is the Department's quality strategy for the HSC and was Launched by Minister in 17 November 2011. It defines **quality** for health and social care in terms of three key components:

i. **Safe** – minimises risk and harm to service users and staff;

ii. **Effective** – informed by an evidence base that it results in improved health and wellbeing; and

iii. **Person centred-** gives due regard to the preferences and aspirations of those who use services, their family and carers.

116. **In simple terms, Quality 2020 is the Department's overarching strategy which will inform the quality agenda up to the year 2020.** The strategy presents a clear Vision for the future, in which we aspire ***to be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care.*** Its purpose is to create a strategic framework and plan of action that will protect and improve quality across all 3 dimensions within health and social care over the next 10 years. It recognises that this will be a period of major challenges, including financial constraints, as well as opportunities and demands from various quarters.

117. It is planned that it will be subject to review every 3 years to ensure that it remains fit for purpose. The strategy highlights **5 strategic goals** that will contribute to that vision being realised, namely:

- Transforming the culture
- Strengthening the Workforce
- Measuring the Improvement
- Raising the Standards, and
- Integrating the Care.

118. The strategy was developed over two years and involved input from a wide range of people including service users, carers, front-line HSC staff, commissioners, departmental policy officials and professionals & Trade Unions. It has also been the subject of public consultation (consultation closed 15 April 2011). A series of presentations were made by senior Departmental staff to Senior Management Teams across the HSC during 2012 in an effort to ensure that the strategic importance and relevance of Quality 2020 going forward was well understood and

rooted in the mindset of HSC senior management teams from the outset

Quality 2020 Implementation Plan approved by Minister 19 April 2012

119. The implementation of QUALITY 2020 will provide both a strategic 'agenda' and 'context' for quality improvement. Its implementation is not simply about a programme of new projects or strategic initiatives, important as they will be in driving forward necessary change and innovation. It is also about recognising and, where appropriate, endorsing the often self-initiated activity of HSC bodies across a multitude of quality improvement initiatives which they all undertake on an on-going basis in seeking to fulfil their Statutory Duty of Quality. The achievement, therefore, of QUALITY 2020's strategic goals, and thus its vision, will be the combined result of HSC organisations driving forward quality improvements in their own right, as well as engaging collectively in a series of projects strategically aimed at securing necessary change across all sectors

120. A Steering Group has been set up to oversee the project. A Management Group is managing the work of the Implementation Team which has been working on seven Tasks. All of these Groups have been meeting on a regular basis for over a year. Additional staff have been contributing to the Tasks where their skills are felt to be appropriate. More detail with regard to the progress of tasks initiated under the auspices of Q2020 is provided in the attached detailed submissions.

Annex A

Supporting Papers to be Provided to the Inquiry

1. To Err is Human (1999)
2. Best practice – Best Care
3. Quality 2020 - A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland