RESPONSE FROM DHSSPS

1. **Paper C.1 from DHSSPS concerns "assurance and accountability arrangements for arms length bodies". At paragraph 8, bullet point 6, and then at paragraph 51, reference is made to the Minister having accountability meetings with around four arms length bodies each year. Please advise:**

    (i) Have these meetings yet started?

    (ii) If they haven't started, when are they expected to start?

    (iii) **To what extent, if any, will they be public or will any record be made available of the meetings**?

    In reply:

    (i) Yes, the first meeting took place with the Northern Ireland Ambulance Service (NIAS) on 21 June 2013. A further meeting was held with Belfast Health and Social Care Trust (BHSCT) on 19 September 2013.

    (ii) See above.

    (iii) The public can attend these meetings, and have the opportunity to submit questions, which are collated and themed before being asked by the Minister on behalf of the public. The meetings are not formally recorded but the Department retains a note of the meeting for its own use. However, this note is not available to the public.

2. Also in paper C.1 at paragraph 51, there is a reference to the Minister engaging in planned visits "to see services being delivered and to hear the views of staff on the ground".

(i) Does the Minister also make unannounced visits?

(ii) To what extent do medically qualified departmental officials such as the Chief Medical Officer make unannounced visits to see services being delivered and to hear the views of staff on the ground?

In reply:

(i) Visits by the Minister are generally arranged with the knowledge of the responsible Trust or other organisation. However, the Minister has made at least one unannounced visit, and may make others in the future.

(ii) Visits by Departmental officials are also generally arranged through the responsible Trust or other organisation. The Permanent Secretary has made some unannounced visits in the past, and he and the Department's Chief Professionals may do so again in the future.

3. Paper C.6 from DHSSPS concerns "nursing governance". From paragraph 44 onwards, there is a section on "Regional Ward Manager Project 2010".

(i) To what extent is the envisaged role of a Ward Manager a new development as opposed to the re-introduction of an older practice?

(ii) How will the role of a Ward Manager be different to that of a Ward Sister or Charge Nurse?

In reply:

(i) The role of Ward Manager/ Ward Sister is pivotal in ensuring person centred, quality care. They also have a responsibility to ensure their team have the necessary training and development and support to deliver that care. Over recent years there had been evidence that a tension existed between their clinical and managerial responsibilities resulting in a loss of clinical nurse leadership. Many believed there was a lack of clarity as to what their role entailed and there had also been a lack of a formal preparation and skills development for this role.

(ii) As a consequence of this the Chief Nursing Officer DHSSPS commissioned NIPEC to undertake a project regionally to clarify and strengthen the role of Ward Manager across Northern Ireland to ensure they had the appropriate skills and authority to enforce the standards of care for which they are accountable. This review put the spotlight on ward sister as guardians of patient care experience and standards.

During the course of the project an objective was set to agree a regional title for the position as it was felt that the previous change from Sister to Ward Manger had further undermined their clinical nurse leadership role in favour of their managerial responsibilities. There was also a lack of consistency in role title across Northern Ireland. The main focus of the ward sister's role following the review was put on Clinical leadership.

Following an extensive review of current Job Descriptions, research and stakeholder engagement a competency framework and a regional Job Description was agreed for the role. Surveys of Sister/Managers and patients and their clients through the patient and client council resulted in agreement that the regional title should be Ward Sister / Charge Nurse

4. Staying with nursing generally, what evidence is there of nurses in Northern Ireland raising concerns in adverse incident or serious adverse incident reports about the actions of doctors, including consultants?

In terms of SAIs, the purpose of the procedure is not to raise those concerns. That is not to say that during the investigation process any professional may raise a concern regarding another but the SAI procedure does not specifically request this to be done.

Following the full investigation, contained in the investigation report for Level 2 investigations (under findings – contributory factors) there is a point 'individual factors' under which organisations could record if a doctor, nurse or any other member of staff who was considered to be a contributory factor to the SAI.

As described in Departmental Submission C2 – Clinical and Social Care Governance, staff are expected to act on genuine concerns about any aspect of an organisations work or colleagues in the knowledge that they have support from the highest level.

Staff have a duty to act when they believe patients' safety is at risk, or that patients' care or dignity is being compromised. Guidance on the Public Interest Disclosure (NI) Order 1998 – Whistle blowing in the HPSS was first issued to the HSC in January 2000. More recent guidance came into effect on 12 March 2012.

5. **Paper C.7 from DHSSPS concerns “medicines governance”. The paper refers to and gives examples of the very useful (and lively) regional newsletters issued by the governance team. While the publication of these newsletters is potentially valuable, is there any tangible evidence of them having any effect on practice? If so, what is that evidence?**

In reply:

The quarterly newsletter is produced as a means of raising awareness of medication safety issues among secondary care medical, nursing and pharmacy staff. The Trust medicines governance team carried out an evaluation of the newsletter between October-December 2007 to gauge staff opinions on its usefulness. A questionnaire was sent to 1,206 medical, nursing and pharmacy staff in hospitals across NI (977 nurses, 196 medical staff and 33 pharmacy staff). The overall response rate was 44% (31.6% medical staff, 44.3% nursing staff and 78.8% pharmacy staff).

Sixty nine per cent of respondents agreed or strongly agreed that the newsletter raised awareness of medicines safety.
Sixty four per cent agreed/strong agreed that they learn something new from reading it and 45% agreed or strongly agreed that they had changed their practice as a result of reading the newsletter.

6. **Paper C.9 from DHSSPS concerns “HSC Complaints”. Please compare the Belfast Trust complaints’ policy found at pages 14 – 16 of its submission and Appendix 8 to that submission with the paper issued by the Department in April 2009 which is found at Tab 13 of File C.9. How does the Belfast Trust’s complaints’ policy comply with the standard set by the Department in its paper? In particular, is the Department satisfied with the limited reference to the family which is found in Appendix 7 of the Belfast Trust policy?**

Standard 4 (Supporting Complainants and staff) of the HSC Complaints Procedure, states that “HSC organisations will facilitate, where appropriate, the use of conciliation”. This standard is met in Annex 7 of the Belfast Trust policy which states “It may be more appropriate depending on the complexity of the complaint that a meeting would be offered to the family to discuss the outcome of the investigation”

Standard 6 (Responding to Complaints) of the HSC Complaints Procedure gives the actions required of the HSC in responding. This standard is met within Appendix 8 of the Belfast Trust policy.

Whilst the Inquiry notes limited reference to the family in Appendices 7 and 8 of the Belfast Trust procedures, the document is in line with the HSC Complaints Procedure. The HSC Complaints Procedure is written with the aim of including all scenarios of complaints from every aspect of Health and Social Care across all Trusts. However, Trusts may incorporate the principles as they feel meets the needs of their organisation and the services provided. The Belfast Trust has covered the points necessary and their procedures are certainly in the spirit of the HSC Complaints Procedure.

7. Paper C.10 from DHSSPS concerns “Death Certification in Northern Ireland”. At paragraphs 55 and 58 there are references to two working groups which were scheduled to meet for the first time on 4 and 8 October 2013. It would be helpful to receive an update on the work of these two groups including the membership of each one and any papers which are available from their first meetings.

As outlined in Paper C.10 an Inter-Departmental Working Group had produced proposals to enhance the existing arrangements for death certification in Northern Ireland with a view to strengthening and improving the process.

Two options were put forward for the future. Option 1 would see an enhancement of exiting arrangements and would include:

- Adding the Doctor's General Medical Council and the deceased's Health and Social Care number to the Medical Certificate of Cause of Death (MCCD) to facilitate improved statistical analysis;
- Improving Death Certification training for registered medical practitioners;
- Incorporating death certification practice as part of the appraisal of registered medical practitioners;
- Developing a set of system standards and improved guidance on certifying death across organisations;
- Building on learning from other established death reporting systems; and
- Health and Social Care Trusts undertaking an analysis of MCCD completion by hospital based doctors under existing governance arrangements.

Option 2 was a more comprehensive model which incorporated all the enhancements of Option 1 alongside the introduction of a new post of Medical Examiner to carry out a basic scrutiny of all non-reportable deaths.

In April 2012 The NI Executive agreed that implementation of Option 1 should begin as soon as was practical, with a view to moving to Option 2 at a later date if this is considered necessary following evaluation of Option 1.

In order to take forward the implementation of Option 1 a Death Certification Implementation Working Group (DCIWG) has been established and an initial meeting took place on October 4.

The purpose of the meeting was to provide an update to key stakeholders on the current position in Northern Ireland and in England, Scotland and Wales and to discuss the way forward regarding implementation of Option1.

The DCIWG will take forward the work required to implement Option 1, and over a period of time will evaluate the need to move to Option 2.

It was agreed that in addition to the DCIWG, a Death Certification Stakeholders Group would be established to garner the wider views of those involved in these reforms. Membership of both groups was discussed and will be subject to the agreement of the DCIWG in due course. The next meeting of the DCIWG will take the form of a workshop when more detailed analysis of the actions required for implementation will be considered.

The minutes of this meeting are attached at **Annex A.**

The Strategic Communication and Decision Making Group referred to at Paragraph 58 of Paper C.10 relates to the Memorandum of Understanding (MoU) on Investigating Patient or Client Safety (Unexpected Death or Serious Untoward Harm). The MoU is between DHSSPS, the Health and Safety Executive for Northern Ireland (HSENI), the Police Service for Northern Ireland (PSNI) and the Coroners Service for Northern Ireland (NICTS).

A MoU was first published in 2006. It was revised and re-issued in March 2013 and provided for the establishment of a Strategic Communication and Decision Making Group (SCDMG). The purpose of this group is to provide strategic oversight of a patient safety incident investigation involving the PSNI, NICTS and/or HSENI.

The first SCDMG meeting took place on 8 October. Representatives from DHSSPS, the Health and Social Care Board, the Regulation and Quality Improvement Authority, PSNI, HSENI, and NICTS were in attendance.

The purpose of the meeting was to review the dissemination and operation of the revised MoU by organisations since it was issued on 15 March 2013 and to identify any issues with it in its current form.

An update was provided on the dissemination of the MoU within each organisation. HSCB/PHA reported that the criteria for what constitutes a Serious Adverse Incident had been revised with effect from 1 October 2013, and as such an amendment will be made to the relevant paragraphs within the MoU.

A further meeting of the group will be arranged to take place in six months. The Group will then consider the need for continued formal meetings and the potential for Chief Executives to report on the operation of the MoU through the normal DHSSPS/HSC accountability arrangements.

The minutes of the meeting are attached at **Annex B**.

8. **In its position paper, the Belfast Health and Social Care Trust has set out at page 31 its position on asserting privilege for expert reports obtained by the Trust for inquests. The fact that the Trust is legally entitled to claim privilege is not in dispute. There is an issue, however, as to why it should assert that right and in whose interests it would do so. In the case of Raychel Ferguson, the Inquiry has heard evidence that the then Altnagelvin Trust obtained an expert's report which was critical of the Trust and which was then withheld from the Coroner. What view does the Department hold on this issue generally? In particular, how can a Trust possibly engender public confidence by obtaining an expert's report which is critical of some actions performed by doctors and nurses and then withholding that report from the Coroner?**

The Department would have a presumption in favour of disclosure as a matter of general principle, the matter of whether to claim privilege is one for a Trust to consider based in its own legal advice.

Annex A

NOTE OF THE INITIAL MEETING DEATH CERTIFICATION IMPLEMENTATION WORKING GROUP
D2 CONFERENCE ROOM, CASTLE BUILDINGS
3PM, 4th October 2013

In Attendance:
Dr Martin Donnelly (DHSSPS) (Chair)
David Best (DHSSPS)
Anne-Marie Blaney (DHSSPS)
Dr Gillian Clarke (Coroners Service)
Dr Kathryn Booth (HSCB)
Claire Rocks (NISRA)
Sandy Fitzpatrick (BSO)
Dr Julian Johnston (BHSCT)
Heather Russell BHSCT)
Dr David Stewart (RQIA)
Elizabeth Bell (DHSSPS) (note)

Apologies
Dr Sloan Harper (HSCB) - (Dr K Booth representing)

1. Introduction

1.1 Dr Donnelly welcomed everyone to the initial meeting of the Death Certification Implementation Working Group (DCIWG). Introductions were made and apologies noted.

2. Summary of Development and the Current Position – DHSSPS

2.1 Dr Donnelly briefed the group on the work of the Inter- departmental Working Group on the Review of Death Certification in Northern Ireland (established in 2008) which completed its review and recommended two options to strengthen death certification in Northern Ireland.

- **Option 1**

  This would see the enhancement of the existing assurance arrangements for death certification with a view to strengthening and improving the current process.

- **Option 2**

  This is a more comprehensive model and represents a longer term aspiration for the death certification process in Northern Ireland. This option

incorporates all of the enhancements proposed in Option 1 alongside the introduction of the new post of Medical Examiner (ME) to carry out a basic scrutiny on all non-reportable deaths

2.2 On 5th April 2012 the NI Executive agreed that Option 1 is implemented as soon as practicable and that an evaluation of this option should be undertaken over a two year period in order to inform a decision on whether Option 2 is necessary.

2.3 Dr Donnelly explained that progress had been delayed due to a lack of resources and other business priorities.

2.4 The group considered the proposed enhancements for Option 1 and Dr Donnelly reported the following updates

- GRONI issued a revised version of the Medical Certificate of Cause of Death (MCCD) in 2011 with space to include the printed name of the doctor and their GMC registration number.

- The Department has reminded HSC staff about the Death, Stillbirth and Cremation Certification guidance first issued September 2008 advising practitioners of their responsibilities to maintain their competence by updating their knowledge and reflecting on their practice and drew particular attention to the section on deaths that must be reported to the Coroner. This document will need to be reviewed during implementation of Option1. http://www.dhsspsni.gov.uk/hss-md-14-2012.pdf

- Work is ongoing in Belfast Health and Social Care Trust (BHSCT) to examine the process, to record review, monitor and analyse mortality and morbidity. (See item 4).

- Further analysis of the proposed enhancements to the process as outlined in Option 1will also be undertaken.

3. Update of the current position in Scotland, England and Wales

3.1 Dr Donnelly outlined the current position on the UK administrations:

- **Scotland:**
  Implementation of the proposed processes in Scotland is due to take place from Spring 2014. The Scottish model will involve randomised reviews of around 25 per cent of all deaths.

- **England and Wales**
  It is hoped to commence implementation in October 2014 and to appoint a National Medical Examiner. The English model will involve 100% checks of all deaths. Wales have formed their own Implementation Board separate to their English counterparts.

4. Work of the Belfast Trust on Mortality and Morbidity Review System

4.1 Dr Johnston gave a power point presentation on the ongoing work of the Belfast Trust to develop a system (Mortality & Morbidity Review System) to record, review and learn from all deaths occurring in the Trust.

4.2 It was suggested that when the system was operational that there may be no need to manually complete the MCCD and that it could be printed from the system. Dr Johnston felt that this could prove difficult and that there were issues around IT.

4.3 It was agreed that the system of reviewing death developed by the Belfast Trust could be integrated into the work on death certification implementation.

5. The Way Forward

5.1 It was agreed that in order to proceed with implementation of Option 1 consideration would be given to the models used in Scotland, England and Wales. It was proposed that two groups would be needed to take forward

implementation and gain the wider views of stakeholders on proposed reforms.

5.2 In addition to the DCIWG a separate Stakeholders Group would be established.

5.3 Discussion arose on the membership of both groups. It was suggested that it would be beneficial to include those individuals/organisations that have knowledge of systems e.g. Cancer Registry, Regional system ICT programme Board, NIMDTA, and Nursing etc on the DCIWG.

5.3 Those present will consider the potential membership of both groups. The secretariat will circulate a draft list of each group.
AP1: Issue proposed list of membership of the DCIWG.
AP2: Issue proposed list of membership of the Death Certification Stakeholders Group

5.4 It was agreed it would be useful to invite representatives of the other UK administrations to address the DCIWG and if this is not possible they will be asked to provide a position paper.

AP3: Invite participation from UK administrations **(SQSD)**

6. Governance Arrangements

6.1 It was proposed that the work of the DCIWG would be operated using the PRINCE methodology.

6.2 A Terms of Reference (TOR) and Project Initiation Document (PID) will be developed and circulated to the group before the next meeting.
AP4: Issue draft TOR and draft PID **(SQSD)**

6.3 Any sub-groups that may be established will report to the DCIWG.

6.4 The DCIWG will report to the Death Certification Steering Group (Steering Group). The composition of the Steering Group will remain unchanged and be determined by the position held within the organisation rather than by the named individual.

7. AOB

7.1 It was clarified that the DCIWG will be implementing Option1 and evaluating the need to move to Option 2.

8. Date of next meeting

8.1 The date of the next meeting is to be arranged and will be run as a workshop.
AP5: Arrange next meeting **(SQSD)**

Summary of Action Points

AP1: Issue proposed list of membership of the DCIWG.

AP2: Issue proposed list of membership of the Death Certification Stakeholders Group

AP3: Invite participation from UK administrations **(SQSD)**

AP4: Issue draft TOR and draft PID **(SQSD)**

AP5: Arrange next meeting **(SQSD)**

Annex B

MINUTES OF THE INAUGURAL MEETING OF THE STRATEGIC COMMUNICATION & DECISION MAKING GROUP
E4.18, CASTLE BUILDINGS
10 am, 8th October 2013

In Attendance:
Dr Martin Donnelly (DHSSPS) (Chair)
David Best (DHSSPS)
Anne-Marie Blaney (DHSSPS)
Elizabeth Bell (DHSSPS) (note)
Dr Gillian Clarke (Coroners Service)
Hall Graham (RQIA)
Anne Kane (HSCB/PHA)
Claire Savage (HSENI)
Christopher Wilson (PSNI)

Apologies
John Roberts (PSNI) - (Chris Wilson representing)
Dr David Stewart (RQIA) - (Hall Graham representing)

1. Welcome/Introduction

1.1 Dr Donnelly welcomed everyone to the inaugural meeting of the Strategic Communication & Decision Making Group. Introductions were made and apologies noted.

2. DHSSPS position on the MoU issued to the HSC March 2013. (Circular HSS (MD) 8/2013).

2.1 Dr Donnelly outlined the background to the MoU and explained that the purpose of the meeting was to review the operation of the revised MoU by organisations since it was issued on 15th March 2013 and to identify any issues with it in its current form.

2.2 Referring to circular HSS (MD) 8/2013, Dr Donnelly confirmed that Sections 1-3 of the assurance template had been actioned by all of the relevant HSC organisations.

http://www.dhsspsni.gov.uk/hss-md-8-2013.pdf

AP 1: Dr Donnelly to discuss with Anne Kane (outside of the meeting) the variation of the assurance arrangements across HSC organisations.

3. Update from each organisation on MoU dissemination

3.1 **PSNI –** Chris Wilson confirmed that the MoU had been disseminated to Crime Branch and those directly involved at middle management level and that there were no issues to report.

3.2 **HSENI -** Claire Savage advised that the MoU had been disseminated to appropriate teams within the HSENI involved in patient or client investigations including senior management.

3.3 **Coroners Service NI –** Dr Clarke confirmed that the principles of the MoU are being followed with good communications between all organisations. She advised the Group that all staff had been informed of the MoU and as there is high turnover within the Coroner Service, the MoU is included as part of their training.

3.4 **HSC -** Anne Kane reported to the group that a Review of the Serious Adverse Incident (SAI) procedure issued in 2010 had taken place. Following consultation across the HSC a revised procedure was issued effective from 1 October 2013 and that the revised SAI reporting criteria will be adopted along with the associated reporting documentation.

3.5 Dr Donnelly suggested reviewing and amending the relevant paragraph in the MoU relating to the HSCB and Public Health Policy criteria on SAIs. Anne Kane agreed to forward an amended section by email for consideration. It was agreed that the revised MoU would be circulated and signed off by January 2014, incorporating HSCB amendments to the process for reporting and follow up of SAIs.

AP 2: Review SAI section for HSCB to include amended and associated documentation by January 2014 **(Group Members).**

3.6 **RQIA** - Hall Graham confirmed that as the reporting of incidents is set in legislation and regulations forming part of the registration system in the Private Sector, he advised there were no problems from the RQIA perspective.

4. Review of use of the MoU

4.1 Discussions arose on the sharing of information:

- Dr Donnelly referred to the assurance template (HSS MD 8/2013) that was returned by organisations on 30 September 2013 and commented that in one

Trust their action plan identified liaison links with the Regional Health,Safety & Risk Practitioners Group (attended by the HSENI) and the Police Liaison Forum. Dr Donnelly suggested it would be beneficial for all organisations to have similar liaison links as a formal route to influence and ensure that the process is working and that nominated Trust leads should have a separate meeting. Ann Kane agreed.

- Anne Kane reported that the Regional Governance Leads meet on a bi-monthly basis.
- Claire Savage confirmed that the HSENI regularly liaise with the PSNI and Coroners Service.
- There was a general discussion on how the MoU had been circulated to front line staff. It was agreed that there should be a more structured approach to discuss within organisations and that awareness training on the MoU be provided for new staff.

4.2 Members were asked to review the MoU and update the section on their organisation including contact details by 15th November 2013

AP 3: Members to provide input on the MoU **(Group Members).**

4.3 Following any revision the MoU will be circulated to the Group for sign off.

4.4 The MoU has been disseminated within organisations and the indications are that the principles of the MoU are being used in investigations.

5. AOB

5.1 Claire Savage referred to the distinction between communication/liaison meetings at an operational level in respect of particular cases and a meeting of the Strategic Communication and Decision Making Group. It was agreed that it would be helpful to have more specific guidance as to how to arrange a meeting of the Strategic Communication and Decision Making Group. It was agreed that if a meeting was necessary, representatives from the organisation concerned could attend providing there was no conflict of interest with regard to the particular incident. A protocol for requesting a meeting will be developed and circulated to members of the Group.

5.2 A draft Terms of Reference (TOR) indicating membership by title within organisations will be drawn up and circulated to Group members for sign off.

AP 4: Draft TOR and protocol for requesting a meeting of the Strategic Communication and Decision Making Group to be drawn up **(SQSD).**

5.3 In terms of reviewing the document, a line is to be inserted stating that the MoU will be subject to review in 2 years.

6. Date of Next meeting

6.1 The next meeting will be arranged to take place in six months. The Group will then consider the need for continued formal meetings and the potential for Chief Executives of Trusts and Boards to report on the operation of the MoU through the normal DHHSSPS/HSC accountability arrangements.

AP 5: Arrange next meeting **(SQSD)**

SUMMARY OF ACTION POINTS

AP1: Dr Donnelly to discuss with Anne Kane (outside of the meeting) the variation of the assurance arrangements across HSC organisations.

AP2: Review SAI section for HSCB to include amended and associated documentation by January 2014 **(Group Members).**

AP 3: Members to provide input on the MoU **(Group Members).**

AP4: Draft TOR and protocol for requesting a meeting of the Strategic Communication and Decision Making Group to be drawn up **(SQSD).**

AP 5: Arrange next meeting **(SQSD).**