From:	Joanna Bolton
To:	Conlon, Bernie (IHRD)
Cc:	Ross, Leanne; Devlin, Denise
Subject:	FW: HSCB FINAL RESPONSE
Date:	30 August 2016 09:19:17
Attachments:	HSCB FINAL RESPONSE.docx
Importance:	High

Dear Bernie,

Further to our conversation please find enclosed HSCB Response. Please note that this version is includes additional information at Question 16 bullet (page 15/16) regarding the SQAT meeting and PIVFAIT Tool. I would be obliged if you could now treat this document as the HSCB's final response.

Kind Regards,

Joanna

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PLEASE ENSURE DLS CASE REF IS QUOTED ON ALL CORRESPONDENCE TO THIS OFFICE

Health and Social Care Board (HSCB) Response to Questions from Inquiry into Hyponatremia Related Deaths – Received June 2016

Question 1

HSCB - Policy for HSCB Staff on the Management of Complaints (April 2016) provides*: "The use of an **independent expert** in the resolution of a complaint may be by the complainant ..."*

Chairman: *"is there a way in Northern Ireland of getting specialist support to help you with a complaint".*

Transcript 11th November 2013 p.19 L.6-8 AVMA/PCC

i. To what extent are independent experts used?

ii. How successful has this been?

Answer

- Specialist Support /Advocacy (Transcript 11th November 2013 p.19 L.6-8) In Northern Ireland the Patient and Client Council (PCC), as part of their role provide assistance to service users to complain about any part of health and social care. Since 1 April 2014 HSC Trusts, the HSC Board and Family Practitioner Services (FPS) have included specific reference in letters of acknowledgement to the availability of the PCC to support complainants. This was introduced in addition to the already existing reference within HSC organisations complaint leaflets, in an effort to further promote public awareness of support available for complainants.

- Independent Experts (HSCB - Policy for HSCB Staff on the Management of Complaints (April 2016)

  The use of independent experts will not be required in every complaint but it may be considered beneficial where the complaint:

  - Cannot be resolved locally;
  - Indicates a risk to public or patient safety;
  - Could give rise to a serious breakdown in relationships, threaten public confidence in services or damage reputation;
  - To give an independent perspective on clinical issues

(Complaints in Health and Social Care Standards & Guidelines for resolution & Learning)

- Independent Lay Persons

  Independent Persons are also available to provide independent perspective of non-clinical/technical issues within local resolution process.
  Input from a lay person may be valuable to test key issues that are part of the complaint, such as:

  - Communication issues;
  - Quality of written documents;
  - Attitudes and relationships;
  - Access arrangements (appointment systems).

(Complaints in Health and Social Care Standards & Guidelines for resolution & Learning)

Independent Experts have been utilised on *12 occasions in the last 2 years in the local resolution of complaints.

The effectiveness of independent experts is difficult to measure. However feedback from the HSC Trusts, as well as HSCB complaints staff in respect of FPS complaints, is that the involvement of independent experts is a useful option available, when required within the complaints process.

*This statistic is based on responses received from the HSC Trusts and in relation to FPS complaints (in which independent experts were used on 5 occasions). Not all HSC Trusts record the use of independent experts specifically on their DATIX system so this figure is not an accurate reflection of engagement of independent experts.

Question 2

Recommendation 10 [from the May 2013 workshop]: (344-001) *"There should be a regionally agreed method of disseminating learning from complaints, that should be developed by the Health & Social Care Board and by the Public Health Agency".*

Transcript 11th November 2013 p.69 L.12-19 AVMA/PCC

i. Has recommendation 10 been implemented?

ii. If so, from what date?

Answer

The recommendation referenced above was a recommendation from the Process Evaluation of 'Complaints in Health and Social Care' undertaken by the HSCB in 2010 and which reported in November 2011. The actions associated with this recommendation were completed by March 2013 and include: the development of a 'learning from complaints' central repository which Trusts use to submit significant learning from complaints which may have potential for regional learning, using an agreed learning template. These examples, along with other examples of learning extracted from the monthly returns from HSC Trusts and local resolution returns from FPS, are considered by the Regional Complaints Sub Group and ultimately the Quality Safety and Experience Group (QSE). Learning is included in the 'Learning Matters' Newsletter includes learning from Serious Adverse Incidents (SAI), Adverse Incidents (AI), Complaints and Early Alerts.

In addition, the HSCB has now held its third Annual Learning from Complaints Event in June 2016. These events are attended by all HSC organisations including representation from Primary Care. Those attending include front line nursing staff, practice managers, General Practitioners, Consultants, Service Managers, Governance and Complaints Managers; and a number of service users who have contributed to and spoke at these events.

The focus of this year's event was learning from complaints regarding privacy, dignity and respect, (Appendix 1). Last year's event, held in June 2015, addressed the issue of Communication and an output of key messages from the event was circulated widely across the HSC (Appendix 2). The initial Annual Learning from Complaints Event was held in June 2014 and focussed on the role of the complaints manager and local resolution arrangements.

Question 3

On 31 March 2014 the Permanent Secretary wrote to HSCB and PHA concerning the complaints systems coming to a halt if there is litigation referring to the need for further guidance: *"In particular such guidance needs to make clear that litigation or legal proceedings should not be an obstacle to engaging with patients, clients and families"*.

i. Was this guidance issued?

ii. If so, what steps have been taken to ensure that the guidance is followed?

Answer

The Permanent Secretary's correspondence to HSCB and PHA on 3 March 2014 stated that "we need to expand on the existing guidance to HSC on engagement with patients, clients and families as part of the SAI process". In addition, he requested that the HSCB and PHA put together a group to draft guidance on patient/client /family engagement as part of the SAI process with a view to sharing a draft of the guidance with the Department of Health Social Services and Public Safety (DHSSPS) before the end of May 2014. The Permanent Secretary indicated that this group should include representation from the Patient and Client Council and the Regulation and Quality Improvement Authority (RQIA).

The HSCB and PHA SAI Procedure makes clear the need for appropriate communication and involvement of service users, relatives and carers, and from 1 April 2014, all SAI Review reports submitted to HSCB/PHA have a Service User/Family Carer Engagement Checklist attached.

In addition, and as requested within the DHSSPS communication, the HSCB and PHA have worked with the Patient Client Council (PCC), RQIA, and Trust Governance Leads to develop guidance for HSC organisations when involving service users/families throughout the relevant stages of the SAI process.

This guidance was issued in February 2015, its main purpose to ensure that communication with service users/families/carers, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner; thereby promoting a culture that effectively leads to improved service user and staff acceptance of the event. The guidance should be read in conjunction with the revised SAI Procedure in order to ensure the engagement process is closely aligned to the required timescales, documentation, levels of review etc. A leaflet has also been developed to provide information for patients/families on the process. (Appendix 3)

The HSCB monitors and reviews service user/family/carer engagement for all HSC Trust and Primary Care SAIs notified. An analysis of this information is now included in the bi-annual SAI Learning Report.

Question 4

HSCB/PHA Annual Quality Report 2014/2015 includes a section on 'Measuring improvement from complaints' (p.64), which refers to the monthly meetings of the Regional Complaints Sub-Group and "*examples of changes implemented as a result of complaints"*.

i. How is learning from complaints actually analysed and evaluated?

Answer

The response to question 2 also refers.

The HSCB receives an anonymised summary of each issue of complaint, along with an outline of the response issued in respect of closed complaints from each HSC Trust. In respect of FPS Practitioners, the Board receives an anonymised copy of each written complaint together with an anonymised copy of the response issued by the Practice/pharmacy.

Complaints staff share this information staff on a monthly basis with professional members of the Regional Complaints Sub Group who consider the following areas: Emergency Department, Maternity and Gynaecology, Patient Experience, Falls and Nutrition, Palliative Care, Allied Health Professional issues, Mis-identification, Venous Thrombo-Embolisms, wheelchairs, Social Care issues, Out of Hours (OOH) services, Independent Service Providers (ISP), and Prison HealthCare. In addition complaints regarding FPS Practitioners that have clinical/professional or regulatory elements are shared for comment with professional medical staff.

Issues of concern/patterns/trends and potential areas of learning are highlighted and discussed at the Regional Complaints Group meetings, which are held bi-monthly, and are escalated to the QSE Group as required, for example in respect of a recommendation for dissemination of learning, or to conduct a 'thematic review'..

Question 5

HSC Board – The sixth Annual Complaints report of the Health and Social Care Board - 1 April 2015 – 31 March 2016.

i. Please provide a copy?

Answer

The 6th Annual Complaints Report, refers to the period 1 April 2014 – 31 March 2015 and is attached for information (Appendix 4)

As clarified previously, the report for the period 1 April 2015 – 31 March 2016 will be produced by the end September/early October 2016.

Question 6

Joint Guidance from GMC and NMC (15 June 2015)*:*

"b. You must report suspected adverse drug reactions to the UK-wide Yellow Card Scheme run by the Medicines and Healthcare products Regulatory Agency (MHRA) and the Commission on Human Medicines.

c. You must report adverse incidents involving medical devices to the UK-wide MHRA reporting system."

i. Is any consideration being given to the professions being required to report adverse incidents and near misses?

Answer

Evidence shows that if the culture of an organisation is safety conscious and people are encouraged to speak up about mistakes and incidents, then patient safety and patients care is improved.

Any adverse incident which meets SAI criteria must be reported to the HSCB in line with the Procedure for the Reporting and Follow up of SAIs (2013) – this includes SAIs involving adverse drug reactions and medical devices.

Whilst the HSCB has in place an adverse incident reporting policy, most incidents reported are mainly health and safety related, due to the administrative function of the HSCB. However, because the HSCB contracts primary care services from many independent contractors, the HSCB's Directorate of Integrated Care (DOIC) has in place an adverse incident process for adverse incidents that occur within family practitioner services which is an important mechanism in helping to develop and maintain a true safety culture within Primary Care.

A key part of achieving good clinical governance is recognising that it is not always possible to achieve the perfect clinical outcome and that lessons learned are an important and integral part of a continuous programme for quality improvement. Learning from incidents is disseminated in a variety of ways by the Directorate of Integrated Care (DOIC) e.g. via newsletters, email alerts, learning letters and training.

A revised adverse incident policy was introduced in DOIC in December 2014 across the 4 primary care contractor services – medical, dental, optometry and community pharmacy. However, due to each individual contractor service regulations / frameworks, adverse incident reporting is not a mandatory requirement for each service, rather it is encouraged as best practice and to identify and share learning to prevent recurrence.

An adverse incident reporting form has been developed for all 4 Primary Care contractor services.

Yellow Card Reporting Scheme

The HSCB continues to support and encourage the reporting of adverse drug reactions using the yellow card scheme. This is done both by encouraging individual practitioners to report adverse incidents that they are aware of and also wider dissemination of information about the scheme e.g. through training and newsletter articles.

Question 7

John Compton *"we have recently written to the coroner to formally request that all coroner's reports that may have learning for health and social care will be sent to us routinely so we can review those and take any necessary action"*

Transcript 14th November 2013 p.21 L.1-5 HSCB and PHA Evidence

i. Please provide copies of the correspondence with the Coroner on this issue and any response received?

ii. How many reports referred to have been received subsequently?

Answer

Find attached the following:

- Paper describing the communication pathways between the Coroners' Office, Northern Ireland and the Public Health Agency / Health and Social Care Board (Appendix 5)

- Letter to Coroner's office re: the above communication paper (Appendix 6)

- Response from Coroner's office accepting the proposed communication paper (Appendix 7)

Question 8

In March of this year [2013] the HSC board announced that, by 2015, plans would be implemented for all paediatric services to admit children up to their 16th birthday"

Transcript 13th November 2013 p.56 L.12-17 RQIA Evidence

i. Have the plans referred to been implemented?

ii. If not, why not?

Answer

The Commissioning Plan 2013 - 2014 communicated the requirement for Trusts to move upper age limits for paediatric services to minimum of age 16. Subsequent to this there has been engagement with Trust clinical and managerial staff to put this increased minimum age cut off into practice. This has included a workshop to explore the professional issues and PHA support for a training day on adolescent health care.

In July 2015 the Director of Commissioning wrote to all Trusts to formally ask them to put in place arrangements to ensure that children admitted to hospital are cared for in age appropriate settings (Appendices 8 – 12).

Two Trusts (South Eastern Trust and the Northern Health and Social Care Trust) have implemented an upper age limit of 16th birthday for their inpatient services. The responses received from the other three Trusts indicated that while they aim to care for children aged 14 and 15 in age appropriate settings and many children aged 14 and 15 are cared for in paediatric wards, physical infrastructure was a barrier to the full implementation of the requirement by the end of March 2016.

All Trusts confirmed that they have plans in place to address the infrastructure issue and increase the upper age limit**.**

The Joint Commissioning Plan for 2016/17 re-iterated the commissioning position on this and includes the following requirements:

- Effective arrangements should be in place to ensure children and young people receive age appropriate care and that the regional upper age limit for paediatric services of 16th birthday is implemented.

- Trust responses should demonstrate how their paediatric services operate a minimum upper age limit of 16th birthday.

- Trusts should also describe how they will ensure that children aged up to their 16th birthday, who are admitted to hospital, are cared for in an age appropriate environment by staff with paediatric expertise with input from paediatricians where necessary.

First responses to these requirements have been received from Trusts. HSCB/PHA will continue to work with Trusts to ensure that the regional upper age limit of 16th birthday is implemented as soon as possible.

Question 9

HSCB/PHA 'Competency Framework for Reducing the Risk of Hyponatremia when Administering Intravenous Infusions to Children and Young People' (2 February 2015): *"This Framework applies to all HSC Trust registered nurses ... midwives, dentists, operating department assistants, medical practitioners and pharmacists, who may be involved in the prescription, administration, monitoring and review of intravenous infusions to children aged over 4 weeks and up to 16th birthday.*
This framework will be formally reviewed by the PHA in January 2016".

i. Did the Review by PHA in January 2016 take place? If so please provide a copy.

ii. If not, when will it happen?

Answer

The Competency Framework for Reducing the Risk of Hyponatremia when Administering Intravenous Infusions to Children and Young People was developed by a cross trust multi professional group and issued in February 2015.

In the course of developing the framework and in response to Trust requests, additional resources were subsequently developed to support clinical knowledge and competencies relating to reducing risk of harm due to hyponatremia. These included the development of 4 detailed case studies along with additional guidance to support a standard approach to the use of fluid balance and prescription charts in paediatric settings. These resources were formally issued on 30 September 2015 and Trusts were asked to provide assurance that actions had been completed.

In light of the additional work undertaken throughout 2015 and ongoing regular meetings with Trusts, it was considered that a review of the competency framework in January 2016 would be premature.

The group also became aware of pending National guidance from NICE on Intravenous fluid therapy in children and young people in hospital (issued December 2015), which is currently being considered by a group commissioned by the Department in relation to current Northern Ireland resources and guidance. This work is due to complete Autumn 2016.

Given these developments, it was agreed that the competency framework would be more appropriately reviewed early in 2017.

Question 10

HSCB/PHA 'Guidelines for use of Child Regional Fluid Balance & Prescription (RFB&P) chart' (June 2015)

i. How (if at all) does the 'Regional Fluid Balance & Prescription chart' equate or relate to the Daily Fluid Balance Chart as a *"single daily chart"* that was recommended by GAIN in its audit of Parenteral Fluid Therapy for Children and Young Persons (8 August 2014)?

Answer

The Regional Fluid Balance & Prescription chart is a 'single daily chart'. Regional paediatric and adult charts were simultaneously issued by the DHSSPS on 1 August 2013.

In recognition of a number of developments in fluid therapy, the charts and associated training documents were revised and reissued on 29 September 2014.

Additional resources including case studies, to support the implementation and the use of the charts were developed during 2015.

Copies of the Regional Fluid Balance & Prescription chart for children along with supporting materials are provided on the central repository for hyponatremia resources, hosted by the PHA at the following address:

http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/nursing/central-repository-hsc-resources-relating-

Question 11

HSCB: Learning Matters (issue 5, April 2016), p.4: *"Prescription of IV Fluids. There have been a number of incidents where intravenous fluids have ... not [been] documented on the Medicine Kardex ... This has ... the potential to result in harm".*

i. How many incidents were there and what were the circumstances?

ii. What monitoring is done of learning/compliance with the safety issues identified in 'Learning Matters' – particularly given the e-learning issued in May 2014

Answer

There were no SAIs recorded on DATIX relating to the prescription of IV medication not having been documented on the medicine kardex. The incidents alluded to in the article were 4 adverse incidents. Adverse incidents are monitored and analysed by the HSC Trusts. The example of learning that had been identified and used in the article related to the review of a Trust complaint. There was no harm recorded due to these incidents. Immediate corrective action was taken locally.

The Learning Matters newsletter provides staff with access to important learning and increases the awareness where learning has been identified. Currently there is no requirement to gain assurances on implementation of the learning from the Learning Matters articles. Issues where assurance is required are communicated by formal letter (primarily Reminder or Learning Letters) and taken forward in line with the HSCB/PHA Protocol for Implementation of Safety and Quality Alerts.

Question 12

Mr John Compton SAIs: *"In total, 966 serious adverse incidents have been reported to the board since 1 May 2010. In the most recent year of 2012/2013, 320 serious adverse incidents were reported to the board. This represents an increase from the previous year when 262 were reported".*

Transcript 14th November 2013 p.15 L.7-11 HSCB Evidence

i. Please provide the latest Learning Report Serious Adverse Incidents (October 2015 – March 2016)

Answer

Learning Report Serious Adverse Incidents, October 2015 – March 2016, attached. (Appendix 13).

Question 13

BH&SCT report **(348-002):** *"There is no regional consistency in the timeframe for a report to be completed and deemed final, which can result in only draft reports being provided to the Coroner & others."*

i. Is the HSCB aware of this?

ii. If so how is it being addressed? If not why not?

Answer

The 2013 Procedure for the Reporting and Follow up of SAIs (section 5.0) clearly states the timescale for submission of SAI reports to HSCB i.e.

- Level 1 reviews– 6 weeks
- Level 2 reviews – 12 weeks
- Level 3 reviews – as per agreement with DRO.

In most instances, SAI reports will have been finalised by the time the Coroner investigation is underway. However, the timing of SAI investigations/reports and Coroner investigations may mean that it is a draft SAI report that is available to the Coroner.

Any future review of the SAI procedure will continue to emphasise timeframes.

Question 14

October 2013 as part of a review of the SAI system and recommending that "Deaths of children from natural causes should not be classified as Serious Adverse Incidents". The letter seeks "to discuss this recommendation"

Reply from Chairman (11.09.15): "I have some concerns. Exempting such deaths... should not become a way of avoiding the reporting of deaths such as those with which the Inquiry has been concerned. The wording and interpretation of 'natural causes' would have to be very narrow to avoid this"

"Learning Report Serous Adverse Incidents (November 2015), 'Child Death Notifications', referring to the requirement to notify as an SAI all deaths of children receiving HSC services and the comments of Donaldson: This was an issue the HSCB/PHA had already identified and work had commenced on an alternative arrangement for child death notification.

DHSSPS intend to issue the new child death notification process to the HSC in November 2015 for implementation on 1 December 2015. In conjunction with this new process, the HSCB will issue a revised set of SAI criteria"

i. Has the new notification been issued?

ii. Have the revised SAI criteria been issued? If not, when is it expected they will be issued?

iii. Please provide copies of anything that has been issued in relation to this.

Answer

DHSSPS issued a new process for reporting child deaths on 13 January 2016 and was implemented on 1 February 2016.

HSCB issued the revised SAI criteria on 13 January 2016 and was implemented on 1 February 2016.

Attached are the following:

- DHSSPS Process for reporting Child Deaths - issued to all HSC organisations (Appendix 14)

- Letter and revised SAI criteria issued to all Arm's Length Bodies (Appendix 15)

Question 15

NI Policy Response to the report, 'Why children die death in infants, children and young people in the UK Part A': "Recommendation 2 - The DHSSPS should enact the legislation in Northern Ireland to allow the creation of a Child Deaths Review Panel managed by the Safeguarding Board for Northern Ireland (SBNI)" (p.6)

Minutes of the BH&SCT Board (03.09.15)- item 37/15(b): Dr Johnston (Death Certification Policy Certification Policy and Legislation Unit): commencing August 2016, the Regional Mortality and Morbidity Review system (RM&MRs) will be introduced throughout hospitals in NI"

Learning Report Serious Adverse Incidents (November 2015), 'Child Death Notifications': "DHSSPS ... with HSCB/PHA and Trusts, have agreed a new process for recording, reviewing and reporting of all child deaths as part of a new Regional Mortality and Morbidity Review (MMR) System. This process will be introduced and regarded as a pilot with a review being performed after one year"

i. What procedures and guidelines had been issued to ensure regional consistency and effectiveness?

ii. Has the 12 month pilot commenced?

Answer

DHSSPS issued a new process for reporting child deaths on 13 January 2016 for implementation on 1 February 2016. As per the above process, the 12 month pilot commenced on 1 February 2016

Question 16

PHA response (14.04.14) **(348-003)** setting out the 'circulars' and the 'alerts' that remain 'open':

- RQIA follow up Review Reducing the Risk of Hyponatraemia when Administering Intravenous Infusions to Children, which was re-opened on 3 June 2013 **(348-008c-004)**

- RQIA Review of Under 18s Accommodation in Adult Hospital Wards, which was left open following a Review by the Safety, Quality and Alerts Team (SQAT) during 1 April – 30 September 2013 **(348-008c-005)**

- MOU on Investigating Patient or Client Safety Incidents – HSS(MD) 8/2013, which was also left open following the same Review **(348-008c-005)**

- RQIA Review on NICE Guidance Implementation Process in HSC Organisations in 2013/2014 **(348-008c-006).**

i. What is the current position in relation to each of these?

Answer

RQIA follow up Review Reducing the Risk of Hyponatremia when Administering Intravenous Infusions to Children, which was re-opened on 3 June 2013 (348-008c-004).

This report remains open to keep this issue on the agenda, ensure a continued focus, and to develop further materials to help staff maintain skills in fluid management. Significant work has been completed to date, as outlined below.

The PHA was asked to facilitate a regional approach to support the development of a competency assessment tool on the administration of intravenous fluids to children to ensure the application of theory to practice. A cross-organisational Group was established in late 2012 and continued to work on the development of a framework

to support assessment of knowledge and competency which was first issued in April 2013.

In light of ongoing work to reduce the risk of harm associated with hyponatremia in this area across Trusts, DHSSPS, PHA and GAIN, this issue was reopened in June 2013 so that the PHA and HSCB could track progress and ensure that links were maintained between the various workstreams which included:

- Development of clinical case studies to support staff in achieving requisite knowledge and skills as outlined in the competency framework (first issued in April 2013). Case studies went through a detailed development and validation phase before being piloted and circulated to the service as an e-learning resource

- DHSSPS wall chart on parental fluid therapy for children and young people (aged over 4 weeks and up to 16 years) was updated and reissued by DHSSPS in June 2014)

- Regional fluid balance and prescription charts which were first issued by DHSSPS during 2013 were also reviewed, updated and reissued in September 2014 for full implementation

  Further resources to support their implementation were developed and included:

  - Advice on use of Regional fluid balance and prescription charts developed to support standardised implementation
  - Regional Pharmacy Group prepared additional resource to support use of regional fluid balance and prescription charts with a focus on prescribing

- Competency Framework reissued by PHA in February 2015 to take account of changes

- In April 2015 a webpage was developed on the PHA website to provide a central repository of all HSC resources related to reducing the risk of hyponatremia

- July 2015 – Plans to develop a simplified version of the GAIN audit tool (PIVFAIT) commenced so that Trusts could monitor progress against recommendations. This tool has been piloted and will shortly be available for use. Update at SQAT meeting July 2016 – PIVFAIT tool not yet cleared by the Department of Health for issue. Update sought from Department of Health in August 2016 advised that the PIVFAIT tool in its most up to date

form is being used in the Royal Belfast Hospital for Sick Children (RBHSC), ie actively being used as a routine performance tool to monitor and improve IV fluid therapy performance. We are advised that the Chief Medical Officer and Chief Nursing Office (DoH) are about to issue the tool regionally – imminently. We have been further advised that DoH will establish a regional group to manage the process (training and monitoring) and will maintain close supervision of this process, in the first instance, so that they can follow progress with the introduction of this audit tool.

- Liaison with Trusts and Northern Ireland Medical and Dental Training Agency (NIMDTA) to encourage use of appraisal processes in assessing competency in fluid management

- NICE guidance on paediatric IV fluids NG 29 issued in Dec 2015.

- In May 2016, the Neonatal Network was asked to lead work on development of resources for full-term neonates being managed in paediatric settings

- All NI resources will be updated in line with NICE guidance once the neonatal work is complete (anticipate Autumn 2016).

RQIA Review of Under 18s Accommodation in Adult Hospital Wards, which was left open following a Review by the Safety, Quality and Alerts Team (SQAT) during 1 April – 30 September 2013 (348-008c-005)

All Trusts were asked to review the recommendations and submit action plans to HSCB/PHA. These were received and reviewed in May 2013. All Trusts had plans in place to address local issues and there were no substantive concerns. HSCB/PHA continues to review progress with the implementation of this Review. Six monthly updates are provided to the Governance Committee of HSCB.

The main focus of HSCB/PHA efforts in this area has been to set and implement a regional minimum upper age limit for paediatric services. Ensuring children under 16 years of age are not cared for in adult wards will address the problems and risks which exist when children are cared for on adult wards.

The Commissioning Plan 2013/14 communicated the requirement for Trusts to move upper age limits for paediatric services to a minimum of 16 years. Subsequent to this, there has been engagement with Trust clinical and managerial staff to put this increased minimum age cut off into practice. This has included a workshop to explore the professional issues and PHA support for a training day on adolescent health care.

In July 2015, the Director of Commissioning wrote to all Trusts to formally ask them to put in place arrangements to ensure that children admitted to hospital are cared for in age-appropriate settings (Appendix 16). Responses from Trusts indicated that they were working on this. Several Trusts indicated that physical infrastructure was a barrier to full implementation but that they have plans in place to address this and achieve the upper age limit required.

The Commissioning Plan for 2016/17 includes the following requirements:

- Effective arrangements should be in place to ensure children and young people receive age-appropriate care and that the regional upper age limit for paediatric services of 16th birthday is implemented.

- Trust responses should demonstrate how their paediatric services operate a minimum upper age limit of 16th birthday.

- Trusts should also describe how they will ensure that children aged up to their 16th birthday, who are admitted to hospital, are cared for in an age appropriate environment by staff with paediatric expertise with input from paediatricians where necessary.

HSCB and PHA have established forums with professional and managerial representation to discuss issues relating to paediatric services. Age-appropriate care and learning from adverse events is a core part of the work of these groups.
A regional paediatric network with representation from all Trusts has been established and has important links with the HSC Safety Forum. Sharing learning from adverse events across organisations is one of the areas these groups focus on.

MOU on Investigating Patient or Client Safety Incidents – HSS(MD) 8/2013, which was also left open following the same Review (348-008c-005)

The following update was sent to the DHSSPS on 30 September 2013. As all actions have been completed this was closed from SQAT on 16 October 2013.

Action	**Progress**
MOU noted by SMT.	Completed - 26 March 2013
MOU shared with members of the Safety Quality Alerts Team where it was agreed the action plan should be joint between HSCB and PHA with the Governance Lead identified as overall lead. It was also agreed MOU should be shared with Assistant Director within Health Protection	Completed - 8 April 2013

for inclusion in the Regional Outbreak Plan.	
MOU shared with Regional SAI Review Group where it was agreed the MOU would be shared with: • Lead Officers and Designated Review Officers (DROs) involved in the Procedure for the Management and Follow up of Serious Adverse Incidents (SAIs). • Corporate Business lead officers within the HSCB and PHA who are responsible for facilities management and health and safety issues; for inclusion in relevant policies.	Completed - 23 May 2013
• Half day workshop for DROs in relation to the revision of the current Procedure for the Management and Follow up of SAIs. • Prior to the workshop all DROs were forwarded a copy of the MOU. During the workshop DROs were advised on the relevance of the MOU in respect of SAI investigations.	Completed - 24 June 2013
• MOU forwarded to Assistant Director Health Protection for inclusion in the Regional Outbreak Plan. • MOU forwarded to HSCB Corporate Business Manager and PHA Senior Operations Manager for inclusion in relevant policies for consideration when carrying out self-assessments for all relevant controls assurance standards during 2013/14	Completed - 4 July 2013 .
Implementation of revised Procedure for the Management and Follow up of SAIs. Revised procedure references the MOU.	Procedure approved by HSCB Board on 12 September and implemented from 1 October 2013
DRO full day workshop/training event. This event will provide DROs with the necessary training/awareness on the revised SAI procedure and will also cover relevant aspects of the MOU in relation to SAI investigations.	Completed 30 October and 11 November 2013

RQIA Review on NICE Guidance Implementation Process in HSC Organisations in 2013/2014 (348-008c-006).

An update paper on progress of RQIA Report recommendations was considered by SQAT on 10 November 2014 (Appendix 17). This item was closed from SQAT subject to clarification that Recommendation 7 on an IT system is being taken forward by Department of Health rather than Task 3 Q2020 as that Task had been formally stood down. Given progress and no material risk from remaining issues, it

was agreed that the overview report should indicate that this report will now be closed.

Question 17

NI Policy Response to the report, 'Why children die death in infants, children and young people in the UK Part A': "Recommendation 21 – "The HSCB, Health and Social Care Trusts and relevant professional associations should ensure that all frontline professionals involved in the acute assessment of infants, children and young people utilise resources such as 'Spotting the sick child' web resource and complete relevant professional development so they are competent and confident to recognise a sick child" (p.15)

i. What if anything has happened about the recommendation for training in relation to competently and confidently recognising the sick child?

Answer

NI Policy Response to the report, 'Why children die death in infants, children and young people in the UK Part A': "Recommendation 21 – "The HSCB, Health and Social Care Trusts and relevant professional associations should ensure that all frontline professionals involved in the acute assessment of infants, children and young people utilise resources such as 'Spotting the sick child' web resource and complete relevant professional development so they are competent and confident to recognise a sick child" (p.15)

The Safety Forum has worked with all Trusts to develop and implement a regional paediatric early warning score (PEWS). This tool uses a range of observations which are recorded by ward staff to give a score. Changes to this score are an objective warning to staff that the child's condition may be changing. When the score changes there are agreed steps which should be taken to ensure the child is reviewed.

The implementation of PEWS has included extensive training in its use in all Trusts. The regional PEWS are now being used in every paediatric unit across Northern Ireland. Trusts continue to work together, through the Safety Forum, to audit its use.

More generally, Trusts have a responsibility to ensure that their clinical staff are appropriately trained and skilled to work in their clinical area. For those working with acutely unwell children, being able to spot the ill and deteriorating child is an important part of this. Medical and nursing staff working in areas where sick children present and are cared for should include recognition of the sick and deteriorating child in their professional development and this should be reviewed through the appraisal and revalidation process for medical and nursing professionals.

Having well-trained, experienced senior staff available to assess acutely unwell children is one of the most important steps that can be taken to ensure that acutely unwell children are “spotted”. Trusts, HSCB and PHA have been working to increase senior presence in paediatric units. The Department’s Review of Paediatric Services includes specific standards in this regard and when it is published, the implementation of the review will help improve care for acutely unwell children.

Learning from child deaths and serious adverse incidents is also shared across Trusts via the regional paediatric network and Safety Forum. Details of individual cases, recurring issues that arise in incidents and recommendations are shared with medical, nursing and managerial leads across Trusts. These are discussed and relevant actions agreed.

Question 18

H&SCB and PHA Annual Quality Report (2014/2015) Learning Report Serous Adverse Incidents (November 2015), p.102: “Paediatric early warning score systems have been established for use in acutely unwell children in order to identify the physiological and behavioural signs of deterioration prior to collapse ... it was agreed that as part of the HSC Safety Forum Paediatric Collaborative, a subgroup would develop and agree a single chart(s) for use in all units to standardise the process and facilitate the moment of patients and staff between HSCTs”

i. Please provide the document that explains this Paediatric Early Warning Score System?

ii. Are standard charts in use now and if not when are they to be introduced

Answer

Early warning scores are generated by combining the scores from a selection of routine observations that include heart rate, respiratory rate, conscious level. If a child's clinical condition is deteriorating, total early warning score (the summation of the scores for individual observations) will (usually) increase - an early indication that intervention may be required. Early recognition and intervention can 'fix' problems and can avoid the need to transfer a child to a higher level of care and thus avoid or reduce harm. Early recognition may also lead to some children being transferred to a higher level of care earlier – thus reducing morbidity and/or risk of death.

As part of the work of the HSC Safety Forum which established a region-wide paediatric quality improvement collaborative, teams caring for all children in patients across all trusts in Northern Ireland have been using a single, regionally-agreed

paediatric early warning score (Appendices 18-21). This was piloted for a period of six months before full implementation in October 2015 and its use will be reviewed after 12 months (November 2016).

Question 19

Regional adverse incident review group, all SAIs are reviewed for regional learning."
Transcript 14th November 2013 p.40 L.8-10 HSCB Evidence

i. How often do the RAIRG meetings take place?

ii. Are there any records of those meetings?

Answer

The regional serious adverse incident review sub-group (RSAIRSG) meets on a monthly basis. A concise action log is taken for each meeting.

Question 20

Chairman's letter (27.03.14) – re table received on 11 November 2013 of incidents across the 5 Trusts: "how reliable is the adverse incident reporting system when there are such gross variations in categorisation?"

Response: There is no consistent method of coding used across all NI Trusts despite all using the same software system.

i. How (if at all) is the HSCB addressing this?

Answer

The HSCB and PHA have been exploring with Departmental Colleagues and Trust Governance Leads how the related recommendation within the Regional Learning System (RLS) report can be taken forward.

Appendices

Response to Question 2

1. Agenda for HSC Complaints Learning Event 2016
2. Learning Output from HSC Complaints Learning Event 2015

Response to Question 3

3. Communication to Service Users/Families and Carers following receipt of an SAI (Leaflet)

Response to Question 4

4. 6th Annual Complaints Report 2014/2015

Response to Question 7 (i)

5. Paper describing the communication pathways between the Coroners' Office, Northern Ireland and the Public Health Agency / Health and Social Care Board
6. Letter to Coroner's office re: the above communication paper
7. Response from Coroner's office accepting the proposed communication paper

Response to Question 8

8. Letter to Elaine Way, 14 July 2015
9. Letter to Hugh McCaughey, 14 July 2015
10. Letter to Michael McBride, 14 July 2015
11. Letter to Paula Clarke, 14 July 2015
12. Letter to Tony Stevens, 14 July 2015

Response to Question 12 (i)

13. Learning Report Serious Adverse Incidents (October 2015 – March 2016)

Response to Question 14 (iii)

14. DHSSPS Process for reporting Child Deaths - issued to all HSC organisations
15. Letter and revised SAI criteria issued to all Arm's Length Bodies

Response to Question 16

16. Correspondence from Director of Commissioning to HSC Trusts, July 2015.
17. Update to SQAT 10 November 2014

Response to Question 18

18. PEWS under 1 year
19. PEWS 1-5 years
20. PEWS 6-12 years
21. PEWS 13-16 years