

By e-mail
From the Head of Safety Strategy Unit
Brian Godfrey



Mr Des McCann (DSO)

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Dear Mr McCann

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS- SCHEDULE OF QUESTIONS TO DEPARTMENT OF HEALTH

Bernie Conlon's letter of 16 August 2016 refers.

Please find attached a schedule outlining the response to each of the questions.

If you require any further information or clarification on any of the answers, please do not hesitate to contact me.

Yours sincerely



BRIAN GODFREY

cc Dr Woods
Conrad Kirkwood
Tricia Finlay
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INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Questions for Department of Health

August 2016

Para 1 (Question 1) Serious Adverse Incidents

- i. **In terms of actual change having been effected in light of the Donaldson report and the Department's role in ensuring that change has occurred and is being applied, what is the current position?**

As stated in the response of 19 July 2016, the Department has asked the HSCB and PHA to take forward a number of pieces of work to progress the SAI related recommendations outlined in the Donaldson report. This work is currently ongoing in liaison with HSC Trusts. The HSCB/PHA is due to provide a progress report to the Department in October 2016.

- ii. **From what date has the deaths of children from natural causes been no longer classified as an SAI? Please describe the "new regional process for recording and reviewing child deaths".**

The mandatory requirement to report the death of a child as an SAI was removed with effect from 1 February 2016. From this date only those cases where the death of the child has been unexpected or unexplained were required to be reported as an SAI and have continued to be investigated in accordance with the SAI process. This change in process is currently being operated as a pilot until 31 January 2017, pending introduction of the Regional Mortality and Morbidity Review System.

A copy of the HSS MD Circular describing the process is attached.



HSS MD 1 2016
Process for Reporting

See Document 401-002s

- iii. **Please provide a copy of the checklist dated February 2015 regarding better engagement of people and their relatives in the SAI process.**

A copy of the guidance checklist on engagement with patients, clients, relatives or carers as part of the SAI process is attached.



See Document 401-002t

- iv. **Please provide copies of any learning reports issued subsequently which include the relevant data.**

Copies of SAI Learning Reports issued by the HSCB since February 2015 are attached.



Para 2 (Question 2)

Please clarify your response to Question 2 (i).

Is there guidance in existence which encompasses the Permanent Secretary's direction that it be made clear that "litigation or legal proceedings should not be an obstacle to engaging with patients, clients and families"? If not, why?

The Minister is currently considering options on the way forward pending the introduction of a Statutory Duty of Candour. Once a decision is made, relevant guidance will be issued.

Para 3 (Question 3)

In relation to your response to Question 3, when was the scoping exercise carried out, is it complete and what is the plan going forward?

The scoping exercise is completed and a summary report was submitted to Top Management Group (TMG) in the Department of Health in July 2016. The plan going forward is that a draft Quality Healthcare Experience Framework will be

prepared for public consultation; this framework sets out the direction for achieving a quality healthcare experience in the north of Ireland and will aim to;

- develop a clear regionally consistent picture of Healthcare Experience
- provide HSC staff with the tools to deliver safe, effective, high quality care to all the people of NI

The key components required for the successful delivery of this framework will be

- setting a clear definition and vision for Quality Healthcare
- an organisational commitment to co-design and co-produce care plans; pathways and services
- setting clear objectives for every member of staff within every organisation for which they are held to account
- a focus on training staff in advanced communication skills and quality improvement methodologies

Para 4 (Question 6)

i. What type of cases were the 15 that attracted confidentiality clauses?

As stated in the previous response, there have been 15 confidentiality clauses contained in the settlements of medical negligence cases taken against health authorities here over the last three years. This represents 2% of all settled cases. The Department recognises that there may be occasions where such clauses are unavoidable but these should only be in exceptional circumstances. Confidentiality clauses are only inserted where the plaintiff or co-defendant request it. It is never requested by the HSC body.

ii. Describe the procedure for seeking and obtaining Departmental approval to a confidentiality clause.

As per (HSC 08-2016), all HSC bodies are required to seek Departmental approval for the use of confidentiality clauses. Therefore, an organisation wishing to use a confidentiality clause must write to the Department setting out the justification for the clause. If the Accounting Officer is satisfied that the clause is unavoidable and has been made in exceptional circumstances, then approval will be given.

Para 5 (Question 7)

When is the final report of the RQIA review of the operation of whistle blowing expected?

The RQIA has advised that the Review of Whistleblowing is expected to be published in the next 2-3 weeks.

Para 6 (Question 9)

- i. On receipt of a rule 23 report how does the Department satisfy itself that the relevant Trust has learned any lessons and made any necessary changes to practice?**

(Under Rule 23 (2) of the Coroners (Practice & Procedures) Rules (NI) 1963, a coroner who believes that action should be taken to prevent the occurrence of fatalities similar to that in respect of which the inquest is being held, may announce that he is reporting the matter to the person or authority who may have the power to take such action and report the matter accordingly.

In providing a response to this particular question, the Department has considered a number of cases referred by the Coroner and it is clear that there is no standardised approach as to how these reports are made. In some cases correspondence is addressed to the Minister, on other occasions information is provided for the Chief Medical Officer or other senior officials, and in some instances there is no mention that the referral is being made under Rule 23 (2).

The HSCB has an agreement in place whereby the Coroner will forward any cases where there may be potential regional learning to the HSCB for consideration. If appropriate, the HSCB will issue a learning letter to all HSC Trusts. The HSCB also provides copies of any learning letter issued to the Coroner's office for information.

It is also clear that there are a wide range of complex issues associated with many of the individual cases and there may not be any learning necessarily for individual HSC Trusts or a requirement for changes to practice.

ii. Are there any meeting dates in place for officials from the Department to meet with Coroners' Office staff regarding Rule 23 reports?

As indicated in the previous response, referrals from the Coroner are dealt with according to the individual circumstances. In some cases this has led to regional action being taken to ensure that the occurrence of similar fatalities may be prevented. In other cases, individual Trusts may take action at a local level which may not necessarily be reported back to the Department.

The Department will however now enter into discussion with the Coroners Service to ensure that a standardised approach to Rule 23 (2) referrals is adopted. You may wish to note that when the Regional Mortality and Morbidity Review System becomes operational from April 2017, there will be the facility for reports from Coroner's Inquests to be considered at multi-disciplinary Mortality and Morbidity meetings by frontline staff who have been directly involved in the care of the patient. The system will also provide the facility for any learning lessons to be recorded and followed up to ensure that all appropriate actions are implemented.

Para 7 (Question 11)

i. Has the Department any evidence of Trusts using the unique identifier to identify errors in coding?

Information relating to the use of the unique identifier to identify errors in coding and Trust's internal auditing of their coding systems is the responsibility of the Regional Clinical Coding Team at the HSCB. This matter should, therefore be referred to the HSCB to answer.

ii. What information does the Department hold regarding Trusts' internal auditing of their coding systems?

The HSCB employ accredited licensed Clinical Coding Auditors to monitor the accuracy of clinical coding on behalf of the DoH and provide assurance to the DoH that all Trusts are adhering to UK clinical coding standards.

Para 8 (Question 12)

Has the Regional Mortality and Morbidity Review System (RMMRS) been rolled out? If so when did it start and if not when is it due to commence?

The Regional Mortality and Morbidity Review System is in the test phase of development in advance of going-live. It is currently being tested by some clinicians in the Belfast Trust and once this has been completed it will be further tested by certain teams in each of the other Trusts over the next few months. It is anticipated that it will be rolled out and fully operational in all Trusts from April 2017.

Para 9 (Question 15)

- i. In simple terms has the Death Certification Implementation Working Group (established in October 2013) reported and if not when is it due to?**

The Death Certification Implementation Working Group (DCIWG) is an inter-departmental working group, led by the Department of Health. Its membership contains representation from the Department of Finance (which has responsibility for the registration of death through the General Register Office); Department of Justice (which has responsibility for Coronial policy); the Department for Communities (which has responsibility for Cremation Policy); and other relevant stakeholders. The DCIWG is currently developing and implementing a series of reforms as approved by the NI Executive.

- ii. What is the department's current position regarding the introduction of an Independent Medical Reviewer who would have powers to refer cases to the Coroner?**

Once the reforms have been completed, an evaluation will be undertaken and a report made to the NI Executive to determine if it is necessary to introduce an Independent Medical Examiner to Northern Ireland. In short, work is continuing to implement and evaluate these reforms and until this work has been concluded, it is not possible to report to the NI Executive. As indicated above, the decision on any potential introduction of an Independent Medical Reviewer will be a matter for

determination by the NI Executive. The introduction of such a role will have implications across the 4 Departments mentioned above and a recommendation will not be made to the NI Executive until the current reforms have been implemented and evaluated and full consideration of the implications has been given by each of the Departments involved.

The Death Certification Steering Group, Co-chaired by the Chief Medical Officer and the General Registrar for Northern Ireland, and comprising membership from Department of Justice and Department for Communities, oversee the work of the DCIWG. They continue to monitor the implementation of reform, the development of the Regional Mortality and Morbidity Review System and the position in the rest of the UK in relation to the introduction of Independent Medical Examiners.

Para 10 (Question 20)

What action has the Department taken to ensure each Trust has actually taken the actions they proposed to the Department as a result of the GAIN report in August 2014?

The Department has been working to finalise the Paediatric IV Fluid Audit Implementation Tool (PIVFAIT) in order to establish a consistent regionally-applied mechanism to evaluate the various processes around UV fluid therapy for children and young people. This is due to be published soon.

Para 11 (Question 23)

In what way has the NIPEC and the CNO initiative on record keeping been communicated to trusts: how are improvements as a result of this work monitored and measured?

NIPEC works across the health and social care system communicating actively across several levels within each organisation. Direct engagement includes the Chief Nursing Officer (CNO)'s regular meetings with the Executive Directors of Nursing (EDoNs). One of the EDoNs is the Chair of the Steering Group of the Recording Care Project (RCP). The RCP steering group includes in its membership

the five Assistant Directors for Nursing and Midwifery Governance, another information conduit to Trusts. NIPEC also works directly with frontline nurses such as children's, adult general, mental health and learning disabilities nurses to achieve a range of project outcomes. Each Trust has a group either specifically for, or through which information relating to improving record keeping practice can be disseminated.

In addition, via the RCP 'trust specific' professional officers from NIPEC implemented the improvement methodologies and cycles of audit over two years (February 2012 – April 2014). During three months this year (February – April 2016), one of NIPEC's professional officers focused in particular on piloting a new approach to recording nurse care plans. The project continues to seek opportunities through local engagement to drive this important agenda in the north of Ireland.

NIPEC has continued to develop and review a tool for audit, based on the regional standards for person centred nursing and midwifery record keeping practice (2013). Initially the audit tool was for adult hospital based environments and more recently NIPEC has developed a tool for all care settings. The audit results are reviewed within each organisation, and on a quarterly basis, a sample are scrutinised by the Steering Group members. Any emerging key messages are then reported by the Chair of Steering Group to the EDoNs via the CNO meeting.

Para 12 (Question 26(i))

Please provide a copy of the Regional Learning System Project Report August 2015. Have the recommendations been accepted and implemented?

A copy of the RLS project report is attached.


Regional Learning
System Report - Final

See Document 401-002w

The findings in this report have been accepted. However due to resource constraints, it has not been possible to progress implementation of the recommendations in this report. However, a scoping study has been carried out by the HSCB to identify those recommendations which can be taken forward at "no

cost". It is intended to set up a group to look at how these recommendations and the other recommendations outlined in the report can be progressed depending on the availability of resources.

Para 13 (Question 28)

Please clarify this response.

The previous response attempted to provide an overview of the Datix system used by HSC Trusts to illustrate the existing capability of the system to provide reports for staff which was the basis of the criticism by the Royal College of Anaesthetists. As the existing functionality of the Datix system and its operation by HSC Trusts in Northern Ireland already provides this capability, the criticism would appear to be unfounded with respect to Northern Ireland.

Para 14 (Question 30)

Your response refers to "multi-agency forums that meet regularly where SAIs and learning from SAIs reviews is considered". Please identify those who meet and how often do they do so. Please provide a copy of the last meeting's agenda.

As the HSCB working together with the PHA has functional operational responsibility for the SAI system including associated learning and its communication to the wider HSC, to facilitate a comprehensive and accurate response to this question, this question should be referred to the HSCB.

Position on review of the complaints process

Dr Michael McBride informed the Chairman at the oral hearings that he had "asked RQIA to do a review of the complaints process in 2013 as part of their thematic reviews and they'll be reviewing the SIA systemin 2014" (ref Transcript 14/11/2013 p69 lines 6-9 HSCB/PHA). RQIA have recently confirmed that they did not carry out a review of the complaints process in 2013, nor review it in 2014. The next work scheduled (since a report dated Feb 2012) is

as part of RQIA Three Review Programme and is currently scheduled for 2017/2018. I would be grateful if you would clarify the position.

We can confirm that a review of the complaints procedure in health and social care is scheduled for 2017/18 under the RQIA's published 3-year review programme.