

The Inquiry into Hyponatraemia-related Deaths

Chairman: Mr John O'Hara QC

Ms Olive McCloud
Chief Executive
RQIA
9th Floor
Riverside Tower
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BELFAST
BT1 3BT

Our Ref: BC-0228-16

Date: 22nd June 2016

Dear Ms McCloud,

I attach for your attention a schedule of questions which the Chairman would like a response to on or before 22nd July 2016. He would be grateful for concise responses specifically tailored to the questions asked and reflecting the numbers used in the schedules.

If you have any queries regarding this matter, please do not hesitate to contact me.

Yours sincerely,



Bernie Conlon
Secretary to the Inquiry

Secretary: Bernie Conlon

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Questions for RQIA

No	Context	Question
1	<p>Dr McBride: “...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 system ... in 2014”.</p> <p>Transcript 14th Nov 2013 p.69 L.6-9 HSCB/PHA</p>	i. Please provide copies of the reviews?
2	<p>Mr Stewart: “How confident are you that the trusts have indeed put in place robust systems for dissemination of learning from adverse incidents? ... that will be a continuing piece of work for RQIA”</p> <p>Transcript 13th November 2013 p.47 L.4-8 RQIA Evidence</p>	i. What has been done since November 2013 as a ‘continuing piece of work’ to assess that?
3	<p>The RQIA Report of December 2014 refers to the limited time for the involvement of families, stating that: “The outcome of this review should be taken into account before finalising this guidance”.</p>	i. What has been the result?
4	<p>BH&SCT reports: “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.”</p>	i. Has this been identified by the RQIA in any Review or Report?
5	<p>Donaldson reports on the lack of training and experience of ‘front line staff’ in ‘investigating properly’ (4.4.3, p.27) and in using ‘root-cause analysis methods’ to ‘identify the cause and specify actionable learning’ (4.4.7, p.30 and 5.4.6, p.41). He goes on to report that “The Regulation and Quality Improvement Authority has established training in Root Cause Analysis for front-line staff, and this will help” – 5.4.8, p.42.</p>	i. What assessment (if any) has been carried out as to the effect of the training on the SAI reporting and learning process?

No	Context	Question
6	<p>RQIA Report of December 2014 comments on the HSCB's Guidance on Reporting and Follow up of SAIs refers to 'interface incidents':</p> <ul style="list-style-type: none"> • Where one Trusts expects another to undertake an investigation • Clear guidance needed on which Trust must take the lead. 	<p>i. Has any such guidance been provided?</p>
7	<p>Dr Ian Carson "... our officers meet with SQS on a bi-monthly basis at the moment"</p> <p>Transcript 13th November 2013 p.50 L.3-4 RQIA Evidence</p>	<p>i. Are those meetings minuted or recorded in any way?</p>
8	<p>OECD Review recommendations for Northern Ireland included:</p> <ul style="list-style-type: none"> • <i>"Undertake a comprehensive review of the inspection and assessment framework of the RQIA giving ... greater emphasis to promoting continuous quality improvement, incorporate robust forms of self-assessment and involve benchmarking of clinical quality and safety metrics;</i> <p><i>Clarify reporting relationships with the DHSSPS central safety and quality function and clearly communicate the role of the RQIA to service providers and the public ..."</i></p>	<p>i. What action (if any) is the RQIA proposing to take as a result of the OECD report?</p> <p>ii. Does it plan any follow up to its December 2014 report?</p>
9	<p>Dr Ian Carson 'Duty of cooperation within the NHS in relation to SAIs'</p> <p>Children's Services Co-operation Act (Northern Ireland) 2015 requires the Department, Trusts and HSCB to co-operate in exercise their functions for the well-being of children, including their <i>"physical and mental health"</i>.</p> <p>Transcript 13th November 2013 p.50 L.11-25 RQIA Evidence</p>	<p>i. Will the RQIA be reviewing (as part of continuous assessment) how the Trust discharges that obligation in respect of SAIs and children?</p>

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10	<p><i>RQIA reports (348-006) in response to the Chairman's letter (27.03.14): "RQIA does not directly receive SAI reports of adverse events which occur in acute hospitals ... since January 2014 two RQIA directors ... are members of the Regional Adverse Incident Steering Group ... [which] reviews a selection of Investigation reports".</i></p>	<p>i. What is the criterion for selection?</p>
11	<p>Dr Ian Carson <i>"The review will include ... reporting, investigation and learning from adverse incidents, complaints handling and whistle-blowing, human resources, risk management, dissemination of alerts".</i></p> <p>Transcript 13th November 2013 p.63 L.15-20 RQIA Evidence</p>	<p>i. Has the review taken place?</p> <p>ii. Is a report available?</p> <p>ii. If not, when will it be available?</p>
12	<p><i>RQIA's report of December 2014 of SAIs refers draft guidance "currently at the final stages of consultation" for HSC organisations on "engagement with patients, clients and families as part of the SAI process" (para.2.2, pgs.3-4)</i></p>	<p>i. Has this guidance been issued?</p> <p>ii. If so please provide a copy.</p> <p>ii. If not when is it expected?</p>
13	<p>Minister of Health's statement on 27 January 2015: <i>"The effectiveness of whistle blowing arrangements within the Health and Care system continues to be a cause for concern. As part of the 2015/18 RQIA Review Programme, I have directed that RQIA should undertake a review of the operation of whistle blowing in health and social care bodies and make recommendations on how we can improve its effectiveness".</i></p> <p>Hansard 27th January 2015 Vol 101 No 4</p>	<p>i. What is the position in relation to the RQIA review of the operation of Whistle blowing?</p>

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14	<p>Minister of Health's statement on 27 January 2015: <i>"The effectiveness of whistle blowing arrangements within the Health and Care system continues to be a cause for concern. As part of the 2015/18 RQIA Review Programme, I have directed that RQIA should undertake a review of the operation of whistle blowing in health and social care bodies and make recommendations on how we can improve its effectiveness".</i></p> <p>Hansard 27th January 2015 vol 101 No 4</p>	<p>i. What is the position in relation to the RQIA review of the operation of whistle- blowing?</p>
15	<p>House of Commons Briefing Paper: NHS whistle blowing procedure in England (18 September 2015), referring to the comment by the Health Select Committee report on Complaints and Raising Concerns (21 January 2015): <i>"the treatment of whistleblowers remains a stain on the reputation of the NHS"</i> and the recommendation of the Francis Review, Freedom to Speak up' (11 February 2015), that there should be a <i>"National Whistle blowing Guardian to protect those who speak up"</i> and <i>"training for staff on how to raise concerns and protect others who do so"</i> (p.6-7).</p>	<p>i. What (if any) consideration has been given to the concept recommended in the Francis Review of a National Whistle-blowing Guardian?</p> <p>ii. What training is provided in Northern Ireland for staff on how to raise concerns and on how to protect others who do so?</p>