Questions for RQIA

No	Context	Question
1	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".* **Transcript 14th Nov 2013 p.69 L.6-9 HSCB/PHA**	**i. Please provide copies of the reviews?** Review of complaints RQIA did not carry out a review of the complaints process in 2013. The Health and Social Care Board (HSCB) was asked by the DHSSPS to lead on a process evaluation of the HSC Complaints Procedure and the report was issued in February 2012. An update on the Action Plan following this Evaluation is available on the HSCB website. Please see attached link: http://www.hscboard.hscni.net/download/PUBLICATIONS/COMPLAINTS/Complaints-in-the-HSC-Evaluation-Report-Action-Plan_2.pdf See Document 401-003c A review of the complaints procedure within Health and Social Care is included as part of the RQIA Three Review Programme for 2015-18. This review is scheduled to take place in 2017/18. . Please see below link to the 3 year review programme (page 25): http://www.rqia.org.uk/cms_resources/Three_Year_Review_Programme_2015-18.pdf See Document 401-003d Serious Adverse Incidents (SAIs): The 3 year review programme for 2012/15 included a planned review of Adverse Incident Management, Reporting and Learning. In April 2014, each Health and Social Care Trust was asked by the Department of Health to carry out a review of the handling of all SAIs reported between 2009 and 2013. RQIA was asked to quality assure the look back exercise carried out by each trust. This was called 'Quality Assurance of the Review of the handling of all

No	Context	Question
		Serious Adverse Incidents reported between 1 January 2009 and 31 December 2013. This quality assurance exercise replaced the original review in the 2012-15 thematic review programme. The report was provided to Sir Liam Donaldson in December 2014 to inform his review of governance arrangements and published by RQIA in 2015. Please find below link to the report: http://www.rqia.org.uk/cms_resources/SAI_REVIEW_05122014.pdf See Document 401-003e
2	**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"* **Transcript 13th November 2013 p.47 L.4-8 RQIA Evidence**	**i. What has been done since November 2013 as a 'continuing piece of work' to assess that?** In 2015 the Guidelines and Audit Implementation Network (GAIN) transferred from the Department of Health to RQIA. GAIN has been commissioned by the Department of Health to undertake two projects relating to the processes for ensuring learning from SAIs. *The first project is examining learning arising from SAIs particularly those which involve the death of a patient.* The purpose of the project is to look at different approaches and review methodologies for identifying learning from serious adverse incidents (SAIs), particularly those involving the death of a patient. The project is being taken forward in partnership with HSC organisations and involves considering the effectiveness of existing tools and processes used to review SAIs. This project is ongoing. The Terms of Reference are: • To assess the effectiveness of existing tools and processes used to review learning from individual SAIs, involving the death of a patient including appropriate

No	Context	Question
		engagement with patients, client's families and staff including front line staff. • To review different approaches and methodologies for identifying organisational and regional learning from SAIs involving the death of a patient including effectiveness of actions taken following the SAI process. • To review dissemination of learning from the SAI process. • To examine good practice elsewhere in the UK and internationally. • To prepare an options appraisal of potential methodologies for ongoing review/audit of the learning from SAIs. • To pilot a number of these methodologies. • To establish linkages where appropriate with existing programmes and systems in Northern Ireland and nationally. *The second project is examining learning arising from SAIs involving suicide, homicide and serious self-harm.* RQIA, under the auspices of GAIN, and working closely in partnership with the Health and Social Care Board, the Public Health Agency, HSC Trusts and other stakeholders were asked to consider a revised methodology/ process to identify the regional learning arising from those of these incidents which are currently reported and reviewed as SAIs including suicide, homicide and cases of serious self-harm. The project is considering approaches for enabling families in these cases to contribute to the identification of learning and also drawing on service user experience.

No	Context	Question
		This project is ongoing. The Terms of Reference are as follows: • To assess the effectiveness of existing tools and processes used to identify learning from individual SAIs involving suicide, homicide and serious self-harm[1], including the degree of patient/family involvement. • To review the present approaches and methodologies for identifying and evaluating organisational and regional learning from SAIs involving suicide, homicide and serious self-harm. This will include looking at actions arising from these SAIs and dissemination of learning. • To examine good practice elsewhere in the UK and internationally in relation to the assessment of SAIs involving suicide, homicide and serious self-harm. • To develop a revised methodology for the investigation of deaths involving suicide, homicide and where appropriate cases of serious self-harm, which will include: o Identification of learning o Dissemination of learning o Improved service user participation o A mechanism whereby cases that require further investigation may be referred to an appropriate independent person or group o A process for ongoing oversight, review/audit of the learning arising from SAIs involving suicide, homicide or self-harm • To establish linkages where appropriate with existing programmes and systems in Northern Ireland and nationally.
3	*The RQIA Report of December 2014 refers to the limited time for the involvement of families, stating that: "The outcome of this*	**i. What has been the result?** The guidance was finalised and issued on 11 February 2015 by the Health and Social

[1] **Defined As:** Those self-harm cases which were reported as a SAI by Trusts

No	Context	Question
	review should be taken into account before finalising this guidance".	Care Board and Public Health Agency. It is entitled: "Guidance on Engagement with Service Users, Families and Carers as part of the Serious Adverse Incident (SAI) Process." This guidance can be accessed at: http://www.hscbusiness.hscni.net/pdf/23-02-2015_Guidance_on_communication_following_a_Serious_Adverse_Incident1.pdf See Document 401-003f A copy of the guidance is attached.
4	*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."*	**i. Has this been identified by the RQIA in any Review or Report?** This specific issue has not been identified during RQIA reviews. The 'Procedure for the Reporting and Follow Up of Serious Adverse Incidents', October 2013 sets out the timescales for completion of both Level 1 investigations (Significant Event Audit) and Level 2 Investigations (Root Cause Analysis). For Level 2 investigations the final report must be submitted to the HSCB within 12 weeks from the date the incident was discovered or within 12 weeks of a previous Significant Event Audit. The procedure can be accessed at: http://www.hscboard.hscni.net/publications/policies-protocols-guidelines/ See Document 401-003g This has also been attached
5	***Donaldson reports*** *on the lack of training and experience of 'front line staff'*	**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
	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.	RQIA is aware that there has been investment by HSC Trusts in training in Root Cause Analysis. In March 2016, RQIA held an externally facilitated course in RCA training for 25 staff including some HSC trust staff. We are not aware of any formal assessment of the impact of RCA training although RQIA is aware anecdotally, that the Northern Trust, for example, found RCA training very valuable for staff involved in investigations.
6	RQIA Report of December 2014 comments on the HSCB's Guidance on Reporting and Follow up of SAIs refers to 'interface incidents': • Where one Trusts expects another to undertake an investigation • Clear guidance needed on which Trust must take the lead.	**i. Has any such guidance been provided?** Guidance on 'interface incidents' was included in the 'Procedure for the Reporting and Follow up of Serious Adverse Incidents' issued by the HSCB in October 2013. This states that: **"3.4 Reporting of HSC Interface Incidents"** Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up investigation may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

No	Context	Question
		Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the investigation. In these instances refer to Appendix 12 – Guidance on Joint Investigations." The procedure can be accessed at: http://www.hscboard.hscni.net/publications/policies-protocols-guidelines/ See Document 401-003g
7	**Dr Ian Carson***"... our officers meet with SQS on a bi-monthly basis at the moment"* **Transcript 13th November 2013 p.50 L.3-4 RQIA Evidence**	**i. Are those meetings minuted or recorded in any way?** The meetings between RQIA and the Department of Health Sponsor Branch have a formal agenda and are minuted. They continue to be held every two months. For information, the RQIA Sponsor Branch at the Department of Health, following a review of branch arrangements, is now renamed as Quality Regulation Policy and Legislation Branch rather than Safety Quality and Standards Branch.
8	**OECD Review recommendations for Northern Ireland included:** • *"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*	**i. What action (if any) is the RQIA proposing to take as a result of the OECD report?** RQIA has reviewed the OECD report and considers it to be a valuable analysis to inform the future arrangements for regulation of health and social care in Northern Ireland in the context of arrangements in other parts of the United Kingdom. In all areas of its work RQIA is considering how to increase its focus on promoting continuous quality improvement and is reviewing its inspection and review processes in this regard. **ii. Does it plan any follow up to its December 2014 report?**

No	Context	Question
	safety metrics; *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 ..."*	RQIA has no plans at present to carry out a follow up review of 'Quality Assurance of the Review of the handling of all Serious Adverse Incidents reported between 1 January 2009 and 31 December 2013' but is taking forward the work outlined at No. 2 referenced above by GAIN.
9	**Dr Ian Carson** *'Duty of cooperation within the NHS in relation to SAIs'* 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 *"physical and mental health"*. **Transcript 13th November 2013 p.50 L.11-25 RQIA Evidence**	**i. Will the RQIA be reviewing (as part of continuous assessment) how the Trust discharges that obligation in respect of SAIs and children?** RQIA has carried out an initial consideration of the Children's Services Co-operation Act (Northern Ireland) 2015 in relation to our functions. No plans have been developed for a specific review regarding this Act. However, the operation of the Act is relevant to our inspection processes for children's services and adults aged 18-21 who fall within the relevant subsections. RQIA will be carrying out a review of child protection arrangements commencing in Autumn 2016 and the Act will also be considered in relation to that review.
10	*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. What is the criterion for selection?** There are no specific criteria in a written format. SAI's are referred by Professional Groups (*Acute, Maternity, Paediatrics, Mental Health etc.)* or by individual DROs (Designated Review Officers) when regional learning has been identified following the review of SEA/RCA reports. This group also provides advice in relation to management and follow up of SAI's and in some instances SAI's may be referred to discuss process / procedural issues.

No	Context	Question
		RQIA directly receives SAI's relating to mental health and learning disability services in respect of its functions under the Mental Health (Northern Ireland) Order 1986. RQIA also receives SAI's which occur within the regulated sector for services which have been commissioned/ funded by an HSC organisation.
11	**Dr Ian Carson** *"The review will include ... reporting, investigation and learning from adverse incidents, complaints handling and whistle-blowing, human resources, risk management, dissemination of alerts".* **Transcript 13th November 2013 p.63 L.15-20 RQIA Evidence**	**i. Has the review taken place?** The fieldwork for the 'Review of Governance Arrangements in HSC Organisations that Support Professional Regulation' has been completed. The Terms of Reference for the Review are: 1. Review the effectiveness of the governance arrangements in place within HSC organisations which underpin systems of professional regulation for the following professions: • Medicine • Nursing and Midwifery • Social Work (to include Social Workers and Social Care Workers) • Pharmacy (to include Pharmacy Technicians) • Dentistry (to include Dental Care Professionals) 2. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvements if required. **ii. Is a report available?** The report has not yet been published but should be available in the autumn of 2016.
12	*RQIA's report of December 2014 of SAIs refers draft guidance "currently at the*	**i. Has this guidance been issued?**

No	Context	Question
	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)	As referred to at No. 3 above, the guidance was finalised and issued on 11 February 2015 by the Health and Social Care Board and Public Health Agency. It is entitled: "Guidance on Engagement with Service Users, Families and Carers as part of the Serious Adverse Incident (SAI) Process." A copy of the guidance is attached.
13	**Minister of Health's statement on 27 January 2015:** *"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".* **Hansard 27th January 2015 Vol 101 No 4**	**i. What is the position in relation to the RQIA review of the operation of Whistle blowing?** The fieldwork for the 'Review of the Operation of Health and Social Care Whistleblowing Arrangements' has been completed and the report of this review will be published within the next few weeks. The report will inform the Department of Health in its consideration of future arrangements in respect of whistleblowing. The review has been carried out with significant input from the organisation, Public Concern at Work who engaged with staff across the organisations. The Terms of Reference for the Review are: 1. The review will consider the: a. existence (current, consistent, robust) b. operation (understanding, training, learning) c. accessibility, availability, support d. governance of Arm's Length Bodies' whistleblowing arrangements. 2. In light of the findings of the review RQIA will identify any recommendations for improvement to the arrangements.

No	Context	Question
14	**Minister of Health's statement on 27 January 2015:** *"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".* **Hansard 27th January 2015 vol 101 No 4**	**i. What is the position in relation to the RQIA review of the operation of whistle- blowing?** Please see above at No 13.
15	**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):** *"the treatment of whistleblowers remains a stain on the reputation of the NHS"* and the recommendation of the Francis Review, Freedom to Speak up' (11 February 2015), that there should be a *"National Whistle blowing Guardian to protect those who speak up"* and "*training for staff on how to raise concerns and*	**i. What (if any) consideration has been given to the concept recommended in the Francis Review of a National Whistle-blowing Guardian?** Consideration was given to the concept of a whistleblowing guardian during the RQIA review but it was not considered that this model should be taken forward in Northern Ireland. The review will recommend that organisations should consider appointing an appropriate number of advisors/ advocates to signpost and provide support to those wishing to raise a concern. **ii. What training is provided in Northern Ireland for staff on how to raise concerns and on how to protect others who do so?** The review identified a need for specific training and will recommend whistleblowing awareness training for all staff and bespoke training for managers dealing with whistleblowing disclosures.

No	Context	Question
	protect others who do so" (p.6-7).	