INTRODUCTORY STATEMENT TO THE INQUIRY INTO

HYPONATRAEMIA RELATED DEATHS

MR JOHN COMPTON,

CHIEF EXECUTIVE, HEALTH AND SOCIAL CARE BOARD

THURSDAY 14 NOVEMBER 2013

Thank you for affording the Health and Social Care Board an opportunity to contribute to the Additional Governance Segment of the Inquiry. My purpose is to provide some assurance in terms of how systems now operate and have improved within Health and Social Care since the tragic deaths of the children being considered by this Inquiry.

- **The Panel**

Firstly may I introduce the Panel:-

- **I am John Compton, Chief Executive of the Health and Social Care Board. I have held the post since the inception of the Board in 2009;**
- **Dr Carolyn Harper is the Director of Public Health in the Public Health Agency and is the Medical Director on the Health and Social Care Board. She provides medical advice to me and to the Health and Social Care Board.**
- **Mary Hinds is Director of Nursing and Allied Health Professionals in the Public Health Agency and Director of Nursing on the Health and Social Care Board. She provides Nursing advice to me and to the Health and Social Care Board. She is currently on secondment to the Northern Trust as Senior Director of Turnaround.**
- **Michael Bloomfield is Director of Performance and Corporate Services at the Health and Social Care Board. He is responsible for overseeing an efficient administrative system within the Board.**

The composition of the panel reflects the close working between the Health and Social Care Board and Public Health Agency – in particular in relation to matters concerning safety and quality of services.

My colleagues and I will seek to respond to any questions, or points that require any clarification that arise during the proceedings later.

- **Context**

It may be helpful for me to provide some context to the Inquiry in relation to the roles and responsibilities of the Health and Social Care Board, and how it works collaboratively with the Public Health Agency and the HSC Trusts to provide safe, quality health and social care services.

The Health and Social Care Board was established in April 2009. It replaced the four previous local area Health and Social Services Boards. The Public Health Agency was also established in April 2009 . The responsibilities of the previous four local area Health and Social Services Boards were transferred to the Regional Health and Social Care Board and the Public Health Agency .

The Health and Social Care Board has a range of functions that can be summarised under three broad headings:-

- **The Commissioning or securing the provision of health and social care services for the needs of the local population, including monitoring the delivery of these services to ensure that health and social care meets established safety and quality standards;**
- **Performance Management and Service Improvement – to ensure that provider organisations meet the relevant health and social care objectives, targets and standards, including those set by the Minister;**
- **Resources Management – to ensure the best possible use of the resources of the health and social care system, both in terms of quality, accessible services for users and value for money for the taxpayer.**

Underpinning all of these functions is our Statutory Duty of Quality in respect of the services we commission. We discharge that Duty through a range of processes to ensure that the services commissioned, and those delivered within the available resources, meet established safety and quality standards. Our colleagues in the Public Health Agency work closely with the Health and Social Care Board by providing professional input into the commissioning process. In regards to Social Care, the Director of Social Care provides the Board with expertise in this arena of care, as does the Director of Integrated Care, who ensures the delivery of General Practice services in Northern Ireland.

As Arms Length Bodies, the Health and Social Care Board and the Public Health Agency are directly accountable to the Department in terms of the commissioning of health and social care services which are provided by the HSC Trusts. In this regard, there is a close working relationship with DHSSPS colleagues.

The Trusts are accountable to the Health and Social Care Board for the delivery of services, and the delivery of these against relevant objectives, targets and standards. However outside of the three key areas where accountability is to the Health and Social Care Board, they are directly accountable to the Department for all other aspects of organisational governance and assurances.

The Health and Social Care Board works with the HSC Trusts in an open way, where information is shared; to provide and promote a supportive approach to resolve issues as and when they may arise.

The Board is made up of five Executive Directors and eight Non Executive Directors. Four other Directors from the Senior Management Team also attend Board meetings and Board Committees. The Patient Client Council is also in attendance at our monthly Board meetings. The Board has a number of Committees, including a Governance Committee that seeks assurance on all aspects of organisational governance including on the safety and quality of the services commissioned by the HSCB. This is chaired by a Non Executive Director.

Since the establishment of the Health and Social Care Board and the Public Health Agency in April 2009, and the significant reorganisation that has occurred since the tragic deaths of these children, there is now a more consistent and straightforward approach to the management of safety and quality issues, in particular when adverse incidents occur. The Health and Social Care Board is the focal point for the SAI process.

In this regard, there are a range of reports received by the Health and Social Care Board which enables it to have an overview of the safety and quality of health and social care services. These include the procedure for reporting of Serious Adverse Incidents, the receipt of Early Alerts, information regarding the Patient Experience, details of all Health and Social Care complaints. Robust procedures exist to receive and process this information in order that any appropriate immediate action can be taken, and any regional learning identified and shared across the region to improve the delivery of services. In addition to this there is the day to day, professional to professional, and service manager to commissioner, lines of communication.

Notably, as a further measure of the safety of hospital services, the Health and Social Care Board has published hospital standardised mortality rates for the past three years, benchmarked against the rates in Trusts in England and independently produced and reviewed by CHKS. This analysis indicates the death rates in all Trusts in Northern Ireland are within or better than expected levels.

In addition, a wide range of other performance indicators in relation to the safety and quality of services are regularly reported to the Board at its monthly meetings, including cancer, fractures, healthcare associated infections and hospital waiting times.

In relation to Complaints –under the revised 2009 Complaints Procedure, the Health and Social Care Board became responsible for having oversight of all Health and Social Care Complaints, including monitoring complaints processes, outcomes and service improvements. The Board receives information relating to approximately 6000 complaints each year, from the Trusts and from

Family Practitioner Services. The number of complaints has risen from 4,733 in 2009/2010 to 5,998 in 2012/13. We are aware that taken together, the categories of Staff Attitude and Communication represent the greatest number of complaints (1700), above that of Treatment and Care (1562). We have, at the request of the Department, undertaken an evaluation of the effectiveness of the Complaints arrangements across Health and Social Care, and produced a report with 14 recommendations aimed at improving the effectiveness of the procedure. One of these recommendations is seeking to address the high number of complaints received regarding staff attitude and communications by promoting positive attitudes. We are also aware, from engaging with service users that there is still much work to be undertaken in relation to addressing the reluctance of some service users to complain and raising the awareness of how to make a complaint. The Board is currently working with HSC organisations, including the Patient Client Council, and the Department in terms of promoting awareness of the procedure and taking forward the recommendations of the Evaluation report.

From 2012, 17 Independent Lay Persons have been appointed by the Health and Social Care Board to assist in the resolution of complaints. These lay persons come from various professional backgrounds, for example former health care professionals, former police officers and prison officers, ex school teachers, retired civil servants, to name but a few.

Their role is NOT intended to act as conciliators or investigators. Their involvement is to help bring about a resolution of the complaint by reviewing the investigation undertaken, providing assurances that the action taken by the HSC body was appropriate, or making suggestions as to further steps that could be taken by the organisation to resolve the complaint. The laypersons role is about bringing independence, impartiality and trust to a situation where relationships may have been damaged.They are invaluable in communicating to service users, the outcome of investigations, in language they understand. Lay persons have been involved in the resolution of 14 complaints regarding FPS Practices to date, and

have been involved with 3 Trusts, on a number of occasions,in complaints resolution. One of these has involved a number of Trusts, and an FPS Practice, where the lay person has co-ordinated the investigation being undertaken by the HSC organisations, to enable the complainant to have one point of contact in the process. Other examples include involvement in resolution of a number of complaints where the death of a loved one has occurred. Their role includes meeting with both parties, reviewing complaints documentation and providing suggestions/recommendations to effect potential resolution.

Recently, the Health and Social Care Board and the Public Health Agency have established an over-arching Quality Safety and Experience Group which consider learning identified through existing arrangements for Serious Adverse Incidents, Complaints, Patient Experience, and Medicines Safety, and determine the most appropriate way to put that learning into practice, monitor progress and seek assurance that practice has changed.

In particular today, I wish to highlight and focus on the arrangements that are now in place to handle incidents that fit the criteria of a Serious Adverse Incident.

There is now a well understood and consistent approach to the reporting of and handling of all Serious Adverse Incidents. There is one point of reporting Serious Adverse Incidents – that is to the Health and Social Care Board.

The Health and Social Care Board became responsible for the management and follow up of Serious Adverse Incidents in May 2010. The Board works tirelessly to promote an open culture of reporting Serious Adverse Incidents, and is continually reviewing and improving the process. It has recently, in October 2013, produced a revised and enhanced process for the reporting of Serious Adverse Incidents, which I will refer to later.

We encourage organisations to report incidents, and work on the basis of, 'if in doubt report'. If in time the incident turns out not to be as significant as first thought, or on further examination of the

details by the reporting organisation, it does not fit the criteria of a Serious Adverse Incident it can be de-escalated. The reporting of Serious Adverse Incidents is increasing year on year which is to be welcomed , and we meet with each Trust individually to review that Trust's reporting activity. In total, 966 Serious Adverse Incidents have been reported to the Board since 1 May 2010. In the most recent year, 2012/13, 320 Serious Adverse Incidents were reported to the Health and Social Care Board. This represents an increase from the previous year when 262 were reported. Increasing numbers are important because it indicates greater appreciation of the SAI process by the service.

The Health and Social Care Board consider these Serious Adverse Incidents at the highest level. Every week the Senior Management Team, which I chair, reviews the Serious Adverse Incidents that have been reported in the previous week. This ensures that the organisation knows at the most senior level, what has been reported and provides extra assurance to the process, which I will outline for you.

The Governance Committee of the Board receives reports on Serious Adverse Incidents at each of its meetings – it is a standing item on the agenda. The full Board itself, receives 6 monthly reports on Serious Adverse Incidents that have been reported, which includes detail of learning that has been identified and shared with the wider HSC. These reports, as with all Board papers, are in the public domain and are placed on the Board's website.

It may be helpful for the Inquiry if I outline briefly the process that is in place to deal with each Serious Adverse Incident. When a Serious Adverse Incident is reported to the Health and Social Care Board, the reporting organisation is required to do so within specified timescales, that is within 24 hours of a death, or within 72 hours of the incident occurring or becoming aware of the incident occurring.

Professional officers, known as Designated Review Officers (DROs), from the Health and Social Care Board and the Public

Health Agency, provide an initial assessment of the serious adverse incident when reported. These officers have a professional or administrative background which is commensurate with the nature of the Serious Adverse Incident, and they will have the ability to engage in a clinical or professional discussion, and the ability to challenge where necessary. They will have the experience of dealing with previous complex SAIs, complaints and difficult family situations. They assess whether all initial immediate and required actions have been taken by the reporting organisation, and they form an initial view on the level of investigation being undertaken by the organisation. For the more complex Serious Adverse Incident, the DRO is required to approve the membership of the team established by the reporting organisation to investigate the incident and to ensure, for example, adequate independence where appropriate, and to agree the Terms of Reference of that team. There are specific timescales for reporting back to the Board when the investigation is complete. This varies from 4 weeks to 12 weeks, dependent upon the level of investigation undertaken.

The core role of the DRO is to ensure robustness of the process. They will review the investigation report and provide a challenge to the reporting organisation in terms of adequacy of the investigation carried out. They will also review recommendations that have been made by the investigating organisation, and identify potential learning from the process which may be considered for wider dissemination across the HSC. Mindful of discussions earlier this week in relation to access by families to the DRO, while it is not common practice, or part of the protocol, on occasion the DRO may meet with families, if it is felt to be appropriate. In circumstances where the DRO is not satisfied with the approach of the Trust, they can escalate to a Director, and ultimately the Chief Executive of the Health and Social Care Board to ensure resolution.

Learning identified by SAIs is considered by the SAI Review Group chaired by the Director of Nursing and Allied Health Professionals, at which the most appropriate and effective method of disseminating the learning is agreed. This may involve the issue of

a learning letter, examples of which are the importance of taking appropriate follow up action on x-ray reports and the management of massive blood loss. Or it may be a thematic review, examples of which have included a review of complaints and serious adverse incidents involving the older person, and a review of suicides undertaken, which we can expand upon if helpful. The learning may involve enhancing training, arranging regional workshops, or bespoke pieces of work taken forward by, for example the Safety Forum on issues such as:- The standard use of early warning systems, assessing and treating patients at risk of developing blood clots in their legs, or the prevention of falls in nursing homes.

There is also an effective mechanism for following up and ensuring that actions contained in learning letters have been implemented. Organisations provide assurance to the multi-disciplinary HSCB/PHA Safety Quality Alerts Team chaired by the Medical Director, to ensure that the requirements within the learning letters have been implemented, and that the action required has been taken. The SQAT Group follows up with Trusts, until it receives satisfactory assurance, through the Trust(s) Chief Executive(s).

Three years ago the Board took over responsibility for the management of the SAI process. We decided it was timely to carry out a review of how it was working and to identify ways in which it could be further strengthened. This led to a number of changes, for example the reporting of suicides. With respect to this Inquiry it is worthwhile noting that the review recommended the inclusion of an additional criteria that all deaths of a child in receipt of HSC services, including hospital and community services will now be required to be reported as a Serious Adverse Incident.

This provides absolute clarity in terms of the reporting of all child deaths involved in Health and Social Care up to the age of 18. The rationale for this was to make reporting routine, and to enhance the culture of learning and review. Obviously this will increase the number of SAIs being reported, and will include deaths of children when death was expected, for example children with a congenital condition or terminal illness.

Since the inclusion of the new criteria, 8 child deaths have been reported to the Board as an SAI, 7 of which specifically relate to the new criterion. This compares with 3 child deaths reported in the same month the previous year, before the new criteria was included.

In addition my colleagues Mr Bloomfield and Mrs Hinds have met with Trusts to review their perspective on the SAI process.

There is regular liaison between the Health and Social Care Board and the Public Health Agency with other key providers. We meet quarterly with the Regulator (RQIA) and the Northern Ireland Post Graduate Medical Dental Training Agency (NIMDTA). We have similar meetings with NIPEC, which has responsibilities for training of nursing staff. In addition, we have recently written to the Coroner to formally request that all Coroners reports that may have learning for Health and Social Care, will be sent to us routinely so that we can review those, and take any necessary and appropriate action.

I very much hope that what I am describing, communicates to you and the public can gain assurance from the arrangements that are now in place that serious incidents are identified quickly and lessons learned are shared across the system to reduce the likelihood of similar incidents recurring. I can assure you that all Serious Adverse Incidents reported to the Board are considered at the highest level, I mentioned earlier the weekly process of reviewing all of these at the Senior Management Team meetings. This allows us to ensure that all Directors are aware of these incidents, and that we are sure that these incidents are being handled and followed up by the appropriate professionals.

Providing Health and Social Care is inherently complex and carries risk of harm and sadly, adverse incidents involving patient safety will always emerge, particularly in the context of 1,000's of patients treated every day, for example there are over 4,000 patients in acute hospitals at any time, there are over 300,000 non-elective and elective admissions in hospitals each year, there are 30,000

paediatric inpatient admissions each year, and there are almost 700,00 attendances at Emergency Departments each year.

The fact that the adverse incidents emerge is positive as it reflects an increasingly open environment where staff feel supported in reporting to enable learning rather than blame. It is a journey, and while we have made progress, it is a process of continuous improvement. I wish to assure the Inquiry that this is treated with the highest priority by the Health and Social Care Board and our colleagues in the Public Health Agency.

As a system, when it goes wrong, it can have enormous and devastating repercussions on individuals and on families, which stay with them for the rest of their lives. This Inquiry is a statement of that fact. What we are about is trying to ensure that this doesn't happen in the first place, or that at the very least, the risk of something being repeated is significantly reduced. We fully recognise the need to restore and maintain the public's confidence in our service.

We work closely with various external professional and expert bodies in an attempt to continually compare, review and enhance our services, for example, from a UK perspective the Health Foundation, or internationally the Institute for Health Improvement.

Managing risk in Health and Social Care requires clarity. Total perfection in the delivery of Health and Social Care is not attainable. What is attainable is the relentless review and improvement of procedures and processes to seek to continually strive to deliver as high a quality of service as we possibly can.

Thank you Chairman. We as a Panel are, of course, happy to take questions or provide further clarification.