Inquiry into Hyponatraemia Related Deaths

DHSSPS Opening Statement 15 November 2013

Andrew McCormick, Permanent Secretary, Michael McBride, Chief Medical Officer and Charlotte McArdle, Chief Nursing Officer

Mr Chairman, thank you for the opportunity to participate in this stage of the work of the Inquiry.

First and foremost, I want to express sympathy and support to the families of the children who died. I know that the present Minister, like Minister Smith who set up the Inquiry, and like the other Ministers in the intervening years, would want to underline that his sympathy is strongly with the families.

The Minister's remit to the Department, as to this Inquiry, is to promote the quality and safety of all aspects of health and social care. He would hope that these hearings, and in due course the Inquiry Report, will provide some degree of explanation of the pain the families have had to face over the years. I would want to emphasise both personally and on behalf of the Department, my commitment to seeking the best possible application of the painful lessons that we have learned from these deaths.

I have no doubt that, as the Minister has made clear many times the goal of safe and high quality service is served by openness and transparency, by a willingness of all parts of the system to learn, and a culture of fair accountability. I do not want to pre-empt the conclusions you will reach on the evidence you have heard, but I do want to underline, on my own behalf as well as the Minister's, that some of the events and actions that have come to light were deeply disturbing and unacceptable. I hope we can draw out today some of the differences that already apply between the time when these tragic and avoidable deaths occurred and now, but with my colleagues I have a responsibility to provide leadership to the HSC system that does all we possibly and reasonably can to prevent incidents and failures such as these.

I also want to express my thanks to the Inquiry for the very thorough, thoughtful and penetrating approach you have taken to fulfilling your Terms of Reference – this is very important to the Minister, as it is so important for the future that no-one can say that there was any hindrance or obstacle to the quest for truth and explanations in relation to these deaths.

I am speaking partly in the role of the organisation which, on behalf of the Minister, is the sponsor and commissioner of the Inquiry. I want to take the opportunity to underline that the issues that gave rise to this Inquiry are of a different order to most of even the most serious incidents that we have faced over the years. Successive Ministers have recognised that it is important for the nature of the investigative process to be proportionate to the degree of concern. For example some very serious issues have been investigated through special RQIA reviews, sometimes led by external experts, including the Troop Review following the deaths from Pseudomonas. Where Ministers have judged that even stronger means of investigation are necessary they have used various forms of Inquiry – for example the Dental Inquiry led by Brian Fee QC, and the C diff Public Inquiry.

Obviously it is not for me to comment on whether or not there was any cover-up. I am saying all this to emphasise that this Inquiry was commissioned because Minister Angela Smith and my predecessor Clive Gowdy recognised the particular significance of credible allegations that the truth of what happened in relation to at least one of these deaths had not come to light. That was seen as an issue of a different order to more general concerns about a closed culture, or of some lack of openness and transparency. It is now for you, Chairman, to reach your conclusions on the evidence you have seen and heard. But, Minister Poots wants to ensure that the truth emerges and that all concerned in the HSC respond appropriately. This is a very unusual Inquiry, but there should be no doubt that the Department will use its powers to convene inquiries on this basis if there are incidents that warrant this type of scrutiny.

I believe very strongly that the future of safe and high quality care depends fundamentally on having a cadre of clinicians across all aspects of services in

Northern Ireland who are willing and able to play their part in managing all the complex risks that arise in modern day health care – and I use that term to embrace all qualified healthcare professionals, not only doctors. Our submission quoted Sir Cyril Chantler and the quotation is well worth emphasis:

"Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous"

It is essential that there is increasing understanding of this reality, and that society – including politicians, commentators and patients, support and recognise the challenges that we expect clinicians to manage on our behalf. It will be very detrimental if clinicians, in the face of an uninformed approach to scrutiny, react by "playing safe", and hesitate to act when we need courageous, confident action to allow everyone to get the best care available. It is also a concern that there could be a perception that some leadership roles – in clinical management as well as executive roles – are so subject to scrutiny and jeopardy that the risks are not worth taking. Society needs courageous leaders, and that in turn requires confidence that the process of accountability is fair. To be clear, I am sure that there are cases when it is fair for leaders to be subject to sanction. I simply want to ask that all those commenting on this Inquiry recognise that sensationalism is not a neutral phenomenon, and that there is a risk that the best leaders will avoid the crucial roles in the HSC if they do not feel supported in managing really difficult risks.

I want to say a little in this opening about the approach we take in the Department to our oversight of the HSC and how we seek through systems and leadership to promote a culture that is open, responsive, always learning, and with good and effective communication. The balance we seek is that we aspire to a culture of fair accountability. All we do and say about Clinical Governance, and the particular aspect of that system in dealing with Serious Adverse Incidents, emphasises that the fundamental reason for these systems is so that there can be timely and effective learning from all that happens in our risky and complex systems – they are not designed as means of enforcing corrective action.

That said, I have set my face against the so called “no-blame culture” and I would stress that that is not our approach. There must be clear individual accountability when the reason for some adverse outcome is an unacceptable standard of care by an individual. It is, in the first instance, for employers to act in relation to sub-standard care as part of their fulfilment of the statutory duty of quality. Where individual deficiencies in practice are identified, employers should take the appropriate remedial action. This may range from a period of retraining to the termination of contract dependent on the nature and extent of the deficiency identified. Where deficiencies are so severe that an individual’s fitness to practise is in question, the involvement of the professional regulator is mandated. Michael will be able to say more about this if you find that helpful, but I would emphasise that the public can take confidence from the fact that these steps are applied in a significant number of cases in the HSC every year.

More often, the issues are more complex than the practice of one clinician: the training arrangements provide clear checks and balances designed to ensure that clinicians are only given the responsibilities that match their standard of training, experience, competence and aptitude. Hence we have in effect designed a system where harm should only arise if more than a few different individual failures coincide (the so-called “swiss cheese” idea). There are and must be fail-safes and opportunities for checking that should and do prevent harm when things begin to go wrong.

It follows that, in my view, “systems failure” is much more serious than individual failure and also harder to prevent. And systems failure is an issue of corporate organisational accountability – because the responsibility for the “system” is at the level of the governing Board, the Chair, Chief Executive and the Directors. And clearly different responses are required at regional level depending on the context: to take two extremes, a single, complex incident that might have very severe consequences, might not merit any sanction against management if it could not reasonably have been foreseen; at the other extreme, a persistent pattern of failure of standards (as was seen, unfortunately, at Mid Staffs) rightly requires a robust intervention from the responsible authorities.

I would like to suggest that the key questions that would be of most value to explore today include:

- what can we, and what should we do as the Department to promote patient safety and good effective clinical governance?

- how can we know if Arms Length Bodies are actually fulfilling the Guidance and Directions issued by the Department;

On the first of these, we see a need for both systematic interventions and cultural interventions. Both of these reflect the fact that quality and safety depend fundamentally on human behaviour. So first of all we need to ensure that the right people are in the right jobs, and that they have and maintain the relevant skills – this does not prevent things from ever going wrong, but maximises the possibility that at least one member of a well balanced, well trained team, will see a problem before harm arises.

All the paraphernalia of governance structures, reporting arrangements and accountability meetings mean nothing if the front line deployment of staff is inappropriate, and I would want Michael and Charlotte to comment on the approach taken by professional leaders to keep this fresh, focussed and effective.

The governance arrangements are very important and we will be happy to elaborate on them if that would help, but I will just make the key point that all the twice yearly accountability meetings that I chair with Trusts focus on the triangle of quality, performance and finance, with structured questioning to secure assurance that procedures for implementing Departmental guidance and other good practice is in place, and that there is systematic learning from SAIs etc. There are clear obligations to disclose governance issues – that is risks that are known and are difficult to manage.

I do not rely solely on the direct line accountability of the HSC bodies to the Department. We are also sensitive to other sources of information, knowing that

they could contain warning signals that we may need to act on. As well as requiring that there are strong and effective internal complaints processes, we also have strong working relationships with RQIA as the regulator and inspector, and with PCC as a very important voice on behalf of the patient.

We also are currently exploring how we can go further in ensuring that patients' views are more easily heard and understood by management teams. Charlotte will be able to elaborate on this.

The Minister wrote to all staff across all our Arms Length Bodies last year to underline his support and authorisation of whistleblowing and his commitment to protect those who draw attention to possible failings in the public interest. He said that the aspiration must be that whistleblowing should not be necessary – because in a good learning culture, teams will all be open to mutual challenge and scrutiny – but we support whistleblowing and all HSC bodies have clear procedures to protect whistleblowers.

So we are very clear that the system should be candid and responsive, engaging effectively with patients and families when things go wrong, and concealment of information or evidence has to be anathema. There are clear duties in this regard already in the key professions, and the Department is considering carefully the implications of the Francis recommendations in relation to a statutory duty of candour. We would be happy to discuss this further today, but we do not have a specific remit on this point from the Minister. In reflecting on the proposal, our view is that the key question is whether a legislative approach will actually achieve the goal of candour – if behaviour adjusts to fit the letter of the law, rather than a culture of confidence and openness. I think it is well worth noting that information is inherently much more open and available than even five years ago, and whether or not the Assembly introduces a statutory duty, we should make sure that we are acting to promote the behaviours we want and need in the HSC.

Mr Chairman, I know that systems and procedures can be undermined by the wrong statements or actions at senior leadership level. So I regard consistency of message, and the reinforcement of appropriate behaviours as critically important in promoting quality and safety. Michael will be able to expand on the section on culture in the Quality 2020 strategy, but I would want to take the opportunity to say here two things that I have said many times in HSC meetings and events: first, that the triangle of quality, performance and finance means that each organisation (and I include the Department) must take a balanced approach to all three obligations. Our message is that Trusts must never use difficulty with one of the three to excuse failure on another – with patient safety as paramount in all cases and contexts. The second point is a subset of that – it is never right to do the wrong thing to meet a target. The performance targets on, for example, access times for elective care are important, but they are means towards the end of providing care, not an end in themselves.

The way we do things now is of course built on the lessons from many difficult issues and previous failings, and on the progress achieved by Departmental and HSC leaders who have gone before us. It is a combination of **systems** informed by world-wide good practice, **people** equipped and trained to manage risk, and **leadership** that aspires to put the patient first always. We know that we will always have to be ready to adapt and change the way we work, because risk increases with familiarity and because best practice is always evolving. But for today's purposes, I hope this introduction shows that key lessons have been learned from the circumstances of the deaths the Inquiry has been investigating, and we look to you, Chairman, to provide wise insight and recommendations from the evidence you have heard.