Witness Statement Ref. No. 063/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: DON HILL

Title: MR.

Present position and department/employer:

Deputy Secretary, Resources and Performance Management Group
Department of Health, Social Services and Public Safety

Length of time in post: 2 years

Previous position and department/employer in 1995:

Deputy Secretary (Schools), Department of Education

Previous position and department/employer in 2000:

Deputy Secretary: Resources, Public Health, Fire & Ambulance Services, Strategic Planning and Information Systems [DHSSPS]

Previous position and department/employer in 2001:

Deputy Secretary: Resources, Public Health, Fire & Ambulance Services, Strategic Planning and Information Systems [DHSSPS]

Membership of Professionals Bodies:

NIL.

Particular areas of interest
[Please attach additional sheets if more space is required]

(i) How and when did you first become aware of the deaths of Adam, Lucy and Raychel?

I first became aware of Adam Strain's death as a result of the Insight programme in October 2004. While I cannot be specific, I think I became aware of Lucy Crawford's death around February 2004, probably at the Board meeting on 17 February (Ref 004-019-236). I became aware of Raychel Ferguson's death later in the year.

(ii) With whom did you discuss their deaths, when and for what purpose?

I have had no detailed discussions with any of my colleagues about their deaths as such. My subsequent involvement is in regard to the need for common procedures to identify and take appropriate action in regard to any serious untoward incident involving hospital patients.

(iii) What steps did you take to ensure that the DHSSPS discovered the cause of death of each child?

None. The cause of death was already known.

(iv) What steps did you take to ensure that lessons were learned within your Directorate, the DHSSPS and in the hospitals?

I took no action in relation to these particular deaths. Action had already been taken.

(v) What was the system in place in Northern Ireland at the time of Adam Strain's death in 1995 for reporting untoward deaths to the DHSSPS and disseminating information on the outcomes of Coroners' Inquests within the health service?

I was not in DHSS in 1995 but I understand that the only formal reporting requirements to the Department related to untoward events in Psychiatric and Specialist Hospitals for People with Learning Disability and adverse incidents relating to medical devices. I also understand that specific issues of concern were occasionally discussed at meetings between Boards' Directors of Public Health and the Chief Medical Officer. I understand there were no arrangements for disseminating information on the outcomes of Coroners' Inquests.

Northern Ireland has participated throughout this period in the National Confidential Inquiry into Stillbirths and Deaths in Infancy, the National Confidential Inquiry into Peri-operative Deaths and the Yellow Card Scheme which provides a system for early detection of emerging dug safety hazards and routine monitoring of all medicines in clinical use in the UK.

(vi) What was the role of the DHSSPS in reporting, analysing and disseminating the information referred to at (v) above and in ensuring that lessons learned would be fed into teaching/training and the care of patients?

I am not aware of any such role being carried out by the Department.

(vii) What procedures existed in 1995 to ensure the fulfilling of roles relating to the reporting, analysing, disseminating of information from a Coroner's Inquest or untoward death and to ensure that lessons would be learned?

I am not aware of any such formal procedures.

(viii) With reference to issues (v) to (vii) above, what was the situation in 2000 and 2001 respectively?

The formal arrangements within the Department as described above were unchanged.

(ix) With reference to (v) to (vii) above, what is the situation now?

Formal arrangements are now in place requiring HPSS organisations to report serious adverse incidents to the Department which considers whether follow-up action should require further assurances from the relevant Trust, whether further independent assessment is necessary and what information should be disseminated to the rest of the HPSS to ensure that lessons are learned. The Department has defined a serious adverse incident as "any event or circumstance arising during the course of the business of a HSS organisation/Special Agency or commissioned service that led, or could have led, to serious unintended or unexpected harm, loss or damage."

A similar assessment would apply to information from a Coroner's Inquest.

Arrangements within HPSS organisations are now governed by a common approach to risk management and a range of controls assurance standards. The risk management standard requires clear lines of accountability throughout each organisation, sets out specific criteria regarding reporting, managing analyzing and learning from adverse incidents, together with examples which can be used by auditors carrying out independent verification of compliance with standards. An independent assessment of these arrangements was carried out in 2003 and compliance continues to be monitored by the Department.

Appropriate arrangements for preventing, detecting, communicating and learning from adverse incidents are also an integral part of the draft quality standards currently under consultation. These will be used by the Regulation and Improvement Authority to assess the quality of care provided by the HPSS.

Arrangements are also well advanced for a formal link with the National Patient Safety Agency (NPSA) which will ensure that NPSA guidance and support (including safety alerts) are available locally and will allow Northern Ireland to be a formal part of the National Reporting and Learning System as it is being rolled out nationally. Work has already begun locally to create a standard method of adverse incident reporting across the Health and Personal Social Services including Trusts, Boards and across the Primary Care sector. This will include creating HPSS-agreed standard incident definitions, a suite of standard reporting forms and regional

coding of incidents. The project is to be completed by March 2006.

(x) Explain the system in place from 1995 to 2001 for the monitoring of both performance and the quality of clinical care within the Health Service in Northern Ireland?

These were not in my areas of responsibility during the part of the period when I was employed within DHSSPS and I was not employed within DHSSPS for most of the period.

(xi) What changes have been made to those systems since 2001?

- Structures have been established within the Department to co-ordinate an integrated approach to the improvement of quality and safety within the Department and across the HPSS as follows:

(a) Clinical and Social Care Governance

- The primary responsibility for monitoring the quality of clinical care rests with Trusts as providers and Boards as commissioners and new legislation has imposed a statutory duty of quality in the HPSS, backed by a system of clinical and social care governance.

- A new independent body – the Health and Social Services Regulation and Improvement Authority (HPSSRIA) has been created to inspect and publicly report on the quality of services delivered by the HPSS.

- In January 2003, the Department issued a circular HSS(PPM)10/2002, "Governance in the HPSS" to ensure a consistent approach to clinical and social care governance arrangements. This circular emphasised the accountability of each Chief Executive for the delivery of quality treatment and care in the same way as for financial and organizational matters and set out arrangements which need to be put in place within each organisation.

- An independent review of progress was subsequently commissioned and the criteria assessed included

  - identifying, promoting and sharing good practice, learning lessons from best practice as well as poor performance;

  - clinical and social care risk assessment and risk management;

  - adverse incident management;

  - quality standards; and

  - complaints management.

- A Clinical and Social Care Governance Support Team has been engaged to support the development of effective clinical and social care governance.

Particular areas of interest (Cont'd)

(b) Standards and Guidelines

- Quality standards (which will be used by HPSSRIA to measure HPSS organisations' clinical and social care governance arrangements) are currently under consultation and set standards that people should expect from the HPSS, under five themes:
  - safe and effective care;
  - timely delivery of quality services;
  - promoting, protecting and improving health and social well-being;
  - open and effective communication; and
  - leadership and accountability of organisations

- To date, 18 controls assurance standards have been issued and arrangements put in place to monitor compliance. These include detailed standards required in regard to risk management, decontamination of re-usable medical devices, infection control and medicines management.

- Formal arrangements are being established with the National Institute for Health and Clinical Excellence and the National Patient Safety Agency, which will mean that technology and other guidance endorsed locally will be mandatory and compliance will be subject to inspection by HPSSRIA.

- A high level policy framework and action plan on safety is under development. This will build on the Quality Standards and other standards and safety initiatives, including professional standards and controls assurance standards.

- The Department continues to facilitate the development of guidance on good practice which may be monitored by HPSSRIA. Recent guidance includes the Use and Control of Medicines, Lymphodoema services and the control of hospital acquired infection.

(c) Professional Development and Workforce Issues

- Appraisal arrangements have been introduced for all GPs and doctors employed in the HPSS. Consideration is now being given to ways of improving the effectiveness of local appraisal.

- Measures have been taken to identify and tackle poor performance more effectively, including the establishment of formal links with the National Clinical Assessment Service which supports Trusts in managing poorly performing doctors and dentists.

- More effective workforce planning and modernisation of the workforce is introducing new ways of working which will improve capacity, productivity and quality. Progress is being monitored by the Department.

- The Department is currently bringing forward a local implementation plan based on the recommendations of the Shipman Inquiry.

(d) Performance Management

- Performance targets have been increasingly expressed as improved outcomes for patients and specific measures taken to improve outcomes in relation, for example, to deaths from Chronic Heart

Disease and cancer survival rates to the improvement of levels of access to both hospital and primary care and progress is monitored by the Department.

- Improvements in quality will form a key part of the non-resource releasing efficiency targets imposed on the HPSS.

(e) Deaths and Coroners' Services

- A Memorandum of Understanding between the Department, the Police Service of Northern Ireland, the Coroner's Service and the Health and Safety Executive is currently being developed. This Memorandum, which will be subject to consultation, will set out an agreed process for the investigation of serious incidents, including deaths, where suspicion exists that health and social care provision has contributed to the death. The Understanding will promote liaison and co-ordinated investigation.

- A regional child death review protocol is being developed, to be followed where there is sudden, unexplained child death from birth to 18 years. This will promote greater sharing of information and an appropriate response to individual circumstances.

- A local interdepartmental group is also considering Home Office proposals for changes to death certification and the Coroner's services in England and Wales. This includes proposals for the verification of death and new certification and investigation arrangements. The implementation of any new local arrangements which will follow consultation, will take into consideration implications for training, resources and delays in burial.

(f) Public Engagement

- Improved structures and procedures are in place for ensuring that the views and concerns of equality groups, focus groups and the general public are taken into account in the development of new policies and changes in the way services are provided.

(xii) What are the procedures in the DHSSPS, Hospital Trusts and Health Boards to handle concerns raised by any person or persons within the hospitals, Boards and Trusts about the running of the health service?

- The HPSS Complaints Procedure as outlined in "*Guidance on Handling HPSS Complaints: Hospital and Community Health and Social Services*" (DHSSPS April 2000) enables an individual to raise concerns about any matter connected with the provision of HPSS services and, through various stages of investigation, receive a response or explanation addressing those concerns. Whilst complaints can be made to any member of staff, all HSS Trusts have named Complaints Officers. In all cases, the complainant is told how the complaint will proceed and advised on the availability of advocacy services (usually Health and Social Services Councils). Where an immediate or "on-the-spot" response is not possible, a complaint may be progressed through local resolution, and then, independent review, stages of the procedure. If still not satisfied the complainant may put their case to the NI Commissioner for Complaints.

- Health and Social Services Councils were established in 1991 to keep under review the operation of the health and personal social services in its area and to make recommendations for the improvement of those services or otherwise advise the relevant Board upon such matters relating to the operation

of the health and personal social services within its area as the Council thinks fit. They have regular meetings with Boards and Trusts to represent the interests of users of health and social services and are consulted on any major developments or changes in service. A key function is to provide members of the public with advice on how to pursue complaints. Councils may assist individual complainants to pursue their complaint and to act as an advocate for patients and complainants throughout the complaints process.

- The Department's Equality Scheme requires the Department and all HPSS organisations to consult widely with focus groups and the general public on all new policies. Regional and local equality forums meet regularly to discuss any issues of concern.

- Arrangements are also in place within the Department, Boards and Trusts for staff to be able to raise concerns about health and social care.

- Ministerial correspondence is also extensively used by both individuals and by local representatives on behalf of individuals.

- Public Satisfaction Surveys seek to establish the level of satisfaction with health and Social Services in Northern Ireland and to indicate those areas in which the public would like to see changes and improvements.

(xiii) In your role as a member of the Departmental Board, explain what information you received or solicited about the procedures, investigations and events that followed the deaths of Adam, Lucy and Raychel

I was aware of the concerns regarding these deaths and subsequent events and that the CMO and her staff had addressed the clinical issues. The Departmental Board discussed the issues at meetings in February (Ref: 004-019-236) and May (Ref: 004-020-238). My role, however, was focused on the procedures investigations, etc, which should apply in the future.

(xiv) Again in your role as a member of the Departmental Board, explain what steps you took to discover why the children died and to ensure that any lessons would be learned.

I ensured that I was aware generally about the deaths of these children and the concerns which had been raised. My primary responsibility related to ensuring that appropriate arrangements were in place to deal appropriately with all untoward incidents and the current position is described in response to question (ix).

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: Don Wall

Dated: 7 July, 2005