Sub|513|2005

From: Andrew Browne
Secondary Care Directorate

Date: 29 September 2005

1. Andrew Hamilton – *Agreed/AH/3/10/05*
2. Shaun Woodward

INQUIRY INTO HYPONATRAEMIA – RELATED DEATHS: FOLLOW-UP TO MEETING WITH THE SLAVIN AND FERGUSON FAMILIES

SUMMARY

Issue:	**When you met with the Slavin and Ferguson families on Sunday 4 September you agreed to consider whether anything could be done to address some of their concerns about the HPSS in advance of the Inquiry's report, which is now delayed indefinitely.**
Timing:	**No undertaking was given to respond to the families by a particular date. However if the Minister were to agree to send a letter to John O'Hara, it may be helpful to the Inquiry to have received it prior to the public hearing on Friday 7 October.**
Implications:	**This submission is fully disclosable.**
Presentational Issues:	**It is possible that any letter to the families may be disclosed to the media.**

Recommendation: **That Minister writes to John O'Hara using the attached draft. A letter to the families can be finalised once Mr O'Hara's response is received.**

Background

At their request, you met with the Slavin and Ferguson families (including Marie Ferguson's sister and brother-in-law) on Sunday 4 September in Hillsborough Castle. This followed a previous meeting with the Crawford family. In the course of the meeting they raised a number of concerns, namely:

- The accountability of medical and nursing staff.
- Communication between coroners and the CMO.
- The system whereby hyponatraemia–related deaths (and incidents not leading to death) are reported to the Department.
- Statistics on the number of adverse incidents that individual doctors are involved in and the availability of this information to the public.
- Whether the final inquiry report will be published.

You undertook to consider their concerns and after the meeting asked me to prepare a short submission on what, if anything, the Department could do at this stage.

2. The concerns of the Slavin and Ferguson families need to be set in the wider context of the patient safety agenda and actions that are already being taken to address this, many of which the families may be unaware of. Three questions that need to be addressed for their benefit, and indeed for the Crawfords also, are:

- What information, if any, would the Inquiry be willing to release to the Department at this stage about how it believes patient safety in the HPSS might be improved?
- What action has the Department already taken, or is taking, to address patient safety?
- What action is the Department proposing to take in the short to medium term?

What the Inquiry may be willing to share at this stage.

3. It is now recognised that the Inquiry is unlikely to be in a position to report until 2007 or beyond. It is understandable therefore that families should be concerned that other patients might be subject to avoidable risk while the Inquiry's recommendations are delayed.

I met with the Inquiry Secretary and Solicitor on Thursday 8 September to take their views on this. While they were sympathetic to the point, they felt that the Inquiry was still very much in its preliminary stages. The initial views of the panel of experts on key areas have not yet been signed off by the peer reviewers. However, they suggested that you write to John O'Hara formally asking if any initial thoughts on how to strengthen patient safety could be supplied to the Department. A draft letter is attached at Annex A.

What action has the Department, taken to strengthen patient safety?

4. The existing guidance on hyponatraemia in both children and adults is probably known to families. They may not be aware of:

(a) The Fluid Care Pathway Group (NI), which was set up last November to review the guidance and agree a fluid care pathway to be used in conjunction with it. Their work is due to be completed shortly.

(b) The National Patient Safety Agency (NPSA) sub-group looking at the management of hypotonic fluids in children. This is a national group chaired by David Cousins of the NPSA and includes Tracey Boyce (a NI pharmacist) and Dr Miriam McCarthy from the Department. David Cousins is due to visit the province in October and the group hopes to complete its work by the end of the year.

(c) Reporting of serious adverse incidents and near misses.

Circulars HSS (PPM) 06/04 and HSS(PPM) 05/05, issued in July 2004 and June 2005 respectively, have set in place a clear system for reporting adverse incidents to the Department. A group chaired by the Deputy CMO decides on appropriate action in respect of each report.

(d) The reporting of inquests by the Coroner to the CMO and/or the Minister has increased greatly, although there may be further changes in the context of the reform of the coronial system.

What action is the Department proposing in the short to medium term?

5. Work is well advanced on a document to be brought to the Departmental Board in October - 'Safety First: A Framework for sustainable Improvement in the HPSS'. This reiterates the Department's commitment to the ongoing development of a safer service, as part of its drive to improve clinical and social care, service user experience and outcomes. The document has been prepared primarily for HPSS managers rather than the public, but the implementation of the framework would make a significant impact on patient safety. It includes a section highlighting the importance of good communication with the public and the media.

6. Part of the framework is an action plan covering the period from now until April 2007. Early actions include:

- Links to the NPSA completed and guidance issued to the HPSS.
- A phased implementation plan in place to support NI membership of the National Reporting and Learning System (NRLS).
- Guidance to the HPSS on the nature of links to NICE and local pathways.
- Following links with NICE, specific guidance on the introduction of new interventional procedures into the HPSS.
- Adoption by all organisations of a new agreed definition of an adverse incident.
- Safety and quality as a permanent agenda item at Board meetings.
- Organisations to have incident reporting levels reviewed at least quarterly by senior management.
- All HPSS organisations to have a designated lead to determine when a serious incident investigation should be instigated.
- A Memorandum of Understanding to be published on the investigation of unexpected deaths or serious harm.
- HPSS organisations to have feedback mechanisms in place to learn from incidents reported by an individual or team.
- An annual report on local serious adverse incidents to be issued to the HPSS.
- A public consultation on a new HPSS complaints' system.
- The Department to publish guidance on Protecting Personal Information.
- Guidance on a new disciplinary framework to be published and implemented in HPSS Trusts.
- The HPSS to complete implementation of the Hine Review on Endoscopes.

- All HPSS organisations to include risk awareness within the organisation's induction programmes and in specific areas of care in the induction programmes of staff.

7. All of the above will go some way to addressing concerns raised by the families. While the adverse incident reporting should identify any near misses, or worse, involving hyponatraemia it will not identify every occurrence of hyponatraemia. The only way to do that would be to monitor all lab test results, of which there are thousands every day. Leaving the practical difficulties aside, there is no medical rationale for singling out this aspect of fluid management from all others that may be potentially harmful. As regards issues affecting the accountability of doctors, the GMC is continuing to bring forward proposals that will be relevant here.

Publication of the Report

8. The families also raised the issue of whether you would publish the Inquiry report when it is received from John O'Hara. Schedule 8 to the HPSS (NI) Order 1972 states only that "The Ministry shall appoint a person to hold the inquiry and to report thereon to the Ministry". However in a press release issued on 18 November 2004 Angela Smith was quoted as saying "the final Report from the Inquiry will be published". That remains our position.

Recommendation

9. It is recommended that you write to John O'Hara inviting him to submit any initial findings on patient safety that he feels could be taken forward in advance of the publication of his report. Once his reply is received a letter can be prepared for issue to all of the families reassuring them that the final Report will be published and advising them of steps being taken to advance the patient safety agenda.

ANDREW BROWNE

Secondary Care

[redacted]

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Dr Ian Carson
Dr Liz Mitchell
Dr Maura Briscoe
Dr Miriam McCarthy
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ANNEX A

DRAFT

Mr John O'Hara QC
Chairman
The Inquiry into Hyponatraemia-related Deaths
3rd Floor
20 Adelaide Street
BELFAST
BT2 8GB

October 2005

Dear

At their request, I recently met with the Slavin and Ferguson families. As you know, I had previously met with Mr and Mrs Crawford.

While they welcome the PSNI investigation into their children's deaths, they are concerned that any recommendations you may have for improving patient safety in the HPSS will not now be available, perhaps for some years, because of the inevitable delay to your report. They believe this may be to the detriment of current and future patients.

I understand that many of your recommendations are likely to be shaped by the seminars that you hoped to hold after the public hearings. Nevertheless I undertook to check with you whether there are any preliminary findings that, even at this early stage, could be released to the Department to help in the development of the patient safety agenda. I appreciate that the more usual approach is to wait until the final report is prepared and you may well feel that there is no way around this, notwithstanding the unavoidable delays created by the police investigation.

My Department will continue to take forward work on patient safety in general, and hyponatraemia in particular, regardless of whether the Inquiry is able to make any input at this stage and we will of course welcome your recommendations whenever they come.

In the meantime I would be grateful for your views on this particular issue.

SHAUN WOODWARD

Parliamentary Under-Secretary of State for Northern Ireland