Health and Social Care Board

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John O'Hara QC
IHRD Chair
Arthur House
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10 April 2014 Your Ref: JOH-0441-14

Dear Mr O'Hara

I refer to your letter of 27 March 2014, in which you have requested comments in relation to a number of points of concern about aspects of the information developed at the Inquiry during week commencing 11 November 2013. The responses below are in the order raised in your letter.

1. Are the medically-qualified members of HSCB restricted to two general practitioners?

In the Departmental process for the appointment of Non Executive Directors to the HSCB in 2009, it was specified that the members should include, amongst others, a member from a medical background and a member from a nursing background. This resulted in the appointment of two members from a medical background, including the Chair, and a member from a nursing background and all of these members remain in post. Both of the members from a medical background are retired General Practitioners - this is coincidental and these posts may be held by medical practitioners from any background.

In addition to these non-Executive Directors, the HSCB receives Executive Medical and Executive Nursing advice from the Public Health Agency. These arrangements were described in the HSCB Chief Executive's Introductory Statement to the Inquiry on 14 November 2013 in which it was advised that Dr Carolyn Harper

is the Director of Public Health in the Public Health Agency (PHA) and the Medical Director of the HSC Board, and that Mrs Mary Hinds is the Director of Nursing and Allied Health Professions in the PHA and the Director of Nursing of the HSC Board.

Both the Medical Director and the Director of Nursing are full members of the HSCB's Senior Management Team; they provide executive advice to the Senior Management Team and participate as full members. They lead on specific areas of responsibility and in practice, have the same authority as they would have if they were employees of the HSCB. They attend all meetings of the HSCB Board, including confidential sessions. They provide the formal medical and nursing advice to the HSCB Board.

In addition, medical and nursing staff employed by the PHA provide day-to-day professional advice to HSCB to enable it to discharge its functions. PHA and HSCB staff work together in fully integrated teams in carrying out the HSCB's core functions of commissioning, performance management and service improvement, and resource management.

The authority of the PHA and hence the Medical Director and Nursing Director of the PHA is underpinned by the Health and Social Care (Reform) Act 2009 which requires the HSCB to obtain the approval of the PHA before it publishes its annual Commissioning Plan.

In effect, the Health and Social Care (Reform) Act 2009 designed the HSCB and PHA as 'conjoined' organisations. Each relies on the other for some of its functions – HSCB relies on PHA for advice on medical, nursing and allied health professional advice; PHA relies on HSCB for primary care, social care, commissioning, finance and performance management functions.

The DHSSPS Framework Document (September 2011), describes the roles and working relationship of all HSC organisations in more detail, and states that "in practice, the employees of the HSCB and PHA work in fully integrated teams to support the commissioning process at local and regional levels".

2. **Was thought given to the HSCB having a medical director and/or director of clinical governance and/or director of quality and patient safety?**

The structures of the HSCB, including Director level posts were developed by the DHSSPS and are specified in the Health and Social Care (Reform) Act 2009 and the Membership Regulations.

The Executive Medical Director function of the HSCB is provided by the Medical Director, PHA. The functions that would be provided by a director of clinical governance and/or quality and patient safety are provided to the HSCB by the Director of Nursing and Allied Health Professions, PHA.

The Director of Nursing and Allied Health Professions, PHA, chairs the overarching HSCB/PHA Quality Safety and Experience Group which oversees all aspects of work relating to patient/client safety, quality of care, and patient/client experience. This Group includes the Medical Director, PHA, the Director of Social Care, HSCB, the Director of Performance and Corporate Services HSCB, and professional heads from HSCB. In addition, the Medical Director chairs the Safety Quality and Alerts Team which reports to the Quality Safety and Experience Group and which oversees assurance that recommendations in safety and quality-related reports, circulars and equivalent documents are implemented.

There is fully integrated joint working between HSCB and PHA on all matters relating to patient and client quality, safety and experience, and the PHA Medical Director and Director of Nursing and Allied Health Professions have provided significant input to this reply.

3. **Is there confusion regarding these arrangements?**

The support of the PHA is essential for the HSCB to perform its role, in particular in relation to the commissioning function and improving the safety and quality of services. The arrangements outlined in point 1 above have developed over time and work effectively, and are well understood by staff in both organisations. There is no confusion regarding these arrangements.

4. How reliable is the adverse incident reporting system when there is variation in categorisation?

Please note, and as advised to the Inquiry in the correspondence appended in your letter, only Serious Adverse Incidents (SAIs) are reported to the HSCB. Adverse Incidents, i.e. incidents of a less serious nature, are investigated by the organisation in which they occurred and learning identified and disseminated, but they are not reported to the HSCB. There are around 80,000-90,000 such incidents per year and they are recorded by Trusts in their Datix systems. DHSSPS is currently taking forward work to establish effective arrangements to identify learning from adverse incidents and share this across the HSC, and the HSCB and PHA are involved in this work.

The system the HSCB and PHA have put in place to centrally collate and process SAIs has brought greater uniformity and consistency. In consultation with the reporting HSC organisations, we continually seek to improve the effectiveness of the SAI system. In particular, a review of the SAI procedure was undertaken during 2013, resulting in a number of changes to strengthen the arrangements for the identification of learning. The revised procedure was introduced from October 2013. More recently, the HSCB and PHA have introduced a checklist to ensure more detailed information on the involvement of families in the SAI process is recorded in SAI Investigation Reports. A copy of the letter issued to Trusts in relation to this requirement, and associated documentation is attached.

While we continue to work with Trusts to standardise the SAI information as much as possible, our focus is primarily on learning and implementation of learning. It is not possible to ensure complete standardisation as categorisation decisions are inherently subjective. This needs to be understood to maintain the focus on improving patient/client care and avoid over interpreting numbers and trends.

5. Involvement of patients/families.

The Procedure for the Reporting and Follow up of Serious Adverse Incidents (revised October 2013) states the need for and importance of appropriate communication and involvement of service users, relatives and carers. Paragraph 5.4 states that *"the Investigation Team should provide an opportunity for the service user / relatives / carers to contribute to the investigation, as is felt necessary. The level of involvement clearly depends on the nature of the incident and the service users / relatives / carers wishes to be involved"*.

In addition, the SAI Notification Form requires confirmation of organisations and persons informed, and includes 'Service User / Family'; and the Investigation Report Template specifies the requirement to include details of family involvement in the Investigation Terms of Reference, the Investigation Methodology, the Findings and Conclusions sections.

While the procedure makes clear the need for family involvement, to further assist Trusts, the HSCB and PHA have reviewed the SAI Notification Form and developed a SAI Investigation Report Checklist which should accompany all SAI Investigation Reports.

The HSCB wrote to Trusts on 31 March 2014 requiring these forms to be implemented with immediate effect for all newly reported SAIs and for ongoing SAIs for which investigations have not yet been completed.

HSCB/PHA Designated Review Officers will require this more detailed information in relation to family involvement to be included in completed Investigation Reports before closing SAIs.

In addition, at the request of DHSSPS, the HSCB and PHA are establishing a group to include representation from the Patient and Client Council and the Regulation and Quality Improvement Authority to develop expanded guidance on effective engagement with families in the SAI process, and this is expected to be complete before the end of May 2014.

I hope that this provides the clarification and assurance you require.

Yours sincerely

Fionnuala McAndrew
Interim Chief Executive

cc Glenn Houston, RQIA
Colm Donaghy, BHSCT
Dr Andrew McCormick, DHSSPS
Dr Eddie Rooney, PHA
Dr Carolyn Harper, PHA
Pat Cullen, PHA
Michael Bloomfield, HSCB