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Mr John O'Hara QC
IHRD Chair
Arthur House
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14 April 2014

Dear Mr O'Hara

Further to your letter dated 3 April 2014 regarding the Inquiry into hyponatraemia-related deaths please find information below as requested:

Q1 What is the relationship, if any, between the NI Safety Forum and the Public Health Agency (PHA)?

The Health and Social Care (HSC) Safety Forum was established in 2007 by the DHSSPSNI. Initially the Safety Forum was hosted by the South Eastern Health and Social Care Trust (SEHSCT). In October 2010, the DHSSPSNI transferred responsibility for the Safety Forum to the Public Health Agency (PHA). The Safety Forum is led by a Clinical Director who reports to the Director of Nursing and Allied Health Professionals who in turn reports to the Chief Executive of the PHA. The Safety Forum develops an annual work plan which reflects the safety and quality priorities of the Health and Social Care Organisations. The annual work plan is approved by the PHA Senior Management Team.

Q2 When, why and how was the NI Safety Forum established?

The Safety Forum was established in 2007 by the DHSSPSNI. The role of the Safety Forum is to support Health and Social Care Organisations to continuously improve the quality of care delivered to patients and clients. The Forum, using a collaborative approach, applies improvement science methodologies to build and develop capacity within all HSC Organisations.

The Safety Forum Clinical Director leads a small team comprising two Patient Safety Advisers and a part time doctor who acts as a clinical lead who are all employees of the Public Health Agency. The annual work plan for the current year includes a range of quality improvement priorities agreed across a range of service areas, including Maternity, Mental Health, Primary Care, Nursing Home care and Unscheduled Care.

Q3 What role does the PHA have (if any) in reporting, management and investigation of SAIs?

The Public Health Agency (PHA) is responsible for reporting, managing and investigating Serious Adverse Incidents (SAIs) that may occur within the PHA. The PHA does this in line with the Health and Social Care Board (HSCB) procedure for the reporting and follow-up of SAIs.

The PHA does not report, manage or investigate SAIs that occur in other HSC organisations. However, the PHA works with the HSCB as outlined in the HSCB procedure for SAIs. Specifically, the PHA allocates Doctors, Nurses and/or Allied Health Professionals who take on the role of the Designated Responsible Officer (DRO). The DRO role is outlined in the HSCB procedure.

The PHA is also represented on the SAI Review Group which in turn reports to the Quality, Safety and Experience (QSE) Group of the HSCB/PHA and through to the Governance Committee of the HSCB. The QSE Group is jointly chaired by the HSCB and the PHA's Director of Nursing and Allied Health professionals, and the Public Health/Medical Director. Membership of this Group includes other PHA staff.

Q4 Do child death review panels exist here?

Not yet, however, a Child Death Overview Panel will be established shortly under the auspices of the Safeguarding Board Northern Ireland. In advance of that, and following the review of the Serious Adverse Incident procedure of the HSCB, from October 2013, "any death of a child in receipt of HSC services (up to eighteenth birthday) must be reported as a Serious Adverse Incident. This includes hospital and community services, Looked After Child or a child whose name is on the Child Protection Register;" (paragraph 4.2.2. of the Procedure for the Reporting and Follow up of Serious Adverse Incidents). You have previously received this procedure. A small number of children die who

are not in receipt of HSC services, for example, if a child has died in a road traffic accident before the ambulance crew has arrived. In those circumstances, the HSC has not provided care and are therefore not reported as SAIs. Those deaths are however reported to and investigated by the Coroner's Office. In effect therefore, through the Coronial procedure and the requirements of the HSCB SAI procedure, all child deaths are currently investigated. The Child Death Overview Panel will add further value by being a single source of review of all deaths to enable identification of themes, causes, or patterns that warrant further action through existing or bespoke arrangements to tackle a specific issue.

Q5 Is there an established system of paediatric early warning scores used in clinical practice in NI?

The Safety Forum Paediatric Improvement Programme has facilitated the development of an agreed Paediatric Early Warning System for Northern Ireland. The current draft is being tested in all five HSC Trusts and is due for review and update at the end of April 2014. The Safety Forum, PHA plan to issue the final draft for a 12-month pilot to test the system in practice before full-scale roll-out. This step is essential. Towards the end of the pilot, we will consult, review and modify the system in liaison with staff who will use it.

Q6 What does the PHA's Safety Quality and Alerts Team do?

The Safety Quality and Alerts Team (SQAT) is actually a joint team of the PHA and the HSCB. It was established in April 2012 and is chaired by the Medical Director/Director of Public Health of the PHA. It includes medical, nursing, pharmacy, social care, governance, Safety Forum and general practice representatives from the HSCB and PHA. The role of the Team is to oversee implementation of safety alerts by HSC Trusts. Safety alerts include HSCB/PHA learning letters, DHSSPS circulars on safety and quality, reports from the Regulation and Quality Improvement Authority (RQIA) and reports from National Confidential Enquiries. The Team fulfills its role by logging each alert that is received into the central coordinating office, reviewing each new alert at its fortnightly meetings,

determining any action required, and as appropriate, seeking assurance from Trusts that all appropriate action has been taken.

In order to ensure a focus on the most significant issues, the Team takes a risk-managed approach to seeking assurance. It therefore asks for assurance on alerts that relate to aspects of care that carry the greatest risk for patients and clients, rather than all alerts. HSC Trusts have strongly welcomed this approach as it enables them to direct their resources to areas of greatest risk.

The Team typically seeks assurance by asking Trusts to confirm that specified actions have been completed. Required actions are set out in HSCB/PHA learning letters, or as recommendations in RQIA reports or DHSSPS circulars. In addition, the Team may instigate regional work, for example, it has asked the Safety Forum to work with Trusts to implement specific recommendations in the RQIA Review of Acute Hospitals at Night and Weekend. It also instigated work to commission regional training on chest drain insertion. This training is now in place and available to all Trusts where previously staff had to travel to England to avail of the training.

The Team reports to the Quality Safety and Experience Group of HSCB/PHA and through it to the Governance Committee of the HSCB. It provides a 6-monthly report to the Governance Committee on its activities; the most recent reports are attached and give an overview of the work of the Team, including most importantly, examples of work to improve patient/client care.

You asked also for any contribution I could make to the queries you raised in your letter to the DHSSPS, Belfast Trust, HSCB and RQIA. Regarding the relationship between the PHA and HSCB, in implementing the 2009 Act and to avoid duplication, the DHSSPS determined that both organisations should share expertise. Through this arrangement, the PHA receives financial, commissioning and performance support as well as professional advice on Social Care from the HSCB . The HSCB Directors of Finance and Social Care attend the PHA management team and PHA Board meetings.

A reciprocal arrangement exists between the PHA and the HSCB. The Directors of Public Health and Nursing /Allied Health Professionals

attend the HSCB Senior Management Team and the HSCB Board meetings. In addition the professional medical, nursing and allied health professional staff within these two Directorates works closely with their HSCB colleagues through joint teams on agreed programmes of work.

This arrangement works well as an efficient and effective way of utilising the pool of expertise to enable both the HSCB and PHA to fulfil their respective functions under the 2009 Act. From the PHA perspective, it enables this organisation to respond to requests from the HSCB to provide information, advice and assistance in support of its statutory functions. At the same time, it enables the PHA to retain sufficient expertise to respond to the HSCB requirement under the 2009 Act to consult the PHA in drawing up the Commissioning Plan (HSCB must pay due regard to any advice or information received from the PHA) and to approve the Commissioning Plan for publication by the HSCB.

Further detail of the PHA/HSCB relationship is set out in the DHSSPS *Framework Document* (copy attached).

Your letter to Mr Colm Donaghy, dated 27 March 2013 (sic), referred to Dr Caroline Harper. This should read Dr Carolyn Harper.

If you require any further information please do not hesitate to contact me.

Yours sincerely

Dr E P Rooney
Chief Executive

eddie.rooney[redacted]

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