From the Chief Medical Officer
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BY EMAIL

Mr John O'Hara QC
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Dear Mr O'Hara

ACCOUNTABILITY ARRANGEMENTS

Thank you for your letter, dated 27 March, in which you posed a number of questions in relation to HSC structure, HSC accountability arrangements and adverse incident data. Dr McCormick is currently on leave and I am replying on behalf.

In points 1 to 3 of your letter, you have raised a number of issues about the working relationship between the Health and Social Care Board and the Public Health Agency. In order to describe the origins of this relationship and its associated governance arrangements, it is necessary to go back to the Review of Public Administration, which was established by the devolved administration in 2002. The Assembly's objective for the Review included the streamlining of public services, the reduction of administrative costs and the maximisation of resources for frontline services.

During the Direct Rule period between the first devolved administration and the current Assembly, proposals were drawn up, which would have included the establishment of a single health and social care authority, broadly embracing the roles now performed by the HSCB and the PHA. However, when devolution returned in 2007, the then Minister of Health, Social Services and Public Safety was not satisfied that the proposals would create a sufficient dynamic to promote public health and wellbeing and address inequalities. The solution to that perceived weakness was to create a separate Public Health Agency charged with ensuring that the commissioning of health and social care services would have health and wellbeing promotion and improvement at its heart. This model has been adopted in other parts of the United Kingdom reflecting a greater emphasis on public health and wellbeing.

This mechanism was the subject of public consultation at the time and, of course, the passage of the Health and Social Care Reform Act by the Assembly. Section 8 of the Act is key in this regard because it imposes on the HSCB a requirement to consult, to have due regard to the advice of, and to secure the agreement of the PHA to the annual Commissioning Plan. The practical outworking of this obligation is that the HSCB must work in full collaboration with the PHA in the discharge of its commissioning, performance management and service improvement responsibilities.

The post of "director" within an HSC body attracts a specific level of remuneration. Because of that, the number of directors became a key indicator for Ministers of the level

of administration costs. As I have already explained, one of the key principles of reform was the maximisation of resources for frontline services. Given the symbiotic relationship between the HSCB and the PHA, the Minister decided that the professional support for the commissioning process should be shared between the HSCB and the PHA. Collaborative working of this nature takes place at all levels between the two organisations and is formally reflected at board level, where the Medical Director and the Nurse Director of the PHA attend and have full speaking rights at HSCB meetings. They are de facto Directors of the HSCB for the joint commissioning responsibilities of the HSCB and the PHA. The retired practitioners you identified in your letter are non-executive directors, appointed by the Minister via the Public Appointment process, rather than employees of either the HSCB or the PHA.

Adverse Incident Recording

The professional expertise to investigate and identify learning from individual adverse and serious adverse incidents resides in Health and Social Care Bodies, rather than the Department itself. The need for a higher degree of professional scrutiny was the impetus behind transferring responsibility for the Serious Adverse Incident system and regional learning to the HSCB/PHA in May 2010. This is why neither individual SAIs nor individual AIs are reported to the Department except where they meet the criteria to be reported as an Early Alert.

The Department however continues to challenge each Trust, the HSCB and the PHA on the operation of the Adverse Incident/Serious Adverse Incident process on an ongoing basis and as part of existing mid and end of year accountability arrangements. The Department has also sought to receive independent assurance with regard to how these arrangements operate in practice by commissioning an RQIA review of adverse incident reporting and learning which is scheduled to begin later this year.

Whilst the guidance on adverse incident reporting remains the same across NI, some variations in categorisation and recording are inevitable in any systems which are used independently in each Trust. However, the anomalies, some of which you referenced by way of example, are being considered by the Department as part of a Regional project working in conjunction with the HSCB, PHA and HSC Trusts. Work on this project began at the start of February 2014 and the team has been meeting with staff from across the HSC to better understand how the various groups, bodies, systems and processes help capture, share and promote learning. The team will scope how the system works at present and any gaps. The work is not confined to adverse incident data as the team is also considering other bodies, groups and processes by which learning can be achieved and shared. The Terms of Reference for the Regional Learning System Project Team are included at **Annexe A**

In respect of adverse incidents, the team's initial work has shown there are some variations of approach within each Trust which do not foster consistency. For example, in some Trusts incident reporting is recorded on a hardcopy IR1 form but in other Trusts, an electronic on-line version is used. In some Trusts, staff at ward level report the adverse incident and complete the documentation but in others, a central team has oversight of all the reports.

Irrespective of inconsistent categorisation, Trust Governance Leads are in a position to review incidents across their Trust and to share learning/trends as part of a quarterly regional meeting of all governance leads which is chaired by the HSCB/PHA. This

meeting affords members the opportunity to raise important issues at a regional level and for groups or trends in adverse incidents to be discussed. This may also result in the escalation of a particular adverse incident to a serious adverse incident.

The HSCB/PHA also reviewed the SAI procedures last year and issued revised guidance in October 2013. It remains their responsibility to monitor and develop those procedures on an ongoing basis and the Department will continue to challenge them to do so in light of new/emerging issues.

Engagement with Families around SAIs

The need for engagement with families has been a feature of serious adverse incident reporting for some time. In September 2007, HSS (SQSD) 24/2007 HSC Regional Template and Guidance for Incident Review Reports was issued to the HSC. The template shows the first thinking in terms of patient/family involvement. The Terms of Reference of Investigation Review Teams included "To ensure sensitivity to the needs of the patient/service user/carer, family member, where appropriate." The methodology for investigation is described as including "Engagement with patient/service users/carers/family members."

The policy imperative for this will have arisen from emerging best practice elsewhere for the provision of safer services. Patient/family involvement was not previously recorded in SAI reports and has only been explicitly referenced/adopted since May 2010 when the SAI system transferred to the HSCB/PHA. It is included in the new HSCB/PHA SAI guidance and remains in revisions to the forms and the guidance right up to the most recent revision in October 2013.

Further emphasis and rigour has been added to this requirement and on 31 March 2014 the HSCB/PHA sent an instruction to HSC Trust Chief Executives putting into place with immediate effect, an SAI Investigation Report Checklist to promote service user / family involvement. That letter, the accompanying form and checklist are attached at **Annexe B**

Guidance on investigating Serious Adverse Incidents stresses the importance of teams involved in investigating the incident ensuring sensitivity to the needs of the service user/relatives/carers involved in the incident and agreeing appropriate communication arrangements, where appropriate. The guidance also 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.

It is important, as part of the serious adverse incident investigation process, that regular and meaningful contact is maintained with all those concerned. If the patient or relative wishes to contribute to an investigation, this should be welcomed as a valuable and key part of the process. In order to reinforce this procedure, Dr McCormick wrote to the HSCB/PHA on 31 March 2014 asking them to expand the existing guidance to the HSC on engagement with patients, clients and families as part of the SAI process **(Annex C).**

You will be aware no doubt of Minister's recent statements to the Assembly and the work he has commissioned to promote quality and good governance across the HSC. This includes –

- A review of governance arrangements across the HSC. This will examine whether an improvement in the quality of governance arrangements is needed and whether the current arrangements support a culture of openness, learning and making amends. An initial approach has been made to Sir Liam Donaldson, former Chief Medical Officer of England to ask him to carry out the review. A copy of the Terms of Reference for the review is attached (**Annexe D).**

- The RQIA has been requested to undertake a rolling programme of inspections of acute hospitals focusing on a range of quality indicators including triage, assessment, care, monitoring and discharge.

- HSC Trusts have been directed to undertake a review of all Serious Adverse Incidents reported between January 2009 and December 2013 and provide information to the Department and HSCB on all Serious Adverse Incidents in this period.

- The RQIA, as part of a planned review of adverse incident management, reporting and learning later this year, will independently investigate and quality assure the work which each Trust has undertaken as part of this exercise. As part of the same planned review RQIA will consider the appropriateness of Trust's systems for identifying Serious Adverse Incidents by considering their current arrangements for reporting and handling adverse incidents, Litigation cases and Complaints. This will involve RQIA in sampling cases from the complaints and litigation systems and reviewing Trusts systems for identifying where appropriate these cases as SAIs.

I trust you find this information helpful.

Yours sincerely

Dr Michael McBride
Chief Medical Officer

Annexe A

Terms of Reference for Task and Finish Group for Regional Learning System

Purpose of Group

1. The overall aim of the project is to implement an interim regional learning system to include an interim Regional Adverse Incident Learning system.

2. The purpose of the system will be to strengthen our support for a culture of learning from all adverse incident systems and from instances of good practice across all regional HSC services.

3. Such learning is expected to include, but not be confined to, complaints systems, statistical data, RQIA reports, GAIN Audits, patient experience surveys etc.

4. This will include considering how we secure assurance that learning is being applied. The purpose of this Task and Finish Group (the Group) is:

    - To map out the current reporting systems for adverse incidents;
    - To map out the current processes whereby learning from good practice and adverse incidents occur;
    - To map out the arrangements that allow learning to be exchanged and disseminated across the HSC sector in Northern Ireland;
    - To identify potential areas to improve the existing arrangements regarding how learning happens; how learning is shared between relevant stakeholders and how assurance is provided that learning is being applied;
    - To determine a requirement for a permanent solution to the Regional Learning System; and
    - To implement an interim solution to the Regional Adverse Incident Learning system.

Timescales and Deliverables

5. It is anticipated the project will begin in January 2014 and will complete by the end of September 2014. The following outputs will provide an indication of the effectiveness of the Group to manage the project to a successful outcome:

- The production of an approved business case to secure appropriate staff to carry out the mapping review. (By end of January 2014)
- The appropriate staff are assigned to the project in a timely manner. (By end of January 2014)
- Interim RAIL dataset secured covering all six HSC Trusts. (By end June 2014)
- To accurately map the current process for the recording/reporting, analysis/investigation, escalation, and dissemination/implementation of information/learning relating to reported adverse incidents and instances of good practice. This should be complete by 30th April 2014.
- The production of adequate and effective agreed recommendations for the future development of a Regional Learning System. (By end of September 2014)

Membership

6. Membership of the steering Group will comprise:

- Fergal Bradley, Director SQSD
- Pat Cullen, PHA
- Oriel Brown, PHA
- Sloan Harper, HSCB
- Mark Timoney, Chief Pharmaceutical Officer
- Brian Godfrey, Health Estates Investment Group
- Conrad Kirkwood, SQSD
- Gillian Hynes, SQSD
- Colin Wallace, SQSD
- IAD representative to be secured
- Michael Bloomfield, HSCB

7. The Joint Chairs of the Group will be the Director of Safety, Quality and Standards Directorate and the Interim Director for Nursing, Midwifery and Allied Health in the Public Health Agency

Frequency of Meetings

8. The first meeting will take place in December 2013.

9. Meetings will be kept to a minimum and will be called to coincide with critical points within the work. It is anticipated that there will be a maximum of four meetings throughout the nine month period.

Governance

10. The Group will make recommendations to the Department through its Chair. SQSD will provide Secretariat.

Communication

11. The Group will communicate directly with relevant stakeholders in writing using formal letters and email, and verbally by telephone and face to face discussions.

Outputs

12. The outputs will be as follows:
    - A business case to secure a staff resource to deliver the objectives of the Group;
    - The creation of an Interim RAIL dataset;
    - A mapping of the current systems, groups, processes together with a gap analysis; and
    - A suggested model for the new interim regional learning system with recommendations for implementation.

Annexe B

SAI Investigation Report Checklist to promote service user / family involvement


HSC SAI NOTIFICATION FORM


Checklist SAI Investigation March 2


Letter to Trust CX's re SAIs - Service User

Annexe C

Department letter to the HSCB/PHA on 31 March 2014 asking them to expand the existing guidance to the HSC on engagement with patients, clients and families as part of the SAI process.

AMCC 4819 letter to HSCB and PHA re Seri

Annexe D

EXPERT EXAMINATION OF THE APPLICATION OF HSC GOVERNANCE ARRANGEMENTS FOR ENSURING THE QUALITY OF CARE PROVISION

Terms of Reference

In a statement to the NI Assembly on 28 March 2014 about the implementation of the improvement programme in the Northern Health & Social Care Trust, the Minister announced his intention to commission a further piece of work to examine the HSC in its entirety in respect of its:

- Openness and transparency
- Appetite for enquiry and learning
- Approach to redress and making amends

This work will focus on the effectiveness of arrangements within HSC Trusts, the HSCB and PHA in ensuring the highest possible quality of care provision. The Department's Quality Strategy (Quality 2020 (Q2020)) sets the direction in protecting and improving quality in health and social care in Northern Ireland.

In common with other countries in the UK and internationally, Q2020 defines quality for health and social care in terms of three key components. High quality care is:

- Safe – it minimises risk and harm to service users and staff.
- Effective – it results in improved health and wellbeing as informed by an evidence base ; and
- Person centred – it gives due regard to the preferences and aspirations of those who use services, their family and carers.

Quality 2020 recognises that culture is critical to ensuring quality throughout the system and as part of its mission of creating a culture of learning and continuous improvement has transforming the culture as one of its five strategic goals. Openness and transparency are recognised as being fundamental to an informed safety culture. The aims of Q2020 are underpinned by the statutory duties of quality (2003) and personal and public involvement (PPI) (2009) placed on HSC organisations.

The terms of reference of the expert examination are described below.

Openness and transparency

1. To consider and provide an assessment of the effectiveness of current governance arrangements across the health and social care sector with specific focus on openness and transparency in cases when things go wrong or patients, clients or families are unhappy with the quality of health and social care they have received.

2. To make recommendations on how these arrangements can be improved in the light of these findings and local, national and international experience.

Appetite for enquiry and learning

3. To consider the effectiveness of current governance arrangements and their supporting systems within the five Health & Social Care Trusts in:

    a. Identifying, reporting, managing, analysing and learning from adverse incidents

    b. Identifying, reporting, escalating and learning from serious adverse incidents

    c. Identifying and reporting Early Alerts to the Department

d. correlating with other systems from which learning can be achieved such as;

- complaints, compliments and letters from the public;
- clinical negligence claims
- service user feedback surveys
- staff surveys
- regulatory inspections

e. Engagement with patients, clients and families when adverse incidents occur and throughout their investigation.

4. To consider the effectiveness of current arrangements and regional systems for learning overseen by the Health & Social Care Board / Public Health Agency including:

   a. Receipt, management, analysis and learning from serious adverse incidents

   b. The dissemination and embedding of learning

   c. Quality Assurance of Trust based processes.

Approach to redress and making amends

5. To consider the effectiveness of current arrangements for handling complaints and adverse incidents in an empathetic, proportionate and compassionate manner and make recommendations on how these can be improved in the light of these findings and local, national and international experience

Scope

The principle focus of this examination is on systems within trusts and across the HSC that support the identification, reporting, investigation of, and learning from, adverse incidents. The examination will also consider the openness of the related processes within and across organisations, particularly with service users and their families who are those most affected by individual incidents. The views of patients, clients and their families and their experiences of the health and social care system remain paramount.

Timescale

It is anticipated that the Expert Panel will provide its full report to the Minister by December 2014.