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An Roinn Sláinte

Mánnystrie O Poustie

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Working Together to Put Things Right – Implementation of Recommendations from the Inquiry into Hyponatraemia-Related Deaths (IHRD) – Update Report

21 March 2019

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Overview

There is a consistent theme that runs through the Inquiry into Hyponatraemia-Related Deaths. It found that time and again authorities and individuals within the system failed to be open and honest with the families of the children who died.

When he delivered his report Mr Justice O'Hara said that of all his 96 recommendations the key one was the need for a statutory Duty of Candour applying both to healthcare organisations and the individuals who work in them.

As we work through how best to implement the recommendations this same theme – of needing transparency around how we do things and the need to be open and honest - does not just apply to the legislation that will be needed for a Duty of Candour, it links to many other recommendations as well.

What is at stake goes beyond dealing with the specific issues raised by the report. It involves changing the entire culture of the health and social care system from top to bottom. What needs to emerge is a service which exhibits transparency and openness at all times and is determined to learn from mistakes. Individual recommendations being taken forward by several of our workstreams will individually and collectively promote greater transparency and openness in how we currently do things, particularly in how we respond when things go badly in the treatment and care of patients and other service users. This is one of the reasons why we are making sure that there is strong dialogue between all the workstreams so they can learn from each other as they work. This update focuses on the link between this broader group of recommendations and promoting candour within health and social care.

This commitment to candour affects not just what we do to put things right, but how we go about doing it. This is why more than 200 people from a wide range of backgrounds are working together to respond to the report. It is why we want to broaden our deliberations to include all organisations and individuals who have an interest. As everyone both funds and uses the health and social care system that's all of us.

We are therefore committed to sharing the maximum amount of information as we progress. We recently published research commissioned by the Duty of Candour workstream. Amongst other things it looks at how other health systems have addressed the issue of openness. It helps us to understand not just what they did but some of the problems faced, how they dealt with them and what we can learn from their experiences.

The setting up of an Independent Medical Examiner to scrutinise deaths which are not referred to the Coroner is another recommendation which has resulted from the Inquiry. In this update we explain what is involved in this and why it is vital that we have the widest possible debate on how best this is implemented.

All our workstreams are now up and running. This update summarises how they are progressing their work.

The Service User and Carer Liaison Group (SU&CLG)

Service user and carer members involved in the implementation programme have come together to form a Liaison Group. Every update will contain a progress report from the group. This is the first.

Who we are?

Experienced Service Users and Family Carers are actively involved within and across the hyponatraemia implementation programme. We have made contributions to the work as individuals and also now on a collective basis. We have recently come together as a Liaison Group, to augment and strengthen the service user and carer perspectives into the work of the implementation programme. The group provides a collective overview of potential service user and carer issues, involvement opportunities and influence across the IHRD programme of work.

What we do?

Our intention is to support each other to embed the ethos and spirit of involvement and co-production into ongoing and new practice, facilitate learning across the programme streams, act as a peer support network to build confidence and enhance the voice of service users and carers in the work. The Liaison Group will also act as a consultative group to advise the programme on service user and carer input into wider workstream involvement plans for other citizen voices. The group's intention is to act to enhance and support widespread understanding of the programme work, particularly for the public.

Other voices?

Through our elected Chairperson, the Liaison Group will provide a representative voice at the Implementation Programme Management Group, to support the development, implementation and evaluation of the Involvement Strategy and highlight collective views, broader challenges etc.

Throughout the programme lifetime, the Liaison Group will review and develop training and learning support needs to sustain continuing and effective involvement and identification of good engagement practice.

There are over 20 Service Users and Family Carers involved across the programme and our unique contributions will help bring a public-centred influence to the IHRD work. Our widespread experience and collective knowledge will enhance the IHRD discussions and help shape a better understanding of the expectations of the public, service users and family carers in the future development of all aspects of the programme's work and implementation of the recommendations.

Workstream 1 - Duty of Candour

When Mr Justice O'Hara announced his findings he said that the most important one of all was the need for a statutory Duty of Candour in Northern Ireland. He said:

“The unfortunate truth to be drawn from this Inquiry is that there are too many people in the Health Service who place reputation before honesty and avoidance of blame before duty. All that is required is that people be told honestly what has happened and a legally enforceable duty of candour for individuals will not threaten those whose conduct is appropriate.”

(Section 8.105, The Inquiry into Hyponatraemia Related Deaths Report January 2018)

He went on: “I recommend that a duty of candour attach to individuals as well as organisations in the event of death or serious harm and that criminal sanctions should apply.”

(Section 8.106, The Inquiry into Hyponatraemia Related Deaths Report January 2018)

The report cited numerous examples where the system failed to be open and honest with the families involved.

Introducing legislation to create a duty of candour is only part of the solution. It will bring in important new rules and regulations but we also need to change our behaviour. That means if we are to really transform the health and social care system into one which is more honest and open we will need to change its culture from top to bottom. Staff will need to be supported through this process.

The end result needs to be a system which learns from mistakes, is open with service users and carers particularly when things go badly wrong and puts the interests of patients first.

What the recommendations are

The workstream and sub-group are looking at five recommendations which can be summarised as follows:

- a) There should be a duty of candour placed on organisations;
- b) There should be a duty of candour placed on individuals and they should be fully supported in this;
- c) There should be a criminal offence attached to a failure to comply with the statutory Duty of Candour; and
- d) There should be a change in the culture of the health and social care system towards candour, openness, transparency.

A Duty of Candour also has implications for many other recommendations which are being addressed by other workstreams. These include for example how Trusts deal with Serious Adverse Incidents, Coroner's Inquests and potential cases of litigation.

The ultimate goal is to create a more open culture which will transform the experience of service users and

carers in the future. The majority of these changes are operational in nature and do not require a statutory Duty of Candour to be in place – so significant progress can be made in the absence of an Executive and Assembly. It is also important to note that the duty will apply to social care as well as health services.

What the workstream is doing

The workstream is applying the principles of openness and honesty to its own work.

It has recently published a series of research papers which it commissioned in order to help understand how candour is applied in other parts of the world, how we can learn from experiences elsewhere and explores some of the legal and human rights issues that can sometimes restrict what can be said and when.

All these are available for anyone interested in studying them for themselves and can be downloaded from the Department of Health website:

www.health-ni.gov.uk/articles/ihrd-get-involved-duty-candour

In addition the workstream wants to hear from anyone, individuals as well as organisations, who wants to submit any relevant additional research or information on the topic.

The objective of this work is to ensure that the health service is truly open and honest, especially when things go wrong. This will involve a willingness to admit to mistakes and a determination to learn from them. This all needs to be achieved in a way that supports staff. If there is a culture of fear amongst staff then the workstream will be setting out to find out why and looking at what steps are needed to overcome that. Everybody will need trust and confidence in the system, staff as well as patients.

That is why we need to be alert to any potential unintended consequences of new legislation. Achieving a truly open and honest service will involve changing behaviours, and that cannot be done by sanctions alone. The end result should be a willingness to admit to mistakes and a determination to learn from them.

The Duty of Candour workstream is also planning a series of workshops to be held in June to explore in more detail how candour should work. People can submit additional research or information and express interest in the workshops by emailing: ihrd.implementation@health-ni.gov.uk . Submissions should be sent in by **31 March 2019**.

Once submissions have been received and workshops completed the workstream will go on to develop proposals as to how organisations and individuals should be subject to a Duty of Candour. Once this is complete there will be a further consultation before they are finalised.

Peter McBride, Chair of the Being Open sub-group, is also planning to carry out wider engagement with the Trusts over the coming months, looking at their existing policies and how these can be built upon and developed regionally in order to meet the requirements set out in the recommendations. He is also keen to link in with other workstreams, including Education and Training, Workforce and Professional Regulation and ALB Board Effectiveness, to explore how their work can contribute to increased openness and transparency.

Lorna Nevin, Duty of Candour workstream

Nobody likes having to tell people news which we know is upsetting to receive, yet this is part of the role of any health and social care professional. Being honest and open in such circumstances takes courage, empathy and skill.

Lorna Nevin sits on the Duty of Candour workstream. She brings a wealth of invaluable knowledge and experience. She is Partnership Manager at Macmillan Cancer Support and is a former palliative care nurse and services manager. She also helped write Living Matters, Dying Matters, Northern Ireland's palliative and end of life care strategy.

She said: "Sharing the truth of a life changing message with an individual or family, be that a diagnosis or a death, is always hard. Doing this in a way which does not add to the burden of shock or grief, held in the memory of that moment, is a skill."

"One of the service users and carers in our group, whilst talking about the implementation of the recommendations around candour, summed it up well: 'Don't do what's easy, do what's right.'"

Lorna has had the sad task of sharing bad news with patients and their families she says: "It requires preparation, making the necessary time, having the appropriate privacy, knowing all you can about the news you are about to share, and then being prepared to sensitively communicate. Training is needed to improve competence, confidence and develop empathy. This should be at the beginning of peoples' careers and also through regular refresher courses."

This applies to administrators and managers as well as clinicians. Being candid can sometimes come across as being blunt, abrasive and even authoritarian. Lorna says "this might sometimes be necessary in boardrooms or when negotiating funding, but not in person centred care."

She said: "Managers are expected to juggle many skills, but a good leader should know what skills to use in various circumstances. What is required is a person-centred approach. This might mean parking their negotiation skills, demonstrating their empathy and not being scared to say sorry."

She believes that being told the truth, with clear, consistent and honest explanations matters in every situation and particularly for those bereaved. "We can never make bad news good news but we can learn to deliver bad news better to minimise the hurt."

Lorna says encouraging a culture of openness and honesty when things go wrong is a broader issue for society. "If you did well at school and have a good career and have not had to face or learn from personal disappointments or failures, then it can be very challenging to admit your mistakes publicly, you've just not been prepared for it. We need to do more to promote honesty and integrity in our society as a whole."

She is very positive about how the work is being taken forward. "We all bring something from our experiences that helps to bring a wider and more informed perspective. I know I have questioned my own views along the way and reflected on the need for everyone employed within our health and social care organisations to live out their values of openness, honesty and empathy regardless of their position or role. It's back to that culture of courage, rather than risk aversion."

“It is invaluable to see the challenges around Duty of Candour through someone else’s eyes.”

Seána Talbot, Being Open Sub-group

Everyone wants to see a more open Health and Social Care Service. When things go wrong, patients and their loved ones should be given a full explanation. We increasingly demand honesty and transparency.

Yet making this a reality is a big challenge.

Seána Talbot is one of the members of the Being Open sub-group of the Duty of Candour workstream. She manages a Sure Start project in West Belfast, runs the Facebook NI Maternity Forum and is a board member of the Patient and Client Council. She has also helped to develop Engage, the website that promotes the involvement of service users and carers in health and social care. She serves on the workstream in a personal capacity, not as a representative of any of those bodies.

She said: “Some of the work we are doing is about a shift in the balance of power. We’ve moved away from the time when we saw professionals as demi gods. Today we don’t want to be talked down to, we want to be seen as equal partners. This is true across all professionals not just those in health. It is based on the idea that those most involved have a right not just for information but also to have a say in how they are treated.”

At issue is the “watch your back” culture that often exists in large organisations. The inquiry cited many instances of this in its report. She said:

“When things go wrong we can’t have a situation where people in the system believe that they should say nothing and watch their backs. This doesn’t help the patient or their families.”

“So what we need to do is to challenge attitudes, beliefs and behaviours and gently but persistently encourage staff to be open. This is not an easy task. It will be hard. If people are acting out of fear we need to understand why and explore the barriers that we need to overcome.”

She conceded that introducing criminal sanctions for not being honest adds to the scale of the task, but added: “There is commitment and goodwill from staff in the system and we will find a way through.”

So whilst a formal Duty of Candour involves devising legislation, the Being Open sub-group is about challenging and changing the culture of health and social services. This is complex and difficult and will take time. Seána said:

“This work has to be done thoroughly and properly. It cannot be rushed because we need to get it right. If what we come up with is not meaningful it is not worth anyone’s time.”

But it is proving to be challenging. Seána says, “We have a good mix of people from different backgrounds and experiences and all voices are equally important. We couldn’t do the work any other way.”

Peter McBride, Being Open sub-group

Making our health and social care system more honest and open in its dealings with patients and their loved ones will take more than new legislation.

It will involve changing the culture of the service. That's why there is a Being Open sub-group within the Duty of Candour workstream.

Work on Duty of Candour involves rules and regulations, the new laws that need to come into effect. The task for the Being Open sub-group is about how people behave.

It is chaired by Peter McBride, chief executive of the charity and social enterprise Inspire. He said:

“What we are setting out to achieve is really ambitious. What we are looking at is how we build a culture of openness into an already very complex system in a supportive way where staff and public alike can see the benefit.”

“We have to ensure the changes are seen as constructive and not destructive to people who work in the system. We need to win hearts and minds.”

Peter says that he understands the pressures staff in the health system are under. If changes are seen as a burden and another “stick to beat them with” there is a danger that they will go into defensive mode. And admitting mistakes is hard for all of us wherever we work.

“What we are seeking to achieve is to contribute to the transformation agenda of the health service. Building on all of the extraordinary work that is already happening but is often forgotten, we want to contribute to developing a health service that has compassionate care and openness with patients at its centre. When people choose to work in health and social care it is taken as a given that they are compassionate and care. To some extent that focus can be lost when the system is under pressure, resources are scarce, and people do not experience those core attributes as being valued. A truly quality health service needs to get all the technical bits right, but it also has to have compassion and openness right at its centre, and with all of the difficulties, I'm concerned that this is more and more challenging.”

Peter's group has completed the first phase of its work, agreeing on the intent behind the inquiry's recommendations, checking for potential unintended consequences, gathering information and studying how health systems in other parts of the world have tried to be more open in their dealings with patients.

It has an action plan which involves talking to the Trusts, professional bodies and other interested parties to produce guidelines around openness for organisations, staff and the public. They will also engage with all the other workstreams to help ensure that openness is embedded in all the work.

It's not just about how staff behave but how organisations respond when things go wrong. Legal teams and PR departments have a legitimate function in protecting Trusts from litigation and preserving their reputations. But a Duty of Candour will also apply to these corporate activities. This poses a major cultural challenge for Peter and his team to address. Peter says:

“We have to be guided by and respectful about what the public want, and introduce those changes to health service staff in a way that is respectful to them and really works, to the benefit of us all.”

Workstream 2 - Death Certification Implementation Working Group (DCIWG)

When our loved ones pass away the very least we should expect is that the cause of their deaths are accurately recorded on their death certificates and that all those cases that need to be are referred to the Coroner.

This did not always happen the way it should have done in the deaths examined by the Inquiry.

In the statement he made when he delivered his report Mr Justice O'Hara highlighted problems with the completion of death certification and in one case said the original death certificate "was wrong, illogical and simply made no sense – it was, in effect, medical gibberish."

This death and others examined by the inquiry were also not reported to the Coroner in the way they should have been.

The reason this can happen is that the process of certifying deaths has remained largely unchanged for the past 100 years. When someone dies of natural causes, a doctor completes a certificate stating the cause of death if the deceased has died of a natural illness or disease for which they have been seen and treated within the previous 28 days. But there is no independent verification of this process. This can lead to mistakes, or in extreme cases, manipulation of the facts.

As a result the inquiry recommended: **"The Department should now institute the office of Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner"**.

Recommendation 87

However mistakes and manipulation are not just confined to deaths in hospital. In 2000 serial killer Dr Harold Shipman was convicted of murdering 15 patients. He covered up his crimes by falsifying death certificates and medical records. A subsequent inquiry estimated his total number of victims at 250.

Our response is therefore to cover all deaths, not just those in hospitals. There is another reason why we need to eliminate errors from death certificates. Death statistics are compiled to improve public health. We need to know precisely the prevalence of different causes of death to help develop health policies. Even minor inaccuracies can cause problems.

An Independent Medical Examiner (IME) has three main tasks: to verify what patients have died from and to make sure this is accurately recorded; to check whether the death needs to be reported to the Coroner and to identify any potential issues with "clinical governance", meaning how the person was treated before death.

It is not envisaged that the role of an IME would be to investigate deaths, rather they would highlight any problems they detected and pass them on to other professionals to investigate.

The way this would work is that the IME would examine the clinical record and medical certificate of cause of death, contact the certifying doctor to discuss the situation and also talk to the bereaved family (usually by phone) to make sure that they understand the cause of death and inquire whether they have any safety concerns about the clinical care provided to their loved one.

It is extremely important that we have a full public debate about how best to make these changes. In Northern Ireland we have a long tradition of holding funerals within approximately three days of death. We need to ensure that the measures we introduce cause minimum disruption to this.

As we continue our work we'll be looking at different ways an IME might operate. In Scotland, for example death certificates are selected at random for scrutiny, with around 10% examined. However in England plans are in place for every death to be examined.

It is important to get this right. It will affect every one of us and we'll be consulting widely on the best way forward.

What the recommendations are?

The DCIWG workstream is looking at 22 actions which arise from 18 recommendations, the most high profile of which is bringing in an Independent Medical Examiner to scrutinise those hospital deaths not referred to the Coroner.

The workstream has three main sub-groups one of which is focused on the single recommendation of developing arrangements for an IME.

The other two sub-groups are looking at a range of actions and recommendations which respond to the specific experiences of families and events described in the Inquiry report.

Preparation for Inquests [and Litigation] sub-group

The Preparation for Inquests [and Litigation] sub-group is considering seven recommendations all of which are designed to ensure openness and transparency. The Inquiry found examples of witness statements to Coroner's inquests being managed or diluted by Trusts because of concerns of litigation. The sub-group will look at how to prevent this happening in future. There is also the need to ensure that all expert reports into incidents that contain evidence are shared with the Coroner. There is also a need to ensure a clear separation within Trusts between those investigating incidents, and those who are dealing with litigation and preparing for inquests.

All this needs to be balanced against the fundamental right of legal privilege. This protects clients from having to disclose confidential communications between clients and their lawyers and third parties (experts for example) where these communications have come into existence to be used in litigation. One recommendation is that when this situation arises the Coroner must be informed about the existence and nature of any document for which privilege is claimed.

IHRD Recommendations delegated to the Preparation for Inquests [and Litigation] sub-group

IHRD Recommendation Number	Recommendation
36	Trust employees who investigate an accident should not be involved with related Trust preparation for inquest or litigation.
50	The Health and Social Care Board ('HSCB') should be notified promptly of all forthcoming healthcare related inquests by the Chief Executive of the Trust(s) involved.
51	Trust employees should not record or otherwise manage witness statements made by Trust staff and submitted to the Coroner's office.
52	Protocol should detail the duties and obligations of all healthcare employees in relation to healthcare related inquests.
53	In the event of a Trust asserting entitlement to legal privilege in respect of an expert report or other document relevant to the proceedings of an inquest, it should inform the Coroner as to the existence and nature of the document for which privilege is claimed.
95	Given that the public is entitled to expect appropriate transparency from a publicly funded service, the Department should bring forward protocol governing how and when legal privilege entitlement might properly be asserted by Trusts.
96	The Department should provide clear standards to govern the management of healthcare litigation by Trusts and the work of Trust employees and legal advisors in this connection should be audited.

HSC Bereavement and Pathology Network sub-group

When people lose loved ones they need support to help with their grief. The report was critical of the way that some bereaved families were treated. The HSC Bereavement and Pathology Network sub-group is responsible for eleven actions arising from seven recommendations, most of which are aimed at providing greater transparency around the commissioning and conduct of post mortems including decisions to have limited post mortems. One of the recommendations is aimed at improving bereavement support to families.

IHRD Recommendations delegated to the HSC Bereavement and Pathology Network sub-group

IHRD Recommendation Number	Recommendation
44	Authorisation for any limitation of a post-mortem examination should be signed by two doctors, acting with the written and informed consent of the family.
45	Check-list protocols should be developed to specify the documentation to be furnished to the pathologist conducting a hospital post-mortem.
46	Where possible treating clinicians should attend for clinico-pathological discussions at the time of post-mortem examination and thereafter upon request.
47	In providing post-mortem reports pathologists should be under a duty to: <ul style="list-style-type: none"> (i) Satisfy themselves, insofar as is practicable, as to the accuracy and completeness of the information briefed them; (ii) Work in liaison with the clinicians involved; (iii) Provide preliminary and final reports with expedition; (iv) Sign the post-mortem report; (v) Forward a copy of the post-mortem report to the family GP.
54	Professional bereavement counselling for families should be made available and should fully co-ordinate bereavement information, follow-up service and facilitated access to family support groups.
59	There should be training in the completion of the post-mortem examination request form.
60	There should be training in the communication of appropriate information and documentation to the Coroner's Office.

What the workstream is doing

The work of both the HSC Bereavement and Pathology Network sub-group and the Preparation for Inquests [and Litigation] sub-group is well advanced. It is hoped that the recommendations will be implemented in advance of any statutory Duty of Candour over the next 6-12 months.

The combined effect of these recommendations will be to introduce a significant degree of improved openness and transparency around these areas. It will put families in a stronger position and provide much greater support to the bereaved. The Coroner will be more confident in the information received about deaths, and this will improve families' confidence in the process.

Clear, regionally agreed policies, procedures and standards will ensure Trust staff and their legal representatives have greater clarity on what is expected of them.

Both groups are working towards having new arrangements ready for implementation before the end of this calendar year with new policies, standards, and guidance as required. Full implementation will also require training for relevant staff. The two sub-groups will be identifying the evidence that will need to be provided to demonstrate that the recommendations have been implemented and are working as intended.

Workstream 3 - Duty of Quality

We all expect the highest possible standards in the quality and safety of the care we and our families receive from the health and social care system.

Crucial to ensuring the quality of care is the quality of leadership. That is why the report recommended: **“The highest priority should be accorded the development and improvement of leadership skills at every level of the health service including both executive and non-executive Board members.”**

Recommendation 9

The whole workstream is entirely focused on the leadership recommendation quoted above but it also has three sub-groups taking forward 27 actions from 22 other recommendations.

What the recommendations are

The ALB Board Effectiveness sub-group is working on eight actions which arise from six of the recommendations, which concern allocating specific responsibilities for patient safety and for candour to both Executive and non-Executive members of Boards and ensuring they are trained to discharge these roles.

IHRD Recommendation Number	Recommendation
55	Trust Chairs and Non-Executive Board Members should be trained to scrutinise the performance of Executive Directors particularly in relation to patient safety objectives.
56	All Trust Board Members should receive induction training in their statutory duties.
69	(i) Trusts should appoint and train Executive Directors with specific responsibility for Issues of Candour; (ii) Trusts should appoint and train Executive Directors with specific responsibility for Child Healthcare; (iii) Trusts should appoint and train Executive Directors with specific responsibility for Learning from SAI related patient deaths.
70	Effective measures should be taken to ensure that minutes of board and committee meetings are preserved.
72	All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director.
84	All Trust Boards should consider the findings and recommendations of this Report and where appropriate amend practice and procedure.

Non-executive directors have a crucial role in scrutinising what happens in their organisation. They act on behalf of the public to provide oversight, assuring themselves that the care delivered is safe, has the right outcomes and respects the rights of the users of the service. They also need to satisfy themselves that carers and families are involved and that staff are well trained and supported. They must ensure that the organisation learns lessons from when things go wrong and that the learning can inform the training and development of staff.

The inquiry report cites instances where this did not happen and states:

“This meant that lessons were not learned, poor standards were tolerated, the coronial system was undermined and grieving parents were misled.”

(Section 3.293. The Inquiry into Hyponatraemia Related Deaths Report January 2018)

Improving the situation will involve providing directors with effective training and also ensuring they receive the right information.

Board members of HSC bodies receive a range of reports on activity, on quality and on safety which they review and hold the chief executive and senior team to account at public board meetings. There is a record made of the meetings and all the reports that have been considered. Another task for the group is to issue guidance on how the records of these important meetings can be made more accessible to the public.

It also has a brief to ensure statements to the media made by or on behalf of the organisation are open and honest in line with the principles of the duty of candour. This recommendation states: **“All Trust publications, media statements and press releases should comply with the requirement for candour and be monitored for accuracy by a nominated non-executive Director.” Recommendation 72**

The Clinical and Social Care Governance sub-group is responsible for implementing 14 actions from 13 recommendations. These recommendations mainly relate to making sure that effective systems are in place to ensure that services are safe and effective and deliver high quality outcomes for all service users.

The recommendations also highlight the importance of data analysis and the identification of learning to inform quality improvement initiatives and promote a culture of learning and continuous improvement.

This sub-group is dealing with a number of specific system recommendations such as learning from Serious Adverse Incidents. The Report states that: **“All Trust Boards should ensure that appropriate governance mechanisms are in place to assure the quality and safety of the healthcare services provided for children and young people.” Recommendation 71**

In practice the work of the group is about ensuring that appropriate governance mechanisms are in place to assure the quality and safety of all healthcare services for all service users with a particular focus on children and young people.

There is a strong link to Candour with the three recommendations below reinforcing the need for transparency and effective shared learning, both within the health and social care system, and also with the public.

IHRD Recommendation Number	Recommendation
41	Trusts should publish the reports of all external investigations, subject to considerations of patient confidentiality.
67	Should findings from investigation or review imply inadequacy in current programmes of medical or nursing education then the relevant teaching authority should be informed.
81	Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member.

The RQIA Remit sub-group is looking at the remit of the regulator, the RQIA, examining its future role. It may need to be given more power to oversee the SAI process and review individual cases. It is also proposed in the recommendations that RQIA will also be given the task of policing the Duty of Candour, including having the power to prosecute in serious cases of non-compliance.

Some of the recommendations may need legislative change so would need to wait for an Executive and Assembly. In the meantime the Department is conducting a wider review of the entire regulatory framework including the role and powers of the RQIA. The work of this group will feed into that review. Key recommendations include:

IHRD Recommendation Number	Recommendation
8	Regulation and Quality Improvement Authority ('RQIA') should review overall compliance (with the Duty of Candour) and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.
34	The most serious adverse clinical incidents should be investigated by wholly independent investigators (i.e. an investigation unit from outside Northern Ireland) with authority to seize evidence and interview witnesses.
86	The Department should expand both the remit and resources of the RQIA in order that it might: <ul style="list-style-type: none"> (i) Maintain oversight of the SAI process; (ii) Be strengthened in its capacity to investigate and review individual cases or groups of cases; and (iii) Scrutinise adherence to duty of candour.

What the workstream is doing

The work of the ALB Board Effectiveness sub-group is progressing well and working to develop:

- A handbook for non-executive directors to support their ability to scrutinise and challenge the performance of organisations;

- A programme for continuous professional development for non-executive directors;
- Creating a support network and mentoring opportunities for non-executive directors to share experience and good practice;
- Specific training on the ability to scrutinise and challenge organisations performance on safety and quality;
- Training in the ability to scrutinise compliance with the duty of candour; and
- Guidance to Trusts on the publication of Board minutes and papers.

More detail on these developments will feature in future updates.

The 'Clinical and Social Care Governance' and RQIA Remit' sub-groups are both continuing to work through their recommendations and to baseline current arrangements.

Eddie Rooney, Chair of the Duty of Quality workstream

Everybody demands a high quality health and social care service. There is already Duty of Quality legislation in place.

But what does that mean? And how do we measure it and make sure that standards are maintained?

Eddie Rooney is a Human Rights Commissioner and an Advisory Board member of Safefood the north-south body which promotes food safety. He is a former senior civil servant and was chief executive of the Public Health Agency.

As chair of the Duty of Quality workstream he is grappling with these issues, and explains that there are not always easy answers to simple questions.

Quality is about ensuring that health services and practices have a positive outcome on patients. But knowing when you have high quality services and ensuring that staff understand how they are doing it is not so straightforward.

He said: "When, as Board members, we look at our responsibilities some are very clearly defined. Finance for example. So in my work as a director I can feel confident that I'm given the right information to have an informed discussion and be confident we can make a sound decision"

"But when it comes to quality of care it is just so complex. All patients have different sets of issues so identifying those critical issues that affect outcomes is not so well developed. It is getting better all the time but the science of measuring outcomes is in its infancy."

Yet Eddie says that everything is ultimately about quality. "It is not just about the person who has to make a decision about care on the day. It covers every step from top to bottom, including both the design and delivery of services, decision-making and planning and includes how services are funded as well."

The Duty of Quality workstream is responsible for 28 actions arising from the report. These cover four areas.

The first is Board effectiveness – making sure that directors of health bodies have the right training to do their work and are provided with the right information.

He said: “They are reliant on specialist expertise. They need to know the right questions so that they can challenge when they need to.”

Second is clinical and social care governance. Eddie describes this as a critical area for change. Clinical and social care staff have a pivotal role to play both in helping Boards to make the right strategic decisions and in turning those decisions into the delivery of high quality care at the front line. But they need support. It is not just about what they do but about absolute clarity of how they fit into the structure of their organisations, and giving them a much more active role in improving care.

Third is reviewing how the regulator the RQIA functions.

Finally there is the issue of leadership. The leadership of the health service in Northern Ireland has come under criticism in the past, not least by the Donaldson Report, which found failings from top to bottom. The Duty of Quality workstream will focus on the improvement of leadership at every level of the health service. Eddie said:

“One important aspect to this is that we need a culture where the natural response to error is to learn from it. We need role models who encourage learning and discourage blame.”

Johnny Graham, ALB Board Effectiveness sub-group

All Health and Social Care Trust Boards are responsible for making sure that everything is in place to ensure the quality and safety of healthcare.

But boards cannot do this unless they are told when things have gone wrong. During his inquiry Mr Justice O’Hara found that boards were either not told, or given insufficient information about the failings that led to avoidable deaths.

Retired Civil Servant Johnny Graham is on the ALB Board Effectiveness sub-group which is looking at what needs to be done to make governance of Trusts work better.

Johnny is a service user and carer having looked after both his parents and his mother-in-law in their declining years. He is an experienced director, serving on the Board of the Northern Ireland Hospice. Johnny represents service users on the Lisburn Integrated Care Partnership (ICP) Committee. He also has extensive inside knowledge of the Civil Service, both in the Department of Health and Social Services and latterly as Head of IT in the Social Security Agency.

He said: “I have spoken to quite a lot of service users and carers and learned a great deal about what people want. And I feel listened to by the health care professionals on the ICP. I like the ethos of co-production because patients need to be at the centre of care.”

Johnny says that ensuring that boards are told everything they should be is a critical but difficult issue. He points out that “a problem uncovered by the inquiry is that when concerns are not passed on to boards they never even get the chance to know about them. There is a danger that you never get to see what goes on under the surface.”

“Part of the solution is for boards to set the standards they expect from their organisations. The Duty of Candour will be very important. If everyone realises that mistakes can and will be made but they have to be honest about them then risks will be reduced. I know a lot of medical professionals and it is rare for a clinician to deliver anything other than the care you need. But mistakes do happen and people understand this”

He is concerned that society is becoming more and more litigious. “When things go wrong most people just want a clear and honest explanation. It’s not about revenge. It should be about fixing problems and making sure they don’t happen again.”

“People generally don’t like complaining, but if they have concerns about care that’s the only way to find out – and that is a very bureaucratic system which can take a long time, meaning that everything can fester.”

“I’m not at all minimising what happened. What we need to do is to create a system where cover ups can’t happen and mistakes are not repeated.”

“I want to make sure this doesn’t happen again. But let’s not forget the health care professionals in this and throw the baby out with the bath water. Both health care professionals and patients, carers and their families need to feel that what emerges makes for a better system and also works for them.”

Professor Mary McColgan, ALB Board Effectiveness sub-group

The health service was criticised from top to bottom in Mr Justice O’Hara’s report.

At the top sit the boards of health organisations and putting things right involves making them more effective. But what does that mean in simple, practical terms?

Mary McColgan is Emerita Professor of Social Work at Ulster University. She is on the ALB Board Effectiveness sub-group. She brings to the task her knowledge and expertise as acting chair of the regulator the RQIA. She has front line experience as a social worker before her later academic career in Social Work education at Ulster University which involved teaching and supervision of social work students preparing to enter the profession.

She said: “I read Mr Justice O’Hara’s report with great interest and also with sadness. There was a failure to be open and honest about health care around avoidable deaths. The Report highlighted issues around the skills and competences of board directors.”

The function of all the Trust Boards is clear. Whilst senior management is responsible for the operational matters, including the delivery of services, boards are responsible for the overall strategy and ensuring it is implemented. These two functions are interdependent. She said:

“The failings of boards identified in the Inquiry concerned scrutiny of information, scrutiny of clinical governance (treatment of patients), communication and it raised issues around the relationship between management and the boards.”

She says “that to be functioning properly a board needs to be clear about how it is achieving the strategic objectives that it has set itself, that it has a clearly defined relationship and effective engagement with the chief executive.” Board members need to have the capacity to challenge respectfully when they need to and to work out what data they need in order to have a full understanding of how the organisation is performing.

Mary is encouraged by an increasing emphasis across the system in using an evidence-based approach to understand performance. Through the NI Confederation for Health and Social Services some initial input has been given to non-executive directors in how to use data to measure performance.

So, as a chair, what qualities does she look for in an effective director? “You are looking for someone with strong public sector values, who is good in a team, understands their strategic role and the interface with operational team and has negotiating and facilitation skills. As a non-executive director, you need a combination of curiosity about the organisation and the ability to scrutinise large volumes of documentation. There must be integrity both with other board members and staff and the capacity to challenge respectfully. There is also a requirement that the non-executive directors have the ability for self-reflection because they have annual appraisals.

She has been encouraged by how the response to the Inquiry is being run. “I am very impressed with the approach taken in setting up workstreams, providing an induction day and being given the opportunity to choose the best workstream to contribute to.

“It is very good to see the involvement of service users and carers. Challenging the professional perspective is important. We also have a chair who is keeping focus on the tasks we need to achieve but also ensuring that everyone is engaged in the process.”

Workstream 4 – Paediatric-Clinical Collaborative

What the recommendations are?

This workstream has been set up to improve the safety and transparency of care. It is responsible for implementing 21 detailed recommendations which were made to cover weaknesses identified by the Inquiry. Several of these recommendations link directly to promoting greater openness and transparency.

The recommendations include:

IHRD Recommendation Number	Recommendation
16	The names of both the consultant responsible and the accountable nurse should be prominently displayed at the bed in order that all can know who is in charge and responsible.
17	Any change in clinical accountability should be recorded in the notes.
23	The care plan should be available at the bed and the reasons for any change in treatment should be recorded.
26	Clinical notes should always record discussions between clinicians and parents relating to patient care and between clinicians at handover or in respect of a change in care.
29	Record keeping should be subject to rigorous, routine and regular audit.
30	Confidential on-line opportunities for reporting clinical concerns should be developed, implemented and reviewed.

The remaining recommendations largely relate to operational arrangements for front line services in acute hospital settings.

What the workstream is doing

The workstream has prioritised work on recommendations 10, 12 and 13. These deal with who is responsible for the care of a child in hospital, how age-appropriate treatment and care is delivered and how foundation doctors are involved in the treatment and care of children. The workstream expects to have agreed a regional position for all three over the next three months. The workstream prioritised these recommendations on the basis that they can make a significant improvement to the quality of services. The expectation is that regional guidance will be issued to the Health and Social Care sector with regard to implementing these recommendations over the next 3-4 months.

IHRD Recommendation Number	Recommendation
10	Health and Social Care ('HSC') Trusts should publish policy and procedure for ensuring that children and young people are cared for in age-appropriate hospital settings
12	Senior paediatric medical staff should hold overall patient responsibility in children's wards accommodating both medical and surgical patients.
13	Foundation doctors should not be employed in children's wards.

There are several other recommendations which would benefit from being supported by IT systems and the workstream has commissioned a specification for what the appropriate IT solution would look like.

Workstream 5 - Serious Adverse Incidents

A Serious Adverse Incident (SAI) is when something happens with someone's treatment or care which could have or did lead to harm. That harm may be unexpected or unexplained and could lead to serious injury or death.

The purpose of them is to understand what went wrong and to learn from it to make the service better.

What the recommendations are?

This workstream is working through 18 actions which arise from 10 recommendations. Central to all of them is that the SAI process is about learning rather than blaming and is intended to make services safer. There also needs to be the maximum involvement of service users and their families, so that they fully understand what is happening and can contribute to the process. This like so many other workstreams is directly linked to the need for candour, openness and transparency.

IHRD Recommendation Number	Recommendation
31	SAI Reporting: Trusts should ensure that all healthcare professionals understand what is expected of them in relation to reporting Serious Adverse Incidents ('SAIs').
33	Compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive.
37	SAI Investigation: Trusts should seek to maximise the involvement of families in SAI investigations and in particular: <ul style="list-style-type: none"> (i) Trusts should publish a statement of patient and family rights in relation to all SAI processes including complaints; (ii) Families should be given the opportunity to become involved in setting the terms of reference for an investigation; (iii) Families should, if they so wish, engage with the investigation and receive feedback on progress; (v) Families in cases of SAI related child death should be entitled to see relevant documentation, including all records, written communication between healthcare professionals and expert reports; (vi) All written Trust communication to parents or family after a SAI related child death should be signed or co-signed by the chief executive; (vii) Families should be afforded the opportunity to respond to the findings of an investigation report and all such responses should be answered in writing; (viii) Family GPs should, with family consent, receive copies of feedback provided; (ix) Families should be formally advised of the lessons learned and the changes effected; and (x) Trusts should seek, and where appropriate act upon, feedback from families about adverse clinical incident handling and investigation.
38	Investigations should be subject to multi-disciplinary peer review.
39	Investigation teams should reconvene after an agreed period to assess both investigation and response.

IHRD Recommendation Number	Recommendation
42	In the event of new information emerging after finalisation of an investigation report or there being a change in conclusion, then the same should be shared promptly with families.
66	Clinicians should be afforded time to consider and assimilate learning feedback from SAI investigations and within contracted hours.
82	Each Trust should publish policy detailing how it will respond to and learn from SAI related patient deaths.
83	Each Trust should publish in its Annual Report, details of every SAI related patient death occurring in its care in the preceding year and particularise the learning gained therefrom.
91	The Department, HBSC, PHA, RQIA and HSC Trusts should synchronise electronic patient safety incident and risk management software systems, codes and classifications to enable effective oversight and analysis of regional information.

What the workstream is doing

The Serious Adverse Incident workstream has now developed a set of principles which set out what you should expect as a service user or carer if you are involved in a Serious Adverse Incident.

Since the focus is on what services users and carers expect, their views will be vital. However, Health and Social Care staff also have a big part to play. They want to make a positive contribution to finding out why something went badly and to learn from it.

The best model of dealing with a Serious Adverse Incident will be where staff and service users or carers communicate well with each other. The principles will make it clear to staff what they need to do to maintain openness and transparency. A Serious Adverse Incident is often distressing for service users or carers. However staff may often find working on Serious Adverse Incidents challenging too and they will want to make sure that they put their views forward.

The work to set out what service users and carers should expect makes the link from the Serious Adverse Incident workstream to the work of the Duty of Candour workstream. It is one of a number of recommendations made by the Inquiry for changes to the Serious Adverse Incident system which should provide greater openness and transparency and therefore help to promote public confidence.

The workstream also intends to ask Trusts to implement two of the recommendations soon. We have mapped out how compliance with investigation procedures should be the personal responsibility of the Trust Chief Executive. As part of the same work, we have also co-produced a process to ensure that all written Trust communication to service users after a SAI related child death should be signed by the Chief Executive or someone with that authority in their absence. The experience of service users on the workstream has been vital to this work.

The Key Principles

The principles are as follows:

1. You have the right to actively engage with the SAI review, have your views listened to, respected, responded to and addressed in a timely manner;
2. You have the right to experience openness, honesty, empathy, kindness, dignity and respect in all communication and interaction with the HSC Organisation;
3. You have the right to be assigned a nominated link person to facilitate communication between you and the Chairperson of the SAI Review Team, and to advice on access to support;
4. You have the right to access relevant information relating to the SAI review and for this information to be provided in an accessible format;
5. You have the right to independent advice and support.
6. You have the right to approach the Northern Ireland Public Service Ombudsman (NIPSO).

We hope that everyone will take time to read the documents which have been shared on Citizen Space with an opportunity for everyone to provide their views: <https://consultations.nidirect.gov.uk/hsc-public-health-agency/d536506d>

Marian Thompson, Serious Adverse Incidents

Marian Thompson is a member of the Serious Adverse Incidents workstream.

She brings a very clear focus to her work: "Foremost in my mind are the children who died and their families who have waited such a long time for this. We need to get change implemented and we need to get it right for them. It is their story, their journey and their Inquiry."

Like many others she had followed the Inquiry closely and had read Mr Justice O'Hara's report before she was invited to contribute to the work as a service user/carer.

She said: "When I was asked to join the group I felt humbled to be involved in such important and sensitive work."

Marian has had a bad experience with the health authorities, knows what it is like when things go wrong and is therefore able to bring her personal knowledge and experience to help the process.

When she joined the group she wasn't sure what to expect. "I really didn't know what I could contribute but everyone, regardless of their background is equally valued and there is a great deal of mutual respect. The work is going well and we have an excellent chairperson who makes sure everyone is heard."

Service users are experts by experience and can bring important insights that staff within the system can learn from. For example in some cases authorities can cause deep upset without realising it.

Marian gives the examples of the timings and authorship of official letters.

"I received many letters on a Friday. This guaranteed a terrible weekend. I even got two on separate Christmas Eves. Also many were not properly signed they had 'pps' or 'on behalf of' written on them. It is very disrespectful to send such important letters out like that." Marian said:

"What we always have to remember is that the patient and their loved ones are the most important people when things go wrong. We must make sure we don't make it harder for them."

And she is insistent that improving the system is not enough. It also has to be constantly checked to ensure it is working the way it should. She said:

"Mistakes happen because we're human. So health care professionals need to put their hands up when they make a mistake, and then something must be done about it. This will always need monitoring if we are to maintain a safe health service for all of us."

Stephanie Lowry, Serious Adverse Incidents workstream

An important aspect of the programme is the inclusion of non-executive directors from health and social care bodies in the workstreams.

Organisations have two types of directors. Executive directors are employees, usually senior managers. Non-executive directors are appointed from outside the organisation and bring an independent perspective to their governance, supporting and challenging their management colleagues.

Stephanie Lowry is a non-executive director of the Health and Social Care Board. It is responsible for commissioning health and social care across Northern Ireland, monitoring the performance of Trusts and managing the £4.5 billion annual funding.

She brings her experience and insights to the Serious Adverse Incident workstream. A Serious Adverse Incident is when something happens with someone's treatment or care which could have or did lead to harm. That harm may be unexpected or unexplained and could lead to serious injury or death.

Mr Justice O'Hara's report found deficiencies in the reporting of Serious Adverse Incidents and in failures to be open and honest with families about them.

Stephanie explained: "A Serious Adverse Incident Review takes place when something goes seriously wrong. The purpose of it is to see what learnings can be taken to improve care in the future. It is an opportunity to make things better rather than an investigation."

If reviews are going to be effective then they have to be open and honest. Stephanie says: "This links right back to a Duty of Candour."

"Involvement of patients or their families is also really important. We have now published a statement of patients' rights which sets out what they should expect from the process and how they can be involved in it. It is not just about informing them of the findings but also what has happened as a result and what will happen next."

She says that she has learned a lot from being on the workstream.

“We have had very honest and robust discussions where everyone has the chance to contribute. I know that people want the recommendations to be implemented quickly, but it is vital that we get this right.”

“I’ve found service users and carers - the people who have been through the experience first-hand - to be very passionate in a constructive way. Hearing some of their personal stories adds a different dimension to the work. It is important to remember that there is a human side to all of this.”

“Another important aspect to our work is that introducing new processes and procedures are not, in themselves, enough. We also need to ensure that the actions are fully implemented and working effectively.”

Workstream 6 – Education and Training

If we are to sustain a high quality health and social care system that is open and transparent, then we will need to support staff to rise to the challenge. Training is key.

What the recommendations are

There are six specific recommendations in the report. One of them requires parents to be involved in designing a programme to train clinicians to communicate with patients more effectively when things go wrong.

IHRD Recommendations delegated to workstream 6 - Education and Training

IHRD Recommendation Number	Recommendation
57	Specific clinical training should always accompany the implementation of important clinical guidelines.
58	HSC Trusts should ensure that all nurses caring for children have facilitated access to e-learning on paediatric fluid management and Hyponatraemia.
61	Clinicians caring for children should be trained in effective communication with both parents and children.
62	Clinicians caring for children should be trained specifically in communication with parents following an adverse clinical incident, which training should include communication with grieving parents after a SAI death.
64	Parents should be involved in the preparation and provision of any such training programme.
65	Training in SAI investigation methods and procedures should be provided to those employed to investigate.

What the workstream is doing

The group is currently benchmarking the position of HSC organisations against these six recommendations.

In addition, all of the workstreams and their sub-groups will identify the education and training needed to fully implement their recommendations. This workstream is developing a strategic framework for these training needs. It will liaise with employers, education bodies and those that set curricula to make sure that all new and changed requirements are covered. It is also providing advice to the other workstreams as they identify needs.

Workstream 7 - User Experience and Advocacy

The central theme of the report is the need for honesty and openness. An important aspect of this is to ensure that patients and their families have a voice so that they can express any concerns. It also covers how patients and their families are involved in care. The User Experience and Advocacy workstream is responsible for three recommendations. It is currently researching how advocacy systems work in other health systems. The workstream is also evaluating the current statutory powers of the Patient and Client Council which currently provides advocacy for patients.

What the recommendations are

The three recommendations being considered by this workstream focus on strengthening the support for and the voice of patients, service users and carers.

IHRD Recommendations delegated to workstream 7 – User Experience and Advocacy

IHRD Recommendation Number	Recommendation
37 (iv)	A fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases.
63	The practice of involving parents in care and the experience of parents and families should be routinely evaluated and the information used to inform training and improvement.
89	The Department should consider establishing an organisation to identify matters of patient concern and to communicate patient perspective directly to the Department.

What the workstream is doing

The workstream is currently benchmarking the position against each of these recommendations and has commissioned research into advocacy services available into other jurisdictions. The workstream will also link closely with a project to consider how a real time user feedback system might be implemented in the health and social care sector.

Workstream 8 - Workforce and Professional Regulation

What the recommendations are

This group is responsible for seven recommendations, all of which are closely linked to the Duty of Candour and which would also affect the contracts of employment of health and social care staff. For the present the workstream is keeping a watching brief on proposals emerging from the Duty of Candour workstream. It is likely that all these recommendations will be progressed as a block when more detail around how the duty of candour is to be implemented emerges.

IHRD Recommendation Number	Recommendation
5	Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the Duty of Candour.
7	Trusts should monitor compliance and take disciplinary action against breach (of Duty of Candour).
32	Failure to report an SAI should be a disciplinary offence.
35	Failure to co-operate with investigation should be a disciplinary offence.
73	General Medical Council ('GMC') 'Good Medical Practice' Code requirements should be incorporated into contracts of employment for doctors.
74	Likewise, professional codes governing nurses and other healthcare professionals should be incorporated into contracts of employment.
75	Notwithstanding referral to the GMC, or other professional body Trusts should treat breaches of professional codes and/or poor performance as disciplinary matters and deal with them independently of professional bodies.

What the workstream is doing

Representatives of Chief Professional Officers in the Department of Health, and Workforce Policy Directorate officials, have produced an initial analysis of the workstream 8 recommendations.

The recommendations being considered by this workstream link very directly to recommendations being progressed by other workstreams. Their work is largely focussed on engaging with these other workstreams as they progress their recommendations.

Workstream 9 - Assurance

It is not enough for the various workstreams to agree how the recommendations are implemented. We also need to know that they have been implemented on the ground. The assurance workstream is responsible for working with all the other groups to make sure that all changes are working effectively. Once it is satisfied with the evidence it will report back to the Department. This is a critically important role.

The other workstreams are currently presenting their proposed “assurance frameworks” to the workstream, outlining what evidence they think is necessary to provide the necessary assurance. Feedback is being provided.

Some of the recommendations will be difficult to measure: changes in culture for example. Those that require legislation will take time to be introduced, depending on the return of an Executive and Assembly.

However most of the recommendations are operational in nature and can be assessed relatively easily. One of the most striking overall impacts of change will be greater candour and transparency across the whole health and social care system.

IHRD Recommendation delegated to workstream 9 - Assurance

IHRD Recommendation Number	Recommendation
93	The Department should review Trust responses to the findings and recommendations of this Report.

What the workstream is doing

The assurance workstream is meeting regularly to scrutinize the material being developed by other workstreams against the programme assurance framework. This workstream will continue in this role for the next few months after which it will begin to play an enhanced role in the monitoring of implementation of recommendations as these are rolled out.

Recommendations being overseen by the programme

There are three recommendations which are not being considered by individual workstreams. Instead these are being directly overseen by the Implementation Programme Management Group which is responsible for ensuring all recommendations are progressed. Two are addressed to the Department and the third will require the return of an Executive and Assembly to put in place. Here are the details of recommendations together with an update on progress:

- **Recommendation 85 – that the Department of Health should appoint a Deputy Chief Medical Officer with specific responsibility for children’s healthcare;**

The Department currently has two Deputy Chief Medical Officers who report to the Chief Medical Officer together with a number of other medical posts. The programme team is now working with the Department, looking at existing roles and responsibilities and examining how the team needs to be reconfigured in order to best meet the recommendation. This work is well underway.

- **Recommendation 88 – The Department should engage with other interested statutory bodies to review the merits of introducing a Child Death Overview Panel;**

There is already agreement on the merits of this. When the Safeguarding Board for Northern Ireland (SBNI) was set up in 2011 one of its roles was to establish a Child Death Overview Panel (CDOP). The aim of a CDOP is to provide multiagency oversight of all deaths and work with partner agencies to prevent avoidable childhood mortality.

The Public Health Agency (PHA) and Health and Social Care Board (HSCB) already have a lead role in surveillance of numbers, causes and learning from child deaths to inform public health programmes and health service development.

Considerable efforts over the past few years have been invested to improve child death review processes within the HSC. Further work has commenced on systems for surveillance and the development of regional protocols for response to and review of child deaths which are sudden and unexpected. This work represents the building blocks to support an effective CDOP.

Building on these structures and learning from across the rest of the UK, the PHA is working closely with the Department on proposals to establish a CDOP. It is anticipated that the work planned and completed to date will facilitate a CDOP to provide a more effective and thorough oversight of child deaths.

This work is well advanced.

- **Recommendation 94 – A Government Committee should examine whether Clinical negligence litigation as it presently operates might be abolished or reformed and/or whether appropriate alternatives can be recommended.**

This is one of the recommendations which will require a Minister in place to progress.

Next Update

The next update will be published on 27th June 2019 and will focus on arrangements for implementation.

Appendix 1

Workstreams

The 120 individual actions arising from the 96 recommendations have been delegated to 9 workstreams that report to the Implementation Programme Management Group.

Workstream	Workstream name	Number of actions
1	Duty of Candour	11
2	Death Certification Implementation Working Group	22
3	Duty of Quality	28
4	Paediatric-Clinical Collaborative	21
5	Serious Adverse Incidents	18
6	Education and Training	6
7	User Experience and Advocacy	3
8	Workforce and Professional Regulation	7
9	Assurance	1

Sub-Groups

There are seven standing sub-groups tasked with taking forward a subset of recommendations within their workstream.

Linkages

There are linkages between the recommendations being looked at by different workstreams and sub-groups.

Appendix 2

Group Chairs

Name:	Group
Quintin Oliver (Stratagem)	Duty of Candour workstream
Professor Peter McBride (Inspire Wellbeing)	Being Open sub-group
David Best (DoH)	Death Certification Implementation Working Group (DCIWG) workstream
Vivien McConvey (VOYPIC)	Preparation for Inquests [and Litigation] sub-group
Paul Finnegan (Cruse Bereavement Care)	Independent Medical Examiner sub-group
Sharon Wright (DoH)	HSC Bereavement and Pathology Network sub-group
Dr Eddie Rooney (Former HSC)	Duty of Quality workstream
Jim Moore (Translink)	ALB Board Effectiveness sub-group
Lynn Charlton (Northern Ireland Ambulance Service)	Clinical and Social Care Governance sub-group
Linda Greenlees (DoH)	RQIA Remit sub-group
Dr John Simpson (Former HSC)	Paediatric-Clinical Collaborative workstream
Conrad Kirkwood (DoH)	Serious Adverse Incidents workstream
Professor Keith Gardiner (Northern Ireland Medical and Dental Training Agency, NIMDTA)	Education and Training workstream
Rodney Morton (DoH)	User Experience and Advocacy workstream
Andrew Dawson (DoH)	Workforce and Professional Regulation workstream
Olive MacLeod (Regulation and Quality Improvement Authority, RQIA)	Assurance workstream