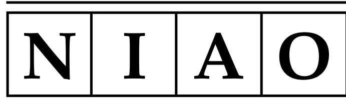
Northern Ireland Audit Office

Follow-up reviews in the Health and Social Care Sector: Locum Doctors and Patient Safety

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
9 April 2019



Follow-up reviews in the Health and Social Care Sector: Locum Doctors and Patient Safety

Published 9 April 2019

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K J Donnelly
Comptroller and Auditor General

Northern Ireland Audit Office
9 April 2019

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Abbreviations

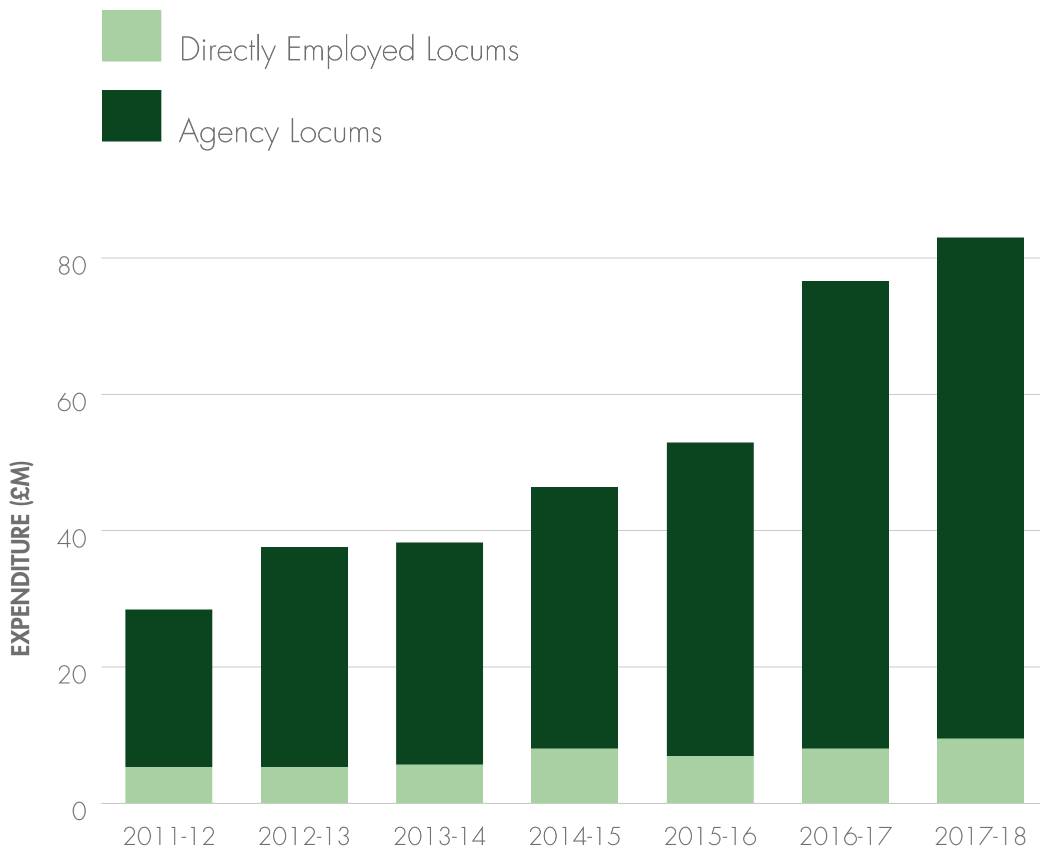
AI	Adverse Incident
BMA	British Medical Association
BSO	Business Services Organisation
EWTD	European Working Time Directive
GMC	General Medical Council
HRPTS	Human Resources, Payroll, Travel and Subsistence System
HSC	Health and Social Care
HSC Board	Health and Social Care Board
HSCNI	Health and Social Care in Northern Ireland
MoR	Memorandum of Response
NIAO	Northern Ireland Audit Office
NRLS	National Reporting and Learning System
PAC	Public Accounts Committee
PHA	Public Health Agency
PSIMS	Patient Safety Information Management System
PSNI	Police Service of Northern Ireland
RAIL	Regional Adverse Incident Learning System
RLS	Regional Learning System
RMMLS	Regionally Managed Medical Locum Service
RO	Responsible Officer
RQIA	Regulation and Quality Improvement Authority
SAI	Serious Adverse Incident

Key Facts

The Use of Locum Doctors by Northern Ireland Hospitals

Total expenditure on locum doctors has increased from £28.4 million in 2011-12 to **£83 million** in 2017-18 (an increase of **190 per cent**).

In 2017-18, **£73.5 million** was spent on agency locums – **90 per cent** of total locum expenditure.



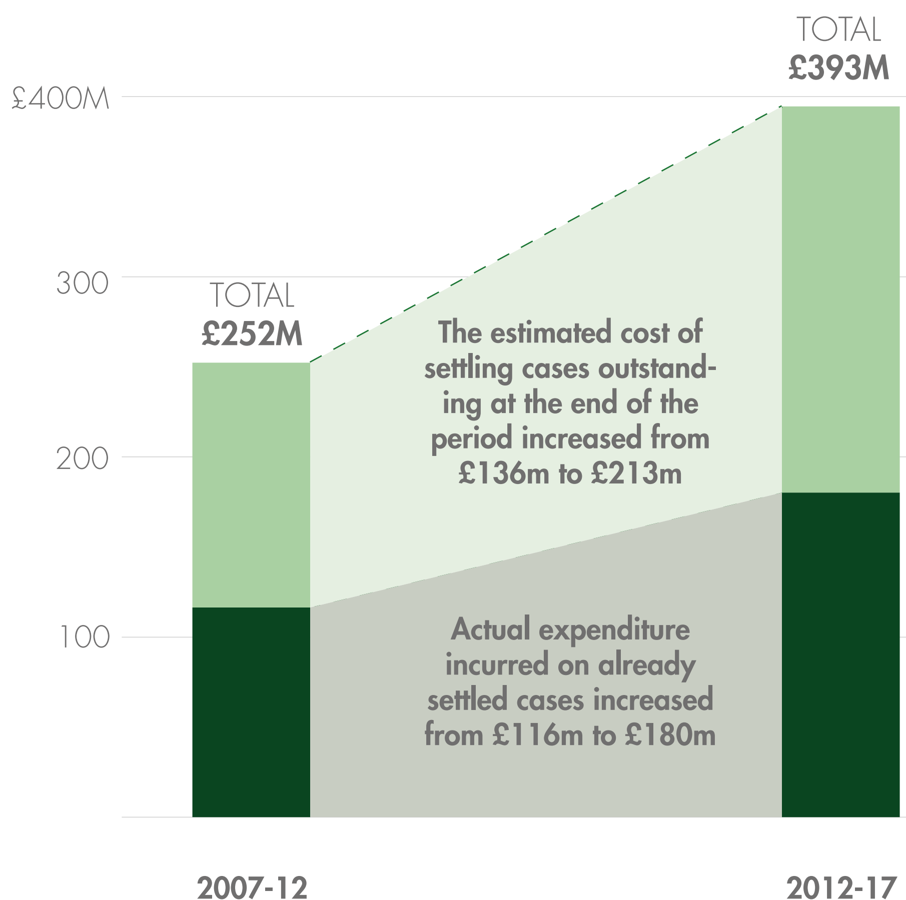
Annual costs of employing an agency locum doctor can be as high as **£242,000** for a trainee or middle ranking doctor and **£376,000** for a consultant.

Key Facts

The Safety of Services provided by Health and Social Care Trusts

In 2017-18, **92,000** Adverse Incidents and in 2018 **349** Serious Adverse Incidents were reported across the HSC Trusts.

Between 2012-13 and 2016-17, total costs of settling clinical negligence claims and estimated costs of unsettled cases amounted to over **£393 million**.



Executive Summary

Executive Summary

Follow-up reviews in the Health and Social Care (HSC) Sector: The Use of Locum Doctors by Northern Ireland Hospitals and The Safety of Services Provided by Health and Social Care Trusts

1. This report presents the findings of follow-up examinations into two key areas within the Health and Social Care (HSC) sector which have previously been the subject of reviews by the Northern Ireland Audit Office (NIAO) and the Public Accounts Committee (PAC):

    - **The Use of Locum Doctors by Northern Ireland Hospitals** – the NIAO issued its report in July 2011, with the PAC holding an evidence session in December 2011, and publishing its report in February 2012.

    - **The Safety of Services Provided by Health and Social Care Trusts** – the NIAO reported in October 2012, with the PAC subsequently taking evidence from the Department in November 2012 and publishing its report in February 2013.

2. The primary objective of this latest examination was to assess the degree of progress made by the Department of Health (the Department) and the HSC Trusts in addressing recommendations for improvement which had been made by the PAC, and to consider developments which have arisen in these areas since the previous reviews. Our key findings are summarised at Paragraphs 3 to 11.

Report One: The Use of Locum Doctors by Northern Ireland Hospitals

3. The use of locum doctors is recognised as being both expensive and as having the potential to increase risks to patient safety. However, since the PAC and the NIAO previously reported, total expenditure on locum doctors has increased by over 190 per cent, from £28.4 million in 2010-11 to £83 million in 2017-18.

4. Reliance on locums to sustain key healthcare services has increased significantly across all Trusts, but is most acute in the Northern and Western Trusts, where it now accounts for over 22 per cent of the total medical pay bill. The increasing amounts being spent on employing locum doctors to maintain healthcare services is placing significant strain on already stretched Trust budgets.

5. Disappointingly, we found that the Department and Trusts have made no tangible progress in implementing effective solutions to reduce the heavy reliance on locums. Whilst a new `eLocums' booking system was introduced in 2012 to try and minimise Trust reliance on the high cost option of using agency staff, by maximising the amount of locum work performed by internally employed doctors, expenditure on agency doctors increased from £23.1 million

in 2011-12 to £73.5 million in 2017-18. Until recently, there had also been little progress in developing workforce planning solutions to identify the optimal number of local trainee doctor places required, which in turn could help reduce longer term dependence on locums. We have highlighted the urgent need for more strategic, innovative and forward-thinking initiatives to reduce future reliance on locum doctors.

NIAO Recommendations

The Department and Trusts must seek to find more effective long-term workforce planning solutions, which can help reduce reliance on locums through providing a sustainable and recurrent workforce. In tandem with policy development, the Department should consider re-establishing short, medium and longer-term targets aimed at reducing the Trusts' current level of reliance on locum doctors.

Trusts need to take action to strengthen their internal monitoring to ensure that pre-employment checks on locum doctors are being undertaken. The Department should also consider commencing central monitoring of this key area.

Trusts should routinely gather and report data on the use of non-contracted agencies and the Department should formally monitor trends in this area to gain assurance that use of such agencies is minimised, and limited to exceptional circumstances.

Report Two: The Safety of Services Provided by Health and Social Care Trusts

6. In the critical area of patient safety, the Department and Trusts have recently made headway in strengthening some processes and procedures across the local HSC sector. For example:

- evidence indicates that levels of reporting of Adverse Incidents has recently been high;
- there is now enhanced public reporting on patient safety performance by Trusts;
- Trusts are increasingly involving patients in the investigations of serious adverse incidents;
- staff appraisal levels in the HSC sector have increased notably; and
- the time taken to settle clinical negligence claims is reducing.

Executive Summary

7. However, there may still be under-reporting of Serious Adverse Incidents by acute settings. The Department also needs to assess why significant numbers of HSC staff do not consider that incidents reported will be properly investigated, and why they do not believe that learning from incidents is being properly disseminated.

8. Despite recent procedural improvements, evidence illustrates how very serious patient safety failings can still arise, most significantly:

   - the highly critical findings of the Hyponatraemia Inquiry which was published in January 2018;
   - the decision by the Belfast Trust in May 2018 to recall more than 2,500 patients due to concerns over possible misdiagnosis by a neurology consultant, and the ongoing investigation of issues around this; and
   - the serious allegations of patients with severe learning disabilities being subject to abuse by staff at Muckamore Hospital in County Antrim. These allegations remain the subject of investigations by the Belfast Trust and the Police Service of Northern Ireland (PSNI).

   These issues illustrate the need for unremitting vigilance to minimise the potential for such events to recur.

9. Since we last reported, total costs for clinical negligence claims settlements and provisions have increased by 56 per cent from £252 million (2007-08 to 2011-12), to £393 million (2012-13 to 2016-17). This diverts already scarce resources away from frontline services and patients, meaning that more patients wait longer for their treatments. It also potentially increases pressure on HSC staff, which in turn may heighten the risk of adverse incidents occurring.

10. Patient safety cases can take a long time to settle, so it may be some time before any improved patient safety practices translate into a reduction in compensation costs being incurred. The Department should analyse the underlying reasons for the recent trend in rising costs, to determine if the apparent increase in incident reporting has not yet translated into a strong learning culture across the HSC sector, and to assess what further steps might prove successful in helping prevent the repetition of serious incidents which are resulting in high compensation costs.

NIAO Recommendations

Progress in developing a regional system to facilitate learning from adverse incidents has been limited, and resource constraints mean that there is uncertainty over if, and when, such a system will be introduced. The Department should now pro-actively seek to establish if linking with the replacement NRLS system in England and Wales is a viable alternative for enhancing local learning.

The Department and Trusts need to actively address the potential risks to patient safety created by staffing shortfalls in key clinical disciplines and, as far as possible, introduce appropriate workforce planning measures to mitigate these risks.

The Department should take all steps within its powers to progress the establishment of a statutory duty of candour and to ensure that all medical staff in the HSC sector are bound by this.

Overall Conclusions

11. Overall, our review has highlighted that value for money is not being achieved in respect of the HSC sector's high and increasing reliance on locum doctors. It is also clear that the Department and Trusts need to consider the steps which might further enhance patient safety standards across the HSC sector. This should include a consideration of lessons that can be learned and embedded into the system from the Hyponatraemia Inquiry and when the ongoing investigations and reviews are completed, from recent concerns over treatment provided by a neurology consultant in the Belfast Trust.

Report One:
The Use of Locum Doctors by Northern Ireland Hospitals

Report One:
The Use of Locum Doctors by Northern Ireland Hospitals

Introduction and Background

1.1 A `*locum doctor*' (or locum) is a professionally-qualified medical practitioner who temporarily covers for staff shortages or unexpected workload peaks. Hospitals use locum doctors in two main ways:

- to provide short-term shift cover for doctors who are temporarily unavailable for work; or
- to fill vacant posts on a longer-term basis as cover for staff on extended leave.

1.2 Although locum doctors have an important role in helping hospitals deliver healthcare services, they are significantly more expensive than permanently employed doctors. It is also generally acknowledged that using locums, particularly those engaged through agencies, can present additional risks to patient safety if the vetting of appointments, induction, supervision and performance are not well managed. In 2011, we reported[1] on:

- whether the Department of Health (the Department) and the Trusts had developed a planned approach to controlling the use of locum doctors, and the associated costs; and
- whether any significant health and safety issues which existed with the use of locums were being properly addressed.

1.3 **Figure 1** summarises our main findings.

Figure 1: NIAO findings on `The Use of Locum Doctors in Northern Ireland' (July 2011)

Costs of using locum doctors

Between 2007-08 and 2010-11, the local Trusts paid £109 million in employing locum doctors, comprising £74 million for agency-supplied locums and £35 million paid to directly employed locums.

Trusts did not routinely monitor expenditure incurred on internal staff providing locum cover.

Expenditure on agency locums had risen steadily from almost £14 million in 2007 to £22.5 million in 2010-11. This represented almost 8 per cent of all local medical staffing expenditure, but stood at 17 per cent in the Western Trust.

If all Trusts could maintain locum costs within the regional average, £5 million could potentially be saved each year.

1 The Use of Locum Doctors by Northern Ireland Hospitals, NIAO, July 2011.

The safe use of locum doctors

Whilst all locum appointments from 2006 were to be subject to a clinical skills review, a 2008 audit identified significant non-compliance with this requirement. Trusts were not always receiving end of placement reports from locum agencies or previous employers, and not always providing exit reports for locum doctors. No systems and safeguards existed to routinely identify whether locums had exceeded the safe level of hours set under the European Working Time Directive (EWTD).

1.4 Our report was considered by the Public Accounts Committee (PAC) in December 2011. When the PAC subsequently published its findings in February 2012[2], it concluded that the Trusts:

- required better information on the use and costs of locums, particularly on those drawn from existing staff;
- could improve their workforce planning and use locums more cost effectively, and potentially achieve annual savings of £1 million through greater use of internal cover rather than using agencies whose rates, particularly those of non-contracted agencies, could be substantially higher; and
- needed to improve how they managed potential risks to patient safety arising from using locums.

1.5 The PAC made nine recommendations aimed at helping local hospitals use locum doctors more efficiently and effectively. The Department subsequently accepted eight of these in the Department of Finance Memorandum of Response (MoR), which was issued in June 2013.

1.6 Paragraphs 1.7 to 1.16 assess recent expenditure trends for locum doctors. Paragraphs 1.17 to 1.49 consider the progress made by the Department and Trusts in addressing the PAC's recommendations.

Expenditure on locum doctors has increased by over 180 per cent since 2010-11

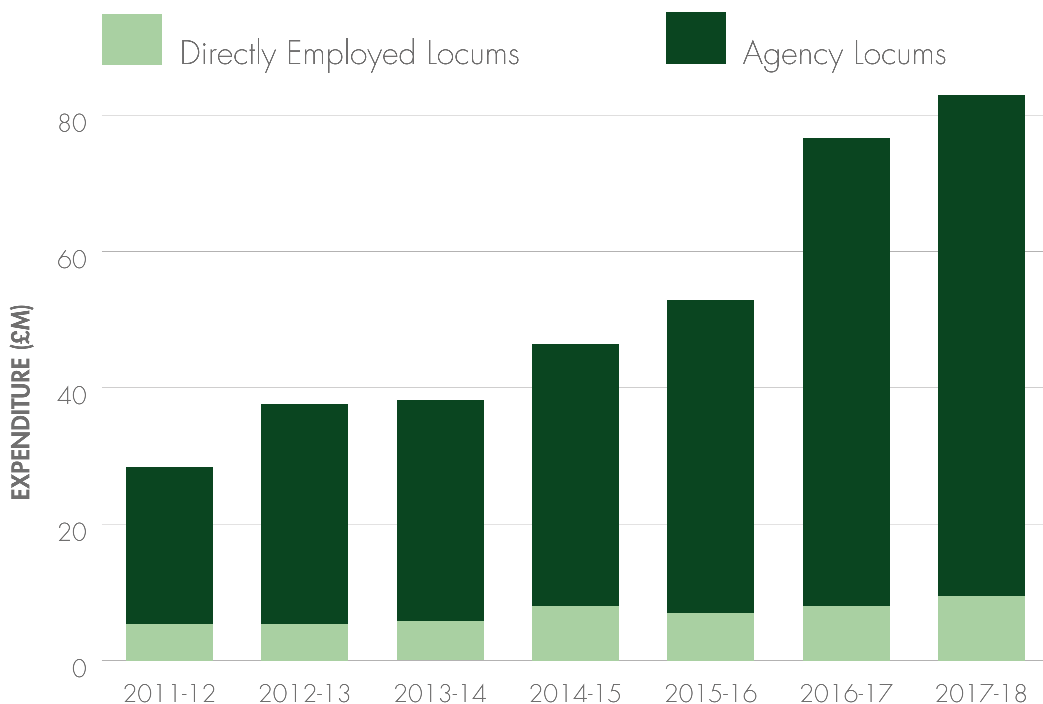
1.7 When we reported in July 2011, Trusts had paid £109 million to engage locum doctors in the four years from 2007-08 to 2010-11, which represented annual average expenditure of £27.3 million. Some £74 million of this (68 per cent) was paid to locum doctors engaged through agencies, with £35 million (32 per cent) spent on directly employed staff who carried out locum duties (directly employed locums).

2 Report on the Use of Locum Doctors by Northern Ireland Hospitals, PAC, 15 February 2012.

Report One:
The Use of Locum Doctors by Northern Ireland Hospitals

1.8 **Figure 2** shows the total costs subsequently incurred by the Trusts on locum doctors between 2011-12 and 2017-18, and also illustrates the expenditure split between agency locums, and directly employed locums.

Figure 2: Locum Doctor Expenditure



Total expenditure on Locum Doctors increased from £28 million in 2011-12 to £83 million in 2017-18.

In 2017-18, almost 90 per cent of spend on Locums related to Doctors provided by agencies.

Source: NIAO, based on HSC Trust data

1.9 In the seven years to 2017-18, £363 million was spent on locums. By 2017-18, total annual costs had risen to £83 million, an increase of 185 per cent compared to £29.1 million in 2010-11. Annual costs increased by almost 57 per cent between 2015-16 and 2017-18 alone.

1.10 While some difficulties exist in assessing trends for costs incurred on agency supplied locums[3], the information available shows that the proportion of expenditure on agency staff has increased from 81 per cent in 2011-12 to 89 per cent in 2017-18. This compares to almost 70 per cent when we reported in 2011.

1.11 Overall, £314 million (86 per cent) of the total £363 million expenditure on locum doctors between 2011-12 and 2017-18 was paid to agencies. Over this period, the ratio of spend on agency locums exceeded 80 per cent in all Trusts, with the Western Trust, at 95 per cent, having the highest dependence on this sector **(Figure 3)**. Furthermore, spend on agency locums increased significantly in all Trusts during this period **(Figure 4)**.

Figure 3: Trusts in Northern Ireland have spent over £363 million on locum doctors since 2011-12

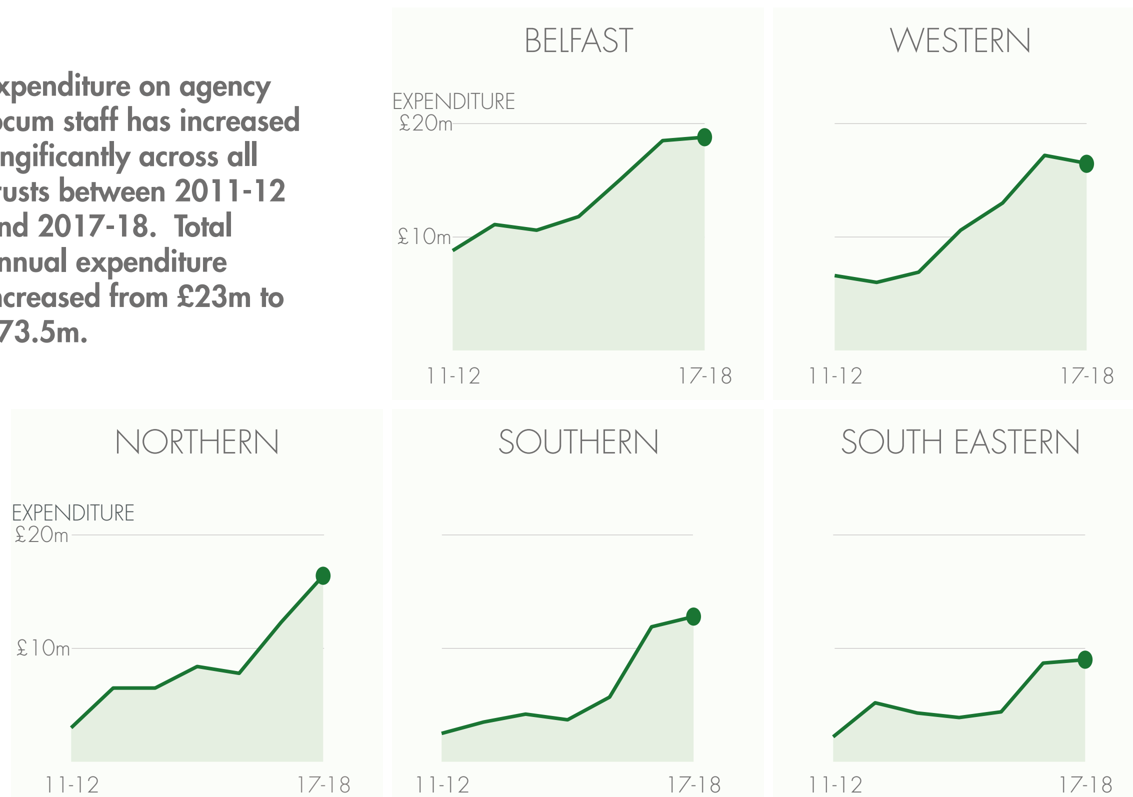
Trust	Overall Locum Expenditure 2011-12 to 2017-18 £m	Spend on agency locums £m/%	Spend on Directly Employed locums £m/%
Belfast	114.3	94.7 (83%)	19.6 (17%)
Northern	72.8	60.9 (84%)	11.9 (16%)
South Eastern	44.5	37.7 (85%)	6.8 (15%)
Southern	50.3	44.3 (88%)	6.0 (12%)
Western	81.2	76.8 (95%)	4.4 (5%)
Total	363.1	314.4 (87%)	48.7 (13%)

Source: NIAO, based on HSC Trust data

3 The South Eastern Trust did not record the relevant expenditure split between 2011-12 and 2013-14, and instead allocated all costs to agency locums. Agency locum costs are therefore overstated for these three years.

Report One:
The Use of Locum Doctors by Northern Ireland Hospitals

Figure 4: Expenditure on agency locums by HSC Trusts 2011-12 to 2017-18



Source: NIAO, based on HSC Trust data

1.12 The heavy reliance by Trusts on locum doctors to maintain the provision of healthcare services is also reflected in the percentage of the medical pay bill being spent on their engagement. In 2017-18, this ranged from 11 per cent in the Belfast Trust to almost 23 per cent in the Northern Trust **(Figure 5).**

1.13 In the MoR, the Department committed to work with Trusts to agree an optimal split between the use of permanent doctors and locums, and to commence monitoring the percentage use of locums against the permanent medical staffing complement.

1.14 Whilst the Department told us that optimal split targets, which measured the percentage of the medical pay bill incurred on locum doctors, were subsequently introduced for each Trust `circa March 2013', it also acknowledged that it no longer actively monitors performance against these targets. The Department told us that whilst this initiative had been introduced to try and

reduce spend on locums, "it seems that this work was not progressed". **Figure 5** illustrates how the Trusts have fallen significantly short in achieving the proposed targets.

Figure 5: In 2017-18, two Trusts spent more than 20% of their medical pay bill on locums

Trust	Optimal Split target set in 2013 (locums % of medical pay bill)	Actual % 2013-14	Actual % 2014-15	Actual % 2015-16	Actual % 2016-17	Actual % 2017-18
Belfast	8.0	8.2	9.2	9.7	11.2	11.0
Northern	12.0	14.0	22.2	14.8	20.4	22.9
South Eastern	9.0	n/a	9.1	9.9	14.9	15.1
Southern	8.0	7.9	7.5	10.3	19.0	19.9
Western	8.0	13.6	18.5	20.0	24.6	22.3

Source: NIAO, based on HSC Trust data

1.15 The extent of dependence by Trusts on locum staffing in recent years is further illustrated by findings from recent reviews which have been undertaken in four of the five Trusts by Business Services Organisation[4] (BSO) Internal Audit **(Figure 6)**.

Figure 6: Summary of Internal Audit findings on locum doctor usage and expenditure

HSC Trust	Period Under Review	Internal Audit Findings
Belfast	2015-16	Of 60 invoices paid to external agencies in 2015-16, 18 exceeded contractually agreed rates. The Trust had no standard definition of what constituted long-term locum cover, which could result in locum cover being unnecessarily extended, when it may be more appropriate to use other recruitment processes.

4 Business Services Organisation provides a broad range of regional business support functions and specialist professional services to the health and social care sector in Northern Ireland.

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HSC Trust	Period Under Review	Internal Audit Findings
South Eastern	2014-15	A locum was appointed to work sessions "as and when" by the Director of HR in 2013. There was no evidence that the post was advertised, or of a contractual arrangement with this doctor. The doctor also received benefits normally reserved for full-time employees, including annual leave and sick leave payments. Furthermore, the substantive post was only advertised in May 2015, two years after the locum was appointed. The Department told us that it will ask HSC employers to provide information on any similar previous cases, and that it will also write to Trusts to instruct them that such anomalous situations must not be allowed to re-occur. In general terms, the Trust had no written guidance on the consistency and use and management of medical locum staff.
Southern	2016-17	Total spend on short term locum doctors in 2016-17 was £13 million, 100 per cent higher than 2015-16. Whilst there are agreed rates for both agency and directly engaged locums, these can be increased when difficulties occur in filling shifts. Of 100 payments reviewed, hourly rates had been enhanced on 31 occasions. Eighty-four locum doctors engaged through agencies had been working for more than three months, with 31 of these having been engaged for longer than a year, mostly to fill vacancies.
Western	2016-17	Spend on agency locum medical staff had increased by 138 per cent, from £7.2 million in 2014-15 to £17.2 million in 2016-17.

Source: BSO Internal Audit reports

1.16 A range of factors has contributed to the high and rising expenditure on locums. Whilst the number and level of vacant medical posts is likely to be a significant factor, it is difficult to measure precisely the strength of any correlation with expenditure on locums, as vacancy data is based on a snapshot of posts being recruited to at a particular point in time. In addition to

vacancies, the Department told us that other issues, including cover for sickness and maternity or paternity leave, and the increase in demand for care over the winter months, have contributed to the rising spend on locums.

NIAO Conclusion

The high costs associated with engaging locum doctors, relative to doctors employed by the Trusts, highlight the importance of restricting their use to supporting temporary flexibility in staffing. However, recent evidence indicates that such shorter-term staffing flexibility has been overtaken by locum doctors being used on a longer-term basis, often as the norm to cover unfilled permanent posts.

When the PAC reported in 2012, it highlighted the need for Trusts to reduce reliance on the use of locum doctors and, in particular, to minimise the use of external agencies. However, the Trusts have instead become increasingly dependent on external agencies to provide locum doctor cover, with very limited utilisation of internal staff banks. In addition to the cost implications, the deployment of agency doctors who are less familiar with the care environment in a particular Trust, also presents greater potential to increase patient safety risks.

Our findings underline the urgency with which the overall workforce challenge needs to be addressed across the health and social care sector to deliver better value for money. In this respect, we acknowledge that the `Health and Social Care Workforce Strategy 2026' which was published by the Department in May 2018, may offer future scope for addressing key concerns in this area.

Progress in implementing the PAC's recommendations

1.17 This section of the report (paragraphs 1.18 to 1.49) sets out the recommendations made by the PAC in its February 2012 report, and the progress made by the Department and Trusts in addressing and implementing these.

Using IT to support internal staff flexibility

PAC Recommendations

In the absence of basic management information, Trusts are not well positioned to manage their use of locums effectively. While the Committee welcomes the Department's assurances that the new Regionally Managed Medical Locum Service (RMMLS) will address the current deficiencies in management information and will allow increased use of substantive staff to cover vacancies, it is concerned that the plans surrounding its implementation are beginning to slip. The Committee recommends that, as a matter of urgency, Trusts implement actions to

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The Use of Locum Doctors by Northern Ireland Hospitals

capture basic information on all locum episodes in order to improve their ability to manage and oversee the use of locums.

The Committee notes that the Department has produced a formal estimate of the savings it expects to achieve through implementation of the RMMLS. The Committee recommends that the Department establish the service as a matter of urgency and expects that the Department provide a progress report on what has been achieved by September 2012.

1.18 To try and reduce the dependency on agencies and increase the use of the bank of directly employed staff in providing locum doctor cover, the Department introduced the "eLocums" system in November 2012. However, at September 2017, only 784 doctors (approximately 20 per cent of all doctors employed across the sector) had registered to use the system. Whilst data for September 2017 shows that 39 per cent of all locum shifts at the Southern Trust were booked through eLocums, usage was significantly lower at the other four Trusts, ranging from 11 per cent to 20 per cent. Commenting on this low usage, BSO Internal Audit concluded that medical staff may be reluctant to use the system due to slow payment, and may instead prefer to cover shifts through agencies, where payment rates are higher. Another limitation with eLocums is that it does not currently accommodate the registration of all medical specialisms. For specialisms which have a relatively small number of staff, this could heighten the risk that services to patients may not be sustained.

1.19 Between July 2015 and September 2017, the Department has estimated that use of eLocums generated savings of £1 million, compared to using external agencies. However, fuller analysis of locum expenditure (see Figure 2) clearly illustrates that the new system has had limited success in redressing the bank/agency balance.

1.20 The Department told us that it acknowledges that system usage has been `fairly low key', and not as successful as originally anticipated. However, it said that it has still generated savings which would otherwise not have been achieved. It highlighted two key reasons behind the low usage:

- the system has not been endorsed by the British Medical Association (BMA), which considers that it should be operated like, and provide the same facilities and rates as, a commercial agency; and
- a reluctance by junior doctors to take up additional work when they are already under pressure, and to instead base their working patterns around lifestyle choices.

1.21 We asked the Department whether it had attempted to quantify the extent to which the system had reduced the amount of locum work carried out by HSC doctors through agencies. The Department told us that when locums are engaged through agencies, it is not possible to

determine if they are also employed by an HSC Trust and that, consequently, it cannot monitor the extent to which HSC-employed doctors are still working as agency locums. Going forward, the Department told us that the Trusts intend to examine collaboratively the scope for reducing costs being incurred on locums, and reliance on agencies, in the context of the current competitive marketplace.

NIAO Conclusion

The eLocums system was introduced with the objective of minimising the high and increasing reliance on agency doctors. Whilst it has had limited success in some Trusts, it has clearly been overtaken by the acute issue of supply and demand of medical staff which is now apparent in other locations. Going forward, it is likely that only a longer term more strategic approach to medical training and workforce planning will reduce the current level of dependency on agency locums.

Workforce planning

PAC Recommendation

The Committee recommends that all future workforce planning exercises must include a detailed analysis of demand and activity levels by medical specialty in order to reduce the need for unplanned locum appointments.

1.22 We recognise that Trusts face a challenge in reducing their spending on locum doctors. For instance, the very high dependence on locums by the Northern and Western Trusts illustrates the particular difficulties they have in recruiting staff in some specialties and grades, and also the limited mobility which is apparent among many local doctors, who prefer to work in the greater Belfast area.

1.23 Several other factors are also likely to have significant influence over future resource requirements of the HSC sector. For example, the Bengoa report[5], envisages that a shift of care into community settings may ultimately reduce the number of doctors required by local hospitals, and reduce this sectors dependence on locums. Underlying these challenges is the need to establish a robust workforce planning system across the Trusts, so that dependency on temporary staff is minimised.

1.24 In response to the PAC's recommendation in this area, the Public Health Agency (PHA), reporting to the Department's Regional Workforce Planning Group, has been undertaking a rolling five year programme of specialty workforce planning since 2013. This was intended to address issues surrounding workforce planning in both the short and longer term, including the need to curtail locum appointments.

5 *Systems, Not Structures – Changing Health and Social Care*, Expert Panel Report, October 2016.

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1.25 However, this programme has made limited progress. To date, specialities accounting for approximately 40 per cent of the medical workforce have been reviewed. Whilst a higher level analysis of medical workforce requirements was originally scheduled to be finalised in June 2015, this was ended by the Department in October 2016 without being completed. The Department told us that it took this decision due to substantive doubts over the methodologies being used by the consultants completing the review, which led it to conclude that the exercise would not provide convincing evidence to inform future medical workforce requirements.

1.26 The Department subsequently commissioned a further review to determine the optimum number of annual medical student places required in Northern Ireland to meet medical workforce requirements. This analysis, which will potentially help identify what longer term steps need to be taken to help Trusts reduce their current high reliance on locum doctors, was published in January 2019. The Department is currently considering options for addressing and implementing the report's ten recommendations.

NIAO Recommendation

Locum doctors provide a valuable contribution to the health service, and help sustain a health system which is subject to constantly fluctuating demands. However, in the current circumstances, when expenditure on locums has become a major drain on Trust finances, the Department and Trusts must find more effective long-term workforce planning solutions which can help reduce reliance on locums, through providing a sustainable and recurrent workforce. In tandem with policy development, the Department should consider re-establishing short, medium and longer-term targets aimed at reducing the Trusts' current level of reliance on locum doctors.

Dealing with the more immediate challenges of locum working

1.27 In lifestyle terms, some doctors prefer having autonomy over where and when they work as a locum, rather than committing to a substantive post. A recent BMA survey found that 72 per cent of locum general practitioners choose their job for its flexibility and work-life balance.

1.28 In choosing locum work, doctors can also regularly earn more than permanently employed doctors due to the higher hourly rates offered by Trusts and the flexibility of negotiating hours and pay-rates, particularly when employed through an agency. Currently, basic hourly rates for locums secured through contracted agencies are between 25 per cent and 126 per cent higher than eLocum rates, and 94 per cent to 174 per cent higher for consultants.

1.29 Using the basic hourly rates, it is possible to illustrate the range in the annual cost of employing a locum doctor from both a contracted agency and a non-contracted agency[6]. When non-contracted agencies have to be used, annual costs of up to £240,000 can be incurred for trainee and middle grade doctors, and of up to £380,000 for consultants **(Figure 7)**

6 Estimates based on a 48 hour week over 52 weeks.

Figure 7: The annual cost of employing a locum doctor from agencies can range from £95,000 to £377,000

Category of doctor (contracted agency)	Annual cost (contracted agency) £*	Category of doctor (non-contracted agency)[7]	Annual cost (non-contracted agency)
Foundation 1	95,272 – 157,972	Training grade	107,328 – 242,112
Specialist Trainee 1 and 2, Foundation 2, CT 1 and 2	118,385 – 187,325	Training grade	107,328 – 242,112
Middle Grade, Specialist Trainee 3 and above, Staff Grade, Speciality Doctor, Associate Specialist	140,774 – 213,108 (non-emergency) 159,944 – 232,203 (emergency) 223,242 – 315,936 (Consultant)	Middle Grade and Consultant	99,840 – 239,616 (Middle Grade) 229,632 – 376,896 (Consultant)

*including agency fee, holiday pay, employers national insurance contribution and apprenticeship levy

Note – Costs of employing agency locums cannot be directly compared to salaries paid to HSC employed doctors

Source: NIAO, based on HSC Trust data

1.30 A recent BSO Internal Audit review of the South Eastern Trust provides further evidence of how lucrative locum work can be. Internal Audit found that a locum doctor had established two separate agencies to undertake locum work. By setting up a private company, a doctor working on a temporary basis can potentially gain income tax advantages as the hourly rates paid to locums can often breach the higher band threshold. The doctor will also receive the commission paid to agencies. In this case, the two agencies set up by the doctor had been paid £125,000 in 2014-15.

1.31 In March 2014, the PAC[8] highlighted how establishing a limited company to undertake agency work could potentially minimise personal tax obligations. The Committee also concluded that, should such arrangements prove non-compliant with regulations and tax was not collected as a result, HM Revenue & Customs could potentially seek restitution from public bodies using such agencies.

7 Based on a range of rates provided by the HSC Trusts.

8 *Report on PSNI: Use of Agency Staff – Volume 1. (26 March 2014).*

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1.32 The Department told us that it is unable to avoid exposure to such liabilities through refusing to engage agencies owned by doctors, as imposing such an exclusion may be subject to legal challenge. This view is based on the Departments interpretation of current legislation[9], which it considers would not permit excluding a tender solely because an agency is owned by a doctor who may or may not be involved in the delivery of medical locum services.

Addressing patient safety risks associated with using locum doctors

1.33 In addition to highlighting the high costs being incurred on locum doctors, the PAC concluded that further action was needed to minimise the additional risks to patient safety brought about by the use of locums. Paragraphs 1.34 to 1.49 assess the progress made in addressing PAC's five recommendations in this area.

Pre-employment checks on locum doctors

PAC Recommendation

The Committee welcomes the Department's acceptance of the need for stringent controls in the appointment of locums. The Committee recommends that the Department should issue immediately to Trusts the planned reminder about complying fully with the relevant checks prior to appointing a locum doctor. In addition, the Committee recommends that Trusts should also develop a monitoring schedule which will allow them to identify the level of compliance with the controls in place for locum appointments and to take action where deficiencies are identified.

1.34 Following the PAC's report, the Department stated that it would direct Trusts to develop arrangements for monitoring compliance with key controls for individual locum appointments, including pre-employment checks. The Department subsequently wrote to the Trusts in November 2011 and October 2012, reminding them of the importance of full compliance with pre-employment requirements. However, it was unable to confirm whether the Trusts had subsequently developed arrangements for monitoring compliance in this area.

1.35 The Department intends to strengthen the monitoring of compliance by requiring Trusts to submit annual assurance statements from 2018-19, and through work which aims to ensure that, from 2019-20, all human resources legal and policy requirements are being followed across the HSC sector. However, as it has not yet not carried out any central monitoring, the Department could not provide assurance on the degree to which Trusts have been completing the necessary

9 The Public Contracts Regulations (2015).

pre-employment checks in appointing locums. As **Figure 8** outlines, findings by Internal Audit indicate that there is still non-compliance in this area within some of the Trusts it has examined.

Figure 8: Internal Audit has found that some Trusts are not undertaking pre-employment checks for locum doctors

HSC Trust	Period under review	Internal Audit findings
South Eastern	2014-15	No evidence existed that full pre-employment checks were carried out when `non-contracted' agencies were used. Of 23 Trust employees engaged as locums, there was no evidence of: Access NI checks (12 cases); occupational health checks (7 cases); and fitness to work in the UK checks (14 cases). No audits had been completed on any of the 25 agencies used by the Trust, to measure their compliance in carrying out pre-employment checks.
Southern	2016-17	Of a sample review of 20 locums engaged from agencies in 2016-17, the necessary pre-employment checks had not been completed on six occasions.
Western	2016-17	In 10 of 40 agency locum appointments examined, no evidence existed that a check had been performed on the doctors' fitness for work.

Source: BSO Internal Audit

NIAO Conclusion

Six years after the PAC reported, it is deeply concerning that there is evidence that some Trusts are not completing the necessary pre-employment checks before making locum appointments. These checks provide vital assurance that doctors are suitably qualified and registered, and that no concerns exist over their fitness to work.

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NIAO Recommendation

The Trusts need to take action to strengthen their internal monitoring to ensure that pre-employment checks of locum doctors are being undertaken. The Department should also consider commencing central monitoring of this key area.

Use of non-contracted agencies

PAC Recommendation

The use of "off-contract" agencies creates additional patient safety risks. The Committee recommends that the use of such agencies must be limited to exceptional circumstances only and that, where they are used, Trusts must put procedures in place to ensure that the performance of such agencies at least matches the service standards and prices available from contracted agencies.

1.36 In response to this recommendation, the Department wrote to the Trusts in November 2012, reminding them of the need to restrict the use of non-contracted agencies to exceptional circumstances. Moreover, it had also envisaged that the introduction of the eLocums system would help restrict the use of `off contract' agencies.

1.37 We asked the Department how much these agencies had been paid since 2011-12, and what proportion of overall locum expenditure they had received. Whilst this information has not been routinely gathered, the Department asked the Trusts to provide any available information. Data provided for the five-year period 2013-14 to 2017-18 showed that:

- The Trusts collectively spent £64.2 million on non-contracted agency locums (almost 25 per cent of the total £259 million agency spend). In 2017-18, £21.3 million (29 per cent) of the total £73.5 million agency spend was paid to non-contracted agencies.

- The proportion of spend on non-contracted agencies has increased at all Trusts between 2013-14 and 2017-18, with the exception of the Western Trust, where it has reduced from 51 per cent to 16 per cent.

- The Northern Trust has become heavily reliant on non-contracted agencies. In 2017-18, £10 million (61 per cent) of its total £16.4 million agency spend was on these agencies. The Department told us that the Trust has recently reported significant recruitment and retention difficulties within a number of medical specialisms.

1.38 We recognise that, on occasions, Trusts can face circumstances where not engaging non-contracted agencies would otherwise lead to vital healthcare services, including Accident

and Emergency, failing and becoming unavailable to the public. However, since the PAC reported, most of the Trusts have become increasingly reliant on what is the least favoured form of provision, in terms of achieving value for money. Whilst trends in this area have not been routinely monitored to date, the Department told us that it will determine an appropriate process with the Trusts for more regular measurement in the near future.

NIAO Recommendation

The Trusts should routinely gather and report data on the use of non-contracted agencies and the Department should formally monitor trends in this area to gain assurance that usage of these agencies is being limited to exceptional circumstances.

Addressing poor locum performance

PAC Recommendation

The Committee recommends that the Department examines the extent of compliance with the controls in place within Trusts for logging concerns about the performance of locum doctors.

1.39 The Department subsequently took several steps to address this area:

- In November 2012, it notified Trusts of the need for full compliance with the established systems for logging concerns about doctors' performance.
- In December 2012, it worked jointly with the General Medical Council (GMC) to introduce the Confidence in Care programme, under which all HSC doctors are subject to medical revalidation and fitness to practice checks.
- In August 2016, it issued updated Human Resource Controls Assurance Standards.

1.40 We welcome these measures, which aim to ensure that concerns about the performance of doctors are identified and disseminated across the HSC sector. Since the Confidence in Care programme was launched in December 2012, GMC data shows that just over 6,000 doctors working in Northern Ireland have been subject to revalidation. Some 82 per cent of these were successfully revalidated, with the remaining 18 per cent having their revalidation deferred[10]

10 Deferral occurs when a Responsible Officer (RO) needs more time before making a revalidation recommendation, for example where there is incomplete information to reach such a recommendation. The doctor may continue to practice pending this recommendation. To make a deferral recommendation, the RO must be satisfied that the doctor is engaging, and will continue to engage, with the local processes that underpin revalidation and that there is a legitimate reason why the doctor needs additional time to provide the outstanding information.

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Reporting of Adverse Incidents

PAC Recommendation

The Committee recommends that, in future, all Adverse Incident reports concerning a doctor's performance should specify the nature of the doctor's employment. This information should then be used to monitor the number of adverse incidents which involve locum doctors and to compare this figure against adverse incidents involving doctors in substantive posts

1.41 In response to this recommendation, the Department committed to issuing guidance to all HSC organisations advising that where there was evidence that the clinical or professional performance of a practitioner had possibly contributed to an Adverse Incident, their employment status should be recorded in the investigatory report. It intended using this information to monitor and compare the number of adverse incidents involving locum clinicians and practitioners, and stated that the HSC Board would report regularly to it on this area.

1.42 The Department told us that Adverse Incidents which raise concerns over the performance of individual staff (either permanent or temporary) are subject to an investigation governed by human resource policies. It stated that any concerns regarding locums which emerge from these investigations are addressed by the Clinical or Medical Director of the relevant Trust, and reported back to the agency through which the locum is employed, or notified to the GMC.

1.43 Whilst this helps ensure that concerns about performance of individual locums are investigated, it does not directly facilitate monitoring of trends for the number of incidents involving locums and substantively employed doctors. In November 2017, the Department asked the HSC Board and the Public Health Agency (PHA) to liaise with Trusts in order to capture and analyse regional data on the employment status of all care staff when their performance is deemed a contributory factor in adverse incidents. It has subsequently been agreed that the Trusts will capture data from Serious Adverse Incident (SAI) reports in respect of concerns about a doctor's performance, which will identify if they are a locum or directly employed doctor. This information will enable the HSC Board to determine whether regional trend analysis is feasible and whether it is possible to determine if locums present greater patient safety risks compared to permanently employed doctors. As such, steps are now being taken which could directly address the PAC's recommendation.

Compliance with the European Working Time Directive

1.44 The Department did not accept a recommendation by PAC relating to patient safety which focused on the need to ensure compliance with the European Working Time Directive (EWTD):

> **PAC Recommendation**
>
> In the Committee's view, given the risk to patient safety, it is not sufficient for Trusts to rely on doctors to verify their compliance with the EWTD. In order to protect the interests of patients, the Committee recommends that the Department ensures Trusts have effective arrangements in place for monitoring the total number of hours worked by each doctor, whether in substantive employment or working as a locum. In addition, this process should measure not only hours worked but that rest breaks are being achieved, and/or adequate compensatory rest provided.

1.45 Prior to the introduction of the EWTD in 1993, hospitals could generally cover temporary staff shortages internally by requiring doctors to work longer shifts. However, under the EWTD, junior doctors are restricted to working a 48 hour week, and are entitled to defined rest periods and paid leave. Whilst this may help enhance patient safety standards, it also potentially increases the reliance of HSC organisations on locum doctors, particularly if they are unable to fill vacant posts.

1.46 The PAC's recommendation that monitoring of compliance with the EWTD should be strengthened was made in the context that this would help manage the risks to patient safety which can arise if doctors work long hours. The Department responded to the recommendation by highlighting that Trusts already monitored total hours worked by permanently employed doctors, but stated that it would not be possible for them to ascertain the hours worked by temporarily employed locums prior to their appointment. Nonetheless, in September 2012, it instructed the BSO to seek assurance from contracting agencies that locum doctors were fully aware of their responsibilities under the EWTD.

1.47 As this provided limited assurance of actual compliance with the EWTD, we asked the Department if it had taken any further steps to enhance control over this area. The Department told us that as employers, Trusts are responsible for ensuring that staff adhere to the EWTD, or alternatively, seek opt-out forms. It also highlighted that all doctors registering with the eLocums system are informed that they must comply with the EWTD. However, in our view this provides limited assurance, given that only a small proportion of HSC doctors are actively using the system (see paragraph 1.18).

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1.48 Since the PAC reported, BSO Internal Audit has found evidence that the EWTD is still being breached in some Trusts:

- In the Southern Trust in 2016-17, it found compliance was not always considered prior to locum shifts being filled by existing HSC staff. Of 40 timesheets reviewed, Internal Audit found that four doctors had worked between 50 and 88 hours.
- In the South Eastern Trust in 2014-15, Internal Audit found instances where locum doctors had worked 40 and 48 hours continuously. It concluded that the Trust had no systems and safeguards to routinely identify instances in which locum doctors exceeded the safe level of working hours set by the EWTD.

1.49 The Department told us that difficulties exist with monitoring compliance with the EWTD, particularly when doctors work for a number of Trusts. It cited an example where a doctor could be employed for 42 hours in full time employment for one Trust, and also work a 10 hour shift in another Trust as a locum. Whilst this would exceed the 48 hour limit, it would not necessarily breach the Directive, as this is based on average hours worked over 26 weeks. The Department considers that the requirement to track outcomes over this period and across a number of organisations makes it difficult for Trusts to accurately monitor hours worked by locums, and that doctors therefore have to accept responsibility for both their own and their patients' safety.

NIAO Conclusion

Despite the logistical difficulties, it is important that monitoring of compliance with the EWTD is further enhanced. As improved compliance with the EWTD could potentially increase the demand for locum doctors, this again emphasises the importance of strengthened workforce planning to accurately identify the number of trainee doctors required across the Trusts.

Overall Conclusions

1.50 In forming overall conclusions on progress made in implementing the PAC's recommendations on the use of locum doctors, it is important to acknowledge the difficulties which Trusts have faced in recent years in recruiting and retaining staff within some key specialisms. In this regard, the Department highlighted a number of specific cases where Trusts had repeatedly sought to fill medical vacancies and achieved very little success. The Department also told us that whilst Trusts will attempt to cover vacancies through utilising their own workforce, they are sometimes left with no alternative but to use locums to maintain service delivery.

1.51 Whilst we recognise these challenges, it is clear that, in most areas which the NIAO and the PAC previously highlighted as requiring improvement, progress has been disappointing, and there remains significant scope for improvement:

- Reliance on locum doctors and the associated costs have risen significantly across all Trusts since 2010-11, and the already high reliance on agency locums has increased further.

- Whilst targets for the optimal use of locums were established for each Trust, the Department has ceased monitoring performance against these, and expenditure on locums is accounting for a continually increasing proportion of the Trusts medical pay bill.

- Although the eLocums system has been introduced across the Trusts, it has had very limited impact in reducing reliance on agency locums, and has not achieved the level of savings or benefits anticipated.

- Limited progress has been achieved in implementing workforce planning solutions specifically aimed at reducing reliance on locum doctors.

- Some Trusts are still not carrying out the necessary pre-employment checks before offering locum appointments.

- The Department has not been routinely monitoring the usage of `non-contracted' agencies by the Trusts, but the data available shows that such usage has not reduced.

- The Department has not been monitoring data gathered by the Trusts to determine if locum doctors are presenting increased risks to patient safety.

- There is no evidence that compliance with the EWTD has improved.

1.52 In our view, the escalating cost of engaging locums in local hospitals is becoming unsustainable. Unless the issues and challenges in this area are tackled urgently through more strategic, effective and forward thinking interventions, there is a risk that reliance on locums will continue to increase. This would result in the already pressurised budgets of Trusts coming under significant strain.

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Background

2.1 Although most patients treated in the HSC sector experience high standards of care, Adverse Incidents (AIs), which have potential to cause harm to patients, do occur, and a small proportion of these, defined as Serious Adverse Incidents (SAIs), can have serious consequences for patients. In some cases, AIs and SAIs can lead to clinical negligence claims. **Figure 9** sets out the definitions of AIs and SAIs.

Figure 9: Definition of Adverse Incidents and Serious Adverse Incidents

Adverse Incident	Any event or circumstance that could have, or did, lead to harm, loss or damage to people, property, environment or reputation.
Serious Adverse Incident	An occurrence where there is: • serious injury to, or the unexpected /unexplained death (including suspected suicides and serious self–harm) of: a service user; a service user known to Mental Health Services (including Child and Adolescent Mental Health Services or Learning Disability) within the last two years; a staff member in the course of their work; or a member of the public whilst visiting an HSC facility; • unexpected serious risk to a service user and/or staff member and/or member of the public; • unexpected or significant threat to the provision of services and/or the maintenance of business continuity; • serious assault (including homicide and sexual assaults) by a service user on other users/staff/members of the public occurring within a healthcare facility or in the community care setting; or • serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

Source: HSC Board

2.2 We previously reported on patient safety and the management of clinical and social care negligence claims across the HSC Trusts in 2012[11]. At that date, around 83,000 incidents were being reported annually in Northern Ireland, including around 270 SAIs. **Figure 10** summarises our main findings.

11 *The Safety of Services Provided by Health and Social Care Trusts*, NIAO, October 2012.

Figure 10: NIAO's main findings on patient safety (October 2012)

- In the five years to March 2012, the Department of Health (the Department) had paid almost £116 million to settle HSC negligence claims, and had estimated that settling outstanding claims would cost a further £136 million.
- Although the competency of HSC workers was central to patient safety, a 2010 survey had identified considerable variation in skills appraisal.
- Whilst incident reporting levels had been increasing, they were still below expected levels, and more action was needed to build an open reporting culture to learn lessons and drive improvements.
- There was no central regional database to collate data on patient and client safety, and the lack of high-quality routinely available information had limited the sector's ability to monitor performance, set targets, and improve patient safety.
- In addition to quantifying the number of patient and client complaints, outcomes from these needed to be assessed, including patient satisfaction with complaints handling.
- To help reduce the distress and pressure associated with taking litigation, potential existed to develop a formal dispute resolution process.

Source: The Safety of Services Provided by Health and Social Care Trusts (NIAO, October 2012)

2.3 Our report was considered by the Public Accounts Committee (PAC) in November 2012. When the PAC reported in February 2013, it concluded that:

- Although policies and initiatives had been introduced, no reliable evidence existed that HSC patients were any safer than a decade ago, and the Department could still not reliably track progress in improving patient safety.
- Enhanced public reporting was required on individual Trust performance, including benchmarking on patient safety levels.
- Whilst increases in reported incidents indicated progress in developing a more open and fair reporting culture, there was still widespread under-reporting, particularly in the acute sector, and more work was required to embed a widespread culture to encourage honest reporting and genuine learning.

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- The lack of appraisal of staff knowledge and expertise identified in 2010 had still not been addressed.
- Patients and clients with valid claims needed to understand their rights and have access to timely remedies, including an explanation, apology, remedial treatment, and, where justified, compensation.
- As a viable alternative to litigation, means such as mediation could potentially help Trusts and patients to reach the non-financial remedies which patients often said they sought.

2.4 The Committee made 14 recommendations for improving patient safety. Progress subsequently made by the Department and Trusts in addressing these is outlined at paragraphs 2.5 to 2.53. Paragraphs 2.54 to 2.68 assess recent trends for key patient safety indicators which help measure performance outcomes, including numbers of AIs and SAIs reported, numbers of clinical negligence cases taken against HSC organisations, and the costs of settling clinical negligence claims.

Progress in addressing PAC's recommendations

2.5 The recommendations from the PAC's 2013 report fell into five broad categories:

- building a positive reporting and learning culture;
- performance management and governance;
- meeting the needs of patients and service users;
- staffing; and
- handling of clinical negligence claims.

Building a Positive Reporting and Learning Culture

2.6 If HSC organisations are to achieve and sustain meaningful improvements in patient safety standards, they must foster an environment which actively encourages staff to report adverse incidents. This is a fundamental principal of a strong patient safety culture and a pre-requisite in helping organisations learn and share lessons. In this area, the PAC recommended that the Department should:

- engage with all staff groups within the HSC sector and take urgent steps to ensure a more open and proactive reporting culture;
- independently verify the extent of compliance with the dissemination of safety alerts across the HSC sector; and
- work closely with the HSC Board and the Trusts to identify fundamental failings in patient safety highlighted by the Francis Reports on Mid Staffordshire NHS Trust, and consider their relevance to the local HSC sector.

Whistleblowing and reporting concerns

2.7 Following recommendations made by the Donaldson Report[12] in December 2014, the Department commissioned the Regulation and Quality Improvement Authority (RQIA) in August 2015 to review whistleblowing arrangements across the Trusts. RQIA reported in September 2016[13].

2.8 As part of the review, the RQIA surveyed HSC staff to gauge awareness of whistleblowing policies and procedures and their confidence in how these were operating[14]. Positively, 83 per cent of respondents were aware that their organisation had a whistleblowing policy. However, only 53 per cent of staff stated that they would be comfortable raising a concern with a senior manager or director in their organisation.

2.9 Shortly before the RQIA conducted its survey, the 2015 HSCNI Staff Survey was undertaken. This indicated that a much higher proportion of staff had reported safety incidents:

- 91 per cent of staff stated that they knew how to report errors, near misses and incidents, and 88 per cent knew how to report unsafe clinical practice; and
- 95 per cent of respondents stated that they or a colleague reported the last incidents of this type which they saw.

2.10 Whilst this survey suggests strong compliance, reporting levels could be overstated, as staff may be reluctant to admit not reporting incidents they had witnessed. In view of the RQIA's less positive findings, and evidence that there may still be under-reporting of SAIs in the acute sector (see paragraph 2.60), we consider that further research on incident reporting is required to confirm that an improved and enhanced reporting culture has been embedded across the HSC sector in recent years.

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12 *The Right Time The Right Place* – an expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland, December 2014.

13 *Review of the Operation of Health and Social Care Whistleblowing Arrangements,* RQIA, September 2016.

14 The survey was issued to all staff from Arm's Length Bodies and attracted almost 3,100 responses.

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2.11 Furthermore, the RQIA and HSCNI surveys indicated that HSC bodies still face challenges in convincing employees that concerns reported will be properly investigated, and that employees will be treated fairly after raising concerns **(Figure 11)**.

Figure 11: RQIA survey and 2015 HSCNI staff survey findings on whistleblowing and patient safety arrangements

RQIA survey	2015 HSCNI staff survey
• **55 per cent of respondents were confident their organisation would robustly investigate concerns raised; and**	• 60 per cent of staff felt secure in raising concerns about unsafe clinical practice, compared to 66 per cent of NHS staff in England; and
• **57 per cent of those who had raised concerns felt that the concern had not been dealt with properly, and 44 per cent considered they had suffered detriment through raising concerns.**	• just over half of staff (54 per cent) were confident that their employer would address their concerns, and only 45 per cent considered that staff involved in an adverse incident were treated fairly.

Source: RQIA survey and HSCNI staff survey

2.12 In assessing the strength of whistleblowing policies and procedures in the HSC sector, the RQIA identified some further concerns. These included a lack of action by most HSC organisations to effectively promote the raising of concerns by staff and to measure the effectiveness of their whistleblowing strategies. The RQIA also found that organisations with low whistleblowing levels were assuming this was positive, without testing the silence to confirm whistleblowing processes were working well.

2.13 The RQIA made 11 recommendations for improvement, including:

- developing a model policy for raising concerns in HSC bodies;
- establishing a pilot confidential helpline to provide independent advice and support; and
- each HSC organisation appointing a non-executive board member to oversee the culture for raising concerns.

2.14 The Department told us that a model whistleblowing policy[15] was subsequently introduced across all HSC organisations in November 2017. Whilst an independent whistleblowing helpline for the HSC sector has not been put in place, the Department told us that the HSC

15 HSC Whistleblowing Framework and Model Policy.

sector has instead promoted Public Concern at Work's[16] helpline services. It also told us that it is continuing to monitor progress being made by Trusts in implementing the review's other recommendations. The Department stated that all of the RQIA recommendations for the HSC sector are being reported as complete, or on target for completion.

NIAO Conclusions

HSC staff survey results suggest that a high percentage of AIs are being reported. However, under-reporting of SAIs in acute settings may still be a problem, and the Trusts need to consider how they can enhance staff confidence that concerns reported will be properly dealt with. The Department also needs to continue monitoring progress by the Trusts in completing the implementation of recommendations from the RQIA review.

Findings of the Hyponatraemia Inquiry

2.15 In January 2018, the findings of the `Inquiry into Hyponatraemia-related Deaths' (the Hyponatraemia Inquiry) were published. The Inquiry was established by the then Minister for Health in November 2004, to investigate concerns about the treatment in local hospitals of five children who had died between 1995 and 2003, in circumstances where hyponatraemia[17] had caused, or was a major factor, in their deaths. In three cases, the Inquiry found conclusive evidence that the children's deaths were avoidable, and had been directly caused by negligent care.

2.16 The findings from the Hyponatraemia Inquiry highlight the devastating consequences of lapses in both patient safety and in not taking appropriate responsive action. The Inquiry identified overwhelming evidence of shortcomings in how the deaths of four children between 1995 and 2001 were reported and investigated, with the hospitals involved having attempted to cover up the true version of events, and mislead subsequent investigations.

2.17 The Inquiry also criticised the role and performance of the Department, highlighting an absence of systems in place for knowing what was going on at its hospitals, with Trusts not having been required, at the time, to report deaths or serious incidents to the Department. It described the then Chief Medical Officer's response to media scrutiny of the deaths as having been inaccurate, defensive, evasive and complacent. Whilst the Inquiry credited the Department for developing the first guidance in the UK on hyponatraemia in 2002, it stated this should have been in place much sooner.

2.18 In examining more recent practices in the local healthcare system, the Inquiry found that any improvements up to late 2013 were inconsistent and patchy. However, it concluded that further measures were subsequently introduced which would bring positive change, providing these were followed and enforced. Moreover, it highlighted the need for the Department, the HSC

16 Public Concern at Work changed its name to Protect in September 2018.

17 Hyponatraemia is a condition in which the concentration of sodium in the blood falls below safe levels.

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Board and other statutory bodies to be vigilant, given that its ultimate finding was that not all doctors and managers could be trusted or relied on to do the right thing at the right time.

2.19 Of the Inquiry's 96 recommendations, 12 related to reporting and investigating SAIs, including calls for the failure to report such incidents and to co-operate with subsequent investigations to be made disciplinary offences. In response, the Department has established a dedicated team to oversee the implementation of the Inquiry's recommendations, which will report directly to the Permanent Secretary on progress being made.

NIAO Conclusion

The Hyponatraemia Inquiry recommendations are designed to further strengthen and enhance an open reporting culture in the HSC sector. Given the gravity of the Inquiry's findings, the Department must ensure that progress is made on addressing its recommendations as quickly as possible.

2.20 More recently, in May 2018, the Belfast Trust has taken action to recall more than 2,500 patients due to concerns arising from a review of work undertaken by one of its neurology consultants, including potential misdiagnoses. The Trust has engaged nine neurology consultants with the objective of re-assessing the condition of these patients, and the treatment provided to them.

2.21 Shortly after the Trust's decision to recall patients, the General Medical Council (GMC) imposed conditions and restrictions on this consultant's ability to practice and launched an investigation into the work carried out by him, which remains ongoing. The Department has also established an independent inquiry to examine the actions taken by the Belfast Trust after the concerns were raised, and whether or not there may have been grounds for earlier intervention.

Learning lessons and managing risks

2.22 Once patient safety concerns have been reported, key lessons from incidents, particularly SAIs, need to be disseminated widely across the HSC sector to facilitate learning. Following the PAC's report, revised arrangements were introduced in August 2013, whereby the HSC Board monitors Trust compliance in disseminating patient safety alerts, and provides annual assurance on this area to the Department.

2.23 In practice, the 2015 HSCNI staff survey results indicate some progress in the area of learning since the PAC reported in 2013. Some 55 per cent of staff considered that their employer informed staff about errors, near misses or incidents compared to 49 per cent in 2012, and 52 per cent felt that their organisation provided feedback about changes made following incidents, compared to 48 per cent previously. However, in view of the improved procedures for disseminating safety alerts, greater progress might have been expected. The lengthy period

which it can take to settle some clinical negligence claims also means that it may be some time before any improved learning translates into reduced clinical negligence costs.

2.24 PAC also highlighted the importance of HSC organisations considering important patient safety lessons which had been identified by the Francis Report on Mid Staffordshire Hospitals NHS Trust in 2013. In this respect, the Department told us that it had:

- sought and received assurance that Trusts had reviewed their organisational governance arrangements in light of the Francis report, and had actively addressed any shortcomings identified; and
- reviewed the findings of the Francis report in the context of Departmental policy in March 2014, and concluded that there was a continued need for vigilance to maintain the quality and safety of local care standards.

2.25 As these initiatives were taken shortly after the Francis report was published in 2013, we asked the Department if it was assured that the Trusts were continuing to properly address the risks which crystallised in Mid Staffordshire. The Department told us that it had taken such assurance from the Donaldson report, which was published in December 2014[18], and which found no evidence of deep seated safety problems in the local HSC sector. However, this was over four years ago, and more recently, the Hyponatraemia Inquiry identified that several areas linked to training, investigations and learning still required attention, and made 14 recommendations for improvement in this area.

NIAO Conclusions

Whilst the actions taken to date show that patient safety remains a key priority for the HSC sector, the views of a significant proportion of HSC staff that learning is not being properly disseminated need to be considered and acted on. As it is now four years since the Donaldson report, it is also important to restate the need for constant vigilance and risk management to maintain an effective safety culture and help prevent the serious problems experienced in Mid Staffordshire occurring locally. Implementation of the recommendations from the Hyponatraemia Inquiry related to investigations and learning also need to be given appropriate priority.

Performance management and governance

2.26 To maximise the potential for learning, the PAC also concluded that the capability of existing information systems within HSC organisations for recording details of adverse incidents needed to be improved. It recommended that the Department should:

18 *The Right Time – the Right Place* (an expert examination of the application of health and social care governance arrangements for ensuing the quality of care provision in Northern Ireland). The review's overall aim was to "examine the arrangements for assuring and improving the quality and safety of care in Northern Ireland".

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- establish an effective reporting and learning system for `near misses' to try and avoid more serious future incidents; and
- given the envisaged lengthy timescales for implementing the Regional Adverse Incident Learning system (RAIL), establish interim arrangements to ensure regional collection of relevant information.

2.27 The Donaldson Report also highlighted the need for enhanced learning systems. It stated that existing systems fell *"well below potential"* and that *"the scale of successful reduction of risk flowing from analysis and investigation of incidents is too small."*

2.28 Following the PAC's report, the Department established a steering group to assess how local learning processes could be improved, and to oversee development of the RAIL system. However, RAIL was terminated in early 2014, as the Department considered that the project had not met its strategic objectives. The steering group subsequently commenced work on developing an interim Regional Learning System (RLS), aimed at strengthening a culture of learning from all adverse incident systems and from good practice identified across the Trusts.

2.29 This work led to the steering group publishing the *RLS Project Report* in May 2015, which confirmed that there were still key deficiencies in the current systems for dealing with adverse incidents, including:

- inadequate utilisation by HSC organisations;
- inconsistency in the coding of incidents;
- limited sharing of results with staff to develop a culture of learning; and
- a need for greater expertise in the analysis of patient safety data, to enable more effective review of the reports produced by existing information systems.

2.30 Whilst this report made 18 recommendations for improvement, only six were subsequently implemented, including reviewing the definition and terms of an adverse incident, developing and agreeing Regional Adverse Incident Guidelines and reviewing and agreeing datasets. Some ten of the group's other 12 recommendations would have required additional funding, and up to early 2018, the PHA and the HSC Board had been assessing the extent of support needed, to help the Department determine if this could be provided in the light of competing demands.

2.31 However, the Department told us that the publication of the Hyponatraemia Inquiry in January 2018 has overtaken implementation of most of the RLS recommendations. The Department told

us that a "degree" of funding, including transformation funding secured from the PHA and the HSC Board is available for implementing the Inquiry's recommendations, which will be used to progress implementation of RLS recommendations which have links to issues raised by the Inquiry, and on developing a Regional Improvement and Innovation System. In summary, the development of local learning systems has been a long and protracted process which remains ongoing.

2.32 As an alternative to developing local systems, the PAC had suggested that the local HSC sector could potentially be linked with the National Reporting and Learning System (NRLS) in England and Wales, but the Department subsequently ruled out the feasibility of this. NHS England is currently developing a new `Patient Safety Information Management System' (PSIMS), to replace NRLS by 2019-20, which aims to facilitate learning, data sharing and trend analysis from safety incidents. The Department acknowledges that this offers potential for the local HSC sector to benefit from the larger scale of learning generated nationally.

2.33 As part of the work to address the Hyponatraemia Inquiry recommendations, the Department told us that initial steps had been taken to improve consistency of reporting of incidents across HSC organisations, and that the transformation funding which had been secured should allow this work to be fully completed by March 2020. This work is necessary to try and ensure that systems in the HSC sector can be sufficiently aligned with the new PSIMS system currently under development, and to ultimately facilitate local participation in the PSIMS.

2.34 In the meantime, the Department told us that some Trusts are currently analysing Adverse Incidents in which patients were ultimately unharmed, to identify potential learning and mitigate the risk of similar incidents recurring.

NIAO Recommendation

Since the PAC reported, progress in developing a regional system to facilitate learning from Adverse Incidents has been limited. The Department should now strive to ensure that the work under way to try and ensure that the HSC sector can participate in the new PSIMS system which is being developed for use in England and Wales is successfully completed.

Meeting the needs of patients and service users

2.35 The PAC emphasised the importance of ensuring that the needs of patients and service users were met when patient safety concerns arise. It recommended that the Department should:

- ensure that reports being produced by the HSC Board are made publicly available, and contain enhanced patient safety data to inform the public on regional and local safety and care standards;

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- advise HSC organisations of the need to inform those involved in any Adverse Incidents; and
- ensure that Trusts become more proactive in obtaining patient feedback on the services they provide.

2.36 A number of steps were subsequently taken to improve public reporting of the extent of Adverse Incidents and patient safety concerns across the HSC Trusts. For example:

- learning reports jointly published by the HSC Board and the PHA twice yearly now disclose the number of SAIs at each Trust, and within individual care programmes; and
- since 2013-14, the Trusts' Annual Quality Reports[19] have reported the total numbers of AIs and SAIs, the numbers of incidents directly affecting patients, and the five most common incident types.

2.37 The HSCB and PHA have also introduced improvements aimed at ensuring that Trusts are properly involving patients and their families and carers in the investigations of adverse incidents **(Figure 12).**

Figure 12: Arrangements for involving patients, family and carers in investigations of Serious Adverse Incidents

Date	Action taken
September 2013	The HSC Board issued revised procedures for the reporting and follow-up of SAIs, which outlined when and how patients, families and carers should be incorporated into the investigatory process for SAIs.
March 2014	The HSC Board wrote to all Trust Chief Executives highlighting the need for, and importance of, appropriate communication and involvement of service users, relatives and carers in investigations of SAIs. To assist the monitoring of compliance with this requirement, a checklist was developed for completion for all future SAIs.
2015	The HSC Board and the PHA issued further guidance on engaging with service users, families and carers following an SAI.
November 2016	The September 2013 procedures for SAIs were further revised to include a mandatory requirement to complete the engagement checklist developed in March 2014.

Source: NIAO, based on Departmental records

19 Whilst the NI Ambulance Trust does not publish an Annual Quality Report, its Annual Report discloses data on the number of AIs and SAIs.

2.38 In late 2016, the HSC Board commenced monitoring and reporting on Trust compliance with these revised requirements. Its analysis of the 161 SAIs reported across the Trusts between October 2016 and March 2017 shows that:

- patients and other relevant parties were informed that the incident was being reviewed as an SAI in 133 cases (83 per cent); and
- in 109 cases (68 per cent), the interim investigatory report was shared with patients and relevant parties, or there were plans to share the final report with them.

The Trusts have attributed any non-compliance with the new requirements to several factors, including: concerns over patients' health and wellbeing; an absence of next of kin or contact details; failure by the parties to respond to correspondence; and families withdrawing from the investigation process.

2.39 More recently, the Hyponatraemia Inquiry also recommended that Trusts should maximise the involvement of families in SAI investigations. The Inquiry called for families to have involvement in setting the terms of reference for investigations, to engage with investigations and receive feedback on progress, and to be allowed to respond to investigation findings.

2.40 When patients or their families are dissatisfied with how Trusts have investigated clinical incidents, they can escalate their concerns to the Northern Ireland Public Services Ombudsman (the Ombudsman) following closure of their complaint by the relevant HSC body. Despite the steps taken by the Trusts to try and enhance patient involvement in the investigatory process, the Ombudsman's 2015-16 annual report suggested that some problems remain in communicating with patients and families:

"Communication, or more properly a lack of clear communication, was raised as an issue in a number of complaints which I reported on in this year. The extent and level of communication with family members of a patient with incapacity or with mental health issues is a difficult issue for HSC providers. I would remind those involved in providing care of the need to communicate clearly and in a timely manner with patients and their families to the extent permitted".

NIAO Conclusion

Important steps have been taken to better inform the public of patient safety incidents and standards across HSC Trusts and to enhance patient involvement in the investigations of serious adverse incidents. However, the Ombudsman's findings suggest that inadequacies remain in communicating with patients and families. Implementation of the Hyponatraemia Inquiry recommendations should help to strengthen policy in this area.

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Staffing

2.41 A further key requirement for HSC organisations in delivering safe patient care is having the right number of appropriately skilled and trained staff. In 2013, the PAC found it unacceptable that so little regard had been given to assessing, maintaining and improving the competency of HSC staff. The Committee recommended that the Department exercise enhanced oversight of this area through annual verification checks on staff appraisal and development plans.

2.42 The Department subsequently introduced a requirement for Trusts to ensure that their healthcare providers[20] included objectives in their annual business plans from 2013-14 to increase the levels of staff appraisal being undertaken. To monitor progress against this requirement, the Department established targets requiring 95 per cent of medical staff and 80 per cent of other staff to be subject to annual appraisal, and these were enhanced in 2015-16, to require a 5 per cent improvement compared to the previous year's outcomes.

2.43 As **Figure 13** shows, some Trusts have not yet reported performance to the Department against the new targets for 2015-16 and 2016-17. Positively, three Trusts achieved the medical staff appraisal target in 2015-16, but the Southern and Northern Trusts have not yet reported performance for that year. Whilst the South Eastern Trust also achieved this target in 2016-17, the other Trusts have not yet reported outcomes. No Trust has achieved the 80 per cent target for other staff in 2015-16 or 2016-17, and most have been some distance from meeting this.

Figure 13: Trust performance against staff appraisal targets 2015-16 and 2016-17

	2015-16		2016-17	
Trust	**Medical staff target - 95% to be appraised**	**Other staff - 80 % to be appraised**	**Medical staff - 95% to be appraised**	**Other staff - 80% to be appraised**
Belfast	96%	73%	Not yet available	Not yet available
Northern	Not yet reported	79%	Not yet available	67%
South Eastern	Not yet reported	42%	95%	48%
Southern	99%	51%	Not yet available	57%
Western	95%	36%	Not yet available	53%

Source: Department and HSC Trusts

20 HSC Trusts manage and administer hospitals, health centres, residential homes, day centres and other health and social care facilities.

2.44 The Department told us that within the HCS Trusts, concerns exist that the Human Resources, Payroll, Travel and Subsistence (HRPTS) system, which was introduced in March 2014, does not readily support the reporting of staff appraisal rates. Despite these difficulties, the Department acknowledges that it is unacceptable for staff appraisal targets to be missed. It intends to continue to hold Trusts accountable for maximising the capability of HRPTS, and to work jointly with the Trusts to embed the use of the system to improve the quality and timeliness of staff appraisals.

2.45 Other evidence indicates that appraisal levels across the HSC sector have been increasing. For example, whilst the 2010 HSC Staff Survey showed that only half of respondents had an annual appraisal and a personal development plan in place, the 2015 survey found that this had increased to 65 per cent for appraisals and 79 per cent for staff development plans.

2.46 In addition to staff appraisal, adequate staffing levels are crucial in helping maintain high standards of patient safety. As recently as November 2017, the RQIA formally notified the Department about the potential impact of the shortage of nurses on the quality of health and social care service provision across Northern Ireland[21]. Report One also highlights ongoing concerns over patient safety associated with the high dependence of Trusts on locum doctors to maintain healthcare services. These findings again illustrate the significant challenge facing the Department in establishing effective workforce planning across the Trusts

NIAO Recommendation

Staff appraisal levels in the HSC sector have increased in recent years, but scope exists to sustain and build on these improvements, including maximising the use of the HRPTS system. The Department and Trusts also need to actively address the potential risks to patient safety created by staffing shortfalls in key clinical disciplines and, as far as possible, introduce appropriate workforce planning measures to mitigate these risks.

Handling of clinical negligence claims

2.47 The PAC's 2013 report criticised how clinical negligence claims were being handled. It recommended that the Department should:

- track outcomes of initiatives to speed up claims handling; and
- give serious consideration to developing formal dispute resolution procedures as an alternative to litigation, which often placed additional stress and expense on patients and on HSC staff.

21 RQIA press release (November 2017).

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2.48 To address the lengthy times for settling claims, the Department introduced an amended protocol in September 2012, aimed at ensuring that cases were resolved within 48 months of a Writ being issued. Some progress has subsequently been made in this area, with the number of open long-running cases (five years or longer) at March 2017 reducing by 16 per cent compared to March 2013 **(Figure 14)**. The number of cases closed has also increased, from 2,837 between 2007-08 and 2011-12, to 3,290 between 2012-13 and 2016-17.

Figure 14: The number of open long-running clinical negligence claims has reduced since 2013

Date	Open Cases 5-10 years	Open Cases 11-15 years	Open Cases 15+ years	Open Cases TOTAL
March 2013	356	74	31	**461**
March 2014	332	62	25	**419**
March 2015	312	52	22	**386**
March 2016	318	45	21	**384**
March 2017	317	49	21	**387**

Source: Department of Health

2.49 The Department told us that it had also given lengthy and serious consideration to the feasibility of developing a formal dispute resolution process as a valid alternative to litigation for injured patients, but had found that:

- no consensus had been reached in respect of such schemes, or on the most appropriate method for compensating clinical negligence victims, in England and Scotland;
- a redress scheme had been introduced for claims below £25,000 in Wales, but was rarely being used; and
- such resolution processes were often used as a preliminary to formal litigation rather than an alternative, and actually increased the length and cost of the overall process.

2.50 Consequently, the Department opted not to pursue a formal dispute resolution process, and instead adopted the findings of the Donaldson report (see paragraph 2.25)[22] as the main influencer of policy development in this area. Instead of developing new measures for redressing injured patients, Donaldson had concluded that the main focus should be on

22 "*The Right Time, The Right Place*, An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland, December 2014.

achieving safer standards of care, mirroring England, where a similar conclusion was reached following an extensive review of clinical negligence in the NHS[23].

2.51 The Donaldson Report recommended that a statutory `duty of candour' should be introduced in Northern Ireland, consistent with similar action taken in other parts of the United Kingdom. The need for a statutory duty of candour, which should apply to HSC organisations and everyone working for them, was also highlighted by the Hyponatraemia Inquiry when it was published in January 2018. Indeed, in launching its findings, the Inquiry Chairman stated that this was the most important of its 96 recommendations.

2.52 The introduction of this approach in Northern Ireland would require health providers to inform patients or their families when there has been a harmful or potentially harmful incident, and offer a written apology and explanation. Whilst the Department acknowledges that this does not represent an alternative to litigation, which would still be available to patients or their families, it considers that it could provide sufficient redress and mitigate against potential litigation.

2.53 To date, the Department has established a dedicated team which has undertaken significant preparatory work on implementing the recommendations of the Hyponatraemia Inquiry report. However, it told us that decisions on proceeding with full implementation of the recommendations would ultimately lie with Ministers.

Trends in key patient safety indicators since the PAC report

2.54 In addition to progress made in implementing the PAC's recommendations, we examined recent trends in indicators which provide measurement of patient safety performance and outcomes:

- the numbers of AIs and SAIs reported;
- numbers of clinical and social care negligence cases taken against HSC organisations; and the costs of settling clinical and social care negligence claims.

Adverse Incidents and Serious Adverse Incidents

2.55 As paragraph 2.6 highlighted, proper reporting of incidents helps identify, manage and minimise risk and promote learning and sharing of lessons. Such information can help highlight issues which could otherwise escalate into significant clusters or trends over time.

23 *Making Amends* - A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS

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2.56 In assessing and interpreting trends for adverse incident data, some caution must be applied. In one respect, an increase in reported incidents can be viewed as an indicator of an open and honest reporting culture. However, if lessons are being properly learned, it would also be a reasonable expectation that such incidents, particularly SAIs, would reduce over the longer term.

2.57 When we reported on patient safety in 2012, approximately 83,000 AIs were being reported annually, and 2,084 SAIs had been reported between July 2004 and March 2012 (an average of 269 per year). **Figure 15** shows the number of AIs reported between 2012-13 and 2017-18, and the number of SAIs reported between January 2012 and 2018.

Figure 15: The number of Adverse Incidents reported has increased since 2012-13

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Total
Adverse Incidents	74,689	77,996	84,533	84,227	84,832	92,091	n/a	498,368
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**Total**
Serious Adverse Incidents	298	406*	760*	626*	415	198	349	**3,052**

*includes 26 child deaths in 2014 and 2015 (between October 2013 and December 2015, a requirement existed to report all child deaths as SAIs).

Source: Department of Health

2.58 Whilst the number of AIs reduced in 2012-13 and 2013-14 from the previous total of 83,000, they began increasing again in 2014-15, and by 2017-18, 92,000 AIs were reported. As paragraph 2.9 highlighted, the 2015 HSCNI staff survey suggested that levels of incident reporting had remained high since 2012[24], at 95 per cent.

2.59 In 2012, some 298 SAIs were reported. In 2014 and 2015, this increased to 760 and 626 SAIs. However, since 2016, when 415 SAIs were reported, there has been a notable downward trend in this area, with the numbers having fallen further to 198 and 349 in 2017 and 2018 respectively.

2.60 Our 2012 report highlighted evidence of significant under-reporting of SAIs from local HSC acute settings. At that time, only 35 per cent of SAIs in Northern Ireland were reported from acute settings, compared to 75 per cent in England and Wales. The proportion of local SAIs in acute settings between 2013 and July 2017 has subsequently risen to 46 per cent, suggesting that whilst progress has been made, under-reporting may still exist. The Department told us that

24 The 2012 and 2015 staff surveys both found that 95 per cent of respondents stated that they or a colleague reported the last error, incident or near miss they saw that could have hurt staff or patients.

this benchmarking does not provide a fully accurate comparison as, unlike Northern Ireland, data recorded in England and Wales does not include SAIs involving social care services.

2.61 In addition to the number of incidents reported, the level of complaints by patients or their families provides further measurement of the extent of local patient safety concerns. Since 2009, when the "*Complaints in health and social care*" policy was introduced, the number of complaints received annually across the HSC sector has increased from around 5,000 to 6,189 in 2016-17, with about one fifth of these related to quality of treatment and care.

2.62 As paragraph 2.40 highlighted, patients or their families can refer their concerns to the Ombudsman when they are dissatisfied with the investigation of clinical incidents by the Trusts.

2.63 Complaints about health and social care providers continue to form a significant element of the Ombudsman's workload, accounting for 42 per cent of the 665 new complaints received in 2017-18 and some 76 per cent of the cases taken forward for detailed investigation in that year. In recent years, the main category of complaint was linked to concerns over clinical care and treatment.

2.64 The Ombudsman's report for 2015-16 also highlighted particular concerns about failings in how HSC Trusts had dealt with a small number of SAIs:

"Three major health cases that were reported on in 2015-2016, reveal failings in how HSC Trusts deal with SAIs...The failings in these Serious Adverse Incidents are both concerning and disappointing. SAIs and the resulting internal reviews should allow the learning from such incidents to be captured and shared so as to improve patient safety and outcomes. In light of these cases, I intend to proactively engage with the five HSC Trusts to secure improvements in the transmission of feedback from SAIs and from complaints generally, so as to increase learning opportunities and process improvements".

NIAO Conclusion

Whilst further evidence is required, there are positive signals that a high percentage of local Adverse Incidents and an increasing proportion of SAIs are being reported. However, the level of complaints received by the Ombudsman about patient experiences and the issues raised over the handling of individual SAIs also raise concerns about how effectively some Trusts are dealing with some patient complaints.

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Numbers of clinical and social care negligence cases, costs of settled cases and estimated costs of settling outstanding cases

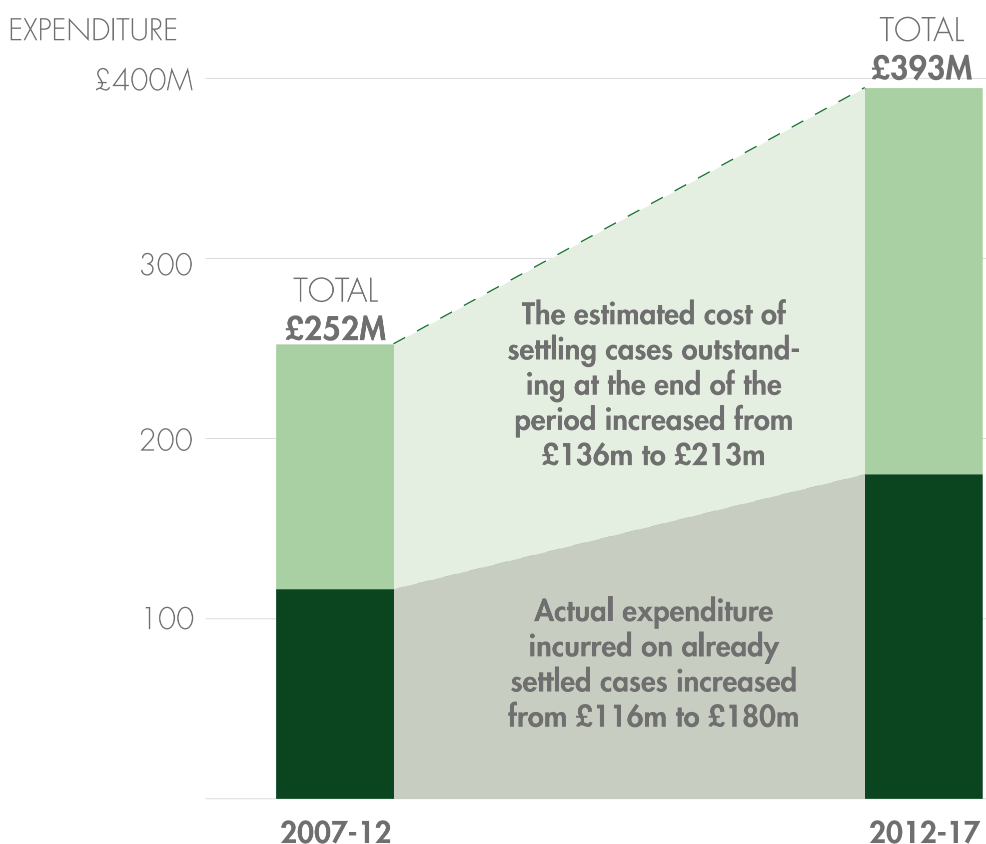
2.65 Between 2007-08 and 2011-12, 3,304 new clinical and social care negligence cases were taken by patients against the HSC sector, a yearly average of 661 claims. This has remained virtually unchanged between 2012-13 and 2016-17, with 3,344 new cases opened (a yearly average of 669 claims).

2.66 The £180 million costs incurred by Trusts in settling clinical negligence claims between 2012-13 and 2016-17 represented an increase of almost 55 per cent compared to the £116 million paid between 2007-08 and 2011-12 **(Figure 16).**

2.67 **Figure 16** also shows that provisions for outstanding claims have increased by 57 per cent from £136 million to £213 million. Whilst the increase in settlements may be partly attributable to some long-running cases being resolved, the significant rise in provisions for outstanding claims potentially provides greater concern around recent patient safety trends, and the extent of harm suffered by patients.

Figure 16. The costs of clinical negligence claims

Total costs increased by 56 per cent from £252 million to £393 million between 2007-12 and 2012-17. This includes the costs of settled cases, as well as the estimated costs of those cases which remain unsettled.



Source: Department of Health

2.68 Together, costs of settlements and provisions have increased by 56 per cent from £252.3 million, to £393.5 million. This diverts already scarce resources away from frontline services and patients, and likely means that more patients will wait longer for their treatments. It also potentially increases pressure on HSC staff, which in turn may heighten the risk of adverse incidents occurring and of increased clinical negligence claims. It is therefore important that the Department regularly reviews trends in this area to establish the specific reasons for any significant increases, and to determine if any further action to address these is necessary.

Overall Conclusions

2.69 Since the PAC reported, the Department and Trusts have taken positive steps in several areas to try and enhance the patient safety culture across the local HSC sector:

- Whilst further research is required, recent evidence points to progress in embedding a culture which encourages the reporting of Adverse Incidents.
- The public is now better informed about patient safety performance and standards across HSC Trusts.
- Patients and their carers and families are increasingly being involved in the investigation of Serious Adverse Incidents.
- Staff appraisal levels in the HSC sector have been increasing notably.
- The time taken to settle clinical negligence claims is reducing.

However, some key challenges remain:

- The Hyponatraemia Inquiry findings indicate that improvements are still required in aspects of SAI reporting and investigations, and in disseminating learning.
- Under-reporting of Serious Adverse Incidents by acute settings may still exist.
- Further work is required to enhance staff confidence that incidents reported will be properly investigated, and to identify why many HSC staff still consider that learning is not being properly disseminated.
- Progress in developing a regional learning system has been limited, and resource constraints mean that there is uncertainty over whether such a system will be introduced.
- In some cases, communicating with patients and families to resolve complaints about serious adverse incidents remains a problem.

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- The Department should assess whether staffing shortfalls in key clinical disciplines are heightening patient safety risks and, if so, how these can be mitigated by stronger workforce planning.

- Analysis of the reasons for the increased costs being incurred in settling clinical negligence claims is required, to identify if the number of high value settlements are increasing and assess what further action might help disseminate lessons learned from SAIs across the HSC sector.

NIAO Reports 2018 and 2019

Title	Date Published
2018	
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Type 2 Diabetes Prevention and Care	06 March 2018
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2019	
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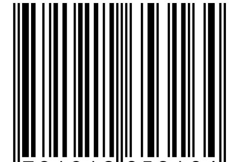
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