WEBSITE STATEMENT

Update from the Department of Health on the implementation of the report of the Inquiry into Hyponatraemia-related Deaths

The Department of Health is today providing a detailed update on the progress made to date to implement the report of the Inquiry into Hyponatraemia-related deaths ("the IHRD Report").

The report was published on 31 January 2018. Mr Justice O'Hara, the Chair of the Inquiry, concluded that the culture of the health service, the arrangements in place to ensure the quality of services, and the behaviour of certain individuals within the health service at the time were not acceptable.

We must never forget Adam Strain, Claire Roberts, Lucy Crawford, Raychel Ferguson and Conor Mitchell. Over four years after the publication of the IHRD Report, the details in relation to each of the cases make for distressing reading. We pay tribute to the courage of their families, and we must honour their suffering by ensuring we continue to work on and implement the recommendations arising from the IHRD report.

In his report Mr Justice O'Hara acknowledged that progress had been made in the guidance and practice of hyponatraemia management, but that a more comprehensive approach for learning from error was needed for further unnecessary harm to be avoided. He set out 96 recommendations across ten themes where he had identified failings in competency in fluid management, honesty in reporting,

professionalism in investigation, focus on leadership and respect for parental involvement.

In response to this report, the Department initiated a comprehensive IHRD implementation programme. The 96 recommendations were broken down into 120 actions, and nine Workstreams were established to take this work forward. From the outset, the Department has been committed to using a co-production approach to ensure that the input of all stakeholders, especially service users and carers, has been central to the decision-making processes. Whilst full implementation of the 96 recommendations is by no means complete, significant progress has been made in many areas over the past four years.

Mr Justice O'Hara's primary recommendations were that a statutory duty of candour should be introduced for healthcare organisations and everyone working for them, so that they are open and honest in all their dealings with patients and the public, and that there should be supports and protections in place to ensure this happens. As a reflection of the seriousness of this, Mr Justice O'Hara also recommended that criminal sanctions should apply to organisations and individuals for serious and intentional breach of these duties.

After considering all the evidence, including the findings of a 20-week public consultation that yielded 334 responses, the Duty of Candour Workstream provided its assessment earlier this year.

As a first step, and in order to understand the barriers to an open and candid culture, officials are developing the policy for a "Being Open Framework" for the health and

social care system. Initial work on the “Being Open Framework” will initially focus on an exploratory exercise in a Trust to establish an understanding of the:

- perceptions of openness;
- barriers to openness;
- levers of power in relation to openness;
- enablers of openness.

This work will include engagement with relevant stakeholders to develop guidance and proposals for the design and rollout of Being Open training across the HSC.

Officials are also carrying out further study on how a duty of candour might work in practice, including additional analysis of the impact of such a duty on the health and care service, both legally, and in workforce terms.

Officials will also engage with counterparts across the UK on duty of candour developments. Earlier this month, the Kirkup Review – *Reading the Signals* – was published. It examined maternity and neonatal services in two hospitals in East Kent between 2009 and 2020. That review “found a clear pattern. Over that period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.” It made a recommendation that “the Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.” Candour and openness are live issues and the Department of Health

will share its experience and learn from others to put the best possible system in place in Northern Ireland.

All work by the Department of Health in Northern Ireland on candour and openness will focus on patient safety and an ongoing commitment to ensuring that individuals and organisations are provided with the support they need to fulfil their responsibilities.

The Department is committed to this cultural change, but recognises that it will not happen overnight. The Being Open Framework will allow organisations to put in place the support and systems required to ensure that individuals will be fully empowered to exercise their individual duty of candour.

Agreeing on a Being Open Framework and implementing its principles will ensure that the public can have confidence that individuals within the health service will have the support and protection of their organisations and legislation to be open and candid in all that they do.

Another significant recommendation from the IHRD Report is the introduction of an Independent Medical Examiner office to scrutinise those hospital deaths not referred to the Coroner.

A non-statutory prototype Independent Medical Examiner service is now operating across all five Health and Social Care Trusts. This means that when a doctor completes a Medical Certificate of Cause of Death, an Independent Medical

Examiner reviews the certificate together with the patient's clinical record and has a discussion with the certifying doctor about the circumstances of the death.

This helps to ensure that deaths occurring in hospital are appropriately reported to the Coroner when there is a need to do so. It also assures the family that the death certificate is reasonable and accurate and that if any safety or governance issues are identified, these are brought to the attention of the relevant Trust in order that immediate action can be taken if this is required.

In the coming months, the prototype non-statutory Independent Medical Examiner office will consider the most appropriate way in which a statutory service might interact with bereaved families, and how such an IME system can include reviews of those deaths occurring in community settings which are usually certified by GPs.

The IME prototype will provide all the required information to inform the development of a statutory Independent Medical Examiner service for Northern Ireland.

The IHRD report also makes ten recommendations regarding Serious Adverse Incident (SAI) reviews, which take place when death or serious harm occurs. The report on the RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents was published on the 7th July 2022 and is available on the Department for Health Website (RQIA Review of Systems and processes | Department of Health). The report makes five recommendations and clearly highlights the need to co-design a new evidence-based, regional procedure, which

delivers an approach to learning from reviews where harm has occurred, and in which the HSC, and the public, can have confidence.

Work on both sets of recommendations and the excellent work already completed by the SAI Workstream will carry forward into a new work programme, which will be led by the Department's dedicated policy team on Serious Adverse Incidents.

Turning to the wider IHRD implementation programme, the Department can confirm that 63 of the 120 actions arising from the 96 recommendations in the IHRD report have been fully actioned. This reflects a huge amount of work by members of the various Workstreams established following the Report's publication, and the Department would like to take this opportunity to thank all of them for their invaluable input and effort. While this was a complex process, there is no doubt that the magnificent contribution of service users, carers and others has provided much added value to the quality and effectiveness of the outcomes. This is borne out by the findings of an independent report commissioned from Mr Peter McBride, the former Chair of the IHRD Being Open Workstream. His report acknowledges the considerable effort put into the co-production process within the overall IHRD Programme, the challenges the process faced and recommendations for future co-production exercises such as the one undertaken in this context.

Whilst there has been significant progress across many areas of the IHRD programme, the work has undoubtedly been impeded by the impact of Covid-19. As we hopefully emerge from the worst of the pandemic, there is renewed momentum.

There has also been ongoing progress on the 57 actions that remain outstanding from the IHRD report, but more work is required. These will be dealt with in what the Department is describing as Phase Two of the IHRD implementation programme. Phase Two of the programme will deal with

- the 20 actions, to be overseen by the IHRD Programme Team, where initial work has been completed by the Workstreams and Sub-groups, but where further work is now required to ensure appropriate implementation at service level. There has been much progress in identifying solutions, new procedures and issuing relevant guidance in the areas of Death Certification, Board Effectiveness, Clinical and Social Care Governance, Training and Workforce issues. This work will continue to ensure that HSC organisations continue to adhere to good practice and that there is a consistent approach across the region; and

- the 37 actions, where initial work has been completed, but where it is now appropriate to transfer responsibility for these recommendations from the IHRD implementation programme to the appropriate DoH policy area. Examples of these actions include those where detailed policy and scoping work is well under way but where primary legislation will be required to go through the Assembly, such as on the Duty of Candour, Serious Adverse Incidents and the Independent Medical Examiner service. Other examples are where there is a need to work on detailed policy, for example, the Being Open Framework.

A new Programme Management Structure, with the Department's Permanent Secretary as the Senior Responsible Owner, has been put in place to drive forward the work needed to complete implementation of all the recommendations.

Detail of the progress on each of the 120 actions is being published today on the Department's website, together with the report on co-production commissioned by the Department.

In concluding, the Department would like to take this opportunity to thank everyone involved in the programme to implement the recommendations set out in Mr Justice O'Hara's IHRD report; in particular, the service users and carers who gave freely of their time to make this work a success. Their continued support will be very welcome as we move into Phase Two of the IHRD Programme.

The improvements that have been and will be achieved will in no way assuage the grief of the families of the children who tragically died, or relieve the sense of injustice. However, it is the hope and intention of all in the Health and Social Care family that the service will be all the better when the recommendations arising from the report have been implemented.