



Review of Governance Arrangements in Independent Hospitals and Hospices in Northern Ireland

June 2021

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Assurance, Challenge and Improvement in Health and Social Care

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's service reviews identify best practice, highlight gaps or shortcomings in services that require improvement, and protect the interests of the public. Our reviews are carried out by teams of independent assessors who are either experienced healthcare practitioners or experts by virtue of their experience. Our reports are submitted to the Department of Health (DoH) and are available on our website at www.rqia.org.uk.

Our Stakeholder Outcomes

RQIA service reviews and inspections pose four key questions:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

Acknowledgements

RQIA wishes to thank all those who facilitated this review through their participation in discussions, surveys and interviews, inspections, attending focus groups and providing relevant information.

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Glossary of Terms

| | |
|---------------------|--|
| AHP | Allied Health Professional |
| Belfast Trust | Belfast Health and Social Care Trust |
| CQC | Care Quality Commission |
| DoH | Department of Health |
| GMC | General Medical Council |
| GP | General Practitioner |
| HSC | Health and Social Care |
| HSC Board | Health and Social Care Board |
| MAC | Medical Advisory Committee |
| NMC | Nursing Midwifery Council |
| Northern Trust | Northern Health and Social Care Trust |
| Organisations | Independent hospitals and hospices |
| PHIN | Private Healthcare Independent Network |
| QC | Queen's Counsel |
| RQIA | Regulation and Quality Improvement Authority |
| South Eastern Trust | South Eastern Health and Social Care Trust |
| Southern Trust | Southern Health and Social Care Trust |
| Trusts | Health and Social Care Trusts |
| UK | United Kingdom |
| Western Trust | Western Health and Social Care Trust |

Foreword

RQIA is committed to assuring that health care services in Northern Ireland are accessible, well managed and meet the required standards.

Over the past year, the coronavirus (COVID-19) pandemic has had a deep and profound effect upon people's lives, affecting how we live, work and socialise. It has represented an unprecedented challenge to health and care services, placing the sector under intense pressure to adapt in continuing to deliver healthcare. We acknowledge the significant contribution of independent hospitals and hospices to this collective effort.

The health and social care system's willingness to adapt to radical change under intense pressure has provided an opportunity to observe the breath-taking potential of our system, and of those who work within it. Transformation which previously may have taken a period of months or even years has been coordinated and rolled out at pace.

Health care workers across HSC Trusts, the independent sector and residential care have responded with courage and dedication, going above and beyond in their roles to develop and implement new ways of working.

Nonetheless, the pandemic has reaffirmed challenges which the sector has long been experiencing and there is, as always, room for improvement.

Our review programme is an important strand of our work, providing independent and professional assurance to the public about the quality, safety and availability of health and social care services in Northern Ireland, driving continuous improvement of those services, and ensuring that the rights of service users are safeguarded.

The independent sector is increasingly important in delivering health and social care for the population of Northern Ireland. It is essential that robust governance arrangements which ensure high standards of care are in place across the independent sector.

In partnership with an Expert Review Team, we visited each of the independent hospitals and hospices in Northern Ireland, and undertook a comprehensive assessment of the governance systems and processes that ensure the delivery of safe and effective care.

Strong organisational and clinical governance are the backbone of a service which delivers safe, high-quality health care. We recognise and applaud the response of the sector in moving rapidly since the fieldwork completed to develop and improve upon their governance systems. We hope that the system-wide recommendations in this Report will form the basis on which the sector can continue to strengthen and improve key areas of governance that underpin the quality of care delivered.

We look forward to working to support the independent sector to ensure further improvements in the delivery of services.

Christine Collins MBE

Contents

| | |
|--|-----------|
| Glossary of Terms | 3 |
| Contents | 4 |
| Foreword | 4 |
| Executive Summary..... | 7 |
| Summary of Recommendations | 11 |
| Section 1: Background and Context | 15 |
| 1.2 What we were asked to do: our Terms of Reference..... | 15 |
| 1.3 What we did and who we heard from: our methodology | 16 |
| 1.4 The Independent Healthcare Sector | 18 |
| 1.5 Profile of Independent Hospitals and Hospices in Northern Ireland | 18 |
| 1.6 Activity in Independent Hospitals and Hospices in Northern Ireland | 24 |
| 1.7 Previous Reviews into Independent Healthcare | 26 |
| 1.8 Developments Following Fieldwork of the Current Review | 27 |
| 1.9 How this Review is Presented..... | 28 |
| Section 2: Well-Led..... | 29 |
| 2.1 Vision and Culture..... | 29 |
| 2.2 Governance and Accountability..... | 31 |
| 2.2.1 Structures and Governance Arrangements..... | 31 |
| 2.2.2 Medical and Clinical Governance | 35 |
| 2.3 Quality Improvement..... | 41 |
| 2.4 Managing Risk | 44 |
| 2.5 Incident Management..... | 47 |
| Section 3: Ensuring Safe and Effective Care | 54 |
| 3.1 Safeguarding..... | 54 |
| 3.2 Staffing | 57 |
| 3.3 Working with General Practitioners (GPs) | 59 |
| 3.4 Medicines Management | 64 |
| 3.5 Records Management | 65 |
| 3.6 Monitoring Quality..... | 68 |
| 3.7 Management of Complaints..... | 73 |
| Section 4: Commissioning and its Governance Arrangements..... | 76 |
| 4.1 Independent hospitals: Commissioning | 76 |
| 4.2 Independent hospitals: Governance Arrangements in respect of Commissioning..... | 77 |
| 4.3 Hospices: Commissioning..... | 80 |

| | |
|---|----|
| 4.4 Hospices: Governance Arrangements in respect of Commissioning | 81 |
| Section 5: Compassionate Care | 83 |
| 5.1 Meeting Patient Needs | 84 |
| 5.2 Providing Patient Information | 87 |
| 5.3 Seeking Patient Feedback | 89 |
| Next steps..... | 92 |
| Appendix A: Contributors | 94 |
| References | 97 |

Executive Summary

This Review was undertaken as part of the RQIA Neurology Work Programme, commissioned by the Department of Health (DoH). The Neurology Work Programme was initiated in May 2018 as one element of a system-wide response to the recall of 2,500 patients who were under the active care of a consultant neurologist in the Belfast Health and Social Care (HSC) Trust (Belfast Trust). The consultant neurologist also practised in a number of independent hospitals in Northern Ireland.

This Review is one of three programmes of work which RQIA is delivering related to Neurology. The other programmes are the Review of Governance arrangements in Outpatients in the Belfast Health and Social Care Trust (published in February 2020) and the Expert Review of Records of Patients of Dr Watt who died 2008-18.

Good organisational and clinical governance is crucial for the delivery of safe, high-quality services to patients. It also plays a significant role in enabling appropriate action to be taken in the event that issues or concerns arise. Key indicators of good governance are effective systems and processes that monitor quality, identify and manage risk and ensure there is a clear understanding of the roles and responsibilities of those who contribute to the organisation. Effective governance in healthcare will also ensure decisions made within the organisation focus on the needs of patients.

The level of demand on health services in Northern Ireland has grown in recent years as its larger ageing population experiences more long-term health conditions. This heavier burden on healthcare is increasingly being shared by both the HSC sector and the nascent independent sector. It is likely, for example, that growing waiting lists for elective procedures in the HSC sector has contributed to a rise in the number of patients opting to pay for services in the independent sector. Meanwhile, HSC organisations are increasingly commissioning hospitals in the independent sector to provide services on their behalf so that this increasing demand can be met.

Hospices, which are part-funded by the HSC and, in Northern Ireland, are provided by independent charities and charitable organisations, supply specialist care and services that are part of a recognised pathway of care. Thus, both independent hospitals and hospices are providing important capacity and essential services to Northern Ireland's HSC system.

Because of this increasingly important role being played by the independent sector in delivering health and social care for the population in Northern Ireland, high standards of care delivery supported by robust governance arrangements must be in operation and applied equally across both the HSC and the independent sector.

RQIA has a key role in the regulation and oversight of the systems that ensure effective clinical governance. It regulates healthcare services in line with the Independent Health Care Regulations (Northern Ireland) 2005 and implements the regulatory framework as a significant tool to support improvement across the sector.

The Review

Fieldwork for this Review commenced in February 2019 with the establishment of an Expert Review Team comprised of members with experience in clinical and corporate governance and patient safety at Medical Director and Director level.

The team also included senior inspection staff for independent health from RQIA's equivalent regulator in England, the Care Quality Commission (CQC).

What we were asked to do

The Review examined governance within six independent hospitals and four hospices in Northern Ireland. Specifically:

- Governance, both organisational and clinical, which assures the quality of care concerning leadership, safety, effectiveness, and compassion.
- Effectiveness of monitoring arrangements in respect of quality and patient outcomes and the identification and management of risk.
- Effectiveness of communication and partnership working with GPs, commissioners, and other HSC organisations.
- Arrangements in place to ensure effective communication with patients, their families, and carers.

A comprehensive methodology was developed which included structured questionnaires, multidisciplinary inspections, stakeholder focus groups, surveys, meetings with staff and a review of extensive documentation. The reports from the inspections which informed this Review are already published on the RQIA website and provide more detail on the governance arrangements found in each individual organisation.

This report provides a strategic and systems-wide assessment of the governance arrangements in place at independent hospitals and hospices throughout Northern Ireland and presents detailed evidence to support its findings.

Key Findings

Throughout this report, the Expert Review Team identified several areas of good practice and has made 20 recommendations that, if implemented, would strengthen the governance arrangements across the independent hospitals and hospices in Northern Ireland and improve quality of care throughout the sector.

Internal Leadership and Accountability

Clear operational structures and accountability arrangements play a fundamental role in effective governance among these organisations.

While the majority of the organisations had wide-ranging committees and groups in place, the Expert Review Team were not assured that all were meeting on a sufficiently regular basis or functioning as described within their terms of reference to fulfil their intended role. The team also found evidence of variation in the constitutions of individual boards, trustees and executive teams and the effectiveness thereof across the organisations visited. The Expert Review Team were unanimous that some organisations needed to undertake further work to ensure these committees were functioning effectively.

Components of Effective Governance Systems

There was a wide variation among organisations in relation to systems of governance and their understanding of what good practice within a robust governance system entailed.

The governance structures in some organisations could not ensure comprehensive oversight, nor could they provide detailed evidence that care delivered was safe and effective.

More robust arrangements were found in the smaller hospitals and hospices, while it was recognised that all four hospices have undertaken internal reviews of governance.

The team also identified poor understanding of the management and monitoring of risk, most significantly in the areas of incident reporting, the maintenance of risk registers and other patient safety alerts and concerns.

In relation to effective medical governance, significant improvement is required to establish robust systems in the larger independent hospitals to ensure records retained are accurate, up to date and clearly specify the individual practitioner's scope of practice and decisions on granting practicing privileges.

Inconsistencies were also identified in operational structures, accountability arrangements and arrangements for Medical Advisory Committees (MACs), with some displaying an insufficient focus on audit, quality monitoring, outcomes and the development of policy and procedures.

While all organisations collect information to monitor the quality of their services, only some were able to demonstrate that their systems (both electronic and paper-based) were able to ensure that service quality was reviewed regularly, and was underpinned by audit, key data and well maintained information. The quality indicators in use that were identified by the Expert Review Team were based largely on activity rather than outcomes and, while organisations were gathering data, some did not disseminate it through their governance structures to provide the required level of assurance to their respective board, trustees or executive team.

All organisations had systems in place for the identification and management of risk. However, these could be improved to ensure all key risks were identified and appropriately communicated. Arrangements for the identification and management of incidents in the majority of the organisations tended to be reactive rather than proactive.

While organisations had good awareness of their complaints policies, the data held for procedures and trends concerning complaints were not sufficiently considered at corporate level. Indeed, in some of the independent hospitals, complaints were redirected to the individuals subject to the complaint, instead of being addressed by independent personnel in the relevant hospital. It is therefore not clear that appropriately robust systems are in place for investigation, oversight and management of complaints received in relation to staff, either directly employed or providing services through practicing privileges arrangements. In some organisations, the Expert Review Team were also not assured that learning from complaints was actively sought, shared and used to drive improvements appropriately. This review, therefore, makes several recommendations concerning the management of complaints.

Linkages with the Wider HSC System

Effective communication and liaison between the independent sector and the wider HSC system is vital for the delivery of effective care and continuity of treatment for the patient. This includes the sharing of digital information. The Expert Review Team did not find an appropriate level of access to the Northern Ireland Electronic Care Record (NIECR) which would assist with the delivery of safe and effective care.

Not all ROs in these organisations were found to be maintaining formal links with the regional RO network which would support them to share information about the performance of medical practitioners and any concerns related to their practice.

The Private Healthcare Independent Network (PHIN) had the potential to be a useful alliance that would support independent hospitals to compare data and information with counterpart organisations in England and Wales. However, Northern Ireland organisations submitting data to PHIN were not provided with outputs or reports that enabled them to utilise the data in a meaningful way.

The Expert Review Team explored how the HSC Board and Trusts actively monitored the quality, safety and effectiveness of services commissioned from the independent sector. The team identified weaknesses in the connectedness of information gathered by Trusts and the HSC Board relating to the performance of independent hospital contracts. This Review found that Trusts were more likely to be informed of issues within the independent sector, but this information was not being systematically conveyed to the HSC Board. Such information could inform future procurements, provide early warnings of any issues regarding the performance of organisations or individuals, and expedite appropriate action.

The Review also found that the arrangements by which the HSC Board commission and monitor the care delivered in hospices could be strengthened. Such arrangements would include improving information gathering and management for incidents, complaints, quality and patient outcomes, as well as for patient and family experiences. Improvements also required include the standard of evidence hospices currently provide to demonstrate the effectiveness of their medical governance systems.

In light of these findings, this Review recommends that the HSC Board, Trusts and independent organisations establish a set of regional Key Performance Indicators (KPIs) in respect of patient care provided by independent hospitals and hospices on behalf of Trusts.

Conclusion

The full implementation of the recommendations in this report will significantly improve the quality and safety of care provided by independent hospitals and hospices in Northern Ireland. RQIA has a central role in monitoring the delivery of such improvements and will continue, through its annual inspection programme and regulatory framework, to support the improvement in these governance systems. RQIA encourages all organisations to strive to learn from best practice and acknowledge that a focus on governance is the best route to ensuring safe, effective and high quality health provision throughout Northern Ireland.

Summary of Recommendations

| Number | Recommendation | Priority |
|--------|---|----------|
| 1 | All independent hospitals must ensure they have in place a well-established and well-functioning MAC, that the MAC is appropriately constituted, meets as frequently as required, provides professional and organisational leadership, and takes a visible and active role in the organisation's governance. | 1 |
| 2 | All Independent hospitals and hospices must ensure their Board of Directors/ Board of Trustees are appropriately constituted and include members with the required range of skills and expertise. This is essential to ensure Boards are fully effective and can execute their responsibilities to oversee robust governance, to lead and define the organisations vision and strategy and to provide oversight of the quality of care. | 1 |
| 3 | All independent hospitals and hospices should strengthen their arrangements for monitoring the quality of care they deliver, through the collection, analysis and dissemination of meaningful data and information relating to patient outcomes, including analysis of information in relation to complaints. | 3 |
| 4 | All independent hospitals and hospices should undertake a detailed review of their internal governance structures and capabilities. Where the required expertise to complete such an assessment is not available within the organisation, external expertise should be secured to undertake such a review. | 1 |
| 5 | <p>The Registered Persons within each independent hospital should ensure there are appropriate systems in place to enact the organisation's responsibilities relating to medical governance by:</p> <ul style="list-style-type: none"> a) ensuring practising privileges agreements are up to date, are reviewed regularly (every two years) and provide detail of specialties, activities and procedures which the relevant doctor may undertake in the hospital/hospice. b) ensuring that where organisations are a designated body Responsible Officers have formal communication links in place with the corresponding persons in relevant HSC organisations. | 1 |

| Number | Recommendation | Priority |
|--------|---|----------|
| 6 | <p>All independent hospitals and hospices should develop and implement a robust quality improvement strategy. This strategy should have:</p> <ul style="list-style-type: none"> a) strong leadership at organisational level and active involvement of staff, who contribute towards a learning culture in each organisation. b) linkages with other independent sector and HSC organisations, HSC QI leads and already established mechanisms such as HSCQI. | 3 |
| 7 | <p>Independent hospitals and hospices should implement effective systems for risk management and develop a comprehensive approach to the oversight of risk management. This should include ensuring that all identified risks are appropriately captured and documented on risk registers, that specific actions to reduce the risks are identified, and that appropriate systems of assurance are put in place.</p> | 2 |
| 8 | <p>Independent hospitals and hospices should implement effective systems for the identification of incidents, appropriate grading of incidents, recording of incidents, identification of learning and implementation of any required actions to improve the safety and quality of services.</p> | 3 |
| 9 | <p>The Executive management teams and boards within independent hospitals and hospices must ensure they have in place a culture of safeguarding and implement effective operational safeguarding arrangements to include providing assurances to their Boards.</p> | 2 |
| 10 | <p>Independent hospitals and hospices should develop and promote clear guidance and specific contact points within each organisation. They should enable GPs and other healthcare professionals to raise a concern about the care which has been provided in an independent hospital or hospice and/or concerns relating to the performance of a healthcare professional involved in the care of their patient(s).</p> | 1 |
| 11 | <p>Independent hospitals must ensure they have a robust system in place to retain and enable access to comprehensive medical records for all patients receiving or who have received care and treatment in the hospital, regardless of whether the patient is seen as an inpatient, outpatient or day case patient, in accordance with the 'Independent Health Care Regulations (Northern Ireland) 2005', Regulation 21 (Records).</p> | 1 |
| 12 | <p>Independent hospitals and hospices should continue to engage with the Electronic Health programme in HSC Board and the BSO to secure appropriate access to NIECR and support provision of safe care and sharing of patient information across both sectors.</p> | 1 |

| Number | Recommendation | Priority |
|--------|---|----------|
| 13 | Independent hospitals should collectively engage with PHIN representatives to develop Northern Ireland reports which contain comparative information with other UK independent hospitals that can be used to drive improvement initiative and improve the quality of services. | 2 |
| 14 | HSC Trusts and all independent hospitals should develop clear mechanisms to enable a HSC professional to advise when a patient presents to an HSC facility with known adverse outcomes or incorrect diagnoses following treatment. This will support the organisation to clearly understand its care outcomes and performance in relation to quality and safety. | 2 |
| 15 | <p>All independent hospitals and hospices should develop effective systems to gather, analyse and communicate information about the quality of care they deliver to inform quality assurance systems/processes and drive continuous improvement in services.</p> <p>This information should be reported through the appropriate governance structures to the Medical Advisory Committee and the Board of Trustees/Directors to enable effective and comprehensive oversight of the quality of care delivered.</p> | 2 |
| 16 | <p>All independent hospitals and hospices should ensure that:</p> <ul style="list-style-type: none"> a) robust systems are in place to appropriately investigate and manage complaints received in relation to staff employed or providing services through practicing privileges arrangements. b) Information and intelligence relating to complaints received must be appropriately triangulated with other available information and used to drive improvements in the safety and quality of care delivered. | 1 |
| 17 | All independent hospitals and hospices must ensure detailed analysis of trends and patterns relating to complaints, with detailed reports being shared with the Medical Advisory Committee or other relevant governance committees. Information should be shared across all staff groups. | 1 |

| Number | Recommendation | Priority |
|--------|---|----------|
| 18 | <p>The Trusts and commissioners should establish formal systems for information sharing in respect of issues of the quality of work undertaken in independent sector for HSC patients for whom care has been commissioned by Trusts.</p> <ul style="list-style-type: none"> a) This information should be fully considered and inform future decisions relating to procurement of HSC work. b) It should also ensure any issues relating to the performance of individuals or organisations are considered appropriately, any immediate actions taken and, if required, are reported to the appropriate organisations (Regulation and Quality Improvement Authority, General Medical Council, Health and Social Care Trust and other relevant professional bodies). | 2 |
| 19 | <p>The commissioners should strengthen its arrangements for monitoring the quality of care it commissions. This should include:</p> <ul style="list-style-type: none"> a) review of data relating to incidents and complaints b) review of data relating to quality, patient outcomes and patient experience | 2 |
| 20 | <p>All independent hospitals and hospices should develop and implement a system to use patient feedback in a considered and systematic way to inform ongoing service development and improvement and provide assurance to their respective Boards.</p> | 2 |

Section 1: Background and Context

This section provides background to the review and the Terms of Reference (ToR) which guided our work. It also provides a brief description of the independent health care organisations subject to review.

1.1 Introduction

This report relates to “*A Review of Governance Arrangements in Independent Hospitals and Hospices in Northern Ireland*”, and evaluates system-level governance arrangements in the independent hospitals and hospices in Northern Ireland.

This review is one of three work streams RQIA was commissioned to undertake by the DoH. These work streams are part of the system-wide response to the recall of patients of a consultant neurologist. Additionally, DoH directed RQIA to undertake “*A Review of Governance of Outpatients Services in the Belfast Trust with a focus on Neurology and other High Volume Specialties*” which was published on 21 February 2020¹. RQIA has also been commissioned by the DoH to facilitate an expert review of the records of all patients of Dr A, who died ten years prior to 2018.

Other work in response to the patient recall was commenced in 2018, including a number of recalls of live patients and an Independent Neurology Inquiry (INI) chaired by Mr Brett Lockhart QC². In July 2018, the DoH also announced a regional review of Neurology Services covering all neurology specialities in Northern Ireland³.

Good governance is critical to delivering safe, effective and high-quality services to patients. Evidence of good governance is seen through the effective functioning of the systems and processes within organisations that enhance the delivery and quality of services. Such systems should monitor quality, identify and manage risk and ensure that all individuals and groups contributing to the organisation have a clear understanding of their roles and responsibilities.

Furthermore, an important element of good governance is ensuring that the needs of the patients using the service are central to the decision-making processes within the organisation.

1.2 What we were asked to do: our Terms of Reference

The terms of reference define the purpose, structure and expectations of the Review outcome. As this Review was commissioned by the DoH, the following terms of reference were agreed with members of RQIA Expert Review Team (here in the Review Team) and with the DoH:

1. To profile independent hospitals and hospices in Northern Ireland.
2. To describe and assess the governance systems and processes (organisational and clinical) within independent hospitals and hospices in Northern Ireland which assure the quality of care, namely:
 - Leadership

- Safety
 - Effectiveness
 - Compassion
3. To assess the effectiveness of arrangements for monitoring the quality of care and patient outcomes within independent hospitals and hospices in Northern Ireland.
 4. To assess the effectiveness of arrangements for identifying and managing risk within independent hospitals and hospices in Northern Ireland.
 5. To describe and assess the interfaces and arrangements in place for liaison with general practitioners, commissioners and other HSC organisations to ensure effective communication and partnership working.
 6. To describe and assess the interfaces and arrangements in place for communication with service users (patients, families, carers) to ensure safe and effective care.
 7. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvement.

Exclusions

In consideration of the context in which the Review was commissioned it was agreed that the following independent sector organisations, which are registered with RQIA organisations were not relevant to this Review:

- Northern Ireland Children’s Hospice
- dental practices
- establishments using prescribed techniques or prescribed technology^a, e.g. cosmetic laser/intense pulsed light (IPL) clinics
- refractive eye treatment providers
- in vitro fertilisation (IVF) services

1.3 What we did and who we heard from: our methodology

Fieldwork for this Review commenced in February 2019 with the development of draft terms of reference and the formation of an independent Review Team. Membership of the Review Team is outlined in Appendix A. The team comprised members with significant experience in clinical and corporate governance at Medical Director level and Director level with expertise in quality improvement, patient safety and regulation of independent hospital services at a national level. A smaller operational team was established to support the work of the Review Team. Membership of this RQIA Core Team is also outlined in Appendix A.

^a Prescribed techniques or prescribed technology – the RQIA categories these establishments as those using intense light sources for example, Class 3B or Class 4 lasers.

A methodology to deliver this review was designed and included the following activities:

- A review of the literature on governance to identify key themes and areas of focus.
- A desktop review of information held by RQIA in relation to the registration and inspection activity of the independent hospitals and hospices to inform our profile of these organisations.
- A structured questionnaire to capture information relating to governance systems in the independent hospitals and hospices and the monitoring arrangement of care commissioned by the HSC within the independent sector. The questionnaire design was informed by the Care Quality Commission (CQC) Inspection Frameworks for NHS Acute Hospitals for Core Service of Outpatients⁵, with further guidance provided by CQC senior staff as part of our Review Team.
- Independent hospitals and hospices submissions of supplementary documentation to support the questionnaire responses.
- Analysis of information relating to extant governance arrangements as shared by each of the organisations, which included around 1200 individual documents.
- Meetings between our Review Team and senior staff from each of the independent hospitals and hospices, the HSC Trusts and the HSC Board.
- A survey to capture the experiences of patients, relatives and carers.
- A survey to capture the experiences of General Practitioners (GPs) working in Northern Ireland and interfacing with the independent hospitals and hospices in the context of services provided to their patients.
- Structured focus groups to engage with front line staff to explore a range of themes related to governance in health care.
- Meetings with senior Trust managers who are involved in contracting services from the independent sector.
- In line with RQIA's statutory requirements under *The Independent Health Care Regulations (Northern Ireland) 2005*⁴, unannounced multidisciplinary inspections in four of the independent hospitals and one hospice (Ulster Independent Clinic, North West Independent Hospital, Kingsbridge Private Hospital and the NI Hospice) were undertaken.
- Meetings with Senior Management and clinicians in each of the independent hospitals and hospices.
- Meetings with contract managers from the five HSC Trusts and commissioners within the HSC Board.
- An assessment framework to systematically analyse the information gathered through our meetings, structured questionnaire, documentation and survey responses.

As previously outlined, this Review concentrated on the system-level aspects of oversight and governance of services delivered by each of the independent hospitals and hospices across Northern Ireland.

1.4 The Independent Healthcare Sector

The independent healthcare sector is comprised of providers that are neither owned nor managed by Health and Social Care (HSC) system⁵. They may provide care that is wholly private or commissioned by the HSC.

The Minimum Standards for Independent Healthcare define an independent hospital as⁶:

“...an establishment the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care, or in which listed services are provided; or in which treatment or nursing (or both) is provided for persons liable to be detained under the Mental Health Order 1986. Hospices are included through providing palliative care.”

Health care services provided by independent hospitals may include a range of surgical, medical, diagnostic and inpatient and outpatient services for both adults and children.

Health care services provided by hospices are services for patients with life-limiting, life-threatening and palliative care needs. The services can be provided to inpatients, part of a day hospice patients or, where available, in the community. Care delivered by hospices is provided without charge to patients in Northern Ireland.

Northern Ireland

Independent hospitals are at times used to provide services commissioned wholly or partly by HSC organisations, but also provide wholly private services to the general public. Additionally, hospices are an essential provider for specialist palliative care services commissioned by the health and social care system. As such, effective communication and planning between HSC organisations and independent hospitals and hospices is particularly important when HSC organisations commission them to deliver health care.

1.5 Profile of Independent Hospitals and Hospices in Northern Ireland

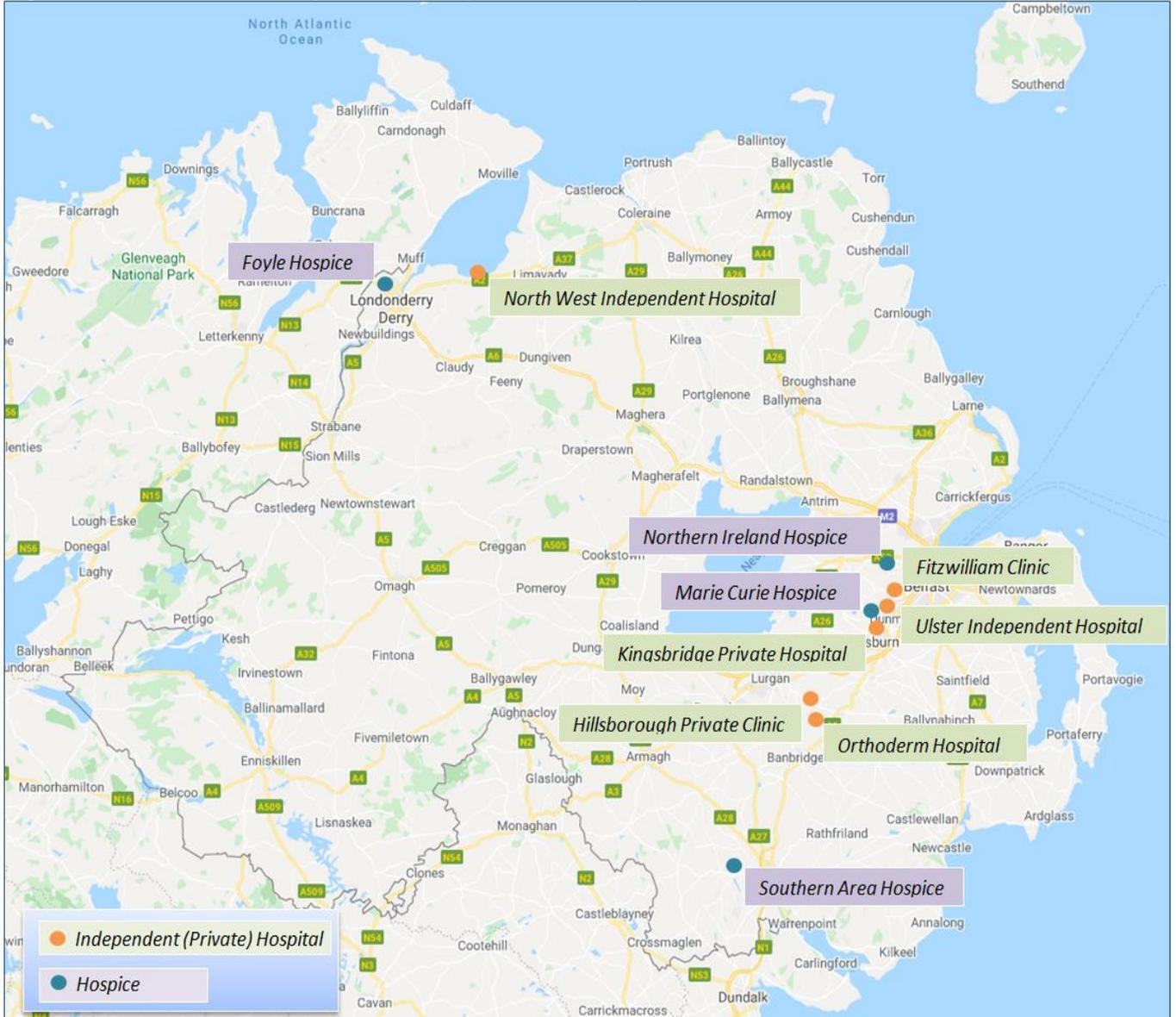
The following section of this report profiles the key independent hospitals and hospices examined as part of this review.

There are currently six independent hospitals in Northern Ireland, these are: Kingsbridge Private Hospital; North West Independent Hospital; the Ulster Independent Clinic; Fitzwilliam Clinic; Hillsborough Private Clinic; and Orthoderm Clinic.

There are currently four hospices: Foyle Hospice, Marie Curie Hospice, Northern Ireland Hospice (excluding Northern Ireland Children’s Hospice) and Southern Area Hospice Services.

Figure 1 shows the locations of the six Independent hospitals and four hospices included in this review.

Figure 1: Location of independent hospitals and hospices in Northern Ireland



Source: Google Maps Data 2019

1.5.2 Independent hospitals

Independent hospitals in Northern Ireland are required to register their establishment with RQIA under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003⁷. Each establishment is also required to register under specific categories of care outlined in the Independent Health Care Regulations (Northern Ireland) 2005⁸. These categories of care describe the type of care each hospital is registered with RQIA to provide. A description of each of the categories of care per the regulations is provided below.

Categories of Care

Independent hospital (IH): This category describes a hospital that is not vested in the Department or managed by an HSS trust.

Acute hospital with overnight beds (AH): This category describes an independent hospital where a patient can stay overnight for a short period following surgery.

Acute hospital (Day Surgery) AH (DS): This category describes an independent hospital where patients receive care and return home on the same day as their treatment.

Prescribed Technologies^b Endoscopy PT (E): This category describes an independent hospital which provides endoscopy procedures.

PT (L) Prescribed Technologies Laser: This category describes an independent hospital which can provide procedures using Class 3B or Class 4 lasers.

PD Private Doctor: This category describes a doctor who is registered with the General Medical Council (GMC) but does not work within the HSC establishment. If the doctor works elsewhere within the HSC, the registration under this category for work undertaken by that doctor is not required.

Table 1 displays the number of inpatient, day patient and outpatient beds and the categories of care each independent hospital has registered with RQIA.

Table 1: Category of care registration for independent hospitals in Northern Ireland (as of November 2019)

| Independent hospital | Registered categories of care | Inpatient places | Day procedure | Outpatient facility | Theatre facility |
|---------------------------------|----------------------------------|--|---------------|---------------------|------------------|
| Kingsbridge Private Hospital | IH; AH; AH(DS); PT(E); PT(L); PD | 22 | 6 | ✓ | ✓ |
| North West Independent Hospital | IH; AH; AH(DS); PT(E); PT(L); PD | 35 | 13 | ✓ | ✓ |
| Ulster Independent Clinic | IH; AH; AH(DS); PT(E); PT(L); PD | 70 (inpatient or day procedure combined) | | ✓ | ✓ |
| Fitzwilliam Clinic | IH; AH(DS); PD | No inpatients Day Surgery only | ✓ | ✓ | ✓ |
| Hillsborough Private Clinic | IH; AH(DS); PT(E); PT(L); PD | No inpatients Day surgery only | ✓ | ✓ | ✓ |
| Orthoderm Clinic | IH; PT(E); PD | N/A | ✓ | ✓ | ✓ |

Source: RQIA Register of Regulated Services, register accessed November 2019

^b Prescribed Technologies are considered as devices that require expertise in delivery and require the setting of use to have certain measures in place for treatment to be delivered safely.

Kingsbridge Private Hospital⁹ was established in 2011 and is located in Belfast. At the time of the Review, the hospital is registered to accommodate a maximum of 22 inpatient places, with six day surgery places. The hospital provides surgical, medical and outpatient services for both adults and children. It also offers a private general practice and minor injuries service. The hospital is also registered with RQIA to include the category of care for Private Doctors. Kingsbridge Private Hospital has two theatres, a dedicated endoscopy suite, an MRI and CT machine, an x-ray department and a range of consulting rooms. Kingsbridge forms part of the 3fivetwo Healthcare Group. At the time of this review, the hospital was planning an expansion of its theatre facilities.

North West Independent Hospital¹⁰ was established in 1989 and is located in Ballykelly, County Derry/Londonderry. The hospital is registered with RQIA to accommodate up to 35 inpatient places, with 13 day surgery places. It provides a range of surgical, medical and outpatient services for both adults and children. The hospital is also registered to include the category of care for Private Doctors. North West Independent Hospital has three operating theatres and an endoscopy suite. It also has a separate outpatients department, an x-ray department and a Central Sterile Services Department (CSSD).

The Ulster Independent Clinic¹¹ was established in 1979 and is located in Belfast. The hospital is registered to accommodate a maximum of 70 patients as inpatients or day surgery cases. It provides a range of surgical, medical and outpatient services for both adults and children. The hospital is also registered to include the category of care for Private Doctors. At the time of the Review, there were five theatres along with recovery units; a dedicated endoscopy suite; a breast care clinic; a limited chemotherapy service; an x-ray and MRI scanning department; a pathology laboratory; and a range of consulting rooms.

Fitzwilliam Clinic¹² was established in 2004 and is located in Belfast. The hospital is registered to accommodate only day surgery patients. Fitzwilliam Clinic has one theatre and a small two-bedded recovery unit. There are no overnight beds provided in this hospital. It provides a range of surgical, cosmetic and outpatient services for adults. The hospital is also registered to include the category of care for Private Doctors.

Hillsborough Private Clinic¹³ was established in 2002 and is located in Hillsborough. The hospital is registered with RQIA to accommodate day surgery patients. There are no overnight beds provided in this hospital. It provides a range of surgical, medical, outpatient, and laser and endoscopy procedures. The hospital is also registered to include the category of care for Private Doctors. While Hillsborough Private Clinic was established in 2002, the hospital did not provide any services which required registration until May 2007; as such the hospital was first registered with RQIA on 1 May 2007.

Orthoderm Clinic¹⁴ was established in 2007 and is located in Hillsborough. The hospital is registered to accommodate day surgery patients only. It provides a limited range of surgical, medical, outpatient and endoscopy procedures. The hospital has one theatre suite for local anaesthetic procedures. The only services and treatments Orthoderm Clinic provide which currently require regulation are flexible cystoscopy and Private Doctor services. While Orthoderm Clinic was established in 2007, the hospital did not provide any services which required registration with RQIA until January 2018; as such the hospital was first registered with RQIA on 25 January 2018.

1.5.3 Hospices

The NHS website states that hospice care aims to improve the lives of people who have an incurable illness and defines hospices as¹⁵:

“Hospices provide care for people from the point at which their illness is diagnosed as terminal to the end of their life, however long that may be.”

Across Northern Ireland, there are four hospices registered with RQIA as independent hospitals, inspected and regulated under the “The Independent Health Care Regulations (Northern Ireland) 2005” legislation. These hospices provide services for people living with any palliative condition or illness.

Each establishment is also required to register under specific categories of care which are outlined in the registration regulations. These categories describe the type of care each hospice is registered with RQIA to provide. A description of each of the categories of care as in the regulations is provided below.

Categories of Care

Independent Hospital (IH): This category describes an establishment the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care, or in which listed services are provided; or in which treatment or nursing (or both) is provided for persons liable to be detained under the Mental Health Order 1986. Hospices are involved in providing palliative care.

H(A) Hospices for Adults: This category describes a Hospice caring for those over the age of 18 years old.

H(C) Hospices for Children: This category describes a Hospice caring for those under the age of 18 years old.

Private Doctor (PD): This category describes a doctor who is registered with the General Medical Council (GMC) but who does not work within the HSC establishment. If the doctor works elsewhere within the HSC, the registration under this category for work undertaken by that doctor is not required.

Table 2: Category of care registration for Independent Hospices in Northern Ireland, as of November 2019)

| Independent Hospice | Registered under RQIA Categories of Care | Number of Inpatient Places | Day Hospice Facilities | Community Care / Home Care |
|--|--|----------------------------|------------------------------|----------------------------|
| Foyle Hospice | IH; H(A); PD | 12 | ✓ | ✓ |
| Marie Curie Hospice | IH; H(A) | 18 | ✓ | ✓ |
| Northern Ireland Hospice (includes Adult Community Hospice and Children's Hospice) | IH; H(A) | 18: Adult | 30: Belfast 7: Ballymoney | ✓ |
| Southern Area Hospice Services | IH; H(A) | 14 | ✓ | ✓ |

Source: RQIA Register of Regulated Services, register accessed November 2019

Foyle Hospice¹⁶ was established in 1985 and is located in Derry/Londonderry. The hospice is registered with RQIA as an independent hospital, with adult hospice and private doctor categories of care. The hospice is registered for 12 inpatient places and provides care for adults with life-limiting illness and palliative care needs. Services include inpatient care, a day hospice, community care, bereavement services and a 24 hour a day advice telephone line. Foyle Hospice is also an accredited training facility for the European Certificate in Essential Palliative Care and European Certificate in Holistic Dementia Care.

Marie Curie Hospice¹⁷ was established in 1965 and is located in Belfast. This hospice is a registered independent hospital providing in-patient hospice services for up to 18 adults with life-limiting and palliative care needs. Marie Curie Hospice also provides community services for adults with life-limiting and palliative care needs in three 'day hospice' sites which are included in the registration of Marie Curie Hospice. One 'day hospice' is based in the Marie Curie Belfast site and operates four days per week, a second 'day hospice' is based at the Newtownards Community Hospital, Newtownards, and operates on two days each week. The third 'day hospice' is based at the Downe Hospital, Downpatrick, and operates one day per week.

The Northern Ireland Hospice and the Northern Ireland Hospice Adult Community Services¹⁸ was established in 1983 in Belfast. The hospice temporarily moved their inpatient services to a site in Whiteabbey Hospital while they demolished and rebuilt their premises in Belfast. In 2016, the hospice moved back to their new purpose-built facility on the Somerton Road, Belfast. The hospice comprises three distinct elements:

The Northern Ireland Hospice: is registered with RQIA as an independent hospital providing inpatient hospice services through 18 adult places. This service supports patients' families and provides ongoing bereavement support.

The NI Hospice Adult Community Services: is registered for day hospice and community-based hospice services for adults with life-limiting and palliative care needs. The day hospice located in Belfast can accommodate up to 30 patients.

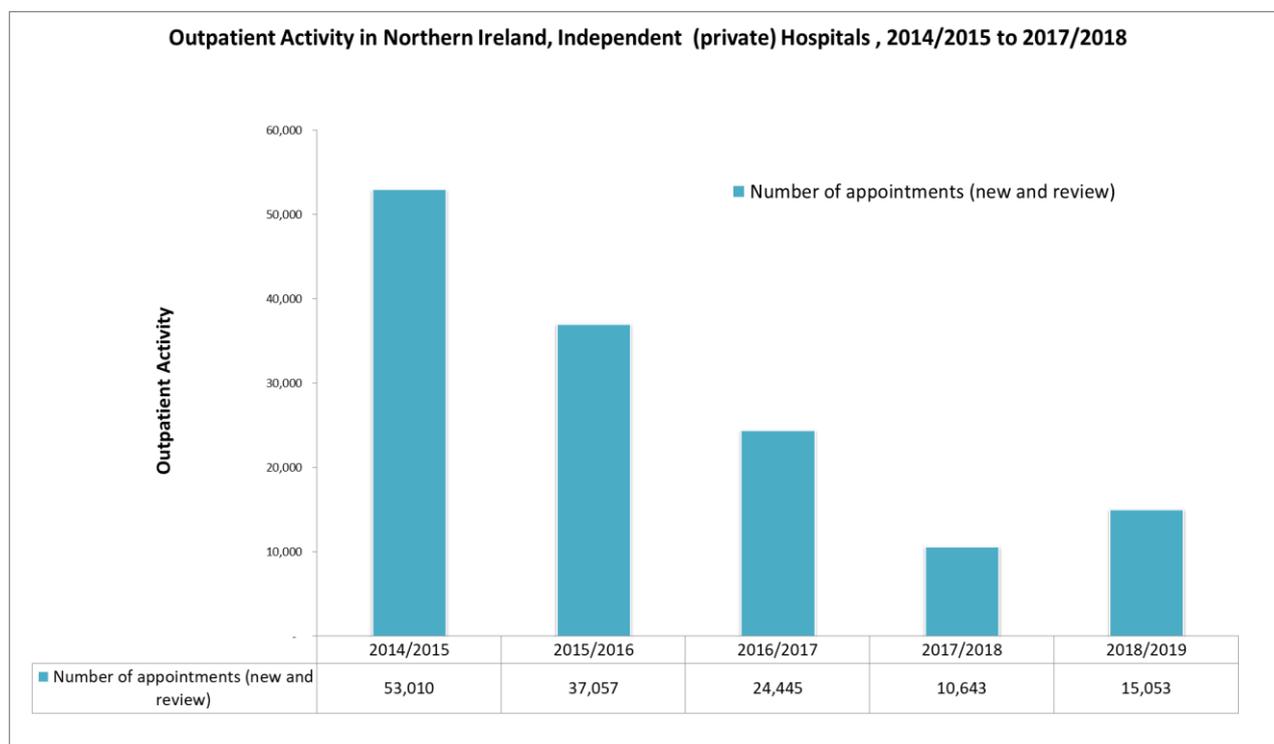
The Hospice Hub: The Hospice Hub provides a range of services for patients to access which include a Wellbeing Clinic and Outpatient Clinic. The Wellbeing Clinic offers a structured six-week programme and is run by a multidisciplinary team who offer patients and their families a variety of services, support and information.

Southern Area Hospice Services¹⁹ was established in 1989 and is located at St John's House, Newry. St Johns House is a registered independent hospital providing in-patient hospice services for up to 14 adults with life-limiting and palliative care needs. This service also supports patients' families and provides ongoing bereavement support. Southern Area Hospice also provides nurse-led services for adults with life-limiting and palliative care needs in two day hospices. The hospice service is available to adults residing in the geographical area of the Southern HSC Trust.

1.6 Activity in Independent Hospitals and Hospices in Northern Ireland

Reliable data was only available for those patients who received care in an independent hospital commissioned by the HSC. Data on outpatient, inpatient and day-case activity is regularly collected and reported on by the DoH Information and Analysis Directorate. Overall levels of HSC commissioned activity in independent hospitals have decreased from levels recorded in 2014/2015 financial year (Figure 2).

Figure 2: Outpatient activity commissioned by HSC Organisations in Northern Ireland, independent hospitals, 2014/2015 to 2017/2018

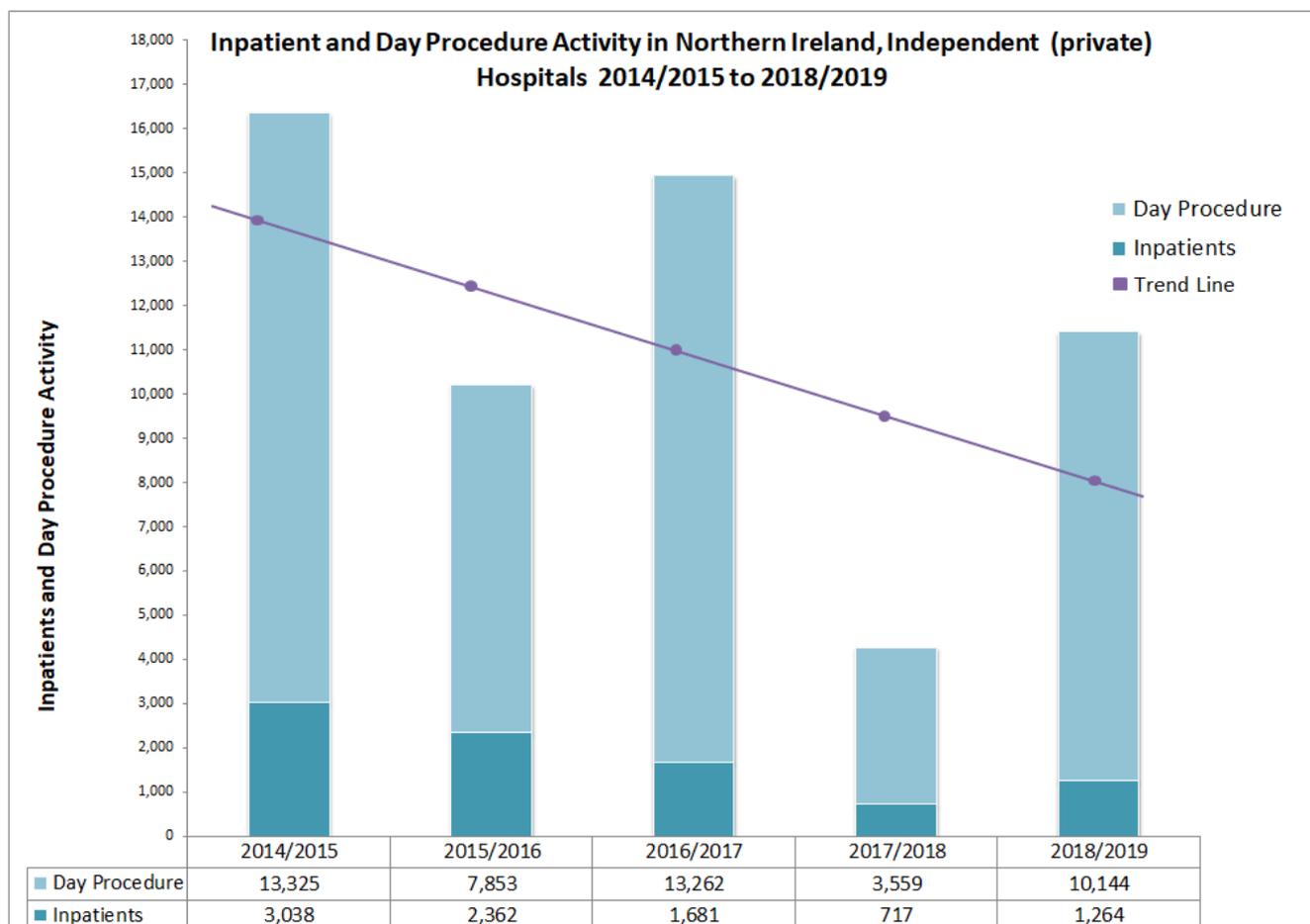


Source: Information and Analysis Directorate, Department of Health (NI) accessed November 2019.

Inpatient and Day Procedure Activity commissioned by HSC Organisations

Similar to trends evident in outpatient activity, total admissions to independent hospitals for inpatient and day procedures commissioned by the HSC have decreased from levels reported in 2014/2015.

Figure 3: Inpatient and Day Procedure Activity commissioned by HSC Organisations in Northern Ireland independent hospitals, 2014/2015 to 2018/2019

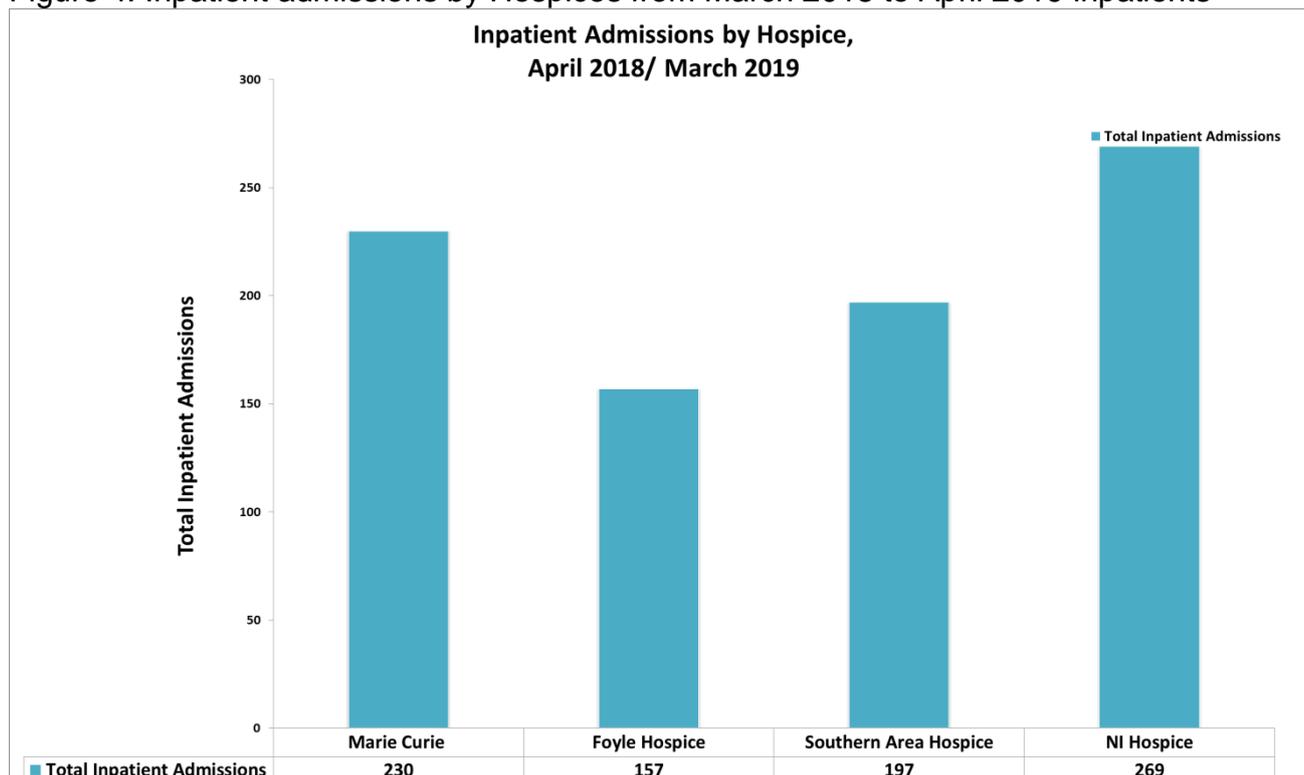


Source: Information and Analysis Directorate, Department of Health (NI) accessed November 2019.

Hospice Activity

At the time of this review, the most recent HSC commissioned activity data relating to hospice inpatient admissions was for 2018/2019. There were a total of 853 Inpatient admissions to hospices over this period, which ranged from 269 admissions at Northern Ireland Hospice to 157 admissions at Foyle Hospice. The activity for each provider is summarised in Figure 4.

Figure 4: Inpatient admissions by Hospices from March 2018 to April 2019 inpatients



Source: Activity data submitted by the Health and Social Care Board (HSCB) June 2019.

While the above figures do not include data on services provide by hospices through day hospice and community services, those presented in this section illustrate that hospices provided approximately 800 inpatients episodes of care in 2018/19

1.7 Previous Reviews into Independent Healthcare

Several previous reviews have examined governance arrangements in independent sector hospitals and governance in health care systems in England. While these have focused on arrangements in England, the similarities between the English and Northern Irish systems mean that findings and recommendations from these reviews can be used to inform the Key Lines of Enquiry for the current review.

In March 2014, an independent review of the governance arrangements at the independent hospitals of Spire Parkway and Little Aston hospitals was published²⁰. The review made several recommendations concerning the management of practising privileges for consultants, monitoring consultant’s scope of practice, the reporting of adverse incidents and multidisciplinary working²¹.

In 2018, the English Health Care Regulator, Care Quality Commission, published its first report of its comprehensive inspection programme into the independent healthcare sector in England, “The State of Care in Independent Acute hospitals (April 2018)”.

CQC found that the majority of Independent hospitals provided high-quality care to patients; however, through their inspections they also identified concerns around the

safety and leadership of some services, which was in part attributed to lack of safety checks and poor monitoring of risks.

CQC highlighted several areas where challenges exist and rated 62 independent hospitals (30%) as requiring improvement.

Significantly, its findings included requirements for improvement in the following areas:

- The quality and effectiveness of governance arrangements, including sound governance structures and reporting; for example, in respect of the Medical Advisory Committee (MAC)
- Formalised governance processes
- Robust oversight in relation to practising privileges
- An effective challenge function
- Effective risk management
- An adequate approach to clinical audit in terms of auditing, reporting and benchmarking and monitoring outcomes
- An embedded safety culture, with learning from incidents and incident reporting, underpinned by robust systems
- The collection of data to evidence effectiveness and to allow comparisons between providers

1.8 Developments Following Fieldwork of the Current Review

Following fieldwork for the current Review, the Independent Inquiry “Report of the Independent Inquiry into the issues raised by Paterson”²², which reviewed the circumstances surrounding Ian Paterson’s practice was published in February 2020.

The inquiry concluded patients had been let down by inappropriate or unnecessary procedures carried out by Ian Paterson, while significant failings within the NHS and independent sector meant his practices were inadequately supervised, and complaints about his practice were not responded to appropriately.

As the independent healthcare sector continues to develop, providing wholly private and HSC commissioned Health Care, effective governance and communication systems are vital to ensuring care provided in Northern Ireland is safe, effective, well-led and compassionate.

1.9 How this Review is Presented

The findings of this review have been presented within the domains of RQIA's inspection and review framework (Figure 5)

Figure 5: RQIA's Inspection and review Framework



Section 2 Well Led: this section contains findings relating to the governance arrangements in place to manage, govern and lead the delivery of services in independent hospitals and hospices.

Section 3 Ensuring Safe and Effective Care: this section contains findings in relation to how independent hospitals and Hospices ensure that treatment provided achieves good outcomes and patients achieve a good quality of life and are protected from avoidable harm.

Section 4 Commissioning: this section outlines findings relating to the governance arrangements related to commissioning of services.

Section 5 Compassionate Care: this section outlines findings relating to the delivery of person-centred care, patient experience and the involvement of patients in the planning and delivery of services.

Where findings have led to recommendations, these are clearly identified in the report. A number of examples of good practice identified through the course of this review have also been included.

Section 2: Well-Led

Well-led services ensure high-quality care and prepare an organisation for growth and development. Governance structures, systems and processes within each organisation with respect to the effectiveness of leadership were examined. Specifically, these investigations focussed on the following elements of a well-led service: the organisations' vision for the future, culture, quality improvement efforts, risk management and accountability. Also reviewed were the mechanisms used to assure quality and evaluate performance and provide assurance to the management teams, directors and commissioners who oversee service delivery.

2.1 Vision and Culture

Vision

A clear vision helps to describe who the organisation is, their purpose, what they value and where they're hoping to go in the future. An effective organisational vision articulates not only the organisation's values and aspirations but helps to guide its development and growth. The Review Team reviewed documentation provided which detailed each organisation's strategic vision and identified elements which have been grouped into four categories:

- **Patient safety:** those elements which promote safe, patient-centred care, that recognise need and reduce the risk of harm
- **Quality:** those elements which promote a positive patient experience, ensure the highest professional and clinical standards and promote professional development
- **Collaboration:** those elements which promote co-operation and collaboration between patients, primary care teams, relatives, statutory and voluntary agencies, commissioners of care and comparable services
- **Growth:** those elements which encourage development and expansion of awareness, services offered and impact

The most salient aspiration repeated across each organisation's strategic vision communicated the importance of safe, patient-centred care aiming to reduce the likelihood of risk and avoidable harm. Within various vision statements were commitments to improving service quality and, to a limited extent, collaboration between organisations. In hospices, it was noted that commitments to drive improvement were often cited. Across the majority of organisations, there was a strong focus on, and stated commitments to, ensuring patient safety would have a key role in how the organisation would grow and develop.

Culture

Culture includes the rules, values, beliefs, and laws which help to shape how an organisation performs. An organisation's culture affects the less visible aspects of a health care service which are identifiable through shared thinking, feeling and behaviour and which become more apparent through how care is delivered.

A positive organisational culture can drive change and improvement which supports safe, patient-centred care, while a negative culture may cause organisation-wide instability; undermining quality, morale and the delivery of safe care.

Independent Hospitals

Frontline staff within independent hospital described a positive, supportive culture where openness, transparency and candour were central. Across all organisations visited, staff described how they enjoyed working at their organisations, which was demonstrated through high levels of staff retention and the length of time many of them had worked in their roles.

During interviews, front line staff at each hospital spoke at length on how Senior Management actively encouraged them to be open and honest to ensure staff would feel confident to report incidents, behaviours, or professional or medical practices that may warrant concern and escalation if encountered.

The Review Team met with Directors and Senior Managers in each of the independent hospitals. Each described an “open door” policy, whereby staff within their organisation were encouraged to speak up and approach Senior Management with any questions, concerns or ideas of quality improvements.

Managers within independent hospitals emphasised the significance they placed on encouraging transparency among staff at all levels to assure safe, patient-focused care.

The Review Team acknowledged the positive comments staff made regarding the culture within their organisations. However, the negative consequences of a ‘close knit’ culture should also be noted, for its potential to limit, particularly in small organisations, opportunities to collaborate, learn and develop at pace.

Additional challenges associated with a ‘close knit’ culture, include an increased reluctance among potential whistle-blowers and acting as a barrier to staff challenging their colleagues or management. Fear of damaging ‘close ties’ between staff can prevent individuals from speaking out and can impair the recognition of issues.

Hospice

In one hospice, staff described shared values of compassion among staff for patients and the relatives of those they cared for. They spoke about the importance placed on developing a patient-centred culture, encouraging staff to take a sense of pride in their roles and being trained to deliver care with courage, compassion and integrity.

Staff commended the safety of the care delivered by the hospice and several staff commented they would be happy for their relatives or themselves to receive care in the hospice. In one hospice, staff said the culture had improved significantly in recent years and had become friendlier and more supportive.

Some staff described how the culture within their organisation could be further enhanced with more formal mechanisms for reflection and debrief, particularly in relation to difficult/complex cases.

The generally positive reflections of staff, who were keen to emphasise the significance each organisation placed on nurturing an open and honest environment that places the delivery of safe patient care at its heart, was encouraging.

These recent improvements in culture across each of the organisations are commendable, and the Review Team encourages all organisations to continue investing in their staff with professional development while promoting a positive working environment.

2.2 Governance and Accountability

2.2.1 Structures and Governance Arrangements

Clear operational structures and accountability arrangements constitute a vital aspect of effective governance in an organisation. The majority of independent hospitals and hospices demonstrated these arrangements by holding various meetings through which assurances were provided to the organisation's board of directors or board of trustees by the Chief Executive or Responsible Individual.

Some differences were found in reporting structures and accountability arrangements between providers. The three smaller independent hospitals (Fitzwilliam Clinic, Hillsborough Private Clinic and Orthoderm Clinic) are governed by Partners/Directors, who are supported in the operational management of the organisation by a senior management team. Fitzwilliam Clinic has a Medical Advisory Committee (MAC) while Hillsborough and Orthoderm Clinic ensures regular Director meetings which undertake the role and function of a MAC. Orthoderm Clinic was the only service of the three smaller independent hospitals that employed a specific Governance Manager during the Review. All three demonstrated effective regular communication with staff through the various meetings.

Smaller independent hospitals more often relied on informal methods of communication to provide key information to staff. The Review Team's view is that such informal methods of communication might increase the risk of key safety and governance information not reaching appropriate staff at the right time.

The three larger independent hospitals (Kingsbridge Private Hospital, North West Independent Hospital and the Ulster Independent Clinic) all had in place Medical Advisory Committees (MACs). This was named the Medical Staff Committee within the Ulster Independent Clinic^c.

In some instances, the minutes and agendas for Medical Advisory Committee meetings within the independent hospitals contained insufficient focus on audit; quality monitoring; patient outcomes; the development and assurance of policy and procedures; and the implementation and assurance of national and regional clinical guidelines and circulars. The MAC is a key forum for ensuring clinical governance within independent organisations and is discussed in the Medical and Clinical governance section of this report.

^c In the UIC the MAC is in effect its Clinical Governance and Medical Audit Sub-Committee MGASC

Both Kingsbridge Private Hospital and the Ulster Independent Clinic had in place Chief Executives, committees and groups to provide a range of functions such as clinical governance, finance, audit, quality management and risk management. Following RQIA inspections and engagements with these services, the Review Team were not assured that all committees and groups were meeting on a sufficiently regular basis or functioning as described within their Terms of Reference to fulfil their intended role. In some instances, the roles of some committees were not clearly described. The North West Independent had a MAC; however, as a result of staffing changes within the organisation, this committee had not met in line with the required minimum standard.

The Review Team determined that not all of the MACs in independent hospitals were fully executing their required functions and this could have been because they were not meeting as often as required. Where this was identified, it was addressed through the inspection follow-up and RQIA's regulatory processes.

| Recommendation 1 | Priority 1 |
|---|------------|
| <p>All independent hospitals must ensure they have in place a well-established and well-functioning MAC, that the MAC is appropriately constituted, meets as frequently as required, provides professional and organisational leadership, and takes a visible and active role in the organisation's governance.</p> | |

Seven organisations (Northern Ireland Hospice, Fitzwilliam Clinic, Hillsborough Private Clinic, Kingsbridge Private Hospital, Orthoderm Clinic, Foyle Hospice and Marie Curie) had sufficiently clear organisational structures. During meetings with RQIA, staff were able to describe their role and responsibilities within these structures.

At the time of the Review, Foyle Hospice had recently restructured its Board of Trustees, with new Trustee members having been appointed in 2017 and 2018. The hospice appointed a new Chief Executive Officer in 2014 and its leadership team had taken several measures to strengthen arrangements and enhance the support from Non-Executive Directors.

Southern Area Hospice Services had undertaken several internal effectiveness reviews and had identified opportunities to strengthen its accountability arrangement. At the time of the Review, it was not evident that significant progress had been made in driving forward all of the necessary changes and improvements identified over the course of these successive internal reviews; however, there was a strong commitment to addressing these issues going forward as evidenced by the appointment of a new Chief Executive Officer and a Board of Trustees.

In relation to Marie Curie, it was considered that there were several potential advantages to the hospice being part of a national organisation, in that there was already access to fully developed governance infrastructure and clear lines of accountability.

During an RQIA unannounced inspection, Northern Ireland Hospice said they had commenced an internal review of their governance systems. Senior management described how this process was being undertaken to ensure the organisation met with the additional requirements of reporting to the Charities Commission, the Fundraising

Regulator, and the Information Commissioner's Office in addition to reporting to the RQIA.

There was variation in the effectiveness and make-up of individual Boards across the independent hospitals and hospices visited. One of the hospitals and each of the independent hospices were charitable enterprises, while one hospice formed part of a UK wide organisation. The Review Team recognised the different size and profile of each organisation and that requirements for governance systems would vary between each of the organisations.

It was clear that some organisations had further work to undertake in order to strengthen the constitution of their Board of Directors, Boards of Trustees or executive teams and have in place the full range of skills and experience required. A well-functioning Board will typically be comprised of individuals who are skilled in governance, strategic leadership, accountability, driving improvement, leading change and horizon scanning. A system of regular governance training/awareness sessions should be implemented for all Directors/Board of Trustees, including a robust induction programme for new Directors/Board of Trustees. These critical elements are required to ensure independent organisations provide high-quality healthcare.

| Recommendation 2 | Priority 1 |
|---|-------------------|
| All independent hospitals and hospices must ensure their Board of Directors/ Board of Trustees are appropriately constituted and include members with the required range of skills and expertise. This is essential to ensure Boards are fully effective and can execute their responsibilities to oversee robust governance, to lead and define the organisations vision and strategy and to provide oversight of the quality of care. | |

We found that in Kingsbridge Private Hospital, the remit and responsibility of the Medical Director and another Director who had a role in medical and clinical governance was not clearly defined. Following our inspection of this hospital, we highlighted that these responsibilities could be better delineated and understood. Senior Managers in Kingsbridge Private Hospital did, however, demonstrate a firm commitment to review and strengthen the hospital's existing governance arrangements which was welcomed by our Review Team.

The review also found that governance arrangements in the North West Independent Hospital and the Ulster Independent Clinic were both overly centralised and reliant upon a small number of key individuals and these arrangements had existed for several years. Following our inspection of Ulster Independent Clinic in January 2019 and the North West Independent Hospital in March 2019, both organisations undertook to review their governance structures. The Review Team welcomed the appointment of additional Deputy Ward Managers in the Ulster Independent Clinic which, they believed, would assist the Senior Management Team in strengthening the effectiveness of their current governance systems considering that these require significant engagement from staff in order to be effective.

Monitoring Quality of Services

During meetings with Senior Management at all independent hospitals and hospices, the Review Team heard that various data and information was collected to monitor the quality of services provided by the organisation. This data was informed by clinical audits and corporate performance indicators and reports.

In Fitzwilliam Clinic, Hillsborough Private Clinic, Foyle Hospice, and Marie Curie, systems were found to ensure that the quality of services provided was reviewed regularly, underpinned by clinical and administrative audits as well as data and information from activity statistics such as theatre figures, emergency/re-operation rates, infection/compliance rates, incidents, complaints and patient satisfaction. During an unannounced inspection at Southern Area Hospices Services, the Review Team identified areas of concern in relation to audit outcomes being shared appropriately and used in a meaningful way throughout their governance structure.

The team heard that Kingsbridge Private Hospital was implementing a new electronic system to capture data and display dashboards of information. This hospital demonstrated good use of information and indicators to inform decisions about care and treatment. Orthoderm Clinic was undertaking similar work in developing Patient Reported Outcomes Measures (PROMs) at the time of this Review.

Meetings with Senior Management in Hillsborough Private Clinic, Orthoderm Clinic and Marie Curie demonstrated that they had a comprehensive understanding of their governance systems and risk while being in possession of existing assurance frameworks.

The Review Team were less clear how information on patient care outcomes was reviewed and used to inform the delivery of safe and effective care at North West Independent Hospital and Ulster Independent Clinic. The Review Team concluded that Senior Management Teams in North West Independent Hospital and Ulster Independent Clinic must ensure that information and intelligence is routinely analysed; quality outcomes are routinely monitored, and all emerging risks are identified appropriately to provide assurance that high-quality care and treatment is being provided.

The Review Team concluded that quality indicators in independent hospitals and hospices were based largely on activity rather than outcomes and that the data and information which was already collected could be used more effectively to support patient choice and improvement initiatives.

| Recommendation 3 | Priority 3 |
|---|-------------------|
| All independent hospitals and hospices should strengthen their arrangements for monitoring the quality of care they deliver, through the collection, analysis and dissemination of meaningful data and information relating to patient outcomes, including analysis of information in relation to complaints ^d . | |

^d See also recommendation 16, page 73.

Governance Structures

There was variation among independent hospitals and hospices in relation to the understanding of what a robust governance structure requires. Not all organisations had governance systems that enabled comprehensive oversight or assurance that services are safe and effective and that the right care, treatment or outcomes were being delivered for patients.

Although there were robust arrangements in place in the smaller hospitals and hospices, there were some weaknesses in each organisation, impacting the system of governance in operation.

All four hospices have undertaken their own internal reviews of governance and oversight arrangements to ensure decision-making are effective and that the right outcomes were achieved for their patients. These reviews identified gaps in skills and capacity within the organisations and informed plans to improve the governance structures. The Review Team advised each hospice to continue the work to strengthen governance arrangements, particularly in view of the services' critical functions and the growing demand for their services.

| Recommendation 4 | Priority 1 |
|--|-------------------|
| All independent hospitals and hospices should undertake a detailed review of their internal governance structures and capabilities. Where the required expertise to complete such an assessment is not available within the organisation, external expertise should be secured to undertake such a review. | |

2.2.2 Medical and Clinical Governance

The General Medical Council (GMC) Handbook on Effective Clinical Governance for the Medical Profession defines clinical governance as²³:

“... a system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence can flourish. Effective clinical governance contributes to the safety and quality of patient care. Good clinical governance must support the early identification of risks and concerns that lead to individual, team and wider organisational learning.”

Standard 30 of the Minimum Care Standards for Independent Healthcare Establishments (2014) outlines that clinical governance should be overseen by a medical advisory committee (MAC)²⁴ where appropriate.

Within an independent hospital, a MAC has an important advisory function and should provide the independent hospital with a mechanism to secure resolved clinical advice as required. It should also provide a forum for discussions with clinicians practising in the

independent hospital on an ongoing basis. The MAC should also review information collated in relation to adverse clinical incidents and advise management on corrective action, where necessary.

During the review, the team examined the role and functions of the MAC / medical committees in each independent hospital and Hospice.

Within the North West Independent Hospital (March 2019), it was identified that there had been a period in which there was no chairperson of the MAC in place and the committee had met only once during 2018. As a result, its operation was insufficient to ensure adequate governance. A medical practitioner has since been appointed as Chair of the MAC and the role and function of the various committees have been better defined and communicated to staff.

Within other hospitals, the Review Team was unable to find evidence of robust discussions, challenge or proactive approaches to the implementation of learning from incidents, complaints and audits by some of the MACs (Kingsbridge Private Hospital, North West Independent Hospital and the Ulster Independent Clinic). Therefore, the Review Team was not assured that all MACs had sufficiently detailed oversight of clinical governance. The role and functioning of many of these committees should therefore be reviewed and, where necessary, strengthened to provide assurance and evidence of safe clinical practice to the Board of Trustees / Directors within each organisation and to RQIA.

Practising Privileges/ Fitness of Workers

In relation to the fitness of workers, regulation 19 (1, 2 and 3) of the *Independent Health Care Regulations (Northern Ireland) 2005* mandates that the Registered Person in the independent hospital and hospice should ensure that medical practitioners granted consulting or practising privileges are fit to work in, or, for the purpose of the establishment, having evidence of professional and revaluation requirements; that the person is of integrity and good character, physically and mentally fit, with the necessary qualifications, skills and experience; and full and satisfactory information is available for the person in relation to the matters specified in Schedule 2. Also, all such healthcare professionals should be covered by appropriate professional indemnity²⁵.

There are several standards in the DoH *Minimum Care Standards for Independent Healthcare Establishments* which also address the following areas:

- Ensuring practitioners are educated, trained and qualified for their roles and responsibilities and maintain their training and qualifications (Standard 10).
- Ensuring that all registered medical practitioners with a licence to practice must meet the GMC requirements for revalidation covering designated bodies and Responsible Officer Regulations (NI) 2010²⁶ (Standard 10).
- Ensuring annual appraisals are undertaken in accordance with the GMC's appraisal and assessment framework (Standard 10).
- Ensuring appropriate and professional indemnity is in place (Standard 10).
- Practising privileges arrangements are in place whereby medical practitioners may only use the facilities in the establishment for consultation with and treatment of patients if they have been granted practising privileges (Standard 11)²⁷.

The Review Team notes that hospices worked differently than hospitals in relation to practicing privileges and having clear systems for granting, maintaining and reviewing practising privileges contracts.

The numbers of medical practitioners working under practising privileges contracts across the independent sector were found to be significant (the Ulster Independent Clinic has more than 400 clinicians working in this regard). Small numbers of these clinicians work exclusively in private practice, with the remainder working in both private and HSC practice.

During the inspections, we reviewed a sample of the personnel files of exclusively private doctors and those who work in both the independent sector and HSC. Not all files contained current information in respect of appraisals, revalidation, mandatory training and professional indemnity and while some instances were found of registers being out of date.

Practising Privileges arrangements are the responsibility of the Registered Person and the MAC, and each organisation must have written procedures that define the process for application, granting, maintenance and withdrawal of practising privileges. Minimum Care Standard 11 outlines that medical practitioners may only use the facilities in the establishment to consult with and treat patients if they have been granted practising privileges. The Minimum Care Standards outline that the following must occur before granting practising privileges:

- That written procedures for practising privileges should be in place.
- Appropriate checks have been undertaken in relation to confirming the applicant's identity; obtaining an Access NI enhanced disclosure/Police check; confirming their registration status with the relevant professional body; qualifications, ensuring the applicant has the required training and experience for the type of treatment they have requested practising privileges for and that indemnity arrangement are in place.
- The applicant must be interviewed.
- The practising privileges granted defines the speciality or specialities in which the practitioner may treat patients.
- A written agreement must be in place between the practitioner and the establishment which sets out terms and conditions and is reviewed at least every two years.
- There is a written procedure for the sharing of information between the establishment and HSC employers to enable 'whole practice appraisal' to take place.
- Those medical practitioners with practising privileges (including those who are employed by an HSC Trust and those who are retired and continued to work within the independent sector) must provide evidence of their annual appraisal and meet the regulatory requirement of their professional body or council²⁸.

Where applicable, most independent hospitals and hospices submitted practising privileges policies and procedures which were in date and clearly outlined the following:

- Roles and responsibilities of those medical practitioners granted practising privileges.
- The role of the MAC and Responsible Person in relation to granting, maintaining and withdrawing practising privileges.
- Eligibility criteria for practising privileges.
- Processes for applying for, granting of, restricting, suspending, withdrawing or variation of practising privileges.

The MAC should review and advise the Registered Person on all matters relating to practising privileges agreements. There were good examples of this being operationalised in Kingsbridge Private Hospital, Orthoderm Clinic, Fitzwilliam Clinic and Hillsborough Clinic.

Practising privileges agreements should be reviewed at least every two years, there was evidence that this was the case in the majority of independent hospitals and hospices, with the exception of the Ulster Independent Clinic.

The practising privileges arrangements in some organisations were not audited or sufficiently robust, therefore organisations would have limited oversight for those doctors with practising privileges agreements. Senior Management advised that in some independent hospitals only the physical facilities are provided and that clinicians “just rent the rooms”, particularly where outpatients are involved, and therefore it was of concern that there was a view there was no requirement for a fully robust governance system around those doctors.

During inspections of the Ulster Independent Clinic in 2019 (in particular, the inspections of 22, 23 and 24 of January 2019, 4 November 2019, 24 February 2020 and 24 March 2020), arrangements for practising privileges were not sufficiently robust and a number of significant governance concerns relating to the oversight and management of practising privileges were identified. Doctors who had not been granted practising privileges were found to be working as surgical assistants under the supervision of Consultants - who themselves had been granted practising privileges - within the hospital. The only provision within *the Independent Health Care Regulations (Northern Ireland) 2005* or the DoH Minimum Care Standards for Independent Healthcare Establishments (2014) for doctors to work in the hospital is either under direct employment with the hospital or a practising privileges agreement as this arrangement was therefore out with these provisions.

Following fieldwork for this Review, RQIA inspectors undertook a further focused inspection in November 2019 to the Ulster Independent Clinic and found a number of clinicians working in the hospital in wholly private practice without the necessary information recorded, as outlined by the Independent Healthcare Regulations (Regulation 19).

Those seeking and holding practising privileges to work in independent hospitals contribute to the generation of income and profit for these organisations, yet the primary responsibility of the organisation must at all times be the provision of safe and effective care. Organisations must, therefore, ensure that requirements for good medical governance and practicing privileges are met in full alongside other corporate objectives.

In conclusion, it was evident that in some independent hospitals, systems for the oversight of practising privileges could be significantly improved to ensure accurate records are retained, up to date and clearly specify the individual practitioner's scope of practice within the hospital.

Area of Good Practice

Systems in place for managing practising privileges in the hospices were also examined and found to be working well. Senior management was able to describe their approaches to granting, maintaining and reviewing practising privileges contracts. The Review Team were also provided with clear examples of when the organisations had refused and withdrawn these privileges for some individuals. The team particularly welcomed the strengthening of both organisational and clinical governance arrangements in the Northern Ireland Hospice.

Responsible Officers (ROs)

In 2010, legislation was enacted in Northern Ireland in relation to Responsible Officers (ROs)²⁹. The DHSSPS (the DoH from 2016) published guidance in February 2011 on the Role of Responsible Officers for Doctors and Employers entitled "Confidence in Care"³⁰.

The Guidance was produced as part of the programme of reform (Confidence in Care) in respect of professional regulation and was aimed at doctors licensed with the GMC to practice medicine; doctors acting as ROs; and organisations designated as having to nominate or appoint an RO in Northern Ireland.^e

All designated healthcare organisations (in the case of the independent sector, those organisations which provide healthcare) can decide to become a designated body and appoint resource and support an RO for their organisation. All medical practitioners working within an independent hospital or hospice must also have a designated Responsible Officer (RO). This RO might be based in another independent or HSC hospital depending on where the medical practitioner undertakes the majority of their practice.

Most independent hospitals and hospices were designated bodies and had appointed an RO. However, some smaller organisations were not required to become designated bodies or had not appointed an RO for the organisation because its medical practitioners had connections to an RO in another organisation

When an RO is advised of concerns about a doctor's practice that is within the sphere of their responsibility, they must first assess the information and determine what actions are required. This may require them to share this information with all relevant stakeholders in all areas of the doctor's work. For this reason, it is important that ROs are connected to the regional RO network. The Review Team was, in the main, satisfied that all the organisations were appropriately linked to this Network.

^e *The document sets out the role and responsibilities of the RO in accordance with legislation (the Medical Act 1983 and the Health and Social Care Act 2008^e), providing guidance for licensed doctors on how they relate to and can identify their RO and the responsibilities of designated organisations.*

Area of Good Practice

In the North West Independent Hospital, the Review Team agreed that there was a clear understanding of the role and responsibility of the RO within that hospital. The current RO was an active member of the MAC and was commended for how he has developed and maintained strong links and effective communication with his counterparts across both the HSC and independent sector.

The RO should evaluate the doctor's fitness to practice through the processes of appraisal and revalidation. Appraisals should be carried out annually and revalidation is required every five years. The RO does this based on the evidence presented to them in the form of a portfolio demonstrating that the individual's practice meets standards as set by the GMC in Good Medical Practice (April 2019)³¹ and the required expectations of their managed healthcare organisation while safely undertaking the clinical role for which they are employed or contracted.

Some of the appraisals provided by medical practitioners, which had been undertaken in the HSC trust in which the practitioner was employed, provided the independent sector organisation with only limited information regarding the competency and capability of the practitioner. Some medical practitioners had only provided the organisations with the sign off sheet confirming the appraisal had taken place without providing any further detail as required to monitoring their ongoing performance.

The Review Team recommended that all independent hospitals and hospices request the full appraisal document for each medical practitioner. This appraisal document should be reviewed and scrutinised by the MAC before granting or renewing practising privileges. A record of this review should be retained. This will provide an added level of assurance for the MAC and can aid in the determination of the appropriate scope of practice for each individual medical practitioner.

Senior Management from Kingsbridge Private Hospital described the current process of gathering information to support practising privileges agreements (as part of the evidence for granting PP) as manual and labour intensive. They said that the hospital was developing a new electronic portal whereby doctors would be able to electronically upload the required documentation to support the maintenance of their practising privileges agreements, such as appraisals, professional indemnity and GMC registration.

Across all organisations, there was a heavy reliance on assurances gained through the appraisal and revalidation taking place within the HSC Trusts in NI which had the potential to limit the depth of assurance and oversight that independent sector organisations could achieve in relation to medical appraisal and revalidation for HSC employed doctors also working in their services.

The importance of good systems to ensure that medical appraisal and revalidation were taking place and sufficiently comprehensive were highlighted by the Review Team. ROs should ensure doctors working in the independent hospitals and hospices in NI undertake a whole practice appraisal with experienced appraisers who have the appropriate skills and knowledge while working in accordance with best practice guidance. In addition, ROs throughout the independent sector should liaise with other ROs (in both the HSC and Independent sector) to share information and concerns, particularly in light of identifying unsatisfactory performance of individuals.

| Recommendation 5 | Priority 1 |
|---|------------|
| <p>The Registered Persons within each independent hospital should ensure there are appropriate systems in place to enact the organisation’s responsibilities relating to medical governance by:</p> <ul style="list-style-type: none"> a) ensuring practising privileges agreements are up to date, are reviewed regularly (every two years) and provide detail of specialties, activities and procedures which the relevant doctor may undertake in the hospital/hospice. b) ensuring that where organisations are a designated body Responsible Officers have formal communication links in place with the corresponding persons in relevant HSC organisations. | |

2.3 Quality Improvement

Effective organisational governance should include a systematic approach to driving improvement in the quality of services. Embedding Quality Improvement (QI) involves a purposeful, systematic change in the behaviours, mechanisms and processes through which care is delivered to encourage improvement.

Development and implementation of a QI strategy requires a significant and sustained allocation of time, resources and effort. By embedding a culture of QI, organisations ensure health care delivery is adaptive, effective, patient-centred, timely and equitable.

An effective QI strategy should be informed by service level data, clearly articulate improvement goals and the processes through which these goals will be realised while providing examples of how success and improvement will be quantified.

The Independent Health Care Regulations (Northern Ireland) 2005 Regulation 17 (1) outlines that the registered person shall introduce and maintain a system for reviewing, at appropriate intervals, the quality of treatment and other services provided in or for the purposes of an establishment or for the purposes of an agency.

Key stakeholders are involved in this process. Furthermore, the Minimum Care Standards (Appendix 1) states: “independent health care providers must develop policies, procedures and protocols appropriate to the setting, to include Quality Improvement”.

Throughout this review, examples were sought of improvement activities or initiatives which each organisation had recently undertaken and evidence of the deliberate deployment of QI methodologies to underpin service improvement.

Quality Improvement strategy

Each organisation was asked by the Review Team to describe their QI strategies and ongoing QI initiatives across services delivered. Each organisation indicated that they recognised the importance of QI in improving patient care and service delivery. However, on deeper examination of individual examples of QI strategies and specific QI initiatives received, there was limited evidence of systematic implementation of QI methods and an over-reliance on clinical audit.

In general, the organisations reviewed did not have well-articulated, defined and implemented QI strategies. The Review Team recommends each organisation included in this review develop and implement a clear QI strategy, led and informed by front line staff and service level data.

Independent Hospitals

The Review Team received a Clinical Governance Strategy document from Kingsbridge Hospital, a Quality Improvement Plan for 2019 from Hillsborough Hospital, a report detailing Ulster Independent Clinic's ongoing participation in Caspe Health Knowledge System CHKS Assurance and Accreditation Programme and a Quality Improvement strategy from North West Independent Hospital.

The documents received described a wide range of activities which included: monitoring of customer satisfaction; the outcomes of quality KPI audits; incidents and trend analysis; investment in services; and ongoing participation in an external Assurance and Accreditation Programme provided by Caspe Health Knowledge System (CHKS).

The Review Team acknowledged that each of these individual activities is fundamental to the ongoing delivery of quality care. However, in most organisations there was an absence of a dedicated QI strategy to identify key QI opportunities and support ongoing QI initiatives.

One exception was the QI strategy received from North West Independent Clinic. This strategy details four key pillars of improvement: patient experience, safe care, effective care and regulatory compliance. The strategy clearly defined the organisation's objectives for improving quality and was underpinned by data relating to service delivery. It included functions relating to collation and analysis of patient experience feedback as well as the provision of comprehensive analysis and subsequent learning outcomes. This QI strategy was comprehensive and the Review Team would encourage North West Independent hospital to continue to link their QI Strategy to their organisational objectives and to ensure the strategy is informed by data relating to the quality of services it delivers.

Hospices

All four hospices reported being involved in the newly formed Hospice Alliance in Northern Ireland. The Hospice Alliance enables the CEO of each organisation to work collaboratively to seek solutions for collective challenges.

One such example was the development of a patient information system which could record hospice care and also link with HSC systems, thereby improving the level of integration and communication between Hospices and the HSC.

Marie Curie Hospice described bursaries offered to staff who wished to undertake QI projects or enrol in a post-graduate course to enhance their training and expertise. They further advised of a number of awards they use to recognise staff who have undertaken QI projects.

While independent hospitals and hospices provided examples of exercises and projects undertaken to improve their service, there was little evidence that this change had been informed by data or evidence which demonstrated that QI affected the quality of health care the service provided.

Hospitals

Ulster Independent Clinic described how they had recently enhanced their outpatient facilities by introducing new clinical equipment which enabled spectral imaging computerized tomography (CT) and DEXA scanning.

North West Independent Hospital's QI Strategy document described their rollout of CompuCare software in outpatient services, which will provide them with a record of room usage and allow receptionists to forward this information to accounts. North West Independent Hospital also described how they had begun to use tracing handsets and computer software that allows the tracing of medication into and out of their Pharmacy department.

During the inspection of Kingsbridge Private Hospital, the Review Team learned of a quality improvement initiative that had been developed to enhance orthopaedic outcomes. A multidisciplinary team, which included surgeons, anaesthetists and physiotherapists, had developed a pre-operative exercise program for patients. Where possible, physiotherapy had also been introduced on the same day as a procedure. The hospital described how the introduction of this initiative had resulted in a shorter hospital stay during the recovery period.

Hospices

Marie Curie described a service improvement that had been informed by their "you say we did" initiative. This example concerned the facilitation of a communal "meet and greet" dining area, which offers patients the opportunity to enjoy a more social dining experience rather than dining alone in their individual rooms. The Review Team were encouraged by Marie Curie's use of patient feedback to inform services they provide while the review team suggested that further effort is expended to collect robust evidence of the impact the changes implemented had for patients and relatives.

Overall, the review team was disappointed by the limited amount and diversity of QI examples encountered in independent hospitals and hospices during this review. It is the view of the Review Team that each independent hospital and hospice is to review their approach to QI, and formulate a structured, strategic approach to QI work which will be informed by patients, their relatives, staff within the service and best practice locally and internationally.

This strategy should be clearly led and informed by service level data; for example, Key Performance Indicators, staff input and patient feedback. It should also include formal mechanisms and tools to measure the impact and outcomes of QI activities. Outcomes from QI initiatives should be shared among staff through QI reports and displayed in patient areas.

| Recommendation 6 | Priority 3 |
|---|-------------------|
| <p>All independent hospitals and hospices should develop and implement a robust quality improvement strategy. This strategy should have:</p> <ul style="list-style-type: none"> a) strong leadership at organisational level and active involvement of staff, who contribute towards a learning culture in each organisation. b) linkages with other independent sector and HSC organisations, HSC QI leads and already established mechanisms such as HSCQI. | |

2.4 Managing Risk

Good governance requires the effective identification, evaluation and prioritisation of risk to reduce the probability and the impact of incidents².

Systems must be in place to accurately identify potential hazards, evaluate the risk they may pose and to who, record significant findings and implement strategies and mechanisms designed to minimise the risk and likelihood an incident will take place.

Regulation 25 of *The Independent Health Care Regulations (Northern Ireland) 2005* outlines that “all parts of the establishment or agency to which patients have access are so far as reasonably practicable free from hazards to their safety.”

Standard 17 of the DoH *Minimum Standards for Independent Healthcare Establishments, 2014* mandates that: “all risks in connection with the establishment, treatment and services are identified, assessed and managed”.

Standard 17 criteria further states that independent Health care organisations should ensure there are “comprehensive risk management procedures that, where appropriate, comply with legislation for the following area of: the identification and assessment of risks throughout the establishment”.

The Review Team asked each organisation to describe how they ensure there are clear and effective processes for identifying and managing organisational risks, which may impact on the day-to-day running of the service.

Risk management strategies

The review team requested independent hospitals and hospices submit copies of their risk management strategies. These were either received in advance or reviewed on inspection.

The Review Team developed a framework to assess each of the risk management strategies submitted by organisations included in this review. This framework examined

if strategies clearly identify risk in the context of health care, defined risk management and why it is important and set out the proposed contents of the risk register.

Upon reviewing each of the risk management strategies it was concluded that each broadly met with the requirements set out above and contained the required level of detail and information to constitute an effective risk strategy. Each independent hospital and hospice should help to ensure new members of staff are introduced to their organisational risk management strategy during induction; this will help ensure risks are identified and escalated at an early stage and promote continued safety.

Risk Registers

Risks should be documented, collated and tracked through the use of departmental and corporate risk registers. A comprehensive corporate risk register should provide assurance about the effective identification and management of risk.

During this review, the Review Team examined the systems and processes by which each independent hospital and hospice identifies and responds to risk.

Through unannounced inspections, it was found that the majority of hospitals and hospices had risk registers in place which were compliant with Independent Health Care Regulations (Northern Ireland) 2005 and Minimum Care Standards for Independent Healthcare Establishments.

However, during announced inspections, the absence of a corporate risk register was identified in North West Independent Hospital and Orthoderm Clinic.

During unannounced inspections that North West Independent Hospital's risk registers were operating at a departmental level; the organisation did not have an overarching corporate risk register which collated all organisational risks.

The inspection team immediately advised Senior Management at North West Independent Hospital that this omission must be addressed through the introduction of corporate risk register which collates and defines the main organisational risks and clearly describes those measures in place to mitigate and minimise these.

Each independent hospital and hospice was asked to submit their corporate and departmental level risk registers dated from 1 April to 31 March 2019. Risk registers were received from Hillsborough Private Clinic, Marie Curie and Foyle Hospice.

Risk registers from Kingsbridge Private Hospital, Northern Ireland Hospice, Ulster Independent Clinic, Fitzwilliam Clinic, North West Independent Hospital, Southern Area Hospice Services and Orthoderm Clinic were reviewed during inspections. At the time of this Review, Orthoderm Clinic was in the process of reviewing and developing their governance strategy which involved the introduction of a corporate risk register.

Of the risk registers reviewed it was found that:

- Risks were clearly set out according to department/area within the organisation.
- There were descriptions of existing controls in place to minimise and manage identified risks.

- Risks were scored according to likelihood and potential consequence to the organisation.
- Risk had identified owners who are responsible for managing said risk and further actions.

It was further found that, of the registers reviewed, only Hillsborough Private Clinic and Marie Curie’s Risk Register included a date of review beside each risk identified. It is expected that each item documented on risk registers would be reviewed frequently and revised to assess if the risk profile (likelihood x consequence) had changed, to gain assurance that risk management is effective and to identify when further action is necessary.

Communicating Risk

A vital element of effective risk management is the mechanisms for communicating and sharing risk information across the various parts of the organisation/system. Such communication encourages sharing of transferable lessons to other areas of service delivery, therefore minimising the likelihood and frequency of these incidents occurring again.

The Review Team examined the mechanisms independent hospitals and hospices have in place for communicating and sharing details of risk.

The Review Team concluded there was a wide range of systems in place for the identification, recording, communication and mitigation of risk; for example, corporate risk registers, weekly review meetings and health and safety forums which are responsible for cascading learning outcomes throughout the organisation.

The practice of good risk management was not consistent or embedded through the active use, oversight and review of risk registers across all organisations. Neither were there strong and clearly defined systems for routinely auditing risk.

Across both independent hospitals and hospices, the Review Team was concerned with the overall effectiveness of risk management. Various organisations demonstrated they were fulfilling some expected elements of effective risk management, but no organisation could demonstrate it was fulfilling all elements. It was determined, therefore, that no organisation had adopted a fully comprehensive approach to the governance and oversight of risk management.

| Recommendation 7 | Priority 2 |
|---|------------|
| Independent hospitals and hospices should implement effective systems for risk management and develop a comprehensive approach to the oversight of risk management. This should include ensuring that all identified risks are appropriately captured and documented on risk registers, that specific actions to reduce the risks are identified, and that appropriate systems of assurance are put in place. | |

2.5 Incident Management

An incident is considered an event or circumstance that could or did lead to harm, loss or damage to people, property, reputation, or another occurrence which could impact on an independent hospital or hospices' ability to meet its objectives. Effective incident management processes are critical to good organisational governance and key to ensuring the delivery of a safe service.

There are several regulations and minimum standards applicable to the management of incidents within *the Independent Health Care Regulations (Northern Ireland) 2005* and *DoH Minimum Standards for Independent Healthcare Establishments, 2014*. These regulations and minimum standards concern the provision of arrangements for monitoring, reviewing, reporting and shared learning arising from incidents and near-miss events. These are presented in Appendix B:

Incident Management Strategy

To examine the effectiveness of incident management arrangements, we examined the systems in place within each organisation for identifying, reviewing, and investigating incidents and deaths. We also reviewed how learning was identified, interpreted and shared throughout each organisation.

Each independent hospital and hospice described how they ensure incidents are managed in line with organisational specific incident management strategies. Evidence of implementation of their respective incident management strategies was sought.

Hospitals

We received incident management strategies from: Kingsbridge Private Hospital, Ulster Independent Clinic, Hillsborough Private Clinic, Orthoderm and North West Independent Hospital. We did not however receive incident management strategy documentation from Fitzwilliam Clinic.

We reviewed the content of each of the incident management strategies received. We found that the strategy documents varied in detail, length and content. As presented in Table 3 the incident management strategies we received from North West Independent Hospital and Kingsbridge Private Hospital were most complete, including detail on the whole incident management process as set out in *The Independent Health Care Regulations (Northern Ireland) 2005*.

Table 3: Independent Hospital Incident Management Strategy Contents

| Provider | Includes incident classification | Includes responsibilities | Describes clear incident reporting procedure | Describes the process for documenting incidents | Describes incident investigation | Explains training requirements |
|---------------------------------|---|---------------------------|--|---|----------------------------------|--------------------------------|
| | | | Reporting | Documenting | | |
| Kingsbridge Private Hospital | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Ulster Independent Clinic | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ |
| North West Independent Hospital | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hillsborough Private Clinic | ✗ | ✓ | ✓ | ✗ | ✗ | ✗ |
| Orthoderm Clinic | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ |
| Fitzwilliam Clinic | Strategy document was reviewed during inspection | | | | | |

✓: Included in Incident Management Strategy

✗: Not included in Incident Management Strategy

Some strategies we reviewed contained insufficient information on incident classification, member of staff responsible for reviewing incidents (staff level), documenting incidents and training. The Review Team concluded that independent hospitals incident strategies required urgent review to ensure they provide comprehensive detail on the aforementioned aspects.

Hospices

In respect of hospices, we received incident management strategies from: Northern Ireland Hospice, Marie Curie and Foyle Hospice. We did not receive incident management strategy documentation from Southern Area Hospice Services; however this strategy was reviewed during our onsite inspections. The documents varied in detail and length; however, in general, the content included classification of incidents; incident responsibilities; reporting procedure; and incident investigation.

Table 4: Hospice Incident Management Strategy Contents

| Provider | Includes Incident classification | Includes Responsibilities | Describes clear Incident Reporting Procedure | Describes the process for Documenting incidents | Describes Incident Investigation | Explains Training requirements |
|--------------------------|---|---------------------------|--|---|----------------------------------|--------------------------------|
| | | | Reporting | Documenting | | |
| Northern Ireland Hospice | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ |
| Marie Curie | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Foyle Hospice | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Southern Area Hospice | Strategy document was reviewed during inspection | | | | | |

✓: Included in Incident Management Strategy

✗: Not included in Incident Management Strategy

Overall, though there was some variation across the incident management strategies submitted by independent hospitals and hospices, those received were of the standard expected and contained sufficient detail in line with good practice.

Reporting Risk/ Incident Reporting Forms

We enquired how each independent hospital and hospice capture and record incidents. Two organisations described electronic systems and the remainder used paper-based reporting systems.

Table 5: Independent Hospital and Hospice Incident Reporting Systems

| Provider | Electronic System | Paper-Based System |
|---------------------------------|-------------------|--------------------|
| Kingsbridge | ✓ | |
| Kingsbridge Private Hospital | | ✓ |
| Ulster Independent Clinic | | ✓ |
| North West Independent Hospital | | ✓ |
| Fitzwilliam Clinic | | ✓ |
| Hillsborough Private Clinic | | ✓ |
| Orthoderm Clinic | | ✓ |
| Northern Ireland Hospice | ✓ | |
| Marie Curie | | ✓ |
| Southern Area Hospice Services | | ✓ |
| Foyle Hospice | | ✓ |

✓: Included in Incident Management Strategy

✗: Not included in Incident Management Strategy

Following detailed consideration of the incident management strategies, we scrutinised the implementation of the incident management processes within each organisation. Those using paper-based incident reporting systems were advised of the benefits of investing in an electronic system that enables consistent reporting and improved accuracy; the ability to more easily analyse incidents for emerging trends; and greater real-time data visibility across the organisation for shared learning.

Incident Investigation Process

All the strategies described the importance of responding to incidents as soon as possible and recording all relevant details of the incident in an impartial manner as the investigation unfolds. Each organisation used a severity/consequence scoring matrix similar to that which is used within the HSC system to grade and determine the level of investigation required to examine incidents.

The classification of incidents adequately informed the level of investigation used to review an incident. For example, the Adverse Risk Policy we received from Kingsbridge Private Hospital described once an incident has been reported via an event form, this is escalated to their Governance Department where the incident form is reviewed and an incident file created. Following this process, a lead investigator is appointed who is then responsible for completing an incident investigation form within two weeks of the event being reported.

Kingsbridge Private Hospital's Adverse Risk Policy also contained a sample Incident Investigation Report Form which we noted included:

- Details of personnel involved in the incident.
- Details of patient involved.
- Investigation details obtained during investigation.
- Impact of the incident.
- Corrective actions.
- Root cause investigation of incidents.
- Learning outcomes.

The policy further described how incident reports are reviewed by Kingsbridge's Clinical Governance Department; who validates the appropriateness of the suggested corrective actions; whether the incident indicates an emerging trend; whether the incident is reportable to an external agency; and whether it should be escalated upwards to their Clinical Governance Committee and MAC.

We noted the comprehensiveness and clarity of the Adverse Incident Policy we received from Kingsbridge Private Hospital, nonetheless, we suggest that the Clinical Governance Committee and MAC should review all incidents regardless of their grading on a regular basis.

Investigating Incidents

North West Independent Hospital's Registered Manager was responsible for assigning an incident investigating officer (which is most often the Department Manager or Deputy Manager) to conduct the incident investigation. The accident and incident reporting strategy outlines that incident investigation should:

- Identify reasons for substandard performance, where appropriate.
- Identify root causes and underlying failures in management systems.
- Enable learning from the event and make recommendations.
- Lead to the implementation of improvement strategies to help prevent or minimise recurrences, thus reducing future risk of harm.
- Satisfy mandatory and reporting requirements.

Following the conclusion of the investigation, the Incident Investigating Officer must submit a formal investigation report to the Registered Manager who is responsible for developing an improvement strategy and selecting a designated Department Manager to oversee the implementation of any required improvements.

While each of the strategies reviewed varied in detail and content, overall we were satisfied that the incident management process outlined in each was sufficiently robust and, if followed and applied appropriately, would support the organisations to investigate and review incidents which had taken place.

Mechanisms for Identifying, interpreting learning and sharing learning

An important element of incident management is ensuring sharing of learning which arises from the investigation of the incident at a local and organisational level. This will help to reduce the risk and prevent similar avoidable incidents from happening again. Throughout our Review, we asked the independent hospitals and hospices to describe how they identify and interpret learning arising from incidents.

The Review Team determined that while most organisations managed their incidents well, systems for sharing learning from incidents throughout the organisation were less robust. All organisations would therefore benefit from reviewing and strengthening how learning arising from incidents is derived and disseminated across their organisations. Each organisation should be able to demonstrate that it captures all related learning associated with incidents and that improvements are identified and implemented which ensure practice and systems change and improve as a result of this learning being shared.

Hospices

Marie Curie described how, following the closure of an investigation, learning was routinely disseminated across the organisation and shared through team meetings and hospice governance meetings. They outlined that learning was also shared across their whole national organisation and respective teams via the Divisional General Managers, Regional Managers, Registered Managers and Lead Nurses. They advised that case studies were often presented as a learning tool, learning from which may result in a change of policy or additional training which was then driven through the Quality Assurance Team and by the Head of Learning and Development.

The Review Team acknowledged the various systems in place to capture collate and respond to incidents. They identified examples of learning shared through clinical and staff meetings, posters, and circulated reports. The Review Team were not convinced that connections between the independent sector and the health and social care system were of a strength which would ensure appropriate learning could be shared more widely than with/across the organisation in which the incident occurred.

The Review Team concluded that current systems and processes in place across independent hospitals and hospices adopted a reactive rather than proactive approach to incident management. Neither was it clear to what extent data and/or intelligence relating to incidents was proactively used to pre-empt risks and to inform plans to enhance patient safety and service quality within the hospice services reviewed.

| Recommendation 8 | Priority 3 |
|---|-------------------|
| Independent hospitals and hospices should implement effective systems for the identification of incidents, appropriate grading of incidents, recording of incidents, identification of learning and implementation of any required actions to improve the safety and quality of services. | |

Section 3: Ensuring Safe and Effective Care

Safety and effectiveness are the cornerstones of high-quality health care. We examined the governance systems which should provide assurance that patients are protected from abuse and avoidable harm; ensure care and treatment achieve good outcomes; promote good quality of life, and ensure that care delivered is underpinned by evidence-based best practice guidance.

3.1 Safeguarding

Safeguarding is the practice of delivering services in a way that protects human rights, treats all persons with dignity and respects their right to choose. Safeguarding should empower patients, including those at risk of harm and abuse to manage their own health and well-being and extends to intervening to protect people where harm has occurred or is likely to occur. It is essential there is a clear and effective understanding of safeguarding at all levels within healthcare organisations.

An effective culture of safeguarding requires all staff at every level of an organisation to understand safeguarding principles, relevant to their individual roles and responsibilities. A safeguarding culture when combined with effective oversight within the organisation ensures the systems for safeguarding are implemented consistently.

Evidence was sought to show that each organisation understood their role in safeguarding patients from abuse and that they had robust systems in place to deal with any potential or actual safeguarding events.

Guidance issued by the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DOJ) (July 2015) Adult Safeguarding Prevention and Protection in Partnership³² sets out measures required to reduce the incidence of harm. The guidance describes that all services have a responsibility to investigate, report and escalate allegations and potential indicators of abuse as soon as they become apparent.

Minimum Care Standards for Independent Healthcare Establishments, Standard 3 requires that “there are arrangements in place for safeguarding in accordance with current regional guidance”. The Standard mandates that independent hospitals and hospices must have written policy and procedures in place for safeguarding which is consistent with the current regional guidance and includes the names of nominated persons within the establishment: contact details for onward referral to external agencies; that staff undertake safeguarding training; and that patient, clients, families and carers are informed of the organisations safeguarding arrangements. The Standard also outlines specific requirements for reporting, investigating and notification of suspected, alleged or actual safeguarding incidents.

All organisations described the mechanisms they used to assure themselves that they were meeting their safeguarding responsibilities. These included safeguarding policies and procedures; designated safeguarding champions; provision for safeguarding training, with frequent training updates; and a record detailing staff training status.

Safeguarding policies examined were found to be in line with Minimum Care Standards for Independent Healthcare Establishments (2005). We noted they included definitions and examples of the potential physical; sexual violence; psychological/emotional; financial; neglect; and institutional abuse indicators and described situations abuse could take place. The policies provided examples of preventative measures staff should undertake to minimise the risk of harm to patients, relatives and colleagues to ensure that safe care is delivered.

The safeguarding policies described how persons concerned about an adult or child at risk of harm, abuse or exploitation, must immediately raise the concern with their line manager, who is required to report to the organisations safeguarding champion. The safeguarding champion is then required to assess the situation to ensure no immediate danger and report the concern to relevant HSCT adult safeguarding team/child protection Gateway Service for risk assessment and RQIA, within the required 72-hour timeframe.

We noted policies contained contact details of a nominated member of staff and details of external agencies, for example, RQIA, AccessNI and HSCT adult safeguarding teams and Gateway Service to contact in the event of a safeguarding concern. Overall we were assured by the content and quality of safeguarding policies we reviewed and the processes and systems described in response to safeguarding concerns.

Each organisation confirmed it incorporated pre-employment checks into their recruitment and selection procedures in line with:

Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005 which mandates:

19. (1) the registered person shall ensure that –

- (a) no person is employed to work in or for the purpose of the establishment or for the purpose of the agency
- (b) no medical practitioner is granted consulting or practising privileges unless that person is fit to work in or for the purpose of the establishment, or for the purposes of the agency
- (c) there is evidence that all professional registration and revaluation requirements are met

(2) A person is not fit to work in or for the purposes of an establishment, or for the purposes of an agency unless –

- (a) he is of integrity and good character
- (b) he has the qualifications, skills and experience which are necessary for the work which he is to perform
- (c) he is physically and mentally fit for that work
- (d) full and satisfactory information is available in relation to him in respect of each of the matters specified in Schedule 2

(3) The registered person shall ensure that all healthcare professionals are covered by appropriate professional indemnity.

Each independent hospital and hospice described how, as part of the pre-employment checks, new staff undergo enhanced Access NI checks before taking up post as an element of assurance. Organisations confirmed to us that new staff, if unable to evidence up-to-date training, received safeguarding training during their induction. This is provided either in-house, online or by external agencies and refreshed in line with their specific safeguarding policies.

The Review Team received examples of the materials used to deliver safeguarding training from Northern Ireland Hospice and Ulster Independent Clinic. These documents were reviewed and found to be comprehensive. In particular, the training undertaken provided varied examples of scenarios which staff could encounter through their roles, which should enhance the recognition of potential safeguarding concerns in future.

When reviewing safeguarding training records a number of the examples received did not display the date of their most recent training. Each independent hospital and hospice was subsequently urged to record the date at which each member of staff completed training, which will assist in efforts to ensure training are timely.

While those frontline staff interviewed could readily identify safeguarding triggers during inspections, they had limited access to information in the form of posters and leaflets located across independent hospitals and hospices to guide and assist them, patients and carers in the event of a safeguarding concern.

Frontline staff demonstrated good knowledge of safeguarding, including potential safeguarding triggers; the name of their organisation's safeguarding champion; the agencies to which they would escalate safeguarding concerns; and their role in relation to safeguarding. Following engagement with Senior Management in each independent hospital and hospice, it was determined that although they understood their individual and organisational responsibilities as described in Independent Health Care Regulations (2005) and Minimum Care Standards (2014), they did not demonstrate a sufficient understanding of the vital importance of creating a wider and proactive safeguarding culture, where rights are proactively protected in the delivery and design of services.

| Recommendation 9 | Priority 2 |
|---|-------------------|
| The Executive management teams and boards within independent hospitals and hospices must ensure they have in place a culture of safeguarding and implement effective operational safeguarding arrangements to include providing assurances to their Boards. | |

3.2 Staffing

Across all areas of healthcare, effective governance requires oversight and assurance of the management and deployment of staff. Appropriate numbers of suitably qualified, skilled and experienced staff with required competencies are a critical element of delivering safe and effective care.

Similar to the HSC, independent hospitals and hospices employ a broad range of staff. Organisations employed administrators, healthcare support workers, medical practitioners, nurses, porters, receptionists, volunteers and a range of other specialist health care professionals including occupational therapists, physiotherapists, podiatrists and radiologists.

The Independent Health Care Regulations (Northern Ireland) 2005 under Regulation 18³³ states that the Registered Person should ensure there is always an appropriate number of suitably qualified, skilled and experienced persons employed. The Regulation mandates staff are to receive a job description outlining their responsibilities, receive mandatory and other appropriate training, supervision and appraisal and be supported to obtain further qualifications appropriate to the work they perform. The Regulation also states that the Registered Person should ensure the fitness of workers through evidence of professional registration and revalidation, ensuring they are of good integrity, character and have the qualifications, skills and experience necessary for the work they perform.

These elements are reiterated in the Minimum Care Standards for Independent Healthcare Establishments. Standard 12 states “The number and ratio of staff on duty at all times meets the care needs of patients and clients”³⁴. This includes arrangements to provide cover at all times by appropriately qualified, trained and experienced practitioners. Records must be kept for all staff (to include training and hours of employment) which shows a rota of staff working over each 24-hour period, and staff meetings must take place on a regular basis, at least quarterly.

Independent hospitals and hospices are autonomous of HSC organisations. Professionals working in independent hospitals and hospices may work solely within independent organisations or may also have employment within HSC Trusts. Doctors can work with the independent sector as: Private Doctors who are doctors which have been granted practising privileges and who do not work in the HSC system; or Doctors who are employed by the HSC but deliver healthcare in hospitals and hospices under practising privileges agreements.

Nursing staff can work with the independent sector as Private Nursing Staff, Nursing staff registered with the Nursing and Midwifery Council (NMC) who are employed to work solely in independent hospitals and hospices; or HSC Nursing staff who are registered with the Nursing and Midwifery Council (NMC) and employed by the HSC sector while also working in independent hospitals and hospices.

Allied Health Professionals (AHPs) which includes occupational therapists, physiotherapists, pharmacists, podiatrists and radiologists can either be directly employed or employed under practising privileges. Support Staff may include porters, receptionists and cleaning staff who are most often employed directly.

Ensuring sufficient numbers of staff with the required competencies across healthcare settings is a significant challenge for those charged with managing and planning services.

During this review, the Review Team examined the mechanisms independent hospitals and hospices have in-place to ensure recruitment and selection is conducted in line with *the Independent Health Care Regulations (Northern Ireland) 2005* and the Minimum Care Standards for Independent Healthcare Establishments (2005).

Recruitment and selection practice were considered and in most cases, the Review Team was satisfied that effective systems were in place with respect to ensuring the right numbers of staff were in place with appropriate skills. Further details can be found in RQIA's inspection reports which include recommendations relating to individual establishments.

In respect of arrangements for the oversight of doctors working in independent hospitals, please see section 2.2 Medical Governance and recommendation 2.2. Clinical Governance.

Effective use of Staffing

The systems and procedures independent hospitals and hospices have in place to ensure that nursing staff and skill mix are planned appropriately were also examined. Staffing rotas were planned to take into account skill mix, number and dependencies of patients accommodated and the planned and unplanned leave of staff. The senior front line staff interviewed reported that they were supported in their roles and that their wards and departments were adequately staffed.

Staff Training

Independent hospitals

Across independent hospitals the Review Team learned of ongoing training opportunities in place to enhance the skills and knowledge of their nursing staff. Provision for training varied greatly between independent hospitals; for example, Fitzwilliam Clinic described how it provides at least one training day per year for statutory and mandatory training, while external agencies deliver additional training days throughout the year. Hillsborough Private Clinic told us about its five-year training plan, which is documented and managed by the Registered Manager.

North West Independent Hospital submitted a copy of the training schedule documentation it retains for registered nurses on their surgical ward. The Review Team reviewed this record and found that training topics included fire, infection control, safeguarding (adults and children), CPR and medication competencies.

Ulster Independent Clinic described a comprehensive training schedule for its nursing staff and provided a training and development plan. The schedule described how the hospital's Quality and Education Department conducts an annual training needs analysis to identify and schedule training sessions which are provided in-house and by external training agencies.

The plan included a range of staff disciplines including nursing, auxiliaries, radiographers, physiotherapists and theatre porters. The Review Team were impressed by the breadth of training provided.

Area of Good Practice

The Review Team learned of Kingsbridge Private Hospital's dedicated training academy situated in premises independent to the hospital. The training academy provides a diverse range of training including topics, from medical and health care training to interview preparation for internal and external clients.

Hospices

Each hospice demonstrated that nursing staff training needs are explored and scheduled following an annual appraisal. Foyle Hospice described how it conducts mandatory training sessions for registered nurses during the first two months of the year and cover topics including; fire safety, safeguarding (adults and children), infection control and prevention, manual handling, medicines management (which is support by the hospice pharmacist) and basic life support. Southern Area Hospice had a comprehensive programme provided by both internal staff and external agencies. Marie Curie Hospice described the electronic learning and development system it used to record and monitor registered nurses progress against mandatory training, which also notifies staff and line management when training is overdue. Northern Ireland Hospice described how it monitors staff compliance with a broad range of mandatory training monthly using an e-learning platform called 'Totara'.

Each organisation provided sufficient evidence of systems to monitor and oversee adherence to mandatory training and provided good opportunities for staff development and training.

3.3 Working with General Practitioners (GPs)

Effective communication is a key element of good governance and such systems should ensure effective communication and partnership between the organisations and the GPs following a patient's attendance or treatment.

Regulation 16 (6) of the *Independent Health Care Regulations (Northern Ireland) 2005* mandates for the care and welfare of patients outlining that the registered person in the independent hospital and hospice should ensure that the patient's GP is kept informed of relevant developments, including significant family distress and that this action is documented³⁵.

Standard 6 and Standard 38 in the DoH *Minimum Care Standards for Independent Healthcare Establishments (2014)* outlines standards in respect of dealing with the patient's GP in relation to discharge communication³⁶.

Interfaces and governance arrangements in place for liaison with GPs to ensure effective communication and partnership working were examined.

Independent hospitals

Patients can be referred to independent hospitals by their GP, a Consultant or via a waiting list initiative contract with an HSC Trust.

Independent hospitals described how clinical staff communicated with GPs and other health professionals involved in patient care for example:

- For all patients, clinical summary letters which detail procedures, treatments carried out, along with outcomes and any medications dispensed.
- For those patients who have undergone surgery, a copy of the operation note is forwarded to the GP, if the patient permits this.
- For patients who have attended outpatients' facilities, medication requests will be forwarded to the patient's GP in order for medications to be prescribed, if permitted by the patient.

In relation to patient discharge arrangements in independent hospitals, standard 6 (9) (Care Pathway) of the DoH *Minimum Care Standards for Independent Healthcare Establishments (2014)* states that "where appropriate to the setting and in line with the patient or client's wishes, a discharge letter summarising the patient or client's treatment and care is sent to their general practitioner and other professionals involved in their ongoing treatment and care"³⁷.

All independent hospitals provided discharge summary letters, with the patient's consent, notifying the GP of the treatment received and the outcome and advising if any follow-up care is required, including instructions in relation to medicines, where appropriate. For some patients undergoing cosmetic procedures, correspondence may not always be forwarded to the patient's GP, such as when the patient has requested that their GP is not contacted.

Although we found appropriate systems for communicating with GPs during most of our inspections, in January 2019 a specific recommendation relating to this area was made in the Ulster Independent Clinic, our inspection team recommended that the provider should ensure discharge letters are clearly legible and provide accurate detail of the specific procedure undertaken and/or treatment provided to the patient. Further details and corresponding recommendation can be found in the report of that inspection.

Hospices

Patients are referred into hospices by their GPs, community and hospital Palliative Care Teams, medical staff from the HSC Trusts, AHPs and District Nursing staff.

We found that hospices have clear, open channels of communication with GPs and other health professionals involved in patient care which assists in the delivery of coordinated, person-centred, high-quality specialist palliative care. This has improved in recent years with the introduction of NIECR in hospices.

During staff focus groups, various methods of communication were described, such as:

- Verbal discussions in relation to complex patient care and discharges.

- Clinical summary letters providing details of the patient’s care and medications currently provided (also uploaded onto NIECR^f).
- Information leaflets and posters provided to all GP practices in relation to the services provided in the hospice (Marie Curie).
- Hospice staff attend GP facilitator training days to provide updates to services (Marie Curie).

Standard 38 (4) of the DoH *Minimum Care Standards for Independent Healthcare Establishments (2014)* outlines that written information on the patient’s treatment and care should be provided to the patient’s GP, other professionals and services involved in the patient’s ongoing treatment and care³⁸.

We found that all hospices provide discharge summary letters, notifying the GP of the care patients’ received and advising of follow-up care, along with advice in relation to medicines. This correspondence is also uploaded onto NIECR and will also be sent to Community Palliative Care Teams and any other healthcare professional involved in the patient’s ongoing care.

GP Survey

Two online surveys were developed. One survey in relation to independent hospitals and one in relation to hospices. In both surveys, we asked if GPs considered communication to be effective.

In total, 77 GPs responded to our independent hospital survey while seven GPs responded to our hospice survey.

We asked GPs to consider if the communication of information regarding services between themselves and the independent hospitals and hospices was effective. Overall, in relation to independent hospitals, 77 %, (57 out of 77) indicated that it was not.

In relation to hospices, communication about services appeared better, with 78% (5 out of 7) describing it as somewhat, very or extremely effective. However, in relation to the hospice questionnaire, there were only a small number of respondents. In both surveys, we asked GPs if they felt that communication could be improved in respect of patients attending the independent hospitals and hospices. For those responding in relation to independent hospitals 88% (59 out of 74) responded “yes”, it could. However, for those responding in relation to hospices, 57% (4 out of 7) said “no”, as previously stated the numbers of respondents to this survey was low.

Table 6: Question: Overall, do you feel that communication in respect of patients from independent hospitals or hospices could be improved?

^f The Northern Ireland Electronic Care Record (NIECR) is a computer system that health and social care staff can use to get information about an individual’s medical history. The NIECR contains information from existing electronic record systems from hospitals and clinics throughout Northern Ireland as well as some information which is recorded directly in the system, such as: Laboratory tests, x-rays, referrals, investigation requests, appointments and encounter and discharge letters.

| Question we asked | Yes | No | Don't Know | Survey |
|--|-----|-----|------------|------------------------------|
| Overall, do you feel that communication in respect of patients from independent hospitals or hospices could be improved? | 88% | 5% | 7% | independent Hospitals (n=74) |
| | 43% | 57% | 0% | hospices (n=7) |

The majority of GPs responding to independent hospitals questionnaire indicated that communication could be improved through:

- Timely and legible clinical summary letters, particularly if the GP is being asked to follow-up with the patient.
- Use of electronic communication methods, such as the NIECR.
- Provision of contact details for individual healthcare professionals treating patients in the independent hospital should the GP need to contact them.

Read-only access to NIECR had greatly improved communications between GPs and services across the HSC sector, and recommended that the work already underway in the HSC Board and Business Services Organisation (BSO) to secure suitable levels of access for both independent hospitals and hospices is progressed without delay. While some independent hospitals and hospices have access to NIECR, this access is read-only. We determined that read/write access for all independent hospitals and hospices would better support the provision of safe care and sharing of patient information across both sectors.

Independent hospitals and hospices should ensure robust arrangements are in place in relation to the sharing of patient information with the HSC. This is discussed further in our section on Records Management (Section 3.5).

GPs were asked if they knew how to raise a concern or a complaint about the care or treatment experienced by a patient in an independent hospital or hospice.

In relation to independent hospitals, three-quarters of respondents, 75% (50 out of 67 respondents) stated they did not know how they could raise a concern or complaint about the care or treatment experienced by a patient. This pattern was similar in hospices with 86% of GPs (6 out of 7 responses) stating they did not know how to raise a concern about the care or treatment received by a patient in a hospice.

We also asked specifically if GPs knew how to raise a concern or a complaint about the performance of a healthcare professional involved in the care of one of their patients in either an independent hospital or hospice. A large number, 76% (51 out of 67 respondents), stated they did not know how to raise a concern or complaint regarding healthcare in relation to independent hospitals.

In relation to hospices, 86% (n=6 out of n=7) stated they did not know how to raise a concern or complaint regarding healthcare (Table 7).

Table 7: Questions: Raising a concern in respect of an independent hospital or hospice

| Questions we asked | Yes | No | Survey |
|---|-----|-----|---|
| Would you know how to raise a concern or a complaint about the care or treatment experienced by a patient? | 25% | 75% | independent hospitals (n= 67) |
| | 14% | 86% | hospices (n=7) |
| Would you know how to raise a concern or a complaint about the performance of a healthcare professional involved in the care of one of your patients in an independent hospital/ hospice? | 24% | 76% | Independent hospitals / Clinics (n= 67) |
| | 14% | 86% | hospices (n=7) |

The majority of GPs who responded were not confident about the processes for raising a concern and reinforced the significance of knowing clearly how to raise concerns about any professionals working in the independent sector or about a particular establishment. This is critically important in ensuring effective governance and oversight of these services. GPs are a vital part of such a system as they may be one of the only professionals with a complete picture of the care received by groups of individuals receiving care in an establishment or with a holistic picture of the various healthcare services received by an individual patient.

| Recommendation 10 | Priority 1 |
|---|-------------------|
| Independent hospitals and hospices should develop and promote clear guidance and specific contact points within each organisation. They should enable GPs and other healthcare professionals to raise a concern about the care which has been provided in an independent hospital or hospice and/or concerns relating to the performance of a healthcare professional involved in the care of their patient(s). | |

3.4 Medicines Management

Each organisation should ensure robust governance and oversight of medicines management. When managed correctly, medicines have the potential to improve a patient's condition, alleviate pain and support patient safety and the effective delivery of healthcare. However, inadequate medicines management has the potential to result in loss of resources, disruptions to service, serious harm and even potential deaths.

Regulation 16 of the *Independent Health Care Regulations (Northern Ireland) 2005* mandates: the registered person shall make suitable arrangements for the ordering, recording, handling, safe keeping, safe administration and disposal of medicines used in or for the purposes of the establishment, or for the purposes of the agency.

Medicines management is included in Minimum Care Standards for Independent Healthcare Establishments under Standard 25, 26, 27 and 28, which states medicines and controlled drugs are managed and stored safely, securely and effectively in compliance with legislative requirements, professional standards and guidelines³⁹.

The policies and procedures used to ensure that medicines are appropriately managed in line with legislative requirements, professional standards, guidelines and best practice. We were mainly satisfied that medicines are managed in line with organisational specific policies and procedures.

Each organisation identified a designated member of staff (this ranged from staff nurse on duty in Hillsborough Private Clinic to a dedicated Pharmacist at the Northern Ireland Hospice). This person was responsible for the management of medications, which included ordering, and storage of received medications from agreed reputable providers of pharmaceutical services via requisition orders.

We reviewed medicine management policies shared by Kingsbridge Private Hospital, North West Independent Hospital, Orthoderm Clinic, Hillsborough Private Clinic, Fitzwilliam Clinic, Northern Ireland Hospice and Foyle Hospice.

We found that these documents differed in size and detail, however, each included:

- Agreed pharmacist suppliers
- Checklists to be completed on receipt of a medication order
- Appropriate storage, administration, actions to be undertaken in the case of adverse reaction
- Disposal and destruction of medications
- In the event of a shortfall, the reporting steps which should be taken if the event of an adverse incident (contacting RQIA)

There were effective systems for medicines management across various areas, for example, the management of controlled drugs; multidisciplinary medicines review; medicine Kardexes were well completed; and medicines were stored safely and securely and in accordance with manufacturer's instructions. Medicine storage areas well maintained and well organised and there were systems in place for assessing, tracking, recording, reporting and investigating medicine-related incidents.

Information about their Medication

Patients and their relatives received written and verbal information and guidance about their medicines from doctors and pharmacists and from registered nurses helping to deliver their care. Written information most often was in the form of an information leaflet.

Area of Good Practice

At discharge from Marie Curie, patients are given written information about their medication in the form of a medication card. This card is completed electronically by the organisation's pharmacist and is used to counsel patients and their relatives about their specific medication needs. Marie Curie described how all patients who receive opioid medication receive counselling and written information, and they are currently in the process of introducing guideline leaflets for those new to receiving opioids.

The Review Team was encouraged by the level of information independent hospitals and hospices provided to patients and their relatives. They encouraged each independent hospital and hospice to continue to develop the provision of information in relation to medication and treatment for patients and their relatives in paper/leaflet form. This will allow patients/relatives with information to reference after their appointment/consultation.

3.5 Records Management

Records management governance requires systems and processes which ensure staff compliance with professional records keeping standards, information governance and organisational policies and procedures. Staff are required to have a comprehensive understanding of what records are held, what format they are held in, who they are managed by, their relationship to groups and individuals within the organisation and who is responsible for accessing them. Only when each of these steps is completed consistently can the organisation be assured that their systems are effective.

We examined the governance systems and processes of independent hospitals and hospices to ensure safe and effective record management was in place. We also examined how patient records are updated, managed and maintained.

The practice of retaining comprehensive medical records in relation to each patient is also mandated in *the Independent Health Care Regulations (Northern Ireland) 2005* under, Regulation Article 21⁴⁰. The Regulations state that the Registered Person should ensure that a comprehensive medical record is maintained for each patient which includes: a contemporaneous note of treatment provided; medical history and any other notes prepared by a healthcare professional; retained as per the legislation; stored securely; kept up to date; and is available for inspection.

This is reiterated in the Minimum Care Standards for Independent Healthcare Establishments (2014), Standard 8, which mandates "Records are maintained for every patient and client in accordance with legislative requirements and best practice guidelines"⁴¹. The Standard covers the requirement for written policy and procedures to include record creation, use, retention, storage, transfer and disposal; compliance with guidelines and standards; records are available for inspection; staff are trained in

records management; and patients/clients have access to their records in line with legislation (Data Protection Act 2018, Information Commissioner's Office Regulations and Freedom of Information).

All independent hospitals and hospices submitted examples of internal policies and procedures which staff were required to adhere to in the context of best practice in the management of records, to cover arrangements for the creation, use, retention, storage, transfer, disposal of and access to records. Policies and procedures in respect of data protection and the General Data Protection Regulations (GDPR), confidentiality and security were also shared and were deemed to be satisfactory by our Expert Review Panel.

Independent hospitals

Independent hospitals used a mixture of electronic records systems secure hosted patient management systems and paper-based systems. Appropriate storage, access arrangements and security were in place for both electronic and paper-based records in all independent hospitals, for example: in Kingsbridge Private Hospital, an electronic system was used for recording and retaining outpatient records which the hospital staff described as allowing them to have full sight of outpatient activity.

The Independent Health Care Regulations (Northern Ireland) 2005 clearly specifies that records should be retained in respect of patients attending for care and treatment; this includes patients attending for review in the outpatients' department of the independent hospital.

There were comprehensive medical records for patients in inpatient facilities which contained medical, nursing and AHP notes detailing results of investigations, care plans, medicine prescription charts, etc. These records were competently completed, concise and clear. The Ulster Independent Clinic also held medical records for those patients attending as day patients and had a dedicated Medical Records Department.

For those patients who attended as outpatients, the independent hospitals did not always hold a comprehensive medical record; instead, we were told that individual Consultants may hold these records off-site, which is not in keeping with regulation.

We did note that a medical secretary service is offered by the Ulster Independent Clinic whereby a record of a patient consultation is typed by a medical secretary and held on an electronic system. However, this was only the case for those Consultants who avail of this service, and not all providers of care in the clinic.

Area of Good Practice

The North West Independent Hospital and Kingsbridge had a system in place whereby clerical support is part of the arrangements and is included in their agreement which allows doctors to use the hospital for outpatient consultations. This ensures the hospital holds all patient records on-site and thus maintains appropriate oversight and governance. The Review Team agreed this was an example of good practice.

In general, we were unable to find patient care records on-site in the majority of independent hospitals for consultations in outpatients, which would enable staff to prepare and provide appropriate assistance for individualised care.

As reported previously, *the Independent Health Care Regulations (Northern Ireland) 2005* clearly specifies that records should be retained in respect of patients attending for care and treatment; this includes patients attending for review in the outpatients' department of the independent hospital.

Our Review Team agreed that this is an area of significant risk and potentially exposes the independent hospitals to unsafe practice and other safety risks, with no systems in place to identify and manage such risks. Without this information, independent hospitals are unlikely to have sufficiently thorough governance and oversight of the care and treatment delivered through their outpatients' services.

| Recommendation 11 | Priority 1 |
|---|------------|
| Independent hospitals must ensure they have a robust system in place to retain and enable access to comprehensive medical records for all patients receiving or who have received care and treatment in the hospital, regardless of whether the patient is seen as an inpatient, outpatient or day case patient, in accordance with the 'Independent Health Care Regulations (Northern Ireland) 2005', Regulation 21 (Records). | |

Clinical staff and Managers expressed a strong desire to secure access to the Northern Ireland Electronic Care Record (NIECR⁹). They highlighted the importance of full access to NIECR, which could provide the independent hospitals with accurate, up-to-date patient information, such as diagnostic test and imaging results, as well as clinical summaries. This would be particularly helpful and ensure access to appropriate information when patients present for admission, particularly if no pre-admission assessment is undertaken.

Our Review Team agreed that access to NIECR would be beneficial for the independent hospitals in ensuring continuity of care across both the HSC and independent sector. We heard that discussions in relation to full access were already progressing by the NIECR Information Governance Group in the HSC Board and the Business Services Organisation (BSO) and a proposal to provide NIECR access to identified independent sector providers had been approved for consideration by the Strategic Information Board, subject to details in respect of cost, consent and information governance addressed. The Review Team welcomed this development and encouraged engagement with BSO in this regard.

| Recommendation 12 | Priority 1 |
|---|------------|
| Independent hospitals and hospices should continue to engage with the Electronic Health programme in HSC Board and the BSO to secure appropriate access to NIECR and support provision of safe care and sharing of patient information across both sectors. | |

⁹ NIECR is a computer system that health and social care staff can use to get information about patients medical history. This information includes for example: referrals, appointments and test results.

In the meantime, our Review Team agreed that independent hospitals should consider developing alternative mechanisms which enable sharing patient information with the HSC, particularly in respect of those undertaking waiting list initiative, contracts to ensure patient safety and continuity of care is to be maintained.

3.5 Records Management Hospices

All hospices used both electronic and paper-based record systems. The Southern Area Hospice Services uses only paper-based records. Marie Curies Hospice has an electronic patient record system EMIS which was introduced in 2016. All Hospices have read-only access to NIECR which our Review Team agreed is vital in terms of monitoring the quality of care and patient outcomes.

Our Review Team was encouraged to hear that the Southern Area Hospice Services was reviewing its patient records management system and planning the implementation of an electronic record system in the near future.

There were comprehensive patient records and no issues were found in relation to information sharing with the HSC. Inspector found patient care records which contained medical, nursing and AHP information, detailing results of investigations, care plans, medicine prescription charts, etc. These records were well documented, contemporaneous and clearly outlined the patient journey.

3.6 Monitoring Quality

The practice of reviewing the quality of treatment and other services is mandated in *the Independent Health Care Regulations (Northern Ireland) 2005*, Regulation 17⁴². The Regulation states that the Registered Person should introduce and maintain a system for reviewing at appropriate intervals the quality of treatment and other services provided. This includes provision for consultation with patients and their representatives, putting in place additional safeguards where shortcomings in systems are highlighted and arrangements for dealing with, and learning from, adverse incidents. All independent hospitals and hospices reported that the patient's assessed needs and resulting care and treatment is based on relevant legislation, standards and evidence-based guidance (for example NICE Quality Standards) and is underpinned by the organisation's policies and procedures and regulated by RQIA.

This is underpinned by the DoH Minimum Care Standards for Independent Healthcare Establishments, Standard 9, which states "Patients and clients are provided with safe and effective treatment and care based on best-practice guidance, demonstrated by procedures for recording and audit"⁴³.

All independent hospitals and hospices use a variety of information to review the quality of their services, for example, complaints; incidents; accidents; and audits. Independent hospitals reported that data from these sources are reviewed at the MAC, as well as the appropriate management meetings or committees within their governance structures, and at staff meetings. They explained these mechanisms help identify required improvements and changes.

To examine how the independent hospitals and hospices assure patients experience satisfactory outcomes, we reviewed how each organisation collected and monitored evidence of the effectiveness of patient treatment, evaluates care against national and local benchmarks, and how audits are used to ensure effective care.

We also examined how the governance structures in each organisation assessed and reviewed clinical data and other outcome information, for example, patient transfers out to other HSC acute hospitals.

We found examples of good practice, for example, Northern Ireland Hospice has introduced a validated suite of Outcome Assessment and Complexity Collaborative (OACC) measures for its adult services and Marie Curie has scheduled training in quality outcome measures, using the OACC suite of measures.

Regional and National Benchmarks

All independent hospitals and hospices provided examples of both regional and national benchmarking initiatives, which they use to monitor care and treatment outcomes for patients receiving their services and to compare with similar services.

Examples we examined included:

Northern Ireland (Regional)

- Northern Ireland Cancer Registry
- Regional Groups, for example, Northern Ireland Endoscopy Group and Northern Ireland Paediatric Collaborative
- Regional Palliative Medicine Audit Group

National

- Independent Healthcare Providers Network
- Independent Healthcare Sector Complaints Adjudication Service
- CHKS Accreditation
- ISO Accreditation: ISO 13485 HDSU/Endoscopy
- Laboratory Accreditation (UK Accreditation Service)
- National Joint Registry
- British Society for Surgery of the Hand
- Hospice UK Patient Safety Clinical Benchmarking in Inpatient Units
- National Benchmarking Audits via Hospice UK
- National FAMCARE Survey of Bereaved Relatives

The independent hospitals provided data to the Private Healthcare Independent Network (PHIN)^h and all reported challenges with this arrangement. The independent hospitals are required to input their patient and Consultant data to the Network for a fee, with the assurance of receiving benchmarking information from across the UK.

However, our Review Team heard that this Network was developed in accordance with clinical codes agreed in England and Wales and, as a result, data from Northern Ireland is not easily extracted and comparable due to these coding issues.

^h PHIN is an independent, government-mandated source of information about private healthcare, working to empower patients to make better informed choices of care provider. PHIN is a not-for-profit organisation, helping to improve data quality and transparency.

We also learned that as limited information was received back from PHIN this had not proved useful in effecting meaningful change to practice in Northern Ireland.

Our Review Team concluded that data and information received from PHIN did not enable comparison between services and could not be used in a way which underpins improvements in care in independent hospitals in Northern Ireland.

| Recommendation 13 | Priority 2 |
|--|-------------------|
| Independent hospitals should collectively engage with PHIN representatives to develop Northern Ireland reports which contain comparative information with other UK independent hospitals that can be used to drive improvement initiative and improve the quality of services. | |

Senior managers from Trusts and HSCB were concerned that sometimes patients present at HSC hospitals with adverse outcomes following treatment in the independent sector. There are not currently any clear mechanisms to ensure that independent hospitals are informed of any adverse outcomes.

Our Review Team agreed that this is a significant risk as the independent hospitals do not have full visibility of eventual patient outcomes and therefore may be unaware of any trends or patterns emerging, specifically in respect of care and/or treatment provided by the same medical practitioner, and any action required.

| Recommendation 14 | Priority 2 |
|--|-------------------|
| HSC Trusts and all independent hospitals should develop clear mechanisms to enable a HSC professional to advise when a patient presents to an HSC facility with known adverse outcomes or incorrect diagnoses following treatment. This will support the organisation to clearly understand its care outcomes and performance in relation to quality and safety. | |

Audit

Standard 9 of the DoH *Minimum Care Standards for Independent Healthcare Establishments* states that “Patients and clients are provided with safe and effective treatment and care based on best-practice guidance, demonstrated by procedures for recording and audit”⁴⁴.

Each independent hospital and hospice returned information that audits are used to assess performance against agreed standards as part of a rolling audit programme. All stated that they had mechanisms in place where results from audits were reviewed by the appropriate committee within the governance structure.

Our inspection teams confirmed that, for most of the independent hospitals and hospices, adequate arrangements were in place to monitor, audit and review the effectiveness and quality of care delivered to patients at appropriate intervals through audit which included a wide range of themes such as:

- Accidents and incidents
- Environment cleanliness
- Infection prevention and control
- Decontamination of flexible cystoscopes and reusable medical instruments
- Medicines management
- Control of substances hazardous to health (COSHH)
- Nutrition and hydration
- Patient records
- Completion of surgical register
- Return to theatre
- Discharge planning and summary

In most of the organisations we also found arrangements in place to monitor, report and review actions from audits and clinical quality indicators by the appropriate committee/group in the organisation’s governance structure. In most cases, we found action plans to address any shortfalls identified during the audit process. We heard that a range of quality assurance data and key performance indicators (KPIs) are fed back to the relevant Trust on a regular basis. As part of the ongoing contract management processes, each independent hospital and hospice provides regular reports covering data on items such as:

- Number of deaths
- Number of serious injuries
- Number of returns to theatre
- Unplanned readmissions
- Surgical site infections
- Number of discharges
- Number of operative procedures
- Number of inpatient bed days

Where services are contracted by HSC trusts, this data could be used to monitor the performance of the hospital or hospice, with meetings arranged at agreed intervals throughout the period of the contract to address any issues or concerns.

We were advised that the meetings included a review of service quality, clinical outcomes and governance arrangements.

We were informed that HSC Trusts reviewed the number of complaints or adverse incidents occurring to monitor the performance of the independent hospitals. We were told by the HSC Trusts that where they identify an increase in the number of complaints or incidents, they may engage with the patient/client to ascertain possible causes. The Trusts will also hold review meetings with the independent hospital to discuss performance issues.

We were told that all incidents are reviewed by the HSC Trust to determine if an adverse incident meets the criteria for classification as a Serious Adverse Incident (SAI). If an SAI is identified, the regional procedure for investigation will be initiated. We report on this in Section 2.5

In relation to hospices, we heard that the HSC Board conducted bi-annual, face to face meetings with each hospice where contract performance against KPIs and quality indicators are reviewed. These included KPIs related to service volumes and quality standards as set out in the Service Level Agreements (SLAs) with all hospices.

Various types of audit information were collected by independent providers however were not assured that the systems in place were operating well enough to ensure the ongoing provision of a safe service. There was not sufficient evidence that information was being used intelligently or that trends and issues were being identified. Our Review Team was particularly concerned that data and information collected was activity-related and there was insufficient focus on quality or patient outcomes.

Our Review Team agreed clinical quality indicators should be identified by multidisciplinary groups with the knowledge and skills to review data, information and trends. The quality indicators should relate to each of the clinical areas and be collated onto a dashboard and made available to all staff to inform both commissioning of and the delivery of services.

| Recommendation 15 | Priority 2 |
|---|-------------------|
| <p>All independent hospitals and hospices should develop effective systems to gather, analyse and communicate information about the quality of care they deliver to inform quality assurance systems/processes and drive continuous improvement in services.</p> <p>This information should be reported through the appropriate governance structures to the Medical Advisory Committee and the Board of Trustees/Directors to enable effective and comprehensive oversight of the quality of care delivered.</p> | |

3.7 Management of Complaints

Complaints offer an invaluable means of feedback to identify safety issues and inform improvement to services delivered.

Effective complaints management is mandated by *the Independent Health Care Regulations (Northern Ireland) 2005* under Regulation 23⁴⁵. The Regulations define the requirement for a procedure to receive, manage and respond to complaints made by a patient or a person acting on behalf of a patient, ensuring full investigation within the specified time periods, appropriate recording with actions and outcomes and timely reporting to RQIA.

The management of complaints is also stated in the Minimum Care Standards for Independent Healthcare Establishments, Standard 7, which requires “All complaints are taken seriously and dealt with appropriately and promptly”⁴⁶. Criteria include a legislatively aligned procedure which is provided to patients in a range of formats and is publicised; that staff know how to receive and deal with complaints; those complaints are investigated in a timely manner and recorded appropriately, and that information coming from complaints is used to improve the quality of services.

The Minimum Care Standards also require the monitoring of the quality of services and stipulates that complaints should be considered as part of this (Standard 9.5), with appropriate reporting to the MAC in relation to complaints against individual medical professionals when reviewing practising privileges (Standard 30).

Independent Hospitals and Hospices

All independent hospitals and hospices had a complaints procedure in place, in most cases this was in line with requirements in relevant legislation. As part of our inspections, we found this to be in line with the relevant legislation and DoH guidance on complaints handling. Relatives and those using the services could access information on how to make a complaint in various ways, such as via patient information leaflets, on the organisation's website and complaints policies and procedures which are displayed in waiting rooms and wards.

Across all organisations, we found good awareness of the complaints procedures and how complaints are handled throughout the organisation. Complaints were recorded appropriately, noting the result of any investigation the outcome and any subsequent actions taken. A sample of complaints in those independent hospitals and hospices inspected demonstrated, in the main, that all were investigated and responded to appropriately.

Area of Good Practice

To ensure staff are equipped to deal with concerns and complaints effectively, Southern Area Hospice Services provided training for 10 senior staff from an externally accredited trainer in relation to complaints handling and investigations. All 10 staff attained Level 5, Self-Regulated Framework (SRF), Business and Technology Education Council (BTEC) Professional Certificate. Following the training, the hospice reviewed its Complaints Policy and updated it to reflect the learning.

In two independent hospitals, we found that the registered individual considered the responsibility for dealing with a complaint lay with the individual doctor with whom the patient had their consultation. The two organisations had been forwarding the complaints on to the individual medical practitioner, rather than responding directly from an organisational level. This process is not in line with regulatory requirements.

Additionally, during inspections of North West Independent Hospital, we found that whilst in some cases complaints had undergone audit, these had not been reviewed by the MAC as because they were not meeting as regularly as mandated by regulation.

Following our inspection to the Ulster Independent Clinic in January 2019, the management of complaints was identified as an area for improvement the details of which can be found in our inspection reports.

As a result of these two examples, our Review Team was concerned about the potential for misunderstanding of the responsibility for addressed complaints resides. They were clear that this responsibility should reside with the individual organisation rather than the consultant.

| Recommendation 16 | Priority 1 |
|---|-------------------|
| <p>All independent hospitals and hospices should ensure that:</p> <ul style="list-style-type: none"> a) robust systems are in place to appropriately investigate and manage complaints received in relation to staff employed or providing services through practicing privileges arrangements. b) Information and intelligence relating to complaints received must be appropriately triangulated with other available information and used to drive improvements in the safety and quality of care delivered. | |

Learning from Complaints

Most organisations were able to describe their efforts to learn from complaints. We heard that complaints are a standing item on agendas of staff meetings, Governance Committees and MAC meetings.

Senior Management in Hillsborough Private Clinic told us that they share relevant information from complaints with all medical staff by email, where appropriate, and Marie Curie ensured complaints are discussed at its Service Improvement Committee. Lessons emanating from complaints are implemented through changes to policies and procedures, with staff notified of these changes via staff meetings.

The Review Team was not convinced that themes emerging from complaints were being analysed fully with sufficient input and scrutiny from relevant Governance Committees or the MAC. This makes identification of appropriate action or learning from complaints difficult. Sufficient scrutiny is required to ensure the correct themes are identified and remedial action is put in place where necessary. It is of vital importance that learning is shared across the organisations in order to drive improvement in the quality of services and identify any risks and manage these effectively.

In March 2019, we made a recommendation for the North West Independent Hospital for improvement against Standard 7.

This was to ensure that themes emerging from complaints analysis are shared with the MAC and other relevant governance committees and that action taken to address themes are recorded, with learning disseminated across all staff groups.

Ensuring learning from complaints is an important aspect of developing a learning culture. A more robust mechanism to examine trends arising from complaints would support learning throughout the independent hospitals and hospices and would inform and influence improvement in relation to practice and/or care delivered throughout the independent hospitals and hospices.

| Recommendation 17 | Priority 1 |
|---|-------------------|
| All independent hospitals and hospices must ensure detailed analysis of trends and patterns relating to complaints, with detailed reports being shared with the Medical Advisory Committee or other relevant governance committees. Information should be shared across all staff groups. | |

Section 4: Commissioning and its Governance Arrangements

As described in Section 1.5 *the Independent Healthcare Sector*, independent hospitals provide a vital additional resource for HSC sector when demand for health care services is greater than capacity and hospices provide specialist care to meet the needs of patients with life-limiting, life-threatening illness and palliative care needs. In this section, we describe the governance systems which support commissioning arrangements between HSC organisations and independent hospitals and hospices.

4.1 Independent hospitals: Commissioning

In responding to our questionnaire, the HSC Board reported that the DoH may fund independent hospitals (for one year only) to reduce elective access waiting lists across the HSC. When this happens additional procedures may be commissioned from the independent hospitals across Northern Ireland in accordance with the Public Contracts Regulations 2015⁴⁷.

The two most commonly used procurement models are:

- Northern Ireland Regional Dynamic Purchasing System (prepared by the HSC Board / HSC Trusts)
- Open Tenders (procured by the HSC Trusts).

Northern Ireland Regional Dynamic Purchasing System utilises two stages:

- **Stage one** is overseen by the HSC Board, with support from the Regional Procurement and Logistics Service (PaLs), Directorate of Legal Services (DLS) and from Regional Business Services (BSO) along with the HSC Trusts. Applicants will provide a range of information concerning legal identity, economic and financial standing, as well as declarations about their technical or professional ability. Applicants can apply to be considered eligible for one or more waiting lists (known as Lots) which are defined in terms of clinical speciality, for example, orthopaedics and ophthalmology.

Evidence of an applicant's registration with a regulator or internationally recognised body is also used to certify compliance with the minimum standards of services, as is a large volume of information relating to the applicant's ability to deliver the specific Lot. An assessment is carried out on a pass/fail basis and a pre-qualified list is derived of those applicants/providers who are considered to be eligible to bid at stage two.

- **Stage two** consists of competition via tender which is delegated by the HSC Board to the individual HSC Trust. Each Trust has a specific department either within their Planning, Performance and Informatics or their Finance and Contracting Directorate for the management of acute independent sector services to award contracts in line with the Public Contracts Regulations 2015⁴⁸.
- HSC Trusts will activate their tender processes whereby service specifications are drawn up detailing the clinical speciality, case-mix and service requirements. These are offered to those on the pre-qualified list. Bids from independent hospitals on the pre-qualified list are assessed by a specific waiting list initiative group in the Trust led by a relevant clinician for the respective speciality.

- Bidders are assessed to ensure they meet all areas outlined in the service specification and price per procedure and available capacity to provide the service. The successful bidder(s) are subject to confirmation (via testing) of the declarations previously made and a contract initiation meeting is held with the independent hospital (bidder).

Particular attention was paid to arrangements for assuring the skills and experience of nominated Consultants appointed to the contract. If satisfactory, the provider is awarded the contract which will confirm the detail of volumes, pricing, timescales, approved staff and patient pathways.

Trust Senior Management, and commissioners from the HSC Board informed us that, in practice, it continues to use a regional framework (now expired) to commission services from the independent hospitals. Work is ongoing, with support from Procurement and Logistics Service (PaLS), the Directorate of Legal Services (DLS) and the HSC Trusts to develop and implement the Northern Ireland Regional Dynamic Purchasing System. Management from the HSC Board anticipated that the Regional Dynamic Purchasing System would be implemented during 2020/2021.

At the time of fieldwork (August 2019), the HSC Trusts also informed us that the new Regional Dynamic Purchasing System had not been implemented. For example, one Trust highlighted that it was being approached by private organisations for potential business, however, the Trust felt vulnerable as they continue to procure using an old process which was out of date in terms of legislation and regulations.

4.2 Independent hospitals: Governance Arrangements in respect of Commissioning

Once a contract has been awarded, the successful independent hospital will undertake a patient pre-assessment and may return patients to the HSC Trust if it considers the case to be clinically unsuitable or if the case is outside of the service specification.

We were informed contracts are regularly monitored and activity is reported to the HSC Trusts on a weekly basis to enable the Trust to track the progress of patients. Patient clinical outcomes are advised to the Trust at various points in the patient journey and upon discharge from the independent hospital. A summary of the treatment received is reported to the Trust. This is used to update the Patient Administration System (PAS) in the Trust and the patient's attendance is also recorded on NIECR.

We enquired about processes for commissioning independent hospitals to deliver services for patients in particular how the organisations assured themselves about the quality of work undertaken. A standard set of terms and conditions being applied to each contract awarded, together with the service specification. These terms and conditions were described as having been developed to assure the efficiency and effectiveness of the service delivery.

A range of quality assurance standards and key performance indicators (KPIs) are included in the contract and the service specification. In particular, the HSC Trusts

referred to the indicators in relation to time efficiency for the delivery of the specified clinical activity being measured rather than outcomes.

HSC Trusts and HSC Board described the ceiling prices within which providers must bid to assure value for money. These price ceilings are based on NHS Healthcare Resource Group (HRG) tariffs. Additional mechanisms include regular formal monitoring meetings, which were used to address any concerns and as a forum for regular informal communication between the HSC Board, the Trusts and the Business Services Organisation (BSO) regarding these contracts.

Various partnership initiatives existed where information about quality outcomes or general concerns could be heard during the commissioning process. For example, we heard about the Regional Independent Sector Group, chaired by HSC Board's Assistant Director for Commissioning, with representation from the Performance Management and Service Improvement Directorate at the HSC Board, the five HSC Trusts, PaLS and DLS. In addition, there is a Regional Complaints Group chaired by HSC Board Corporate Services and a Procurement Network chaired by PaLS.

When challenges arise between the HSC Trust and the independent hospital in respect of services provided, we were informed that contract documentation contained procedures for engagement and dispute resolution. Clinical governance issues were usually addressed through dialogue between clinicians from both organisations and were followed up in writing as a contract variation. Administrative or financial governance issues will be usually addressed through dialogue at scheduled monitoring meetings, where remedial actions and/or contract variations are agreed and recorded. Escalation procedures are included in the contract, ranging from issuing a performance notice at the initial stage to a legal remedy for non-compliance or under-performance. The contract also details how complaints and adverse incidents will be dealt with.

Senior managers from the five Trusts, they described that the commissioning process is providing some assurance when procuring waiting list initiative work, however, at times there was concern in relation to the robustness of the overall governance systems within the independent hospitals themselves.

In particular, when a patient self-presented to an HSC hospital after having received care in an independent hospital they were not clear on how the original care provider would be kept informed of the patient's eventual outcomes and thus be assured in respect of the quality of care originally provided.

Other Trust concerns related to interfaces with the independent hospitals included the Consultants not having access to NIECR and therefore not having access to all available information in respect of the patient's medical history. They reported at times being concerned about the practice of numerous Consultants being involved in treating individual patients resulting in a lack of continuity of care. They were also concerned at the practice in place in two independent hospitals, of using non-consultant grade consultant surgical assistants working under the supervision of Consultants to deliver care, and whether there were practising privileges agreements in place as required.

Our Review Team acknowledged that there were several stages during the commissioning process where there were limited point in time checks that would support some level of governance and oversight, for example, checks of registration, qualifications and AccessNI.

There remained some weaknesses in respect to the continual oversight of the various organisations involved within the contracting processes and this had the potential for gaps in oversight.

It was not clear if the HSC Board would be formally notified of ongoing quality issues or concerns by the HSC Trusts or organisations commissioned or how that information would inform the first stage of pre-qualifying for future contracts. It was also not clear if the processes for complaints and concerns during contract monitoring was effectively linked to medical governance systems within the HSC Trusts or independent hospitals.

Our Review Team also agreed that there was a risk that any poor outcomes associated with independent sector work would only be identified following discharge from the independent hospital within the HSC system and those arrangements for feeding this information back to individual independent hospitals and Consultants appeared somewhat ad-hoc.

| Recommendation 18 | Priority 2 |
|--|-------------------|
| <p>The Trusts and commissioners should establish formal systems for information sharing in respect of issues of the quality of work undertaken in independent sector for HSC patients for whom care has been commissioned by Trusts.</p> <ul style="list-style-type: none">a) This information should be fully considered and inform future decisions relating to procurement of HSC work.b) It should also ensure any issues relating to the performance of individuals or organisations are considered appropriately, any immediate actions taken and, if required, are reported to the appropriate organisations (Regulation and Quality Improvement Authority, General Medical Council, Health and Social Care Trust and other relevant professional bodies). | |

4.3 Hospices: Commissioning

The HSC Board commission hospice inpatient, day hospice and specialist community palliative care services across Northern Ireland. A number of historic local arrangements (HSC Board described these as legacy arrangements) also remain with HSC Trusts and the trusts are also involved with the commissioning of night sitting services at district nursing level.

Table 14: Independent Service Providers and Commissioning by Individual HSC Trust and the HSC Board

| HSC Commissioning Organisations | Independent Service Providers | | | |
|---------------------------------|-------------------------------|---------------------|--------------------------|--------------------------------|
| | Foyle Hospice | Marie Curie Hospice | Northern Ireland Hospice | Southern Area Hospice Services |
| HSC Board | ✓ | ✓ | ✓ | ✓ |
| Belfast Trust | | ✓ | | |
| Northern Trust | | ✓ | ✓ | |
| South Eastern Trust | | ✓ | | |
| Southern Trust | | | | ✓ |
| Western Trust | | | ✓ | |

Source: RQIA Returned Questionnaires

Representatives of the HSC Board and commissioners reported that oversight arrangements for hospice services are primarily the responsibility of the multidisciplinary Palliative and End of Life Care Planning Team. This planning team was comprised of medical, nursing, AHP, social work, pharmacy, finance, project management and information professionals.

Commissioning of these services was informed by the Palliative Care in Partnership's Regional Needs Assessment Analysis and development of specifications of service volumes, Key Performance Indicators (KPIs) and quality standards as set out in Service Level Agreements (SLAs) with all hospices.

Discussions also take place between the commissioner and a range of stakeholders to identify the need at the local level. Input is sought from patients and their families and carers via the Programme's Voice4Care Forum.

4.4 Hospices: Governance Arrangements in respect of Commissioning

The HSC Board advised of several mechanisms through which it assures itself that services commissioned from the hospices are safe and effective. These included:

- meetings with each hospice, undertaken generally three times per year to monitor the delivery of activity as per the Service Level Agreement (SLA) Bi-annual performance meetings to review achievement of quality indicators.
- feedback from services users via the Voice4Care Forum, the 10,000 Voices Project and complaints, which inform monitoring meetings; and
- review of RQIA inspection findings in relation to issues raised in respect of hospice services is usually undertaken annually and information sharing takes place on an as-required basis.

If the HSC Board identifies issues or concerns between an HSC Trust and hospice provider, its Palliative and End of Life Planning Team will arrange bespoke meetings to address the specific issues and will also discuss these with the DoH at its bi-annual accountability meeting, when appropriate. Issues may also be discussed at locality palliative care fora and then escalated to the Palliative and End of Life Planning Team or the Regional Palliative Care in Partnership Board.

The HSC Board outlined several reviews it had undertaken in relation to aspects of services provided by the hospices, for example:

- review of the day hospice model provided by hospices
- reviews of core funding model to hospices
- review of pharmacy input to hospices
- interdisciplinary specialist palliative care workforce review
- review of the opportunities to report on service quality outcomes within the hospice sector

Commissioners reported that HSC Board received general activity data from each of the hospices in relation to inpatient admissions, day-care and specialist community palliative care services. This data included occupied bed days; occupancy rate; the number of deaths; the number of discharges; the average length of stay (LOS); day-care attendances; numbers of cancer and non-cancer patients; referral source; telephone activity and the number of visits in community services.

There was a collective desire and need for the palliative care model to evolve from an activity-based model of commissioning to one which is driven by quality and patient outcomes. This would need to be supported by the HSCB, HSC and the hospices with a view to transforming the model of service delivery to have a greater emphasis on connectivity between community and inpatient services. As these services span community and inpatient provision and are commissioned separately by Trusts and HSCB we were informed that current arrangements do not easily support necessary change and transformation.

A renewed focus on quality and patient outcomes by commissioners is required which would be an important driver of improvement, but ultimately realisation of such improvements would be contingent on effective governance within each hospice.

During a meeting Senior Management teams from each Trust, we heard that current contracts were commissioned on a legacy agreement which had been in place for more than 10 years and this had not been modernised to reflect current needs of the population. The responsibility for monitoring the delivery of the required activity for inpatient hospice activity was primarily the responsibility of the HSC Board however, there were some opportunities for communication about any issues or concerns at the quarterly Locality Palliative Care in Partnership Board meetings and Palliative Care Forum Meetings. All those Senior Managers responsible for the delivery of hospice care described the ongoing financial challenges resulting from the current shared funding model.

Trusts reviewed historic contracts annually based on a range of measures, including performance, value for money, quality and outcomes. Contracts had been rolled forward year-on-year following the annual review of contracts. Additional meetings may be called if there are any issues raised or if the SLA needs to be reviewed prior to the annual review meeting.

The Trusts, the HSC Board and leaders within hospices agreed that the current monitoring arrangements with the HSC Board are overly focussed on length of stay and bed occupancy and that the quality and outcomes were not yet the primary driver in relation to the commissioning of hospice services.

Our Review Team concluded that though the HSC board was responsible for the delivery of the contracts there were a number of missed opportunities for communication with the hospices and Trusts as key stakeholders in the delivery of care.

Good communication between all stakeholders would facilitate the early identification of issues or concerns that could be indicative of significant weaknesses in the quality of the services provided or governance with a hospice. However, we recognised that the number of forums, meetings and stakeholders involved may make the managing of this information difficult. It was not clear to what extent the HSC Board assured itself those effective safety systems and robust leadership systems were in place during its ongoing contract monitoring with respect of hospices.

| Recommendation 19 | Priority 2 |
|--|-------------------|
| <p>The commissioners should strengthen its arrangements for monitoring the quality of care it commissions. This should include:</p> <ul style="list-style-type: none"> a) review of data relating to incidents and complaints. b) review of data relating to quality, patient outcomes and patient experience. | |

Section 5: Compassionate Care

Governance systems should ensure that care delivered by independent hospitals and hospices is compassionate. Compassionate care ensures staff in each independent hospital and hospice treat people with kindness, dignity, respect and empathy.

Regulation 16 of the *Independent Health Care Regulations (Northern Ireland) 2005*⁴⁹ mandates for the care and welfare of patients outlining that patients should be enabled “to make decisions about matters affecting the way they are cared for and their general welfare; that their privacy, dignity and specific needs are respected; and that information and communication procedures for the establishment or agency meets the needs of patients and their families”.

These specific requirements are underpinned by the DoH *Minimum Care Standards for Independent Healthcare Establishments*⁵⁰ which outline standards for informed decision-making (Standard 1), dignity, respect and rights (Standard 4), harnessing and acting upon the views of patients, their carers and families (Standard 5) and access to bereavement services (Standard 39).

The Review team received sufficient evidence that all independent hospitals and hospices, actively involve patients, their carers and families throughout the whole patient journey, from their first outpatient appointment or first visit to the facility through to their discharge. There were numerous examples of patients being encouraged to bring a family member or friend along with them to appointments to ensure clarity and to provide support.

Hospice staff described to us how they involved patients and families in all aspects of their care and decision-making, from admission to discharge or end of life. These arrangements were reviewed regularly as the patient’s symptoms, needs and overall condition changed.

Hospital staff provided patients and their families with written and verbal information about their care and treatment which they could take home. One hospital described its nursing staff telephone patients at home the day after they have undergone a procedure to answer any questions the patient may have and to enquire as to how the patient is recovering.

Having assessed this aspect of care, our Review Team agreed that every independent hospital and hospice provided evidence of considered efforts to provide compassionate care in services provided to patients. It is of note that no requirements or areas for improvement were made in relation to compassionate care during inspections to all independent hospitals and hospices in 2018/2019.

Our findings are presented under the following areas; meeting patient needs; providing patient information; and patient feedback.

5.1 Meeting Patient Needs

An essential aspect of providing compassionate care is recognising and addressing patient needs. All organisations described how staff protect patient privacy and dignity, information management, chaperoning and safeguarding.

Standard 4 (Dignity, Respect and Rights) in the DoH Minimum Care Standards for Independent Healthcare Establishments states that “patients, clients, visitors and staff are respected and their rights are recognised and upheld”. This covers patient modesty; dignity; privacy; being treated and cared for with regard to equality and their rights upheld; as well as the patient’s right to make decisions being acknowledged and respected.

A wide range of policies and procedures covering consent, delivering/breaking bad news and maintaining patient confidentiality were in place in each of the organisations.

Area of Good Practice

Kingsbridge Private Hospital reported its recent awareness session for staff (both clinical and non-clinical staff) which examined why a person-centred approach to care is important and understanding the benefits of staff introducing themselves to the patient.

This session was facilitated by the founder of the #hellomynameis campaign.

Observations of Practices

In all independent hospitals and hospices staff displayed courtesy and respect towards patients. Staff were informative, friendly and respectful introducing themselves and explaining procedures and treatment to patients in a kind and caring manner.

In all independent hospitals and hospices, our inspectors observed positive interactions between staff and patients and those patients who spoke with us advised that they were happy with the care being provided to them. We also found that patients’ wishes were acknowledged and respected.

Further discussions with patients and relatives confirmed they had the opportunity to comment on the quality of care and treatment provided, including their interactions with staff who work within the facilities.

All premises visited had adequate arrangements for maintaining patient privacy, such as single rooms, modesty screens and curtains. Staff were observed to knock doors and wait for a response before entering any rooms.

A review of patient care records confirmed that treatment and care are planned and developed with meaningful patient involvement, and facilitated and provided flexibly to meet the assessed needs of each individual patient.

Patient Survey

Our survey provided evidence of the positive way patients and their relatives felt about the care and treatment they had received. There was adequate time to discuss problems with healthcare professionals; they had been involved in their treatment and

care; and the reasons for treatment or procedures and next steps were explained to them in a way in which they could understand. The results are presented in Table 15.

Table 15: Patient and Relative’s Perception of Care

| Question (answered by 68 respondents) | Yes | No |
|---|-----|-----|
| Did you have enough time to discuss your health and/or medical problem with the doctor or nurse? | 94% | 6% |
| Were you involved as much as you wanted in decisions about your care and treatment? | 90% | 10% |
| Did the doctor or nurse explain the reasons for any treatment and/or next steps in a way that you / your relative could understand? | 94% | 6% |

We asked if patients and/or relatives felt that the level of care received during their most recent visit to the independent hospital and hospice had been compassionate; 91% (62 people of the 68) were satisfied that it was. The results are presented in Table 16.

Table 16: Do you think Care was Compassionate?

| Question (answered by 68 respondents) | Very Satisfied | Satisfied | Neither Satisfied nor Dissatisfied | Dissatisfied | Very Dissatisfied |
|---|----------------|-----------|------------------------------------|--------------|-------------------|
| Do you think the care you and/or your relative received was compassionate | 79% | 12% | 3% | 5% | 1% |

For those respondents who said they were either very satisfied or satisfied, additional feedback comments included:

- *“The whole experience felt personal, that I was being treated as a person”;*
- *“From the secretaries to the nurses, everyone was kind, caring and helpful”*
- *“Staff were very compassionate and patient. Listened to my requests for adequate pain relief and never made me feel like anything was too much trouble.”*

However, some respondents highlighted a negative experience, for example:

- *“Follow-up is poor....”*
- *“Felt they didn’t care about me, as long as they got me in and out of the door...”*

We also asked if the doctor and/or staff member had listened to what patients or their relatives had said during their appointment; 94% (64 people of the 68 who responded) agreed that this was the case.

In addition to feeling listened to, 88% of respondents (60 people out of 68) indicated that the doctor and/or other staff asked them/their relative what was important to them in managing their condition or illness. The results are presented in Table 17.

Table 17: Did the doctor/nurse listen to what you had to say and what was important to you?

| Question (answered by 68 respondents) | Yes | No |
|---|-----|-----|
| During your / your relative's appointment did the doctor or nurse listen to what you had to say | 94% | 6% |
| Did the nurse/doctor ask what was important to you in managing the condition or illness | 88% | 12% |

The majority of feedback received from our online survey was positive. However, there were examples where patients and their relatives felt their experience had not been as compassionate as they would have liked.

These examples centred on concerns relating to fees for services and treatment and indicating the reason for having to use services in the independent sector was, in fact, due to waiting times in the HSC.

Examples of these comments included patients who were:

- *"...worried about the transparency of fees..."*
- *"hidden and high cost of paying for a private appointment..."*
- *With other comments reflecting "...I had to pay for this appointment as my GP told me there was a five-year waiting list in the NHS..."*
- *"...we shouldn't have to use private healthcare for the same treatment that is provided on NHS..."*

Hospices: Bereavement Care Services

Standard 39 of the DoH Minimum Care Standards for Independent Healthcare Establishments⁵¹ states that "the patient's family and significant others have access to bereavement care services".

This includes services and support in accordance with the organisation's Statement of Purpose, which covers written information about the range of, and access to, services available, as well as referral and assessment procedures and support from trained staff.

Marie Curie staff described a bereavement group facilitated by the hospice social work team, with the help of bereavement volunteers. The hospices' Bereavement Events Committee holds a 'Celebration of Life' event every six months to which families are invited to attend, and counselling services are also accessible for families and staff.

Southern Area Hospice Services also had a bereavement care service facilitated by the hospice social work team, delivered with the support of volunteers and chaplains. The hospice provides an informal monthly bereavement group meeting, a twice-monthly walking group and an annual bereavement service. There is a range of information available regarding the provision of bereavement care services. Counselling services are accessible for families and staff and religious services can be provided in the hospice's chapel.

The Northern Ireland Hospice has a bereavement care service which supports patient's families, providing ongoing bereavement support. The hospice reported that its adult service participates in a national audit (National FAMCARE Survey) of bereaved relatives' feedback in relation to the service their loved one received.

In the Foyle Hospice, we heard about two bereavement support groups which had been established to meet particular needs. These were:

1. The Forget-Me-Not Bereavement Support Group, which meets twice per year to give families a space to share and discuss any difficulties they may be experiencing following a bereavement. Families, who have had a loved one in receipt of care in the Hospice 20-24 weeks prior, are invited onto the six-week programme.
2. Healing Heart, which provides specialist bereavement support for children/young people (aged 4-16 years old) who have experienced the death of someone close to them, or are experiencing pre-bereavement. Referrals come from a variety of sources, which result in assessments, followed by future visits with the child/young person at home, in school or in the hospice.

All of the independent hospitals and hospices were found to be providing compassionate care and patients and relatives were treated with dignity and respect. There was an impressive commitment of staff to ensure that patients, their carers and relatives were fully involved in all aspects of their care and decision-making and were treated with the utmost respect from their first attendance to or engagement with the hospice services.

5.2 Providing Patient Information

Standard 1 of the DoH *Minimum Care Standards for Independent Healthcare Establishments*⁵² states that "Patients and clients and prospective patients and clients have access to clear, accurate and accessible information about the establishment and the services it offers".

Providing appropriately tailored information is vital to enabling a person to be an active participant in their care and treatment. Information about care, treatment procedures and investigations should be delivered in a way that meets the individual patient's needs and preferences.

As part of our returned submissions, we found a wide range of up-to-date information for patients which provided a clear and user-friendly explanation of available services, procedures and treatment, risks, options and expected outcomes.

We asked patients and relatives about the amount of information they had received about their/their relatives' treatment during their appointment/visit to the independent hospital or hospice and 91% felt they had received the right amount of information.

Verbal Information

Inspectors often observed patients being provided with verbal information on their care and treatment from a Consultant or nurse. In Hillsborough Private Clinic inspectors witnessed staff advising patients that interpreters would be arranged for patients whose

first language was not English. All independent hospitals and hospices described many methods and examples of providing verbal information to patients, such as:

- In the Fitzwilliam Clinic, following a procedure, a nurse contacts each patient by telephone the next day to enquire as to how the patient is, to answer any questions the patient may have and to check that the patient is recovering well from their treatment/surgery.
- If patients have a concern following surgery or a clinical procedure, they are advised to call into the Orthoderm Clinic.
- Foyle Hospice reported that all conversations in relation to decisions about patient care are made in collaboration with patients and their families. Advice in relation to medicines was provided by medical and nursing staff and, upon discharge, the hospice pharmacist will meet with the patient and their family to explain any prescribed medicines.
- Regular joint patient, family and multidisciplinary staff meetings take place in the Northern Ireland Hospice to ensure comprehensive information is provided to enable informed decision-making.

Written Information

Independent hospitals

Written information was provided in many forms various forms, such as:

- Appointment cards provided when the patient requires a review appointment (Ulster Independent Clinic).
- Condition-specific patient information leaflets (Ulster Independent Clinic, Fitzwilliam Clinic, Orthoderm Clinic and Hillsborough Private Clinic). Some leaflets were used to help the patient prepare for attendance at the independent hospital and included specific information, for example, in relation to fasting.
- Patient leaflets/written advice which provided post-operative instructions, medication information and contact details as to whom the patient should contact if they have concerns following discharge (Kingsbridge Private Hospital, North West Independent Hospital, Ulster Independent Clinic) and a 24-hour contact telephone number was shared with patients from Fitzwilliam Clinic and Orthoderm Clinic.
- Clinical summary letters and theatre notes sent to the patient's GP with a choice for patients to be copied into this correspondence (Kingsbridge Private Hospital, Ulster Independent Clinic and Hillsborough Private Clinic).
- Discharge letters are provided to the patient, who will then share this with their GP (North West Independent Hospital).
- Advice leaflets for medication (Fitzwilliam Clinic).

Hospices

Each of the Hospices provides information leaflets for patients and their relatives in relation to the services they provide.

For example, these included details of:

- How to Access the Service
- Referral Criteria
- Services Available, for example, day hospice, community teams

- Meals
- Transport
- What Happens at First Visit
- Medication
- Liaison with the patient's GP
- Details on how to contact the Hospice

Each of the hospices provided a very wide range of written literature to patients and their families relevant to their specific condition and requirements. In Marie Curie, information booklets were available at each patient's bedside which explained the processes within the hospice and the arrangements for raising concerns or giving feedback in relation to the patient's experience. Foyle Hospice provided written details of their volunteers' counselling service and carer's support group for patients, their carers and families. In Southern Area Hospice Service and Northern Ireland Hospice, information leaflets were available around the hospice informing patients and their families of information relating to their condition and the services provided by the hospice.

Our Review Team agreed that there had been very significant efforts to provide a wide range of written information (both verbal and written) in all independent hospitals and Hospices, the content of which was clear and comprehensive for those using these services.

5.3 Seeking Patient Feedback

Patient feedback is an important source of information that drives improvements in the patient experience. Standard 5 of the DoH *Minimum Care Standards for Independent Healthcare Establishments*⁵³ states that "the views of patients and clients, carers and family members are obtained and acted on in the evaluation of treatment, information and care".

All independent hospitals and hospices provided evidence of mechanisms for proactive engagement with patients and harnessing patient feedback in order to use it to improve services, such as:

- Continuous patient feedback between patient and clinician during their stay or treatment at the independent hospital/hospice which provided patients with the opportunity to discuss their care or express any concerns they may have at the time.
- Patient comment forms/cards/questionnaires (both anonymous and named) were available in various locations throughout the independent hospital/hospice and returns are collated, analysed and reported to the senior clinicians and managers on a regular basis (Ulster Independent Clinic; North West Independent Hospital).
- Patient feedback is shared on the independent hospital's website (Ulster Independent Clinic, Orthoderm Clinic).
- Patient satisfaction surveys completed by patients at various stages (during the use of the services and after use of the services).
- Feedback from social media channels allows patients to be honest and candid.

Some of the independent hospitals and hospices told us about identified staff who visits patients when they are attending the service and use an iPad/tablet to collect real-time

data. This helps to resolve any concerns promptly preventing a formal complaint being made (Marie Curie, Southern Area Hospice Services) and ensuring a good experience.

The patient questionnaires and satisfaction surveys we reviewed included questions on:

- Care and treatment
- Involvement in decision-making
- Environment and cleanliness
- Patient's records
- Quality of information
- Staff attitude/behaviour
- Support for family/relatives (mainly hospice facilities)
- Overall experience

Responses from patient satisfaction surveys and patient's comments were analysed on a regular basis and any concerns were reported to senior management through the governance structures of the organisation. Patient's comments and responses to the patient satisfaction survey were used by the organisations to identify good practice and also to enable them to develop action plans to address any emerging themes or trends.

In Marie Curie, we were told that monthly patient and carer experience and feedback is also reported nationally by each regional area. This includes feedback from patients in Northern Ireland, detailing their experience of care and whether they would recommend the service.

The Northern Ireland Hospice participates in a national audit of bereaved relative's feedback in relation to the care their loved ones received.

The Ulster Independent Clinic told us that initiatives for quality improvement and innovation are brought forward for consideration from its user groups.

Our Review Team agreed that there were robust mechanisms in place across all independent hospitals and hospices to collect, assess and report on feedback from patients, their carers and relatives.

Service Developments Informed by Feedback

A small number of examples were identified relating to improvement initiatives which had been introduced as a result of patient feedback. These included:

- Additional car parking spaces made available, to include extra parking spaces for disabled patients and their relatives (Ulster Independent Clinic).
- Signage improved with colour coding to denote different departments (Ulster Independent Clinic).
- Patient information booklet updated to explain what a patient should bring with them, financial arrangements and GDPR information (Ulster Independent Clinic).
- The provision of advice to patients by nurses in relation to the relevant fee prior to a test being undertaken (Hillsborough Private Clinic).
- Community services patient information leaflet updated with details on who to contact for advice, both in hours and out of hours (Northern Ireland Hospice).

- Clear signposting and information in relation to external support agencies available (Northern Ireland Hospice).

Our Review Team was encouraged and welcomed the learning mechanisms across the Marie Curie group of hospices in relation to how patient feedback is used to make and evidence improvements. Although all independent hospitals and hospices provided examples of systems to gather patient feedback, when we examined the governance system as a whole we could not identify how this information was used for strategic planning or to drive improvement.

Our Review Team determined that there was not sufficient evidence in all independent hospitals and hospices that feedback from patients, their carers and relatives was being used systematically to inform improvement and those improvements were made as a result of this patient feedback. Patient feedback must be used in a systematic way in order to ensure it delivers real improvement to services.

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|---|-------------------|
| Recommendation 20 | Priority 2 |
| All independent hospitals and hospices should develop and implement a system to use patient feedback in a considered and systematic way to inform ongoing service development and improvement and provide assurance to their respective Boards. | |

Next steps

This Review of governance in independent hospitals and hospices in Northern Ireland has provided detailed insights into the arrangements deployed within these services at the time of this Review.

From its outset, this Review has sought to use the most comprehensive methodology available, drawing on the expertise of clinical and corporate governance professionals, while engaging an extensive range of stakeholders to contribute to the multidisciplinary inspections conducted. The Review Team also visited each of the organisations referred to within this report.

This meticulous and collaborative approach has resulted in a definitive assessment of the governance systems and processes employed by independent hospitals and hospices and outlines whether they are delivering safe and effective care.

The Review Team is confident that the findings herein accurately reflect the governance arrangements at the time of this Review and their influence on the quality of care.

During the course of the Review, many good examples of compassionate and patient-centred care were observed, as well as high standards of compliance in respect of medicines management and patient information. Feedback from patients and their relatives was particularly positive among relatives of those who had received or were receiving hospice care.

The Review Team recognised the efforts that some organisations are making to improve the quality of patient care. However, there remains a significant number of organisations that were yet to develop and implement a robust quality improvement strategy that nurtures a culture of learning in the pursuit of delivering an excellent standard of care.

It is essential that HSCB and Trusts monitor the quality, safety and effectiveness of services which have been commissioned from the independent sector. This will require mechanisms for formal information sharing, along with key performance indicators that track patient outcome data, not just patient activity. This data will play a pivotal role in identifying organisations and individuals of concern. It will provide an early warning system that will drive appropriate and timely escalation, as well as inform future procurement and commissioning, all of which will, in turn, deliver improved services for patients.

This Review has also identified the indispensable role that effective communication plays in the continuity of safe and effective care provision. Fundamental to these communications will be the safe and responsible sharing of patient information and medical records between HSC Trusts and independent hospitals. This should be a central aspect of current and future planning by both the independent and HSC sectors. A critical element of this will be the implementation of full and appropriate access to the Northern Ireland Electronic Care Record (NIECR) for independent hospitals and hospices.

The large number of recommendations within this Review and scale of the changes it proposes is significant. But it is the view of RQIA that this is entirely proportionate to the challenges currently faced by both the HSC and independent sectors.

For change to be meaningful and sustained, each of these recommendations should be implemented. This will require effective leadership across both HSC and independent sectors. RQIA remains dedicated to playing its central role of ensuring the improvements outlined are implemented in the interests of patients and the public at large and will continue to monitor their effectiveness through its programme of inspections.

It is RQIA's view, based on its extensive experience regulating services across the independent sector, that the learnings contained within this Review are applicable to organisations of all sizes and specialisms.

It is therefore incumbent upon independent hospitals and hospices to give due consideration to these recommendations along with HSC Trusts, the Health and Social Care Board, Public Health Agency and the wider Regulation, Quality Improvement Authority.

Having given their due consideration, each of these organisations must now mobilise and collaborate to devote the resources required to not only to meet regulatory compliance and fulfil their professional responsibilities, but to ensure the high quality, safe and effective care is provided to the population of Northern Ireland.

Appendix A: Contributors

Membership of Expert Review Team

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**Appendix B: Arrangements for monitoring, reviewing, reporting and shared learning arising from incidents and near-miss events-
Independent Health Care Regulations (Northern Ireland) 2005 and
Department of Health *Minimum Standards for Independent Healthcare
Establishments, 2014,***

Regulation 17 (4): “Where shortcomings in systems are highlighted as a result of an investigation, additional safeguards are put in place.”

Regulation 17 (5): “The registered person shall ensure there are arrangements for identifying, recording analysing and learning from adverse incidents”.

Regulation 28 (1): “The registered person shall give notice to the Regulation and Improvement Authority of –

- (a) the death of a patient -
 - (i) in an establishment;
 - (ii) during treatment provided by an establishment or agency; or
 - (iii) as a consequence of treatment provided by an establishment or agency within the period of seven days ending on the date of the death, and the circumstances of his death;
- (b) any serious injury to a patient;
- (c) the outbreak in an establishment of any infectious disease, which in the opinion of any medical practitioner employed in the establishment is sufficiently serious to be so notified;
- (d) any event in the establishment or agency which adversely affects the well-being or safety of any patient;
- (e) any allegation of misconduct resulting in actual or potential harm to a patient by the registered person, any person employed in or for the purposes of the establishment or for the purposes of the agency, or any medical practitioner with practising privileges;
- (f) any theft, burglary or accident in the establishment or agency.

Standard 9.7: “Where appropriate, there are clear arrangements for monitoring the quality of clinical care that include as a minimum the following clinical indicators: Adverse clinical incidents”.

Standard 9.9: “All accidents, incidents, communicable diseases and deaths occurring in the establishment are reported to the RQIA and other relevant organisations in accordance with legislation and procedures”.

Standard 17.4: “The Registered Person/Manager reviews all information relating to accidents, incidents, near misses and claims and ensures that corrective action is taken and learning disseminated through the organisation. Regular audits are carried out.

Standard 25.9: “The organisation has an effective incident reporting system in place for the identifying, recording, reporting, analysing and learning from adverse incidents and near misses involving medicines and medicinal products.

Standard 30.6: “The medical advisory committee reviews information collated by the Registered Manager on adverse clinical incidents (broken down by speciality, procedure and by clinical responsibility) on a quarterly basis to include as a minimum:

- All deaths at the hospital or clinic;
- All unplanned re-admissions to hospital or clinic;
- All unplanned returns to theatre;
- Adverse events;
- All unplanned transfers to other hospitals or clinics;
- Other relevant clinical incidents; and
- Complaints and compliments.

The medical advisory committee should advise the hospital or clinic management on corrective action when necessary. This information is then made available to the RQIA.

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- ¹² Fitzwilliam Clinic: <http://fitzwilliamclinic.com>
- ¹³ Hillsborough Private Clinic: <https://www.hillsboroughprivateclinic.com>
- ¹⁴ Orthoderm Clinic: <http://www.orthodermclinic.com/>

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