The Regulation and Quality Improvement Authority

# tNJ2ƎNJŜăă 2y/2YYλűYŜyűă YlŘŜ λywvL!Ωă wŜLJ2Nű 2yűKŜ 9ÈLJŜNJű wŜØλŜø 2Ŧ wŜŎ2NJŘă 2Ŧ 5ŜŎŜlăŜŘ tlűλŜyűă óbŜdzNJ2f2Ǝèó£ b2ØŜYōŜNJ нлнн

Update at October 2024

**Background and Context**

In May 2018, following a recall of 2,500 patients in relation to concerns about the clinical practice of consultant neurologist, Dr Michael Watt, the Department of Health directed the RQIA to undertake an expert review of the records of patients or former patients of Dr Watt who had died over the previous ten years (2008-2018).

Given the potential size and the complexity of this exercise, it was agreed that it would be taken forward on a phased approach, with RQIA initially commissioning the Royal College of Physicians (RCP) to undertake an expert review of 44 cases of deceased patients. That review identified significant failures in the care and treatment of patients, and concerns over clinical decision-making, diagnostic approach, communications with other clinicians, and communication with patients and families.

The RCP report made a number of recommendations as a result. In addition, RQIA added a number of additional commitments to take actions that would help ensure there would be a tangible 'legacy' from the review. The actions were to:

1. Monitor and evaluate the Belfast Health and Social Care Trust's implementation of this work through RQIA's continued programme of service reviews and inspections.
2. Respond appropriately to the findings of individual complaint investigations notified to the Trust by patients, families, or victims.
3. Consider and evaluate evidence that each of the health and social care (HSC) trusts takes account of the recommendations from the review, and can evidence actions taken to act on them.
4. Share the findings with current practising clinicians, through identifying existing networks, through trusts and professional bodies, and encourage collaboration, reflection, peer support and collective actions to ensure poor practices are recognised and addressed.
5. Influence the training and development of health care professionals; so that as part of that training and development, the importance of compliance with clinical standards and guidelines, and of effective communication with patients, openness and active listening to capture their concerns is made obvious.
6. Strengthen how RQIA reviews and inspects services to ensure that the level of scrutiny of clinical practice, and of adherence to clinical standards, is evaluated.
7. Strengthen the assessment of a safety culture, particularly around evidence of listening to patients and families, and evidence that staff feel safe to challenge each other and raise concerns.
8. Require improvements if there is evidence of substandard systems, or poor culture or care
9. Use RQIA's position as independent regulator to support the adoption of openness and candour across all services, especially when reporting that care has gone wrong

This provides an update on each of these commitments as at October 2024.

| | Commitment | Update |
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| **1.** | Monitor and evaluate the Belfast Health and Social Care Trust's implementation of this work through RQIA's continued programme of service reviews and inspections | RQIA followed up with Belfast HSC Trust on the specific actions relating to the individual cases reviewed by the RCP Expert Panel. The recommendations made by RCP were reported as completed by the Trust. RQIA has continued to undertake reviews and inspections of the trust services where patient safety and quality issues are identified. The following reports are published on RQIA's website<br>• Inspection of Royal Belfast Hospital for Sick Children Emergency Department, Aug 2022<br>• Inspection of Royal Victoria Hospital (RVH) Emergency Department, Nov 2022 - Feb 2023<br>• Follow up Inspection of RVH ED Emergency Department, Nov 2023 - Jan 2024 |
| **2** | Respond appropriately to the findings of individual complaint investigations notified to it by patients, families, or victims. | RQIA has received specific assurances from Belfast HSC Trust that individual complaints received by the trust, relating to cases considered by the RCP have been responded to in line with the Department of Health's Guidance in Relation to the Health and Social Care Complaints Procedure. |
| **3** | Consider and evaluate evidence that each of the health and social care trusts takes account of the recommendations from this review, and can evidence actions taken to act on them. | RQIA received correspondence from DoH (SPPG) in July 2024, which notes that whilst the recommendations have been fully implemented in Belfast HSC Trust, further work is required in the remaining HSC Trusts, although progress is being made.<br><br>RQIA will assess implementation through upcoming outpatient inspections within HSC Trusts undertaken by its Hospital Inspection Programme. The first of these has been completed: Inspection of Outpatient Departments Western HSC Trust Hospital 5 June - 7 September 2023 |
| **4** | Share these findings with current practising clinicians, through identifying existing networks, through Trusts and professional bodies, and encourage collaboration, reflection, peer support and collective actions to ensure poor practices are recognised and addressed | RQIA's Report on the Expert Review of Records of Deceased Patients (Neurology) was published in November 2022 and shared with HSC Trusts and professional regulators, including GMC, NMC and NISCC, and training agencies such as NIMDTA and NIPEC. |

| | Commitment | Update |
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| **5** | Influence the training and development of health care professionals; so that as part of that training and development, the importance of compliance with clinical standards and guidelines, and of effective communication with patients, openness and active listening to capture their concerns is made obvious. | RQIA is developing an e-learning programme to be hosted on LearnHSCNI (from late 2024) to facilitate access to training programmes for HSC trust staff. This will provide information and insights for practising doctors, and clinicians more widely, on learning identified from the expert review, with a particular focus on: evidence-based practice; person-centred care; listening to patients and families; openness and raising concerns. Central to this e-learning is the lived experience of a family member of a deceased patient. The e-learning programme , with the family lived experience at the centre of it, will provide powerful evidence of the need for changing the culture within HSC. |
| 6<br><br><br><br><br><br>7 | Strengthen how RQIA reviews and inspects services to ensure that the level of scrutiny of clinical practice, and of adherence to clinical standards, is evaluated.<br><br>Strengthen the assessment of a safety culture, particularly around evidence of listening to patients and families, and evidence that staff feel safe to challenge each other and raise concerns. | RQIA is undertaking work to develop a robust approach to encouraging and assessing the patient safety culture across the HSC system regionally. (See action 9 for further information).<br><br>RQIA will lead on engaging with others to develop and implement a patient safety culture assessment tool/framework. This will be co-produced and act as an enabler to organisations to improve the focus on patient safety. Providers will be able to use the tool to self-assess and make improvements. RQIA will also use this tool/framework in undertaking reviews and inspections of organisations and services, and provide independent feedback on its findings and areas in need of improvement. This work will progress during 2024 and into 2025. See Section 9 for the outline plan for this work.<br><br>Professional regulators, including GMC and NMC, with RQIA agreed a Framework for Sharing Intelligence Among Regulators of Health and Social Care in Northern Ireland, and have subsequently developed an approach to sharing 'Emerging Concerns'. This aims to ensure closer working between health and social care regulators, improving how concerns and intelligence are shared so that earlier inquiries or actions can be taken where there is evidence of patient safety issues. This will also provide intelligence to strengthen and inform RQIA reviews and inspections plans. |

| | Commitment | Update |
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| **8** | Require improvements if there is evidence of substandard systems, or poor culture or care. | RQIA is committed to ensuring that where HSC systems, culture or practice falls below the standards, whether set out within DOH Quality Standards for Health and Social Care, 2006, other relevant regulatory standards or best practice standards, RQIA uses its powers in a proportionate and effective way to secure improvement in the quality and safety of services. This includes publishing our inspection and review finding relating to HSC services. By way of example, on 16 August 2024 RQIA served an improvement notice relating to the Belfast HSC Trust's Acute Mental Health Inpatient Centre detailing RQIA findings and the actions required of Belfast Trust can be found here. |
| **9** | Use its position as independent regulator to support the adoption of openness and candour across all services, especially when reporting that care has gone wrong | RQIA held round table events in November 2023 and May 2024, bringing together senior leaders, commissioners, policy makers, academics, healthcare professionals, regulators, advocates and those with lived experience to explore and identify the actions needed to ensure a focus on patient safety and the development of an open culture across the HSC. RQIA has published the outcome of the May 2024 round table event Developing an Open, Just and Learning Culture in Health and Social Care in Northern Ireland. What Needs to Change to Make It Happen? This sets out a plan for RQIA to take forward the development of a HSC Patient Safety Culture Assessment Tool/ Framework in collaboration with all stakeholders. That work is now commencing. |

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