EHSSB Eastern Health and Social Services Board

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our ref:

your ref:

18th July 2005

Dear Fiona

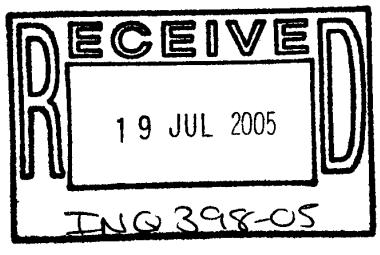
Re: Inquiry into Hyponatraemia-related Deaths

Thank you for your letter dated 17th May 2005 on the above matter.

Please find enclosed response from the Eastern Health and Social Services Board together with three supporting documents.

I trust you will find this information of assistance.

Yours sincerely



Dr M P J KILBANE
Chief Executive

Encs:

EHSSB Response to the Inquiry into Hyponatraemia-Related Deaths
EHSSB Corporate Plan 2005/2006
EHSSB Quality Standards document
EHSSB Technical Information Associated with the Commissioning Intentions Document for the Period 2000/2001 to 2002/2003

EHSSB

Eastern Health & Social Services Board Response to

The Inquiry into Hyponatraemia-related Deaths

Glossary

Department of Health and Social Services NI (DHSS NI)
Department of Health, Social Services and Public Safety (DHSSPS)
Eastern Health and Social Services Board (EHSSB)
Health and Social Care Groups (HSCGs)
Health and Social Services Trusts (Trusts)
Local Supervisory Authority (LSA)
Ministry – formerly Ministry of Home Affairs

1. Legislative and Structural Context

1.1. Health and Social Services Boards

Article 16 (1) of the Health & Personal Social Services (Northern Ireland) Order 1972 provides for the Ministry to establish bodies to be called Health and Social Services Boards for such areas as it may by order determine. Article 17 (1) (a) of the 1972 Order provides that Boards are to:

- "exercise on behalf of the Ministry, such functions (including functions imposed under an order of any court) with respect to the administration of such health and personal social services as the Ministry may direct; and ...

- exercise on behalf of the Ministry of Home Affairs such functions (including functions imposed under an order of any court) with respect to the administration of such personal social services under the Adoption Act (Northern Ireland) 1967 (**a**) and the Children and Young Persons Act (Northern Ireland) 1968 as that Ministry may direct"

in accordance with regulations and directions. Four Boards – Eastern, Northern, Southern and Western – were established in 1973.

In 1973, each Board established administrative districts which served local populations.

In 1983, the then UK Secretary of State for Health and Social Security established an inquiry into the effective use of manpower and related resources in the NHS. Sir Roy Griffiths subsequently produced a report in October 1983 which introduced into the NHS the concept of general management. The recommendations of the Griffiths Report were accepted by Parliament in June 1984.

The introduction of general management brought to an end the health authority's district management team and the philosophy of "management by consensus".

General management represented a radical change to both organisation and management across the NHS since it offered active, strategic direction and devolved responsibility through a clear structure of line management and devolved budgets. A crucial element in the introduction of general management was the recognition of the need to find a way of involving doctors, in particular senior doctors, in the day to day management of the NHS and a "clinical directorate" model was eventually adopted.

Fourteen Units of Management, each led by a Unit General Manager, were established in the Eastern Board area and were managerially accountable to the Board.

In 1989, Government announced a fundamental review of the NHS which led to the publication of a White Paper *"Working for Patients"* which proposed major reforms. The Government's principal objective was to show real improvement for every patient and in Northern Ireland this involved:

- *"delegating as much power and responsibility as possible to local level, including the appointment of Unit General Managers in major acute hospitals and the reorganisation of the management of the major teaching hospitals in Belfast;*
- *engaging doctors in the management of the services and obtaining their commitment to medical audit;*
- *encouraging a small number of hospitals to progress towards self governing status as Hospital Trusts;*
- *encouraging larger GP practices to opt for their own budgets for buying particular services direct from hospitals;*
- *reconstituting Health and Social Services Boards as management bodies;*

- *developing a simpler system for resource allocation which will fund Boards for the population they serve rather than the services they provide;*
- *strengthening arrangements for the external audit of the services to ensure better value for money."*

(Source: *Working for Patients: A Summary of the White Paper on the Government's Proposals Following its Review of the NHS – January 1989)*

The delegation of responsibility for the delivery of healthcare to local level was to be achieved through the introduction of an internal market, where money would follow the patient and go more directly to where the service was delivered. This also introduced the concept of a "Purchaser/Provider split", with Boards assuming the role of Service Commissioners (or Purchasers) with Trusts as Providers of services.

Article 3 (1) of the Health & Personal Social Services (Northern Ireland) Order 1991 amended Schedule 1 of the 1972 Order and outlined the new constitution of a Health and Social Services Board.

Article 10 of the same Order gave the Department of Health and Social Services (DHSS) (NI) the power to establish Health and Social Services Trusts, with a remit to provide local acute and community health services. Nine Trusts were subsequently established in the EHSSB area during the period 1992 – 1994 (Section 1.2 below refers).

In tandem with the development of structural change, the DHSS (NI) policy document *"People First"* (1990), introduced a division between the commissioning and provision of health and social services. **The implementation of the major Community Care Reforms in 1993 established Boards as commissioners of services responsible for:**

- ***"assessing the health and social care needs of their resident population;***
- ***strategic planning to meet need;***

- ***and the development of purchasing plans."***

(Source: *"People First" 1990)*

The Community Care Reforms also required Boards to promote a mixed economy of care and a range of providers to maximise user choice and ensure the economic, effective and efficient delivery of services.

The Nursing and Midwifery Order 2001, Articles 42 and 43 requires the establishment of a Local Supervisory Authority (LSA) with responsibility for ensuring that the statutory supervision of midwives and midwifery practice is carried out within its area of jurisdiction. In Northern Ireland, the four Health and Social Services Boards are the designated Authorities.

As an LSA, the Board is responsible for the appointment of Supervisors of Midwives in Health and Social Services Trusts. It is also responsible for the investigation of reported alleged misconduct and is empowered to suspend a midwife from midwifery practice if it considers that this action is necessary in the interest of public protection. The Board also receives and processes to the Nursing & Midwifery Council a Notification to Practice Form from every midwife who intends to practice in its Board area and the Eastern Board has employed a designated midwife on a part-time basis to undertake this role and function.

1.2. Health and Social Services Trusts

Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 gave the DHSS (NI) the power to establish Health and Social Services Trusts, with a remit to provide local acute and community health services. Schedule 3 of the 1991 Order sets out the duties, powers and status of Trusts.

The DHSS (NI) document "HSS Trusts: A Working Guide" (1991) states *"A key element of the changes is the introduction of HSS Trusts. They are hospitals and other units which are run by their own Boards of Directors; are independent of Health and Social*

Services Board Management; and have wide-ranging freedoms not available to units which remain under Health and Social Services Board control ie., ***directly managed units****.*

Whilst remaining fully within the health and personal social services, Trusts differ in one fundamental respect from directly managed units – they are ***operationally independent****. Trusts have the power to make their own decisions – right or wrong!- without being subject to bureaucratic procedures, processes or pressure from higher tiers of management."*

Trusts were created as self-governing bodies, managerially and administratively independent of Boards. The Royal Hospitals Trust was established in shadow form in April 1992, becoming operational on 1 April 1993 along with a further three Hospital Trusts – Belfast City Hospital Trust, Greenpark Healthcare Trust (comprising Musgrave, Belvoir and Forster Green Hospitals) and the Ulster, North Down and Ards Hospitals Trust. The Mater Hospital Trust became operational on 1 April 1994.

Until 1993/94, Units of Management had been directly responsible to Boards for the provision of social services and the discharge of the Board's statutory roles and obligations. As Health & Social Services were integrated under the HPSS Order 1972 in Northern Ireland, the extension of these provisions had to take account of the Board's existing responsibilities for the discharge of statutory functions in relation to children and adult users of social services. Legal provision had to be made to enable newly-established Trusts to discharge statutory functions on behalf of their respective Boards.

The four Community Health and Social Services Trusts – Down Lisburn Trust, North & West Belfast Community Trust, North Down & Ards Trust, South and East Belfast Trust became operational on 1 April 1994. The Ulster, North Down and Ards Hospitals Trust amalgamated with the North Down & Ards Community Trust on 1 April 1998 as The Ulster Community & Hospitals Trust.

Under the Community Care Reforms referred to above, Trusts became providers of social services in a contractual relationship with Boards as purchasers/commissioners, although Trusts were also able to commission services from the independent sector on behalf of Boards. Trusts were also required to assess needs within their respective local areas and plan to address these in consultation with Boards.

The Health and Personal Social Services (NI) Order 1994 (HPSS Order 1994) and its related regulations provided the legal basis for a Scheme of Delegation to Trusts of statutory functions formerly exercised by Boards. The Order and its regulations made Trusts accountable, through their commissioning Boards, to DHSS (NI) for the discharge of those statutory functions delegated to them. This included those in relation to mental health services as well as the majority of the statutory powers and duties arising from the Children (Northern Ireland) Order 1995, which commenced in November 1996 and those contained in the Adoption (Northern Ireland) Order 1987(which replaced the Adoption Act (NI) 1967), although the DHSS(NI) continued to retain a direct administrative and professional quality assurance role in respect of intercountry adoption.

A further range of statutory duties in relation to children has been conferred on Trusts with the enactment of subsequent legislation such as the Adoption (Intercountry Aspects) Act (NI) 2001; the Carers' and Direct Payments Act (NI) 2002; The Children Leaving Care Act (NI) 2002; and the Protection of Children and Vulnerable Adults (NI) Order 2003.

Trusts are accountable in law for the discharge of those statutory functions which have been delegated to them by Boards.

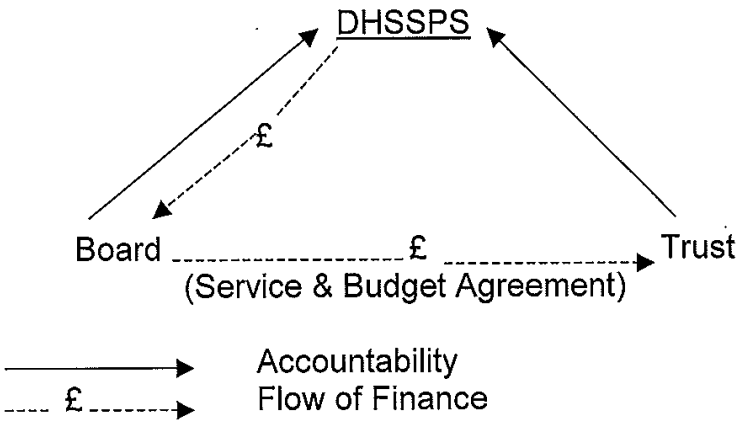
Trusts are, however, directly accountable to the Department of Health, Social Services and Public Safety for all other commissioned services.

1.3 Department of Health, Social Services and Public Safety (DHSSPS)

The powers of the Department of Health, Social Services and Public Safety derive from the Health & Personal Social Services (NI) Order 1972 and subsequent amending legislation. Article 4 of the Order imposes on the Ministry the duty to:

- *"provide or secure the provision of integrated health services in NI designed to promote the physical and mental health of the people of NI through the prevention, diagnosis and treatment of illness;*
- *provide or secure the provision of personal social services in Northern Ireland designed to promote the social welfare of the people of Northern Ireland; and*
- *to discharge its duty as to secure the efficient coordination of health and personal social services."*

The Departments (NI) Order (1999) expanded the functions of the Department of Health and Social Services to include responsibility for Public Safety. The following diagram represents a simplified version of current relationships:



2. Composition, Role and Responsiblities of the Board and Interaction with Trusts

2.1 Composition of the Eastern Health & Social Services Board

Article 3 (1) of the Health & Personal Social Services (Northern Ireland) Order 1991 amended Schedule 1 of the 1972 Order and outlined the new constitution of a Health and Services Board.

There are thirteen Directors of the Eastern Board.The Chairman of the Eastern Health & Social Services Board (the Board), David Russell, and his six Non Executive Director colleagues were appointed by the Minister following interviews conducted by the Public Appointments Unit at the DHSSPS. The six Executive Directors are Senior Officers within the Board and include the Chief Executive, Dr Paula Kilbane.

In accordance with Circular HSS (PCD)1/2002 the Board, at its meeting on 12th September 2002, approved the establishment of six Health and Social Care Groups (HSCGs) in the Eastern Board area, and the appointment of the six HSCG Chairs as Associate Directors of the Board. Associate Directors do not have voting rights at Board Meetings.

The HSCGs are Committees of the Board. The Management Boards of HSCGs are responsible for ensuring that the Groups fulfil their primary care development role and, in collaboration with HPSS Boards, develop the capacity to take on responsibility for the commissioning of relevant local services in community and primary care and for the elderly. The membership of each HSCG Management Board is broadly based, embracing a range of professional and community interests.

2.2. Role of the Board

The Eastern Board is Northern Ireland's largest local health authority and is responsible for the care of 660,000 people (approximately 39% of NI population) who live within its area.

This area includes all of Belfast and Lisburn City Council areas, Ards Borough Council, Castlereagh Borough Council, North Down Borough Council and Down District Council areas.

The Board's activities are funded directly by government, through the taxpayer. This currently amounts to over £1billion every year, which is an indicator of the scale, complexity and very substantial cost of health and social services. This constitutes over 41% of the overall NI HPSS services budget of the NI block.

The Board is accountable to DHSSPS for the performance of its functions and may be directed by DHSSPS regarding the exercise of these functions.

"A Health and Social Services Board is responsible for ensuring that, through the Chief Executive and executive members, the Board:

- *undertakes an assessment of the health and social care needs of the local population;*
- *receives, at Board level, a comprehensive report on the health of its population each year, together with advice on appropriate action;*
- *co-operates with other Boards, Departments and other statutory bodies to promote the health and wellbeing of the population of Northern Ireland;*
- *increases public understanding about health and social care and the changing nature of health and social care services;*
- *develops its strategy for health and social care gain, based on the priorities in the Programme for Government and the Minister's annual priorities for service development as expressed in Priorities for Action;*

- *collaborates with health and social care professionals, providers, local authorities, local people, Health and Social Services Councils and other agencies in developing the strategy and in seeking to secure improvements in health and social care;*
- *plans for and procures within available resources a pattern of care which best meets the needs of its population;*
- *engages in appropriate contract negotiations with providers based on local needs assessment and not solely on a central planning process and establishes contract monitoring procedures;*
- *remains within its cash limits, uses available resources effectively and controls and reports its funding within the guidelines issued by the Department;*
- *meets objectives and targets set by the Department;*
- *works towards the development of a primary care led service in which decisions about the commissioning and provision of health and social care are taken as close as possible to the patient/user;*
- *manages arrangements with local GPs, dentists, ophthalmic practitioners and pharmacists, including administering the terms of service of Family Health Service contractors and ensuring probity;*
- *carries out its statutory responsibilities and related duties eg., control of communicable disease and family and child care responsibilities;*
- *actively promotes the values and achievements of the HPSS;*
- *monitors in collaboration with GPs and other professionals, the quality and standards of care in the primary, secondary and community care settings;*
- *plays a full part in the Health and Personal Social Services (HPSS) complaints procedure"*

(Source: DHSSPS Public Appointments Unit Information Pack for Non-Executive Directors)

The purpose of the Board is to seek to secure a comprehensive range of quality health and social services for local people. It is the responsibility of the Board to determine what they need, plan, secure and pay for those services, within the resources made available by the DHSSPS. This role is referred to as the "purchasing" or "commissioning" of care services on behalf of the people served by the Board.

The principal aim of the Board is to make a real and lasting improvement to the health and welfare of local people.

The work of the Board is guided by an overarching statement of purpose and an associated set of values, which are consistent with the Board's core functions and statutory remit, and which form the context within which the Board seeks to fulfil its long-term goals. A copy of the Board's Corporate Plan for 2005/06, which details the values and corporate goals, is attached for information. (EB Paper No: 31/05)

2.3 Responsibilities of the Board

The Board's responsibilities can be broadly categorised under a number of headings:

- Strategic Planning and Delivery of Services;
- Monitoring Functions;
- Controls Framework and;
- Adherence to Standards.

Each embrace the statutory duties of the Board, whilst highlighting the formal ongoing interactions between Boards and Trusts as well as the less formal ad-hoc interactions in respect of specific issues.

The following provides an illustration of the interaction between the Board and HSS Trusts.

2.3.1 Strategic Planning and Delivery of Services

The delivery of services to the community is at the heart of the Board's business. This is achieved by:

- assessing what people need,
- negotiating service agreements for care services with organisations and agencies which directly provide these services;
- arranging services that are readily accessible;
- ensuring that these services are delivered to high standards;
- monitoring the quality and effectiveness of these services;
- planning and developing new services and;
- demonstrating value-for-money on all services.

The Board is obliged to develop long-term strategies for service development and to meet changing standards and this is taken forward through multidisciplinary Programme Planning Groups, which engage widely with providers, users and other partners.

As a commissioner of health and social services, the Board sets out its annual spending plans and programme of activity in its Health and Wellbeing Investment Plan (HWIP). This itemises all the services and developments, subject to resource availability, which will be delivered in the financial year. It is the Board's contribution to government's overall health development strategy "Priorities for Action".

The Board's strategic planning of services is guided by the targets and delivery dates set out by DHSSPS in the "Priorities for Action" framework and it has to develop strategies over the necessary time period, taking into account local needs and circumstances to deliver national priorities and targets within available resources. These requirements are not negotiable, given that they represent government's commitment to the public to improve health care in return for the resources allocated from public taxation.

In strategically planning services, the Board must agree the best way to deliver such services to its population and works with other organisations both within and outside the Health Service, to take account of the wider health and social care environment, local patient needs and preferences.

The main providers of service are the 8 Trusts located in the Eastern Board area with whom the Board contracts for services in order to meet the needs of its population. The Northern Ireland Ambulance Service is a regional body and provides services to all four HPSS Boards. However, the Board also puts in place arrangements to commission care from the voluntary and independent sectors as well as providers from Great Britain or the Republic of Ireland, the latter two being for specialist services for named service users.

The Board seeks to ensure that funds for services are directed towards those in greatest need and is obliged to prioritise how its funds are deployed within the constraints set by the DHSSPS.

2.3.2 Monitoring Functions: Service Contracts

Service and Budget Agreements between the Board and service providers, mainly Trusts, provide descriptions of the range, volume, and cost of services commissioned by the Board as well as core standards and conditions. Monitoring arrangements are also summarised along with a set of key quality issues on which Trusts will report during the course of the year. Formal monitoring review meetings are held on a quarterly basis between the Board and each local Trust provider. A Service Agreement Monitoring Report is submitted for information to the monthly public Board Meeting with a more detailed monitoring report presented, on a quarterly basis, for noting at the public Board Meeting.

In addition, a wide range of other interactions take place between Board and Trust staff to take forward strategic and operational issues.

Examples include:

- Meetings at Chief Executive level between all Board and Trust Chief Executives across the Board area
- Monthly meetings between relevant Board and Trust Officers to monitor the levels of emergency pressure in the system and take appropriate joint action
- Discussions on the strategic development of specific services or to address current issues of concern
- Input from Professional staff in Trusts to the established Professional Advisory arrangements including the Area Medical Advisory and Nursing Committees.
- Discussions on the handling of complaints which have been received by the Board from residents of the Board area.

The Board seeks to maintain co-operative arrangements with all providers of services to its residents. Trusts may enter into agreements for the delivery of services with several Boards and are directly accountable for their individual management to the DHSSPS.

2.3.3 Personal Social Services

The Board receives a number of reports from the Director of Social Services who monitors the services provided for children – Annual Childcare Plan, which is a product of the Eastern Area Childcare Partnership, and an Annual Report of the Area Child Protection Committee, which provides substantial details of children in need of protection and service responses to them.

In 1998, DHSSPS exercised its powers under Article 18(4) of the Children Order to add to the duties of Boards. This resulted in the Children (1995 Order) (Amendment) (Childrens Services Planning) Order (NI) 1998 (The CSP Order) which requires each Board to review the services provided in its area under Part IV of the Children Order and prepare and review plans in light of the review of services. The Board receives an annual review on progress being made towards the targets in the Children's Services Plan, which covers a three year period, and which is approved by the Board.

DHSSPS issued a Circular, CC3/02 on 14th June 2002 to all Board Directors on the "Role and Responsibilities of Directors for the Care and Protection of Children".

This circular clarified the role of Directors for the health and wellbeing of children in the Board area and stated that under Article 18 of the Children (Northern Ireland) Order 1995, each authority had a general duty to safeguard and promote the welfare of children in need within its area, with additional particular responsibilities for

children who are looked after by an authority. The Board receives a bi-annual report from the Director of Social Services.

2.3.4 Public Health

It is a function of the Board to make a real and lasting improvement to the health and welfare of local people.

The Director of Public Health has a statutory duty to present an annual Public Health Report to the Board in order to inform it about the health of the population for which it is responsible and to be an integral component of the health planning and contracting cycle. The most recent Annual Report of the Director of Public Health can be accessed at www.publichealthmatters.org.

The Director of Public Health is also responsible for ensuring effective health protection arrangements are in place e.g., control of outbreaks of communicable diseases.

The Board also has responsibility for establishing effective partnership working in order to take forward the objectives set out in the DHSSPS "Investing for Health" Strategy (2002) which set out the process for achieving one of the five priorities of "Programme for Government" – *Working for a Healthier People.* HPSS bodies assumed a lead role in planning and co-ordinating action for health improvement and HPSS Boards are required to produce a Health Improvement Plan, which contains proposals on how to reduce health inequalities.

This is rolled forward on an annual basis with the Health and Wellbeing Investment Plan (HWIP).

The HPSS Boards are charged with establishing and leading Investing for Health Partnerships in their respective Board areas and, in so doing, discharge their collaborative working function.

2.3.5 Nursing

As a commissioner of Health and Social Services, the Board has to assure itself of the availability of an appropriately skilled nursing workforce in the Trusts and works in collaboration with Trusts in respect of nursing workforce issues. It is usual for the Trusts to undertake their own workforce arrangements, however, the Board assists by providing guidance and advice and by quality assuring the completed assessments. The Board's Nursing staff are available at all times to provide nursing advice as required.

From time to time, often in response to service pressures, the Board's nursing staff undertake analysis of nurse staffing and grade mix particularly in specialist areas such as Intensive Care Units, Theatres, Burns and Neurosurgery. They also evaluate and review Trust requests for additional staffing in respect of major or new capital projects ie., Phase 1 of the Royal Victoria Hospital and Mater Hospital.

In February 2000, the Directors of Nursing in the four Health and Social Services Board produced a report "Overview of Nursing within Northern Ireland".

This overview detailed their views on the pressures faced by nursing, one of which was the difficulty in recruiting qualified staff to both the statutory and independent sectors. This report was presented to DHSSPS. In October 2000 the Eastern Board undertook to determine if there was a pool of qualified nurses currently not employed as nurses who would wish to return to practice as a nurse, midwife or health visitor.

A Free Phone Helpline was established for three days in October 2000 to provide information and advice to nurses wishing to return to practice.

The Board has also undertaken surveys of Enrolled Nurses employed in Trusts in the Eastern Board area in order to ascertain views in relation to Conversion Courses. In the June 2000 survey, enrolled nurses employed in the private and voluntary sectors were also targeted. The Board and Trust staff work together to ensure implementation of Regional guidelines eg., Neonatal Hearing Screening and Ante-natal Infections Screening, Hall 4 etc.,

The Board's Nursing staff may also undertake specific practice reviews such as the use of seclusion within Eastern Health and Social Services facilities. In order to ensure that the Statutory Supervision of Midwifery Practice is exercised in accordance with the Midwives Rules and Standard Rule 2 II (I) the Board has the responsibility to appoint as Supervisor of Midwives in Trusts, experienced midwives with the appropriate training.

2.3.6 General Medical Services (GMS)

The Board's statutory functions in relation to General Medical Services (GMS) include:

- Management of the Performers' List Under the Health and Personal Social Services (Primary Medical Services Performers List) Regulations (Northern Ireland) 2004, the Board is required to prepare and maintain a primary medical services performers list of medical practitioners who may perform primary medical services for which the Board is under a duty to provide or secure the provision of;

- GP Appraisal

  The Board oversees the delivery of the GP appraisal scheme throughout the Eastern Board area.
  Each GP is required to undergo an appraisal on an annual basis (Circular HSS (MD) 30/2002)

- GMS Contract

  The Board is empowered by the Health and Personal Social Services (NI) Order 1972 and the Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004 to enter into a general medical services contract with Contractors to provide primary medical services and other services

  - Commissioning essential, additional and enhanced services from General Medical Services contractors;
  - Administering all aspects of and variations to the contract
  - Monitoring and ensuring contract compliance
  - Quality and Outcome Framework Assessment
  - Payment approvals associated with contract delivery
  - Provision of GMS Out of Hours services

- Probity

The Board is required to undertake the verification of payments

- Premises

Under the Health and Personal Social Services (General Medical Services – Premises Costs) Directions (Northern Ireland) 2004, the Board has an involvement in work associated with premises

development and improvements and recurring premises costs

2.3.7. Finance

For each financial year (1 April – 31 March), the DHSSPS allocates to each HSS Board an expenditure limit for revenue (current) and capital expenditure respectively, which is not be exceeded (either in-year or recurrently).

Distribution of "revenue" resources is influenced by a continuously researched needs weighted capitation formula, designed to allocate resources fairly between Boards, relative to their respective resident population needs. In turn, Boards are expected to ensure that resources are allocated fairly between localities across their geographical areas.

This annual allocation broadly comprises a baseline allocation designed to sustain existing care services, together with a range of specific additional allocations designated to meet particular pressures (eg., inflation or cost of new national contracts) and priority service developments approved by DHSSPS or the Minister. Additional allocations are earmarked to specific expenditure targets which, to the extent they are not required/spent in full, must be declared as surplus back to DHSSPS for re-application to other HPSS expenditure pressures and priorities or returned to the Department of Finance and Personnel.

Within the overall annual allocation, DHSSPS also prescribes an expenditure limit for Board management and administration, the remainder of resources (98.5% approximately) to be deployed in the commissioning of health and social care.

Following approval of its detailed financial plan by DHSSPS, the Board is required to report monthly on overall financial performance and on ear-marked allocations (against the approved Plan) to DHSSPS and secures more detailed financial monitoring reports internally to assure itself that DHSSPS targets can be met. The Board is required to submit by mid-August, following each financial year, fully (independently) audited Board approved Annual Accounts for presentation to Parliament/NI Assembly and their consolidation into the Departmental (NI HPSS) Annual Statement of Accounts.

The Chief Executive of the Board has been designated by the DHSSPS Permanent Secretary and Accounting Officer as Accountable Officer for the Board.

Each year, the Chief Executive as Accountable Officer is required to assure the Board, DHSSPS Accounting Officers and Parliament/NI Assembly of the adequacy of the Internal Control within the Board, including progress made against the DHSSPS stipulated Controls Assurance programme. This Internal Control statement is published each year as an integral part of the Board's Annual Accounts, which are openly available to the public via the Board's website, www.ehssb.n-i.nhs.uk, following their laying before Parliament. Key aspects of the Board's financial performance must be summarised and included in the Board's Annual Report which is published each autumn.

Whilst the availability of public funds each year will influence and constrain the level of care service development, the impact of a decreasing population trend in the Greater Belfast area on the level of resources available to the Belfast population (as indicated by the Ministerially-approved capitation formula) represents the

single greatest risk to the securing of adequate care services in the Eastern Board area.

2.3.8 Complaints

A Complaints Procedure is provided for the people who live in the Eastern Board area. Each Trust has a designated Complaints Officer, guidance is available on how to complain and members of the public who have concerns are encouraged to raise them as near to the point of service delivery as possible.

Each Trust will receive complaints by telephone, in writing, in person or by e-mail. People are encouraged to seek local resolution to their complaint. The Board has a similar complaints process in respect of the services it provides, a designated Complaints Officer, similar access arrangements and leaflet.

The Board has a specific responsibility in respect of complaints for residents of the Eastern area. If a complainant is not satisfied with the local handling of their complaint they have the right to ask the Board's Convenor to consider their complaint for an Independent Review. The first stage is referred to as the Convening Stage and this is undertaken by independent laypersons (who are not Board staff). A Lay Chairperson and Convenor will assess the documentation received from the respective provider or organisation (Trust or FHS Practitioner) and will assess whether or not the local response is satisfactory. The Convenor may secure professional advice (Medical, Nursing, Social Care) initially from within the Board to assist the laypersons in making their decision. The Convenor has three options within the Convening Stage: to reject the request and advise the complainant; to refer the matter back to the provider for further local resolution or; to refer the matter to an Independent Review Panel with specific terms of reference.

The second stage of the Independent Review process is when a Panel is convened. This will comprise of three laypersons who will re-examine the complaint fully and obtain independent specialist clinical and/or social care advice as necessary. The Panel will prepare a report, which is issued to the complainant, the provider/organisation, the participants in the Panel investigation and DHSS&PS.

At the end of this process the complainant is advised that they can refer the matter for further consideration to the NI Commissioner for Complaints (Ombudsman).

The Board has a Complaints Committee which meets twice a year to monitor and improve the Board's operation of complaints procedures, to review the findings and recommendations of the Independent Review Panels and agree a mechanism of ensuring the recommendations are implemented. It also monitors reports of Independent Review Panels to identify recommendations that should be shared with other HPSS bodies and to monitor the local resolution of complaints against the Board as a means of learning from complaints in order to improve services and standards. The Complaints Committee has a core membership of two Non-Executive Directors of the Board, two Executive Directors and the Chief Officer of the Eastern Health and Social Services Council and other Non-Executive Directors of the Board have a standing invitation to attend the meetings unless they hold membership of the Board's Reference Committee. The laypersons appointed by the Board - Consultancy Convenors, Lay Chairpersons and Lay Panel Members also have the right to attend alongside Senior Officers and Directors from the Board.

Issues arising from the Complaints Committee are included in service contract monitoring meetings with Trusts (See 2.3.2) above.

The Board publishes an Annual Report which gives an overview of complaints handled by the Board in instances where it acts as "honest broker" in complaints regarding FHS Practitioners, complaints regarding the Board itself and requests for Independent Reviews received in that year.

There is also a Representations and Complaints Procedure established under the Children (NI) Order 1995, which deals with complaints about Trust support for families and their children provided under the Adoption Order (NI) 1987, and the Trust's exercise of its functions under paragraph 4 of Schedule 5 of the Order. Trusts are responsible for this process.

2.3.9 Controls Framework

Following the recommendations of the Turnbull Report in 1999, which concentrated on the controls which Boards are obliged to maintain, more robust Controls Assurance requirements were introduced. The previous annual assurance on internal financial control was required to be expanded into a Statement of Internal Control. In the wake of Inquiries into Bristol and Alder Hey Hospitals and other Inquiries, it is recognised that quality management is a multi-facetted responsibility and that this should be encapsulated for the NHS in a system of Clinical Governance, which in the NI HPSS context becomes Clinical and Social Care Governance.

During the 1990s, in the context of "the purchaser/ provider split", the Board produced detailed service-specific Quality Standards for use with Service and Budget Agreements, a copy of which is appended for information. This system was superceded by new arrangements, in June 2002, which was based on proposals

outlined in the consultation document *"Best Practice, Best Care"* produced by DHSSPS in April 2001.

This defined clinical and social care governance as *"the framework within which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment."*

The new arrangements included strengthening professional regulation, producing central standards and guidelines (by DHSSPS) and the establishment, from April 2005, of a new Health and Social Services Regulation and Improvement Authority (HSSRIA). The Authority was established under the Health & Personal Social Services (Quality Improvement and Regulation) (NI) Order 2003. Under Article 34 (1) of the same Order a *"statutory duty of quality"* was also imposed on all HPSS organisations - Boards and Trusts. HSSRIA assumed the registration and inspection functions , which had previously been the responsibility of HPSS Boards.

Within a concerted programme to improve Governance and Risk Management the following initiatives have been progressed across the HPSS:

- Controls Assurance: DHSSPS has issued 18 Controls Assurance Standards to the service with specified levels of compliance, to ensure that effective controls are in place on the main legislative and regulatory requirements placed on Boards and Trusts.

  A self assessment process is applied, and this is subjected to auditing for those Controls Assurance Standards which require substantive compliance (70% and above).

An action plan to improve compliance is agreed within the Board and progress is reported regularly to the Board's Governance and Audit Committee.

- Risk Management /Registers: Risk Management is a system that is used to identify, evaluate and appropriately manage the risks to the achievement of the organisation's objectives.

  The Board's assessment of risks in Directorates and corporately is collated in Risk Registers that include treatment plans to reduce the likelihood/impact of the risk.

  By April 2005 the Board had a Corporate Risk Register which is available to the public on its website, www.ehssb.n-i.nhs.uk.

- Clinical & Social Care Governance:

  Circular HSS (PPM) 10/2002 "Governance in the HPSS – Clinical and Social Care Governance: Guidelines for Implementation" was issued in January 2003 and DHSSPS made it clear that **each Board and Trust would be individually accountable to DHSSPS** for having clinical and social care governance arrangements in place, which would ensure that each could discharge its duty of quality. The Circular highlighted the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure delivery of high quality health and social care in a context of openness, honesty and proactive reporting.

  To facilitate this programme of activities, the Board's Senior Management Team and the Governance Officers Group have developed, and keep under review revised mechanisms to identify and action matters of Governance/Risk Management which are

reported to the Board's Governance and Audit Committee.

2.3.10 **Standards**

At its meeting on 8 December 1994, the Board agreed to formally adopt Circular HSS (PDD) 8/94 "Codes of Conduct and Accountability" which had been issued by DHSS (NI) on 15 November 1994.

The principles of these Codes have been developed into an accountability and control framework for the Board, known as "Standing Orders" which include Standing Financial Instructions. These Standing Orders are reviewed and updated annually and approved by the Board. Inter alia they include the requirement for all Board Directors to declare interests which are relevant and material to the HPSS Board of which they are a Director and this Register is available for public scrutiny.

The Board conducts its business in an open and transparent way with Board Meetings open to the public.

3. **Please explain what role, if any, the Board has in the education and continuous development of doctors and nursing staff employed by the Trust**

3.1 Doctors

The Board does not have a direct responsibility for the education or continuous development of doctors employed by Trusts.

The Board does recognise the importance of these functions and the clear links between education and service delivery and seeks to maintain effective links with the relevant bodies. Examples include:

- Joint meetings between Senior Officers of Queen's University Belfast (QUB), the four Boards and DHSSPS.
- Membership on the Eastern Board of a Senior QUB Officer currently Head of the School of Medicine and Nursing.
- Links to the Northern Ireland Medical and Dental Training Agency for example through Board representation on the Modernising Medical Careers Steering Group.
- Board representation through the Director of Public Health on the Regional Medical Workforce Planning Group and attendance at the Specialty Advisory Committees of the DHSSPS

The Board does support training initiatives for Primary Care Medical Practitioners and also links with the Medical and Dental Training Agency in this regard.

Through its commissioning functions the Board is engaged with Trusts on issues such as the new Consultant Contract and Junior Doctors Hours of Work which are relevant to ensuring that doctors have adequate time for continuous professional development.

3.2 Nurses

Background

In the 1990's, prior to the introduction of Project 2000 Nurse Training, the Board was responsible for determining the number of pre-registration students, and the number of District Nurses and Health Visitors requiring training each year. The Boards nursing budget included the salaries of the pre-registration students and the replacement costs of the staff undertaking District Nursing and Health Visiting training. Following the introduction of Project 2000 Nurse Training, the DHSSPS became responsible for pre-registration training and the budget in respect of this was retained by DHSSPS. The funds in respect of District Nursing and Health Visiting remained with the Board until 2003.

The Board was also responsible for determining the need for post-registration training. This included courses such as 'Accident and Emergency', 'Coronary Care' and 'Renal'. The funds for these courses were provided by 'Top Slicing' the Board's nursing budget. In 1990, these funds were transferred to the then Units of Management as ring fenced nurse training monies.

Between 1990 and March 2003 the Board received an annual allocation for Nurse Education from DHSSPS. The Board in partnership with Trusts, identified the need for District Nursing, Health Visiting, Community Psychiatric Nursing, Community Learning Disability Nursing and Enrolled Nurse Conversions and resources were allocated accordingly. Remaining funds were allocated following evaluation of requests from Trust in respect of other training eg., Diabetes Awareness, Neo-Natal Resuscitation, and Domestic Violence Training.

In 2001/02 and 2002/03 having identified difficulties in recruiting staff to some specialist areas the EHSSB provided funds to facilitate in-service training on a supernummery basis for theatres, intensive care areas

and neurosurgery. This initiative had a very positive outcome in relation to recruitment and retention of staff in specialist areas.

Current

The Commissioner of post-registration education for nurses and midwives is the DHSSPS. Following the outcome of a consultation paper in 2000 a Steering Group was established to oversee new arrangements for commissioning post registration education for nurses, midwives and health visitors. Two Education Commissioning Groups (ECGs) were established, one to cover North & West and the other South & East in line with respective HSS Board areas

The North & West ECG comprises the:

- Three Trusts within the Western Health & Social Services Boards;
- Three Trusts within the Northern Health & Social Services Board;
- WHSSB, NHSSB and the DHSSPS

The South & East ECG comprises the:

- Eight Trusts within the Eastern Health & Social Services Board
- Four Trusts within the Southern Health and Social Services Board
- SHSSB, EHSSB and the DHSSPS

Aim

To ensure access to, through the commissioning processes, to education, learning and development opportunities for registered nurse and midwives that will develop the knowledge, skills and competencies required to enable them to deliver safe and effective care to patients, families, communities and populations.

Terms of Reference

Inform the post-registration commissioning process of identified learning and development needs of registered nurses and midwives in the context of the delivery of services.

To ensure equality of opportunity,openness and transparency in all commissioning activity.

Work jointly in partnership with the Business and Contracts Manager to produce an annual draft commissioning plan for DHSSPS approval.

Manage the allocated budget in accordance with DHSSPS policies and guidelines securing value for money.

Work collaboratively with all stakeholders to develop an annual commissioning plan, within available financial resources that is reflective of agreed principles for post-registration commissioning of nursing and midwifery education.

Monitor the uptake of commissioned programme places to ensure that uptake is maximised and attrition is minimised.

Monitor and evaluate the impact of commissioned activity on service provision and patient outcomes.

Produce an annual report demonstrating compliance with Terms of Reference.

Membership of the ECGs includes the Director of Nursing of each Trust and Boards. Currently these groups are chaired by the Director of Nursing in the NHSSB and EHSSB. There is an annual cycle of activity which includes assessment of learning needs, decisions on what is to be commissioned, from whom and in what form. The process includes monitoring and evaluation and the production of a detailed commissioning plan on an annual basis.

The ECGs are accountable to DHSSPS – the aim being that this new arrangement will lead to a closer partnership between DHSSPS, the HPSS and Education Providers.

4. **Please explain the procedure in place within the Board for Disseminating information learned as a result of Coroner's Inquests or other events both to the Trusts and to your colleagues or other Health Boards in Northern Ireland.**

Information about events which may require dissemination is received by the Board from different sources including:

a. Direct reporting, or information provided, by Trust Officers of events which have occurred within a Trust;
b. Information received from complainants or during the Independent Review Processing of complaints;
c. Information received through the Professional Advisory mechanisms of the Board including the Area Medical, Nursing, Dental and Clinical Audit Advisory Committees;
d. Information received by relevant Board officers in respect of their statutory functions such as the Director of Public Health in relation to Health Protection issues and the Director of Nursing in relation to midwifery;
e. Reports in the media which require to be followed-up.

The Board does not routinely receive the reports of Coroners' Inquests but the Coroner has forwarded reports on specific matters and Board Officers have, on occasions, also requested reports.

It is important to note that such reports relate to Eastern Board residents only. There have been occasions when a Coroner's Inquest has been conducted into the death of a patient, not resident in this area, in a facility located in the Eastern Board area. The Board has not been involved in the Inquest, follow-up action or provided with a copy of the Coroner's report.

The Board is responsible for the management of Clinical Negligence Claims relating to treatment prior to the establishment of Trusts (1993/94). It does not routinely receive reports of cases managed by Trusts, but liaises with Trusts in managing the pre-1993/94 Claims and discusses relevant follow-up actions/lessons.

The procedure for disseminating information is dependent on the particular situation as demonstrated by recent examples.

1. During the Independent Review Stage of a complaint against a Trust an expert medical advisor raised significant concerns relating to the management of the patient. In the light of the issues raised, the Board halted the Independent Review and requested the Trust to carry out a Root Cause Analysis of the Incident and set up an Independent Inquiry and has followed up on Trust actions in light of the recommendations.

   The Report of the Inquiry was forwarded to the Coroner and the DHSSPS and lessons learned have been shared with other Boards and also with other providers through the mechanism of the Northern Ireland Cancer Network.

2. Following a medical negligence case, a Trust Chief Executive requested Board assistance to develop a protocol for the management of neonatal jaundice.

   A joint team from the Board and several Trusts developed agreed guidelines and these have been sent by the Board's Chief Executive to each Trust Chief Executive for implementation and to the Directors of Public Health and Nursing in other Boards for consideration in relation to their respective Board areas.

3. Examples of relevant issues which have arisen from the Independent Review of complaints include: changes in Trust policies and procedures in A & E Departments; changes in Obstetrics and Gynaecological procedures; revision to General Medical Practitioner minor surgery procedures and; a review of ambulance equipment availability.

5. **Please explain the interaction between the Health Board and the DHSSPS , in particular, how information that comes to the attention of the Board that may impact on the future care of patients within other Health Boards is disseminated to the DHSSPS, other Health Boards and Trusts in Northern Ireland.**

If Board Officers become aware of information that could impact on the future care of patients within other Health Boards they will bring this to the attention of appropriate Board and DHSSPS Officers.

The mechanism giving interim guidance for reporting and follow-up on serious adverse incidents is set out in DHSSPS Circular HSS (PPM) 06/04. This requires Boards, Trusts and Agencies to:

- *Inform the Department immediately about incidents which are regarded as serious enough for regional action to be taken to ensure improved care or safety for patients, clients or staff.*
- *Inform the Department where it is considered that the event is of such seriousness that it is likely to be of public concern.*
- *Inform the Department where it is considered that an incident requires independent review.*

The Board's Chief Executive has written to each Trust Chief Executive to request that all serious adverse incident reports are copied to the Board at the same time as DHSSPS is informed.

The Board and Trusts receive advice from the Department following incidents by different mechanisms depending on the nature of the incident including:

- The Northern Ireland Adverse Incident Centre (NIAIC) issues advice bulletins in relation to the safety of devices and equipment .

With the establishment of HSS RIA in April 2005, the responsibility for ensuring that these notices are drawn to the attention of all independent clinics and hospitals within a HPSS Board area has transferred from the Board's Chief Executive to the new Authority.

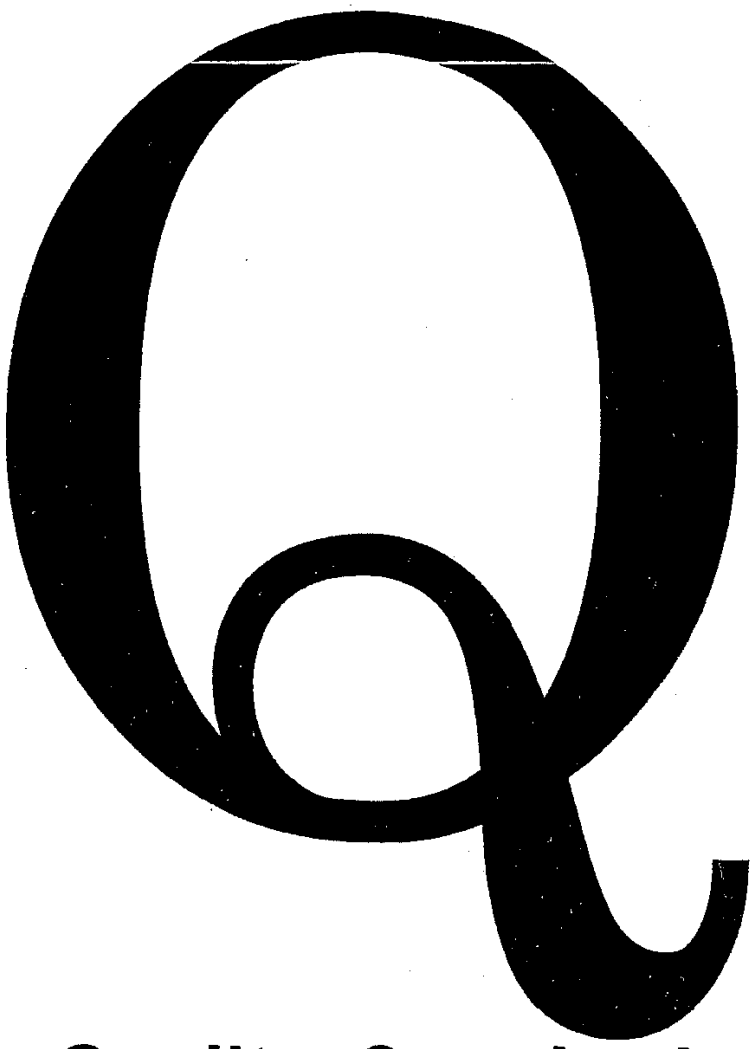
- Chief Professional Officers at DHSSPS issue urgent advice on specific issues. A Cascade System operates through which such advice can be relayed by email to appropriate officers in Boards, Trusts and Agencies and then forwarded within organisations. The Board has the responsibility to cascade, if necessary, the information by email or fax to general practitioners.

- The Medicines Governance team of Pharmacists issue guidance on pharmaceutical matters based on their analyses of reported pharmaceutical incidents.

- Board Officers contribute to the work of CREST which develops guidelines on clinical issues and disseminates it widely throughout the service and to regional clinical audit initiatives

  A further DHSSPS Circular HSS (PPM) 05/05 was issued in June 2005. It updates progress on safety issues, the work of the Regional Safety Group and information collated on adverse incident and near miss reporting. Work is in hand to standardise definitions and develop a safety framework for the HPSS, enabled by links to the National Patient Safety Agency (UK). EHSSB would welcome the formalisation of a regional approach on these matters and agreed processes for the dissemination of information.

Eastern Health & Social Services Board



Quality Standards

EHSSB

COMMISSIONING QUALITY CARE

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UNTOWARD EVENTS

The Board will require evidence from each of its Provider Trusts of implementation of a comprehensive system of reporting and acting on untoward events in all services.

An untoward event is "any happening or activity, including a clinical activity, which is not part of normal operations and which causes or has the potential to cause serious harm or injury to any patient or client for whom the Board commissions services".