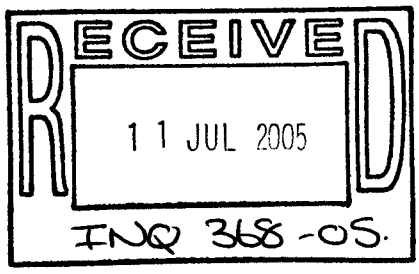
Southern Health and Social Services Board
Office of the Chief Executive
Direct Line: [redacted]

7 July 2005



Ms F Chamberlain
Solicitor to the Inquiry
The Inquiry into Hyponatraemia-related Deaths
3rd Floor
20 Adelaide Street
BELFAST BT2 8GB

Dear Ms Chamberlain

Inquiry into Hyponatraemia-related Deaths

I enclose the SHSSB responses to the queries raised in your letter of 17 May 2005. Should you require any further clarification or have any queries, please contact Dr Brid Farrell, Consultant in Public Health.

Yours sincerely

C Donaghy
Chief Executive

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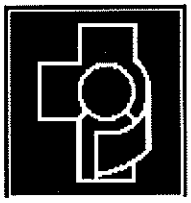


Southern Health and Social Services Board

Inquiry into Hyponatraemia-related Deaths

Response from
Southern Health and Social Services Board

July 2005

Structure of Response

Background Legislation for HPSS

Health and Social Services Boards

Article 16 (1) of the Health & Personal Social Services (Northern Ireland) Order 1972 provides for the Ministry of Health and Social Services to establish Health and Social Services Board 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 with respect to the administration of such health and personal social services as the Department may direct; and

* Exercise on behalf of the Ministry of Home Affairs such functions with respect to the administration of such personal social services under the Children and Young Persons Act (NI) 1968 and the Adoption Act (NI) 1967 which was subsequently replaced by the Adoption (NI) Order 1987;

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 until a further period of reorganisation in the early 1990's which resulted in the integration of local districts and the creation of General Units of Management, which remained managerially accountable to the Boards.

In 1993, the direct rule administration in Northern Ireland extended the structural changes that had been implemented in the health services in England and Wales to Northern Ireland. Central to the reforms in England and Wales was the establishment of health trusts with a remit to provide local acute and community health services and Health and Social Services Boards were reconstituted as commissioners of services.

In Northern Ireland, as health and social services were integrated under the HPSS Order 1972, the extension of these provisions had to take account of the existing Board's 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.

Health and Social Services Trusts

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. Article 10 (1) of the Health & Personal Social Services (NI) Order 1991 gave the DHSS the power to establish, by Order, Health and Social Services Trusts. Schedule 3 of the 1991 Order sets out the duties, powers and statuses of the Trusts.

The first Health and Social Services Trusts were established in shadow form in 1993 and were created as self-governing bodies, managerially and administratively independent of Boards. Following the Community Care Reforms, 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 the delegation to Trusts of statutory functions formerly exercised by Boards. Trusts are accountable in law for the discharge of statutory functions, delegated to them by Boards.

These delegated functions include:

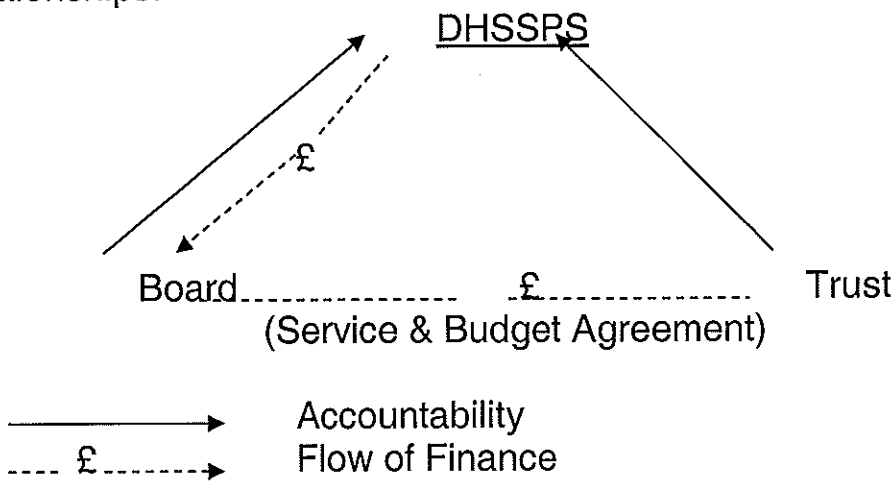
- The Children (Northern Ireland) Order 1995,
- Adoption (Northern Ireland) Order 1987, although the DHSS continued to retain a direct administrative and professional quality assurance role in respect of intercountry adoption.
- Adoption (Intercountry Aspects) Act (NI) 2001
- The Carers' and Direct Payments Act (NI) 2002
- The Children Leaving Care Act (NI) 2002
- The Protection of Children and Vulnerable Adults (NI) Order 2003.
- Children and Young People Act (NI) 1968
- Mental Health Order 1986
- HPSS Order 1972
- Chronically sick and Disabled (NI) Act 1978
- Disabled Persons (NI) Act 1989

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;
* to discharge its duty as to secure the efficient coordination of health and personal social services.

In 2000, the Northern Ireland Act 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:



1 Please explain the role and responsibilities of your Health Board.

2 Please explain the interaction between your Health Board and HSS Trusts

These questions are answered together.

Composition of the Southern 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 with 13 members in total.

The Chairwoman of the Southern Health & Social Services Board (the Board), Fionnuala Cook, and her 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, Colm Donaghy

In accordance with Circular HSS (PCD)1/2002, the Board, at its meeting on 12th February 2002, approved the establishment of three Health and Social Care Groups (HSCGs) in the Southern Board area, and the appointment of the three HSCG Chairs as Associate Directors of the Board was approved at the Board meeting on 12 November 2002.

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a "statutory duty of quality" on HPSS Boards and Trusts. This means that each organisation, large or small has a legal responsibility to ensure that the care it provides must meet a required standard.

Role of the Board

The Southern Health and Social Services Board (the Board) serves a population of approximately 319,000 and includes the five District Council areas – Armagh, Dungannon, Craigavon, Banbridge, Newry and Mourne

The aim of the Board is to improve the health and wellbeing of the population of the Southern Area, tackle health and social inequalities,

and ensure that our population has access to high quality services to meet their needs.
The Board's activities are funded directly by Government, through the taxpayer. This currently amounts to over £500m every year.

The Board recognises that it cannot achieve improvements to health and wellbeing of its population without engaging with local communities and outside agencies.

The Board's work is characterised by:

- Working in partnership with a wide range of agencies whose work has an impact on health and social wellbeing.
- Developing the capacity and skills of our communities to improve their own health and wellbeing.
- Focusing on the individual needs of people as well as the wider needs of our population.
- Promoting innovation and new and better ways of working to meet the changing needs of our population.
- Ensuring fairness of access to care and treatment.
- Valuing and developing our staff.

The Board's Corporate Objectives are:

- To plan and deliver the government's targets for the Health and Personal Social Services (HPSS) and to respond to local priorities.
- To actively promote community and user empowerment and extend involvement in health and social care planning, delivery and monitoring of performance.
- To further develop partnerships with statutory and independent sector organisations to deliver improved health and social wellbeing.
- To improve decision making and ensure effective and equitable use of resources.
- To lead service improvement and workforce modernisation to ensure and improve the quality of health and social care provided to our population.
- To further enhance public and user safety.
- To continually improve how we work to ensure that the Board operates as effectively as possible.

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

Responsibilities of the Board

Commissioning

There are a number of interrelated processes in place to assist the Board in its responsibility to commission services to meet the health and social care needs of the resident population. These are described in the following sections.

Strategy Development

The Board has responsibility for developing long term (5 year +) strategies to ensure that services develop to meet changing needs, modernisation requirements, evidence based practice and quality standards. There are a number of multidisciplinary planning fora that undertake strategy development within the Board, including:

- Acute Hospital Services Programme Commissioning Group
- Mental Health Services Programme Commissioning Group
- Learning Disability Programme Commissioning Group
- Care of Older People Programme Commissioning Group and LHSCG Locality Commissioning Groups (joint PCG/LHSCG commissioning arrangements in place for elderly programme of care)
- Child Care/Maternal & Child Health Programme Commissioning Group with a subgroup to address the needs of Children with Disabilities.
- Physical & Sensory Disability Programme Commissioning Group
- Commissioning of General Medical Services is led by the Directorate of Primary Care.
- Health Promotion Services commissioning forum
- Board's Dental Department leads the commissioning of community dental services provided by Trusts.
- Public Health Department (including Pharmacy).

In developing strategy, the planning fora engage with a wide range of stakeholders, including:

- Services user and Care Groups
- Trust professional and managerial staff
- Voluntary and Community Groups

- District Councils
- Local Politicians
- GPs

The Board's strategy development is also informed and shaped by a range of partnerships which the Board either leads or contributes to. These partnerships include:

- Southern Investing for Health Partnership (SIHP)
- Co-operation and Working Together (CAWT)
- Local Strategy Partnerships within each Council area.
- Children's Services Planning (CSP)
- Area Child Protection Committee (ACPC)
- Wraparound
- Health Promotion partnerships
    - Tobacco Action
    - Teenage Action
    - Parenthood
    - Sexual Health
    - Drugs and Alcohol
    - Physical Activity
    - Screening programmes (Diabetic Retinopathy, Neonatal Hearing)
    - Mental Health

There are also formal consultation processes in place before final decisions are made by the Board.

Structure

The Southern Health and Social Services Board consists of six Executive Officers including the Chief Executive and six Non-Executive Officers plus the Chairperson. The seven Non Executives are appointed for a four year period by the Minister in keeping with current Northern Ireland Office procedures for public appointments.

Local Health and Social Care Groups (LHSCGs) function as sub committees of the Board and the Chair person of each local group sits on the Board.

The Board holds a public meeting once a month and every second month endeavours to hold the meeting in a local setting. Members of the public are able to request speaking rights at any public Board meeting.

The Board considers a wide range of issues and makes its decisions in keeping with its published 'Purpose and Core Values' and its agreed Health and Well-being Investment Plan.

The Board is accountable to the Department of Health & Social Services and Public Safety for Northern Ireland (DHSSPSNI). Formal bilateral accountability review meetings are held twice a year against which the Board's progress against delivering on agreed objectives and targets is assessed.

Many of the policies and actions agreed by the Board will have been subjected to a period of public consultation and members of the public and interested groups are invited to address the Board in relation to their concerns or agreement to the course of action proposed.

In addition to engaging with partners and members of the public the Board is obligated to screen all policies for Equality Impact (section 75 N.I Act).

Annual Commissioning Priorities

Each year, the Board publishes its' commissioning priorities and spending plans. This process is informed by:

- Programme for Government and associated Public Service Agreements
- Priorities for Action (DHSSPS), the development of which the Board contributes to in relation to local needs assessment, service priorities/pressures and the need to continue to implement key Board Strategies.
- Ongoing implementation of Board Strategies for individual programmes of care.
- Local service pressures/development priorities identified though performance management monitoring and through consultation with local communities and service users/carers.)
- SIHP Health Improvement Plan

- Local Health & Social Care Group primary care development plans.
- Managing Acute Pressures

Health & Wellbeing Investment Plan (HWIP)

The above process results in the development of the annual HWIP which sets out in detail the Board commissioning intentions and planned investments for the coming year. The HWIP has to be approved by the Board and submitted for Ministerial approval.

Trusts are required to respond to the HWIP by developing annual Trust Delivery Plans which are submitted to DHSSPS for approval.

Service and Budget Agreements (SBAs)

Following approval of the HWIP, the Board commissions the required services from Trusts across Northern Ireland. The services to be commissioned are set out in an individual Service and Budget Agreement with each Trust which includes:

- Service volumes
- Service standards
- Procedures and protocols to be observed
- Funding arrangements
- Scheme of delegation for delegated services
- Legislative and service quality requirements
- Performance monitoring arrangements and reporting mechanisms

Performance Management and Monitoring

The Board's own performance is monitored by DHSSPS through quarterly monitoring of progress against HWIP/PFA targets and through:

- Bi-annual DHSSPS/Board Performance Review meetings
- Chair/Chief Executive annual Performance Review meetings with Minister.

The Board monitors its own internal performance through a number of mechanisms, including:

- Internal Governance Arrangements (Governance Committee, Risk Registers, etc.)
- Setting of annual Corporate Objectives,

- Directorate/PCG/LHSCG Business Plans for delivery of corporate objectives
- Individual performance objective-setting based on corporate objectives and monitored by regular meetings between member of staff and manager.

The Board monitors the performance of service providers including Trusts against the Service and Budget Agreement, the Health & Wellbeing Investment Plan targets and statutory standards.

The mechanisms and information used by the Board in undertaking this performance monitoring includes:

- Performance Management Reports for Care Management, Hospital performance on Waiting Lists and other performance indicators, Mental Health, Child Care, Learning Disability and Physical Disability and Sensory Impairment.
- Priorities for Action Monitoring
- Monitoring of actual activity against agreed activity levels in SBAs.
- Service reviews/evaluations (e.g. Learning Disability, Dementia, Mental Health etc)
- System reviews (e.g. Care Management Review)
- Untoward Events reports
- Complaints information supplied by Trusts
- Case Reviews

Governance Committee

The Governance Committee oversees the implementation of Governance and reports to the Board on a regular basis to ensure it is kept fully aware of progress. It also provide assurances to the Board that reporting mechanisms are in place to ensure risk is being identified and managed through the operation of effective controls, in all aspects of the Board's business.

Membership includes:

- Non-Executive Director (Chair)
- One Non-Executive Director
- Chief Executive
- All Executive Directors

The Board meets each Trust in the Southern Area three times per year for a formal performance management meeting. PCGs also undertake performance monitoring with Trusts on a programme-specific basis. For the Elderly services, this performance monitoring is jointly undertaken by LHSCG's and PCG. Regular meetings take place with external trusts to monitor performance against SABA.

A number of service quality issues are identified in SABAs with Trusts each year. Normally these issues are programme specific and relate to practice development in keeping with national and regional guidance or new legislative requirements. Trusts are asked to provide reports to the Board against progress on achieving these quality standards. Examples include:

- Access to Cancer Services
- Person Centred Ethos in the delivery of Services to Elderly Persons
- Modernizing and Improving Services
- Recommendations from Confidential Enquiries

Role and Responsibilities of Directors for the Care and Protection of Children

Circular CC3/02 issued in June 2002 identified the roles and responsibilities of Board Directors in their role as Corporate Parent for all children who are in the scope of the Children (NI) Order 1995 ie children in need, children on the child protection register, looked after children, care leavers. Boards and Trust have a legal and ethical duty to provide children who are looked after with "the kind of support that any good parent would give to their children". Reporting arrangements are in place to ensure the requirements of the circular are fulfilled.

The Commissioning and Monitoring Of Delegated Social Services Statutory Functions

Social Care Directorate has the lead role in relation to delegated social services statutory functions.

- The Director of Social Services reports to and advises the Chief Executive in relation to the discharge of delegated statutory functions
- The Assistant Directors of Social Services report to and advise the Director of Social Services, each having lead role, on behalf of the

Director, in relation to delegated statutory functions in a specific programme or programmes of care.

The Health and Personal Social Services (NI) Order 1994 permits Boards to delegate to Trusts certain statutory functions. These statutory functions had been conferred directly on Boards or delegated to them by the Department.

Statutory functions are delegated by the Board to Trusts under the Delegation of Statutory Functions Scheme of Delegation.

Service and Budget Agreement
The Service and Budget Agreement is the means by which the board specifies its requirements of a Trust in relation to

- The discharge by the Trust of delegated statutory functions
- The Trust's accountability relationship with the Board in respect of the delegated statutory functions.

The Service and Budget Agreement requires the Trust to adhere to the Scheme of Delegation. It may additionally detail specific standards, procedures and protocols to ensure the effective discharge of statutory functions.

Performance Monitoring and Needs Identification
Monitoring of the discharge of the delegated statutory functions is achieved primarily through the Board's performance management arrangements. Nine strands of performance monitoring are in place:

- Performance Management and Improvement Meetings
- Participation in Cross-Trust consortia
- Multi-agency partnerships
- Reports from Trusts
- Inspection
- Audit
- Case Management Reviews
- Research and evaluation
- Service User and Carer Consultation

Statutory Child Care Monitoring Meeting take place two monthly. The meeting is chaired on a rotational basis by the Assistant Director of Social Services (Child and Family Care) and the Trust Directors of Social

Services. It is supported by the Area Child Protection Committee (ACPC) Principal Social Worker/ Professional Officer and includes senior professional child care staff from Trusts.

Three sub-groups report to the Statutory Child Care Monitoring Meetings. They are:

- The Residential Child Care Forum
- The Family Placement Committee
- The Child Care Managers Meeting

The meeting provides a mechanism to review standards, practice and the discharge of statutory functions on a Board-wide basis, to share information and to promote common and collaborative approaches to the discharge of statutory functions. It

- Receives reports on statutory child care services
- Reviews the discharge of statutory functions in child care
- Identifies service issues, pressures and shortfalls
- Reviews issues of professional social work practice
- Reviews the training and qualifications of the workforce
- Considers standards which should be applied
- Agrees revised procedures and protocols
- Commissions joint planning and service development
- Identifies areas for audit and review

Southern Area Directors of Social Services Meeting takes place three monthly. It is a senior professional forum which identifies and addresses professional social work issues

- Problems in the discharge of delegated statutory functions
- Operation of monitoring and reporting arrangements
- Collaborative working across the Southern Board's area
- Workforce, including recruitment and retention and training and development
- Identification of issues which require to be addressed regionally

Cross Trust Consortia

Cross Trust Consortia have been established in three areas which are fundamental to the discharge of statutory functions They are a means by which the Trusts can work together, with the support of the Board, to share work and resources and to agree a common, consistent approach.

The consortia in the Southern Area are:

- **The Social Services Training Consortium**, of which the Board is a full member. This is comprised of the Trust Directors of Social Services and the Assistant Director of Social Services (Training). It is the management Board of the Southern Area Social Services Training Unit which is operationally managed by the Board. The Consortium oversees the commissioning of Social Services Training in the Southern Area. Six monthly reports are made to the Board and the Social Services Inspectorate. An annual Social Services Training Business Plan is also compiled.

- **The Adoption Consortium**, which is comprised of the three community Trust and at which the Assistant Director of Social Services (Child and Family Care) is in attendance. This provides the Adoption Panel for the Southern Area and specialist common adoption services. It provides common procedures and training. It produces an annual report which contains considerable information on discharge of statutory functions.

- **The Contract Consortium** for adult community care, which is comprised of the three community Trusts and at which the Assistant Director of Social Services (Older People and Physical Disability) is in attendance. This deals with contracting for community care services, agreeing common contracts, quality and prices.

- **The Out of Hours Social Work Consortium** is comprised of the three Trusts. Through the Consortium Out of Hours services are provided across the Southern area. The Consortium produces an Annual Report reviewing the service provided and issues arising, particularly in relation to the discharge of statutory functions.

Multi-Agency Partnerships

Information relevant to the commissioning and monitoring of delegated statutory functions is gathered through inter-agency partnerships, particularly those of which the Board is the lead partner. This can assist the Board in the assessment of quality of the discharge of statutory functions as well as contributing information on unmet need.

- **The Area Child Protection Committee (ACPC)** as a multi-agency and multi-disciplinary partnership led by the Board provides

a strategic approach to child protection within the overall children's services planning process. The Trust Child Protection Panels make reports to the ACPC quarterly.

The ACPC provides a means for the Board to assure itself of the effective operation of child protection processes in its area. It also provides a means to address shortcomings and areas of improvement which are identified. In particular following Case Management Reviews the ACPC is charged with drawing up an action plan and monitoring its implementation. Annual Reports provide considerable monitoring information on the discharge of statutory functions in child protection.

The ACPC also commissions a comprehensive training programme each year disseminating lessons from reviews and inspections on a multi-disciplinary, inter-agency basis contributing to governance quality and risk management.

- **The Child Care Partnership** is the multi-sectoral, multi-agency partnership with leadership role in the development of child care and early years services. It has a central role in developing family support as part of the overall children's services planning process.

  The Local Early Years Forum in each Trust area is a sub-committee of the Child Care Partnership.

  The Child Care Partnership produces a three year Child Care Plan and an annual review which provide considerable information on aspects of discharge of statutory functions.

- **Children's Services Planning** is the strategic planning process for children and young people who are in need or vulnerable. It is led by the Children and Young People's Committee and includes a number of working groups (currently nine) which focus on a range of areas of need. These contribute to assessment of need, review the ways in which need is addressed and bring forward proposals for service development and inter-agency working. Children's Services Planning publishes a three yearly Children's Services Plan and an annual review.

- **The Adult Protection Forum** provides a means of ensuring continued application of policy and procedures in relation to the protection of vulnerable adults. The Forum is chaired by the Assistant Director of Social Services (Older People) and comprises representation from each of the four Trusts. It is multi disciplinary in nature and has worked closely with PSNI to ensure full implementation of joint investigation procedures. Statistical data on adult protection referrals is collated on a quarterly basis.

- **The Southern Area Supporting People Partnership** is a multi agency Forum designed to assess and prioritise needs for housing with support across the Southern Board. It encompasses both adult and children's services and external agencies, including NIHE and Probation Board N.I.

Reports From Trusts

Both statistical and qualitative reports are required from Trusts in relation to delegated statutory functions. These include:

- Information required under the Roles and Responsibilities of Directors for Child Care and Child Protection (Circular CC3/02). This includes Looked After Children Chairs' Reports, the Residential Child Care Monitoring Report, the Trust Child Protection Panels' annual reports, quarterly Trust child protection statistical reports and the Adoption Committee Annual Report.
- Untoward Event Reports
- Second Stage Complaints referred to the Board
- Information on the discharge of statutory functions in mental health and learning disability, including on the approved social worker duties
- Annual report on the out of hours social work service

Statutory Supervision of Midwives

The Nursing and Midwifery Order 2001 requires the Nursing and Midwifery Council (NMC) to set rules and standards for the statutory supervision of midwifes by local supervising authorities (LSA).

Currently the Board's Chief Executive is the Accountable officer for the Board as an LSA and the Chief Nurse is the LSA Midwifery officer (LSAMO), with responsibility to ensure that supervision is carried out in accordance with the Midwives Rules and Standards (NMC 2004). The

Board has the responsibility to appoint supervisors and maintain an optimal ratio of supervisors to supervisees. It also has the responsibility to ensure optimal communication and reporting arrangements between supervisors and the LSAMO and other relevant bodies such as NIPEC and Midwifery education providers. It also has the responsibility to receive and process with the NMC a notification to practice form from every midwife in its area.

Operational responsibility for supervision lies within Trusts and is coordinated through the Board's Link supervisor.

Performance monitoring and needs identification

Monitoring of supervision is achieved primarily through the Board's supervisors of midwifery committee, through meetings with the link supervisor and through formalized meetings with the Trust Directors of Nursing. These meetings take place quarterly and provide a forum which identifies and addresses:

- Problems in the discharge of statutory functions
- Workforce, including recruitment, retention, training and development
- Unmet need
- Production of the LSA annual report
- Meeting the requirements of the NMC Rules and Standards.

GMS Statutory Regulatory Functions

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

- Management of the Performers List
  Under the Health and Personal Social Services (Primary Medical Services Performers Lists) 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 has established a Local Appraisal Group to oversee the delivery of the GP appraisal scheme throughout the SHSSB. 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 service.

- Probity
  The Board is required to under take 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.

Pharmacy Statutory Functions

The function of the Board, described under the Pharmaceutical Services Regulations (Northern Ireland) 1997, is exercised by its Director of Pharmaceutical Services, and includes:

Regulation No.	'BOARD' FUNCTION	
4(2)a	Approval of health promotion leaflets for display by a chemist	1
6(1)	Preparation and maintenance of the Pharmaceutical List	1 & 2
6(2)	Submission of applications	1 & 2
6(3)	Granting of applications for transfer of ownership of pharmacy premises	1, 2 & 3
6(5)	Allowance for a period of interruption in the provision of pharmaceutical services	1
6(4) to 6(8)	Minor and temporary relocations of pharmacy premises	1, 2 & 3
6(7)	Seeking the views of the Local Pharmaceutical Committee	1, 2 & 3
6(4D) and 6(13)	Making relevant entries in the Pharmaceutical List	1 & 2
6(12)	Applicant's knowledge of English	1 & 2(a)
7(1)(a) and (b)	Removal from Pharmaceutical List	1 & 2
7(2) to 7(4)	Removal from Pharmaceutical List	1
7(5)	Removal from Pharmaceutical List	1 & 2
8	Preparation of a drug and appliance testing scheme	1 & 2
9(2)	Determining authority for Drug Tariff specified fees, other fees and additional professional allowances	1
9(4)	Consultation with Local Pharmaceutical Committee	1
9(5)	Publication of arrangements for claiming Drug Tariff fees and allowances	1
10(1)	Payments to suspended chemists	CSA
10(A)	Reward Scheme payment	1 & 2
12 and 12A	Arrangements for the provision of pharmaceutical services by doctors	Disp Dr Ctte
12B and 12C	Arrangements for publication and maintenance of a Dispensing Doctor List	2
14(1)	Availability of documents at Board offices	1
14(2)	Availability of documents at other places	1 & 2
14(3)	Distribution of Pharmaceutical List and Dispensing Doctor List	1 & 2
16(2)	Notification of overpayment to a chemist or dispensing doctor	1 & 2

Sch 2 Part II, 1A	Directed services	1
Sch 2 Part II, 4	Chemists' hours of service	1
Sch 2 Part II, 6	Particulars of pharmacists	1
Sch 2 Part II, 8	Inspection of records and premises	1
Sch 2 Part II, 9	Remuneration of chemists	1 & 2
Sch 2 Part II, 10(1)	Withdrawal from the Pharmaceutical List	1, 2 & 3
Sch 2 Part II, 12	Investigation of complaints	Complaints Officer.
Sch 3 Part I, Form A, Para 5	?	?
Sch 4 Part I, 1(1) to 1(3)	Procedures on application	1 & 2
Sch 4 Part I, 3	Notification of decisions	1 & 2
Sch 4 Part I, 4(4)	Referral of notice of appeal	1
Sch 4 Part I, 4(5)	Notification of National Appeal Panel Chairman's determination	1
Sch 4 Part II, 8	Pharmacy Practices Committee membership lists	1
Sch 4 Part IV, 14(1)	Submission of nominees for National Appeal Panel under Schedule 4, Part III, Paragraph 14(1) of the Pharmaceutical Services Regulations (Northern Ireland) 1997.	1
Sch 4 Part IV, 15(1)	Consultation with Board on appointment of Chairman and Vice-chairman of National Appeal Panel	1
Sch 4 Part IV, 20(3)	Notification of decisions of National Appeal Panel under Schedule 4, Part IV, Paragraph 20(3) of the Pharmaceutical Services Regulations (Northern Ireland) 1997.	1 & 2

1 The responsibility for this function is delegated by the Board to the Director of Pharmaceutical Services or in the case of their absence to a nominated Board officer.

2 However the execution of the process(es) can be undertaken by the Central Services Agency according to a protocol determined by the Board's Director of Pharmaceutical Services detailing all functions required by the Regulations.

2(a) However the execution of the process(es) can be undertaken by the Pharmaceutical Society of Northern Ireland according to a protocol determined by the Board's Director of Pharmaceutical Services detailing all functions required by the Regulations.

3 Upon completion of all processes required by the Regulation the function will be executed by the Director of Pharmaceutical Services.

Dental Statutory Regulatory Functions

The Board's statutory functions include:

- Inclusion on/removal of practitioners from the Dental List and relevant practice inspections
- Authorisation of provision of care by deputies/assistants
- Approval of payments/recovery of overpayments in the event of suspension or failure to adhere to Quality Assurance Scheme

For General Dental Services, as independent contractors the care provided will relate to the practitioners assessment.

The payment function is delivered by CSA on behalf of the Board with management data generated to facilitate analysis of trends regarding payments/treatment provided.

Quality of treatment is assessed via the Referral Dental Officer Service (RDO)
The Community Dental Service is a salaried service, which is provided on an area wide basis and managed via Armagh

Dungannon HSS Trust. The Board details the service specification which is monitored via Performance review meetings and outcomes in relation to Priorities for Action. Where appropriate, specific audits are undertaken regarding particular aspects of service provision.

Public Health

The Control of Communicable Disease, Emergency Planning and the Prevention and Management of Chemical, Biological Radiation and Nuclear Hazard are areas where essential statutory functions rest with the Director of Public Health.

Control of Communicable Disease and Infection

DHSS NI Circular 24 March 1989, HSS (CH) 1/89 Health of the Population: Responsibility of the Board requires that:

"At Board level the Director of Public Health (DPH) will have overall responsibility for the control of communicable disease and infection throughout the Board area. The DPH should assign executive responsibility for prevention, surveillance and control of communicable disease and infection in the population of the area to a named consultant in public health medicine. (S)He will be known as the Consultant in the Communicable Disease Control (CCDC) and will be accountable to the DPH. The CCDC will be expected to maintain specific arrangements for dealing with communicable diseases. (S)He should also develop effective liaison arrangements with those agencies and professional groups who play an important role in the prevention, surveillance and control of infection in the community. These will include nurses in the community, general practitioners and district council environmental health departments. Regular meetings should be held with such departments. Liaison arrangements between hospital infection control doctors (usually microbiologists) and the CCDC will also be necessary to enable the CCDC to assume overall responsibility for outbreak control, including the implications outside the hospital."

Surveillance

A list of statutory notifiable diseases in N Ireland is prescribed by the DHSSPS under the Public Health Notifiable Disease order NI (1990). Under this order all doctors if they encounter such diseases, are required to notify the DPH/CCDC. Surveillance also strengthened using hospital laboratory reports and information from Environmental Health Officers.

Control and Prevention of Notifiable Diseases

Many General Practitioners, professionals within Trusts, GPs and Environmental Health Officers from the District Councils assist the CCDC to carry out follow-up of notified cases. The CCDC is supported by Public Health Consultants, and Health Protection Nurses. Control measures include contact tracing, giving of chemoprophylaxis and in vaccine preventable diseases vaccination may be offered.

Regular meetings take place between the CCDC, consultant microbiologists, infection control nurses and the environmental health officers. TB contacts are followed by community health doctors at the Trusts.

The CCDC co-ordinates notification, follow-up and any other measures that require to be taken.

Emergency Planning

This involves working with Trusts, other emergency and statutory services (e.g. Ambulance, Police, Council services and Fire Services), industrial/business settings and groups such as airport authorities. It includes the development, regular testing and updating of Emergency Plans for major incidents plus involvement in the management of major incidents and follow-up review of them.

Prevention and Management of Chemical Biological, Radiation and Nuclear Hazards

In recent years, following international terrorist incidents and the changing nature of industry in N. Ireland has brought many new areas of multi-chemical use with risks associated with air and

water borne leakage and with chemical fire-smoke which require effective interagency responses.

Monitoring of statutory functions

Surveillance

All notified diseases are reported on a weekly basis to the DHSSPSNI/HPA(NI) by the Directorate of Public Health.

The Director of Public Health includes statistics and trends of all reported diseases on an annual basis in her Annual Public Health Report.

For certain vaccine preventable diseases (measles, mumps and rubella) the CCDC carries out enhanced surveillance through salivary antibody testing.

For other non statutory notifiable diseases (eg HIV and MRSA) the CCDC and consultant microbiologist carry out voluntary monitoring.

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).

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 Minister. Additional allocations are earmarked to specific expenditure targets which, to the extent they are not required/spent in full, must be declared 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(1.9% ceiling), the remainder of resources 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 (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 each year, fully (independently) audited Board approved Annual Accounts for presentation to Parliament/NI Assembly and their consolidation into 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.

Controls Framework

The Controls Assurance process provides assurance that effective controls are in place and bring together some of the main legislative and regulatory requirements placed upon the Board. These also provide for the self-assessment of risks in operating the systems of the organisation.

In line with the consolidation of governance, the Board has progressed the controls assurance agenda as required, and has systematically self assessed the levels of compliance with the core controls assurance standards for Risk Management, Governance and Financial Management, all of which have demonstrated 'substantive' compliance.

The Board has also self assessed and achieved the required levels of compliance for the other standards which were relevant for the period 04/05.

Risk Management

The Board's arrangements for risk management are designed to ensure that the Board identifies and manages the risks which threaten its ability to meet its objectives. It can be used to question the effectiveness of organisational structure and processes, standards of conduct and the effectiveness of all other control systems.

In order to continuously improve the quality of services and to safeguard high standards of care, the Board has put in place a multi-level Governance Framework which permeates all levels of responsibility within the organisation and outlines the accountability structures in place to implement governance arrangements.

These arrangements span all aspects of the Board's activities whether financial, organisational or clinical and social care. The specific objective being, to protect the organisation against loss, the threat of loss and the consequences of loss, whilst at the same time having a framework in place that highlights the roles, responsibilities, reporting and monitoring mechanisms that are necessary to ensure commissioning and delivery of high quality health and social care.

The Board's systematic and unified approach to the management of risk has led to the implementation of a fully functioning board wide risk register at both directorate and corporate levels. This process is based on the AS/NZS 4260:1999 standard which has been adopted by DHSSPS and which all HPSS organisations must comply with.

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

Doctors

The Board does not have direct responsibility for undergraduate or postgraduate medical education. As part of the appraisal process for doctors in Boards and Trusts participation in Continuous Professional Development and their Personal Development Plans are checked.

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.
- 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

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.

Southern Area Learning as Teams (SALT)

The SALT project in the SHSSB allows professionals working in the community in health and social care eg GPs, community nurses, midwives, social workers, pharmacists, Allied Health Professionals, dentists, optometrists, administration/IT staff to attend educational seminars and develop their skills as a team and provide updates on developments in health and social care. SALT training takes place 8 times per year in local venues. Subjects covered during SALT events are informed by a local educational needs analysis.

ACPC Multidisciplinary training

The Area Child Protection Committee (ACPC) provide multidisciplinary training in child protection for hospital and community staff.

The Role of the Board in the education and continuous development of nursing staff employed by the Trusts

Following the outcome of a consultation paper in 2000 new arrangements for commissioning post registration education for nurses, midwives and health visitors was were determined. Two Education Commissioning groups (ECGs) were established (one to cover North & West and the other South & East in line with respective HSS Board areas). Membership of the ECG's 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 ECG's are accountable to DHSSPS – the aim being that this new arrangement will lead to a closer partnership between DHSSPS, the HPSS and Education Providers. The Director of Human Resources at the Department retains a level of control on the way in which this money is allocated between formal academic and practice based learning.

Also falling under these commissioning arrangements are the processes for in-service education commissioning and provision. Within the Southern Board in-service education is commissioned from the Nursing and Midwifery Unit of the Beeches Management Centre (BMC). The in-service educational needs of Trust nurses are locally determined by each Trust through a specific service level agreement. Key personnel from the Trusts liaise with the BMC to arrange educational programmes according to identified education and development needs. At present the Southern Board has no specific commissioning or liaison role with the BMC except for infrequent access to pre-arranged programmes for nurses within its employment.

Disseminating information learned from" Other Events" in the HPSS

There are a range of approaches used by the Southern Health and Social Services Board and local Trusts to ensure quality services are provided. The introduction of Clinical and Social Care Governance into the HPSS has provided a framework for ensuring quality.

Clinical and Social Care Governance

Clinical and social care governance is a framework within which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment. In January 2003, DHSS&PS issued guidance to Boards and Trusts about arrangements for Northern Ireland.

The clinical and social care governance framework builds on and strengthens existing activity relating to the delivery of high quality care and treatment. This includes activity on:

- audit;
- identifying, promoting and sharing good practice, learning lessons from best practice as well as poor performance.
- risk assessment and risk management;
- adverse incident management;
- quality standards;
- complaints management;
- clinical and social care effectiveness;
- evidence-based practice;
- research and education;
- effective leadership and management;
- a clear policy aimed at improving communication between management, users, staff and local communities;
- policies aimed at securing effective user involvement, and which enable local communities to engage in all aspects of clinical and social care governance;
- effective recruitment and selection procedures;
- continuing professional and personal development; and
- professional regulation.

The framework is designed to bring all of these components together to secure a co-ordinated approach to the provision of high quality care and treatment, while ensuring a greater focus on the standard of clinical and social care practice. This will ensure that high quality, effective treatment and care is delivered and that where things do go wrong, they are quickly addressed and lessons are learnt to help prevent re-occurrence.

These require Boards and Trusts to have

- clear lines of responsibility and accountability for the overall quality of treatment and care;
- effective systems to identify, value, promote and share good practice within the organisation and where appropriate outwith the organisation particularly in circumstances where services are commissioned from an external provider;
- a comprehensive programme of quality improvement activities, including arrangements for ensuring users and local communities will be fully involved in securing high quality services;
- clear policies aimed at assessing and managing risk;
- an open, honest and proactive system where people can report poor performance, near-misses and adverse events to allow them to be appropriately dealt with, lessons learnt and shared within and where appropriate outwith the organisation.

Confidential Enquiries

All Trusts in Northern Ireland participate in the three National Confidential Enquiries. These are:

- Confidential Enquiry into Maternal and Child Health
- Confidential Enquiry into Patient Outcome and Death
- Confidential Enquiry into Suicide and Homicide by people with mental illness

The Boards are involved in the initial enquiry stage in some of these. The recommendations from these enquiries are disseminated widely in Northern Ireland and included in Service and Budget Agreements with trusts for local implementation.

National Clinical Assessment Service (formerly NCAA)

The NCAS promotes public confidence in Doctors and Dentists by helping address concerns about the performance of individual medical and dental practitioners. It provides confidential support to the health service in managing practitioners whose performance gives cause for concern. If a concern comes to light, the employer/contracting body, or the practitioner themselves, can contact the NCAS for help. The NCAS will work with all parties to clarify concerns and make recommendations to help the practitioner continue to deliver a high Quality and safe service for patients.

Professional Regulatory Bodies

Regulatory Bodies exist for all Health and Social Care Professionals whose purpose is to protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of health and social care. These regulatory bodies eg Northern Ireland Social Care Council, General Medical Council, Nursing and Midwifery Council respond to complaints about professionals and the fitness to practice of an individual professional. They have the authority to take action against a professional which can include suspension or being struck off the professional register.

Complaints

Each HPSS body has a legal duty to operate a complaints procedure. This includes monitoring the effectiveness of the complaints procedure and publicising the arrangements for dealing with complaints. All HPSS organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring.

The HPSS Complaints Procedures are designed to provide ease of access, simplicity, rapid and open processes and fairness for staff and complainants.

The Southern Board publishes an annual report which gives an overview of the numbers of complaints dealt with by Trusts in the Board's area under the HPSS Complaints Procedure and details the

number of complaints received and investigated by GPs (including Out of Hours) and Dentists

There is also a Representations and Complaints Procedure established under the Children (NI) Order 1995, which deals with complaints in relation to the provision of personal social services for children, and operates separately to the Board.

Medical Negligence

The SHSSB is responsible for medical negligence cases that arose before the formation of trusts in the early 1990s. Information on case is collected on a database held in the SHSSB. This information is collated regionally by DHSS&PS.

Letters to Professionals

The Board regularly issues advice to professionals when issues of concern arise or to remind professionals of what to do in certain situations.

Serious Adverse Incidents

This is described in answer to question 5.

Health and Personal Social Services Regulation and Improvement Authority

The Health and Personal Social Services Regulation and Improvement Authority (HPSSRIA) is a new independent organisation which will commence operation on a phased basis from April 2005. The role of HPSSRIA include:

- Inspection of the services provided by the HPSS in Northern Ireland
- Regulation of specified health and social health and social care services provided by the HPSS and independent sector
- Provision of advice

- Carrying out reviews of clinical and social care governance arrangements

- Undertaking investigations

The HPSS (Quality, Improvement and Regulation) (NI) Order 2003 made provision for the Department to publish statements of minimum standards. These standards shall be taken account of by the HPSSRIA in the regulation of establishments and agencies that provide services to people in response to a broad range of health and social care needs.

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.

A coroner can only investigate a death if it is reported to him. Medical practitioners refer a death to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death or the medical practitioner has reason to believe the person died from an industrial lung disease. This means doctors are expected to report to the coroner:

- All deaths from unnatural causes eg trauma
- All deaths from industrial diseases eg asbestosis
- All deaths from natural illness or disease if the deceased has not been seen and treated by a medical practitioner within 28 days of death.
- All deaths on the operating table or under anaesthetic or in the course of or following a medical procedure
- The death of a patient who had an accident in the hospital environment
- The death of a patient where there is an allegation of negligence of a nursing or medical mishap.

When a death is reported to the Coroner he may:

1. Permit the registration of the death after initial enquiries without conducting a post mortem examination.
2. Order a post mortem and if satisfied with the cause of death in the post mortem report may decide not to hold an inquest.
3. Proceed to hold an inquest whether or not a post mortem examination has been carried out.

The Northern Ireland Coroner Service was included in the review "Death Certification and Investigation in England, Wales and Northern Ireland" also known as the Luce Review which reported in 2003.

In Northern Ireland there are approximately 14,500 deaths every year, of which approximately a quarter are referred to the Coroner In 2002 there were 3564 deaths reported to the Coroner in Northern Ireland and 230 inquests held. Coroner post mortems

were carried out on 8.8% of deaths in 2002 compared to 23% in England and Wales.

The SHSSB responds to Coroner communications but these are received infrequently.

There are 3 main reasons why greater use is not made of Coroner reports:

1. Delays in completing the Coroner investigation.

The Luce Review (2003) reported that

"One of the consequences of the discretionary inquest system as it has developed in Northern Ireland is that there is an accumulation of reported cases where, because of the practice of waiting until all other investigations and inquiries are concluded, the coroner has not yet decided whether to hold an inquest"

At the end of 2001 in Northern Ireland there were 1897 deaths still awaiting an inquest or a decision whether or not to hold an inquest.

2. Restrictive Findings of Inquests

The Coroners Inquest is an inquisitorial court proceeding which is held in public for the purpose of determining the facts relating to the death. There are a restricted number of verdicts a coroner can use. The 1959 Coroners Act requires the inquest to return a finding indicating who the deceased was and determining how, when and where he or she came by their death. The Coroners Rules (Northern Ireland) 1980 restrict the "findings" available at inquest to ensure that one of only five possible forms of words could be recorded as a finding.

3. Coroner Recommendations

A Coroner who believes that action should be taken to prevent the recurrence of fatalities similar to that of which the inquest is being held may announce at the inquest that he is reporting the matter to the person or authority who may have the power to take such action and report the matter accordingly. The Coroner has no power to follow up whether or not the person or authority has taken the action recommended by the Coroner. The Luce Review (2003) reported that on average recommendations are made in just less than one inquest in fifty and 29% of these were directed at Health Bodies. The review also showed variation between

coroners on how they issue recommendations and reported that some coroners said
"..they sometimes rely on press reports of inquests to convey such messages to public authorities"
Recommendations are made infrequently in suitable cases where the death has been investigated but there has been no public inquest.

The use of coroners reports for surveillance purposes and identifying trends in cause of death has been researched in selected areas. One study from Northern Ireland in 1993 examined the use of coroners reports on childhood accidental death as the basis of a surveillance system and concluded "...the reports which the Coroner uses to inform the Registrar General of his or her findings are not of a standard format and in many cases do not report enough detail to allow an analysis of the circumstances of the accidents which could be used to establish opportunities for prevention".

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 Department Officers.

Serious Adverse Incidents

The formal mechanism giving interim guidance for reporting and follow-up on serious adverse incidents is set out in 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.

Boards and Trusts attended a workshop on 15th June 2005 which described the operation of the reporting and management arrangements described in PPM 06/04 and the results to date.

Incident and Near Miss Reporting Policy and Procedures for All SHSSB Facilities including GMS Out of Hours

This procedure applies to the reporting of all incidents within the Board, which occur on Board premises or as a result of a service provided by a Board employee. This policy affects:

- Service Users
- Employees
- Bank/agency and other contracted staff
- Contractors
- Trainees and students on placement
- Other NHS staff working on behalf of the SHSSB
- Visitors and members of the public

The Board has a requirement to report certain incidents, analyse causes and take appropriate action. The legislation and key references which reflect this requirement are contained in the following:

- Risk Management Controls Assurance Standard
- Health & Safety Management Controls Assurance Standard
- Fire Safety Management Controls Assurance Standard
- Circular HSS (PPM) 06/04 - Reporting and Follow-Up on Serious Adverse Incidents
- HPSS Complaints Procedure

Depending on the type and severity of the incident the following agencies may need to be informed:

Department of Health, Social Services and Public Safety

All serious adverse incidents to be reported in line with Circular HSS(PPM) 06/04.

Health & Safety Executive

Serious accidents, building incidents and certain work related diseases in accordance with the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations (Northern Ireland) 1997. This includes serious injury, over 3 day injuries, specified work related illnesses and serious building related problems.

Police Service for Northern Ireland

There may be certain instances for example theft of property, burglary, fraud, assault etc that the PSNI should be notified.

Counter Fraud Unit

In circumstances involving fraudulent activity, the CSA Counter Fraud Unit should be contacted.

Directorate of Information Systems (DIS)

All significant ICT security incidents especially those which could adversely affect HSSnet to be reported to the Directorate of Information Systems.

Circular HSS (PPM) 05/05

In June 2005 further guidance was issued on the reporting of serious adverse incidents in the HPSS (Circular HSS (PPM) 05/05). It describes a number of new regional initiatives being undertaken including:

- work to standardise definitions and coding of serious adverse incidents;
- the development of formal links with the National Patient Safety Agency;
- the development of a safety framework for the HPSS.

Case Management Review

There is an Area Child Protection Committee (ACPC) in each Board which is accountable to the HSS Board. This Committee is constituted in line with DHSSPS Guidance "Co-operating to Safeguard Children". This guidance specifies circumstances when the ACPC requires to undertake a Case Management Review.
An ACPC should always undertake a Case Management Review when:

- A child dies, including death by suicide, and abuse or neglect is known or suspected to be a factor in the child's death (paragraph 10.5)

An ACPC should always consider whether to undertake a Case Management Review where:

- A child has sustained a potentially life-threatening injury through abuse (including sexual abuse) or neglect;
- A child has sustained serious and permanent impairment of health or development through abuse or neglect;
- The case gives rise to concerns about the way in which local professionals and services worked together to safeguard children (paragraph 10.6).

This process provides a rigorous examination of the involvement of agencies and professionals with the child and his/her family. The finalised report with recommendations are made available to participating agencies and are submitted to DHSSPS. Summary documents are also shared with ACPCs in other Boards. In the Southern Board workshops have been convened on a multidisciplinary/interagency basis to share the findings.

Social Services Inspectorate

The Social Services Inspectorate (SSI) is a Professional Group within the Department of Health, Social Services and Public Safety which supports Ministers, the Department, other Government Departments and agencies working in the field of social care.

The main aim of the Inspectorate is to work with others to ensure social work and social care services are responsive to the needs of the population of Northern Ireland and allow the public to have confidence in them.

The SSI conduct inspections under statutory powers contained in the following enactments:

- Health and Personal Social Services (NI) Order 1972;
- The Adoption (NI) Order 1987;
- The Probation Board (Northern Ireland) 1982 as amended by the Criminal Justice (NI) Order 1991;
- The Registered Homes (NI) Order 1992;
- The Children (NI) Order 1995.

The SSI inspect services provided by the statutory and independent sectors. The purposes of inspections are to promote:

- the quality of social work and social care services for those who require, or need them;
- professional values and the development of standards;
- compliance with departmental and statutory requirements;
- the equitable distribution of services within Northern Ireland;
- the identification of gaps in existing provision and initiatives to remedy these;

and to report

- to Government departments, statutory, voluntary, private agencies and to users and carers, on standards of service, whether they achieve best value for money and how effective they are in meeting the needs of those who need and use them.

Draft Multiagency Protocol to be followed in cases of Sudden Unexpected Child deaths from Birth to 18 Years

Following the Briggs Case Management Review and the Lewis Inquiry, the SHSSB in association with the Coroner service and the State Pathology service co-ordinated the drafting of a multiagency protocol to be followed in cases of sudden unexpected deaths from birth to 18 years. This is currently with DHSS&PS.

Other methods of communication between Health Board and DHSS&PS

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.
- Chief Professional Officers at DHSSPS issue urgent and non-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.
- Workshops are organised by DHSS&PS for different clinical areas when a change in practice or the organisation of services is planned.

- CMO Newsletter is issued monthly, it provides updates on a range of initiatives in the HPSS.