WESTERN
HEALTH AND SOCIAL SERVICES BOARD

Our Ref: SL/TP
Date: 11 July 2005

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

Dear Ms Chamberlain

Re: Inquiry into Hyponatraemia-related Deaths

Thank you for your letter dated 17 May 2005 in relation to the Inquiry into Hyponatraemia-related Deaths. Please find attached the Western Health and Social Services Board response.

Yours sincerely

Steven Lindsay

STEVEN LINDSAY
CHIEF EXECUTIVE

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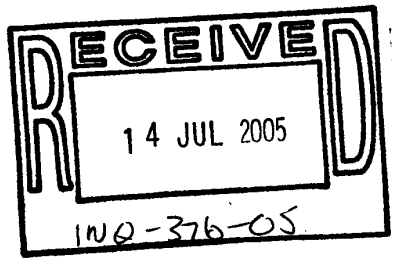

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The Inquiry into Hyponatraemia-related Deaths

WHSSB response to the correspondence dated 17th May 2005 from Fiona Chamberlain, Solicitor to the Inquiry

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 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.

In Northern Ireland, however, 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.

The Department of Health and Social Services (DHSS) policy document People First (1990) also introduced, for the first time, 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.

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.

1.2 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 status of 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. 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 the delegation to Trusts of statutory functions formerly exercised by Boards. The Order and its regulations made Trusts accountable through their commissioning Boards to DHSS for the discharge of all 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, although the DHSS 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 have 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 statutory functions, delegated to them by Boards.

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.

Trusts are managerially accountable to the Department and receive their funding through Service and Budget agreements with the Board.

In 2000, the Northern Ireland Act expanded the functions of the Department of Health and Social Services to include responsibility for Public Safety.

2. Composition, Roles and Responsibilities of the Board and interaction with Trusts

2.1 Composition of the Western 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. The composition of the Western Health & Social Services Board (the Board) is determined as follows:

- the Chairwoman of the Board
- six non-officer members (non-executive directors)
- up to six officer members (executive directors) including the Chief Executive and the Director of Finance
- associate members, chairmen of Local Health and Social Care Groups (currently two), associate members do not have voting rights at Board meetings

The Chairwoman of the Board, Karen Meehan, and her six Non Executive Director colleagues were appointed by the Minister following interviews conducted by the Public Appointments Unit at the DHSSPS. The Board has four Executive Director positions are three of which are held by Senior Officers within the Board including the Chief Executive, Mr Steven Lindsay. One of the Executive Director positions is currently vacant.

In accordance with Circular HSS (PCD)1/2002, two Local Health and Social Care Groups (LHSCGs) were formed in the Western Board area in July 2002 . The Chairs of these two groups were appointed as Associate Directors of the Board.

2.2. Role of the Board

The Western Board serves a population of over 285,000 people who live in the District Council areas of Limavady, Derry, Fermanagh, Strabane and Omagh, a total of 4,842 square kilometres. The Western board covers the smallest population and the largest geographical area of all of Northern Ireland's health authorities.

The Board receives approximately £450 million per year from government to fund its activities (including Family Practitioner Services).

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

The Board's role is to identify health and social care needs and to ensure that services are provided to meet these needs. The purpose of the Board is to seek a comprehensive range of quality health and social services for local people. It is the responsibility of the Board to determine what the population needs and to 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 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.

The Board's statement of purpose is as follows:

WHSSB Statement of Purpose (Summary)

The primary purpose of the Board is to improve health and wellbeing for all the people of the Western Board area. In doing this we will address inequalities and work to create an environment in which all stakeholders can contribute.

In working together to improve health and wellbeing, we will:

- provide strategic leadership to the HPSS in the Western Board area
- put people at the centre of our work
- make decisions on the basis of assessed need and evidence
- work to promote and develop an integrated health and social care system in the Western Board area
- work in partnership with all those who can impact positively on health and social wellbeing
- constantly review our performance
- work to secure the equitable allocation of resources based on assessed needs
- work with the public to facilitate understanding about the Board's role.

In doing this we will:

- value and develop our staff
- work to a set of agreed values, including:
    - integrity, openness and honesty;
    - accountability for our actions and decisions;
    - an empowering approach to leadership;
    - innovation and continuous improvement in all of our services;
    - an ethos that places the care, well being and safety of the public at the heart of everything we do.

2.3 Responsibilities of the Board and Interaction with Trusts

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

- Strategic Planning and ensuring Delivery of Services
- Monitoring Functions
- Controls Framework
- Standards.

Each of these 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 describes the interaction between the Board and HSS Trusts.

2.3.1 Strategic Planning and ensuring Delivery of Services

Ensuring 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 contracts 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; closely monitoring the quality and effectiveness of these services; planning and developing new services and; demonstrating value-for-money on all services.

The Board has to develop long-term strategies for service development and to meet changing standards and this was taken forward through Programme of care based Planning Groups. In WHSSB, as a result of the increasing emphasis on intersectoral partnership working, joint working and shared decision making and the importance of meaningful user/community involvement, these group are being replaced by Strategic Commissioning Teams (SCTs). The SCTs commission services on the basis of age to ensure that commissioning is undertaken around the changing needs of service users as they progress through the normal life cycle. Three SCTs have been established, for Children Young People and their Families, for Adults and for Older People.

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.

This itemises all the services and developments, subject to resources, 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 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 has to 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 three Trusts in the Western 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 from the voluntary and independent sectors as well as providers from Great Britain or the Republic of Ireland for specialist services for named service users.

The Board also has to ensure that funds for services are directed towards those in greatest need and has to prioritise how its funds are deployed.

2.3.2 Service and Budget Agreements

The formal relationships between the Board and the Trusts for the delivery of services to residents of the Board area are set out in Annual Service and Budget Agreements. These describe the range, volume, and cost of services commissioned by the Board as well as standards, new guidance, payment and monitoring arrangements. Actions against SBA targets are reported on a monthly basis regular monitoring meetings take place between Board and Trust officers to assess compliance with the Service and Budget Agreements.

A wide range of other interactions take place between Board and Trust staff to take forward strategic and operational issues. Examples include:

- Regular meetings at Chief Executive level between the Board and Trust Chief Executives across the Board area
- Reports on pressures in the system are completed on a daily and weekly basis. Monthly meetings are held with Board and Trust officers.
- Discussions between the Board and Providers on the strategic development of specific services or to address current issues of concern
- Regular formal performance review meetings are held with local Trusts
- 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 receive by the Board from residents of the Board area.

The Board and the Trusts in the Western area seek to work co-operatively together to take a whole systems approach to the commissioning and delivery of services in the Western area. Trusts can 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 which monitors the services provided for children – Annual Childcare Plan, which is a product of the Western 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.

A major role of the Director of Public Health and his/her staff in the Public Health Medicine department is to provide independent advice on public health issues to Health Service Commissioners, Providers and to other organisations who have relevance to health care issues. The responsibilities also include:-

- Assessment of the health needs of the population including an assessment of the capacity for the population to benefit from specific services; monitoring the health status of the population contributing to improving it and reporting to the Board and publicly on the health status of the Board's resident population.

- Providing input to Health Service commissioning on the effectiveness of existing and proposed services and on which services are likely to most improve the health of the population.

- Specific delegated responsibility for the prevention, monitoring and control of communicable disease and non-communicable environmental hazard exposure including collaboration within the Health Services and outside Health Services with other relevant statutory and independent agencies.

- Specific delegated responsibility for Emergency Planning and the Management of Major Incidents.

- Commissioning, monitoring and contributing to the delivery of health promotion services. Developing and implementing local health improvement/health promotion strategies and the alliances necessary to implement them.

- Informing the public about health issues and what can be done to improve them; engaging the community in discussion about health needs and service provision.

- Developing and sustaining effective relationships with local clinicians in primary, secondary and community based settings and ensuring that they have adequate and appropriate Public Health advice.

- Acting as a key interface between the medical profession and other professions and general management at both Commissioner and Provider level in order to stimulate dialogue and understanding (e.g. through medical advisory arrangements, etc.) of important professional issues relating to medicine.

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 are vested in the Director of Public Health. These functions are only deliverable through key local networking arrangements both within and outside the health services. Such networks include vital relationships with District Council staff such as Environmental Health departments. These networks add significantly to the effective delivery of these statutory functions. It is important that they are maintained and developed.

- *Control of Communicable Disease* includes the prevention, investigation and management of communicable disease, including outbreaks of illness and related follow-up action.

- *Emergency Planning* involves work 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* are rapidly expanding areas of PHM work. The changed international terrorism situation has added to this. Also, 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.

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).

2.3.5 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 cannot 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 (e.g. 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 or 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 prescribes an expenditure limit for Board management and administration, for WHSSB this is 1.9% of income. During the year 2004/05, the costs incurred were 1.64% of income with the balance of resources (98.36%) 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, 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.

2.3.6 Complaints

WHSSB provides a complaints procedure for the people who live in the Western area, which can be accessed in writing, via the internet and on a Freephone telephone number. People are encouraged to seek local resolution to their

complaint, and most people find that this answers their concerns. If the complainant is not satisfied with the local outcome, they have the right to ask the Board to consider taking their complaint to an Independent Review. The request for independent review will be considered by a non-executive director of the Board (a convenor) who will decide either that the local response was satisfactory, ask the local provider to do more to respond to the complaint or will set up an Independent review panel. The panel will re-examine the complaint fully and will obtain specialist clinical and/or social care advice if necessary. If at the end of the WHSSB procedure the complainant is still dissatisfied, they are advised that they can ask the Northern Ireland Commissioner for Complaints (the Ombudsman) to investigate their case.

2.3.7 Controls Framework

Following the recommendations of the Turnbull Report in 1999, which concentrated on the controls which Board had to maintain, more robust Controls Assurance requirements and Statement of Internal Control were introduced. In the wake of the Bristol and Alder Hey Hospital and other inquiries, it was recognised that quality management was a multi-facetted responsibility and this was encapsulated for the NHS in a system of Clinical Governance.

Controls Assurance: The Controls Assurance process provides assurance that effective controls are in place and the Controls Assurance Standards 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. An outcome of the Controls Assurance process is an annual statement on the effectiveness of internal controls, signed by the Chief Executive on behalf of the Board. The Board's Governance and Audit Committee receives regular updates reports on progress with compliance with the fourteen Controls Assurance Standards which all HPSS bodies are required to comply with, except where they are not relevant.

Clinical & Social Care Governance: "Best Practice, Best Care" produced by DHSSPS in July 2002 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. Clinical and social care governance is about organisations taking corporate responsibility for performance and providing the highest possible standard of clinical and social care.

Article 34 (1) of the Health & Personal Social Services (Quality Improvement and Regulation) (NI) Order 2003 imposes a "duty of quality" on Boards and Trusts.

In Circular HSS (PPM) 10/2002 "Governance in the HPSS – Clinical and Social Care Governance: Guidelines for Implementation" which was issued on 13 January 2003, 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. Paragraph 5 of the Circular outlined the "minimum list of actions" which had to be taken by Boards and Trusts. The Circular highlighted the roles, responsibilities, reporting and monitoring

mechanisms that are necessary to ensure delivery of high quality health and social care. In developing clinical and social care governance, 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.

Risk Management is a system that is used to identify and control the risks to the achievement of the organisation's objectives.

It can be used to question the effectiveness of organisational structure and processes, standards of conduct and the effectiveness of other control systems, including the Clinical and Social Care Governance and Finance Management systems. The Board has Risk Registers in each Directorate and for the two LHSCG offices.

2.3.8 Standards

At its meeting on 8 December 1994, the Board agreed to formally adopt the Codes of Conduct and Accountability. This includes 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. The role of the Board in the education and continuous development of doctors and nursing staff employed by the Trust

3.1 Doctors employed by the Trust

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

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 employed by the Trust

Post-registration Education

The Commissioner of post-registration education for nurses and midwives is the DHSSPS. The arrangements to inform and support the commissioning of post-registration education for nurses and midwives include two education and commissioning groups, one for the South and East and one for the North and West.

The North and West Education Commissioning Groups comprises the:

- Three Trusts within the WHSSB
- Three Trusts within the NHSSB
- WHSSB, NHSSB and the DHSSPS.

In the main each Trust and Board has one representative on the Education Commissioning Group.

The South and East Education Commissioning Group comprises the:

- Eight Trusts within the EHSSB
- Four Trusts within the SHSSB
- SHSSB, EHSSB and the DHSSPS.

Again each Trust and Board has one representative.

The Terms of Reference for the Education Commissioning Groups are as follows:

NURSING AND MIDWIFERY EDUCATION COMMISSIONING GROUPS

TERMS OF REFERENCE

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 or registered nurses and midwives in the context of the delivery of services.

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 Departmental 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.

At operational level, Trusts identify training needs for nurses and midwives in their employ. An analysis of these training needs is undertaken at Trust level which is fed back to DHSSPS.

Funding (normally specified on a Trust by Trust basis) by the DHSSPS, to support the delivery of certain elements of the education commissioned, is released from the DHSSPS to the Board, Trusts and education providers.

In –service training for nurses and midwives

The arrangements for in-service training fall within the commissioning process, established by the DHSS in 1997.

The North West In-service Consortium comprises of five Trusts:

- Altnagelvin Hospitals Health and Social Services Trust
- Causeway Health and Social Services Trust
- Foyle Health and Social Services Trust
- Homefirst Community Trust
- Sperrin Lakeland Health and Social Care Trust

The purpose of the Consortium is to provide a range of in-service education to the five member Trusts in a high quality cost effective manner. The work of the Consortium is identified through the conduct of training needs analysis with the aforementioned five Trusts. Neither the WHSSB nor NHSSB are involved in this arrangement.

In addition, each Trust will also avail of a range of other study days, which are directly purchased by the Trust.

4. 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 colleagues or other Health Boards in Northern Ireland.

The Board may become aware of information from Coroner's Inquests or other events which might impact on the future care of patients through;

(i) information provided by Trust staff who have been involved in inquests bringing this directly to our attention for the purpose of wider dissemination,
(ii) information provided by our legal advisers where they have become aware of information which they consider could be of wider importance
(iii) making enquiries as a result of information gleaned from the media/press.

There seems to have been no standard method used by Coroners to communicate relevant issues to Boards.

Where information of potential wider importance becomes known, the Board, through relevant senior professional officers or managers (as appropriate to the circumstances), would communicate this to senior professionals in our local Trusts, to professional equivalents in other Boards and to DHSSPS.

5. 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.

In the past, the usual mechanism would have been for the Medical Director of a Trust within our geography where an incident had occurred to contact the Director of Public Health and provide some detail of the concerns. The Director of Public Health would then have:

- circulated the information to the relevant Medical Director/s locally plus any other relevant people,
- advised Director of Public Health colleagues elsewhere in Northern Ireland,
- advised the Chief Medical Officer either urgently, if needed, or if more appropriate, at the next regular meeting, about the issues/concerns.

Often, the Medical Director of the Trust would also have contacted the CMO directly if it was considered a matter of urgency.

There is now a system of direct notification from Trusts to DHSSPS of adverse incidents with the Board being notified additionally. This direct notification to DHSSPS is in line with the accountability of Trusts to DHSSPS rather than to the Board as Commissioners.

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.

The Board has agreed with the three Trusts in the Western Board area that all serious adverse incident reports sent to the DHSSPS will be copied to the Board. Upon notification of a serious adverse incident having occurred, appropriate Board Officers(s) will liase with relevant trust personnel to provide support where necessary and obtain assurance that appropriate control measures have been implemented to reduce the risk of recurrence.

In January 2005, the four Board governance group wrote to the Directorate of Planning and Performance management at DHSSPS raising a number of queries on the role of Health and Social Service Boards following the interim guidance on the Reporting of Serious Adverse Incidents provided in circular HSS(PPM) 06/04. We understand that these queries are receiving consideration by the DHSSPS and we look forward to receiving further guidance on our role in relation to the management of serious adverse incidents as soon as possible.

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 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 do 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