HSC Business Services Organisation

Directorate of Legal Services
PRACTITIONERS IN LAW TO THE HEALTH & SOCIAL CARE SECTOR

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Your Ref:
AD-0561-13

Our Ref:
HYP W50/01

Date:
19th April 2013

Ms A Dillon
Solicitor to the Inquiry
Inquiry into Hyponatraemia-related Deaths
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Madam,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS-RAYCHEL FERGUSON

I refer to the above and your letter of 15th April 2013.

I now enclose a copy of the Service Agreement for 1999/2000 – 2001/2002 between the Western Health & Social Services Board and Altnagelvin Trust as requested.

Yours faithfully

JR Bolton

Joanna Bolton
Solicitor Consultant

SERVICE AGREEMENT

ACUTE HOSPITAL SERVICES

PURCHASER: *WESTERN HEALTH & SOCIAL SERVICES BOARD*

PROVIDER: *ALTNAGELVIN HSS TRUST*

JUNE 1999

WESTERN HEALTH AND SOCIAL SERVICES BOARD
SERVICE AGREEMENT WITH
ALTNAGELVIN HSS TRUST

1 Introduction

1.1 On 15 December 1998 the Health and Social Services Executive issued Circular PCCDD 26/98 entitled 'Guidelines for 1999/2000 Service Agreements'. This guidance was published to assist commissioners and providers in developing an appropriate framework for the purchase and delivery of health/social care services.

1.2 The key themes to emerge from this circular are intended to form the basis of service agreements in 1999/2000 and subsequent years. These relate to 7 core principles:

- Equity;
- Promoting Health & Well-Being;
- Quality;
- A Local Focus;
- Partnership;
- Efficiency and Openness; and
- Accountability.

1.3 There is continued emphasis placed on the need for service agreements to be drawn up covering a more strategic timeframe. Longer term agreements are intended to add a greater degree of stability to the commissioning process and enable more attention to be focused on issues such as:

- assessing service needs and the effective delivery of appropriate health/social care provision
- improving/enhancing the quality and outcome of treatment/care
- involving clinicians, other professionals, patients, clients, users and carers more in the development of clinical care outcome measures, quality standards etc; and
- adopting a shared approach to the management of financial risk.

2 Strategic Context

2.1 The Department's Regional Strategy document 'Health & Social Wellbeing: Into the Next Millennium' provides the framework for improving acute care over the next number of years. This policy direction reflects the changing environment within which acute hospital services now operate. The overall aim is to ensure a better quality of treatment/care/investigation for patients in the future.

2.2 In light of the Department's requirements the Board has completed a review of acute services and has developed a cancer services strategy.

The review process takes account of the various factors which will combine together to reshape the future provision of acute hospital care. In particular, this involves a critical review of the pattern of acute inpatient services which will continue to be purchased by the Board over the next few years.

2.3 It is important therefore that providers are fully aware of the Board's intention to make strategic purchasing shifts, in appropriate circumstances, over the period covered by this agreement. This may involve having to adjust the level of inpatient activity being purchased in order to reflect shifts between provider organisations.

3 Clinical Governance

3.1 An increasingly important consideration for the delivery of acute hospital services is the concept of clinical governance. The Board will be adopting a proactive approach to this initiative to ensure that a structured and coherent clinical governance programme is in place within Trusts.

3.2 Clinical governance places clearly defined duties and responsibilities on health care organisations and individuals within them. To be effective, a clinical governance programme must include key elements such as:

- processes for recording and deriving lessons from untoward incidents, complaints and claims;
- a risk management programme;
- effective clinical audit arrangements;
- evidence-based medical practice; and
- a supportive culture committed to the concept of lifelong learning.

3.3 The Board intends to include clinical governance as a standing item which will feature prominently in its ongoing discussions with providers.

4 Year 2000 Compliance

4.1 Year 2000 Compliance is the highest non-clinical priority for the HPSS (although it clearly has clinical implications). The provider will ensure that:-

- A Y2K programme has been established in line with HSSE guidance;
- All necessary steps are taken to ensure that it will not be adversely affected by the impact of the Year 2000;
- Due cognisance is being taken of all Year 2000 issues impacting or likely to impact on the provision of Health & Social Services Care;

- Effective action is being taken to modify or replace critical products which are not Year 2000 compliant, or to establish effective contingency arrangements for products which will not be made compliant; and in particular to ensure that

- Year 2000 programmes include the development of effective contingency, business continuity and emergency (i.e. major incident) plans.

4.2 Furthermore the provider must ensure that agreements placed with other providers of care are aware of and will not be adversely affected by the Year 2000 problem.

4.3 In addition the provider must have signed up to the principles contained in Action 2000 - Pledge 2000.

4.4 The provider should identify anticipated pressures and the measures which will be taken to deal with these pressures, and should reflect local assessment of additional or changed demand for Health & Social Services consequent upon:-

- Millennium celebrations;
- Extended Millennium public holidays;
- Millennium date change induced failure or reduced reliability of equipment or any utility or other service essential to the continuity, safe operation or public access to the clinical and supporting services of the HPSS;
- Possible failure of equipment or of any service essential to the care of patients at home, nursing home or otherwise in the community;
- Public Health implications of possible failure of equipment or service necessary to the safe supply, storage or processing of food or water;
- Possible interruption of communications or transport links upon which reinforcement and support of local HPSS services normally depend; and
- "First in the new millennium" events throughout 2000 (and possibly 2001), which may continue to pressurise emergency services.

5 Partners to the Agreement

5.1 The partners to this agreement are the Western Health and Social Services Board (the purchaser) and the Altnagelvin HSS Trust (the provider).

5.2 The term 'purchaser' will be used to refer to the Western Health and Social Services Board and the term 'provider' will mean the Altnagelvin HSS Trust.

5.3 Where appropriate, it will continue to be the responsibility of GP fundholders to agree separate purchasing arrangements with the provider for their patients.

6 Scope of the Agreement

6.1 The agreement will be used as a means to secure progressive and meaningful improvements in service provision through an open and collaborative approach.

6.2 This agreement will cover the provision of the following services by the provider to or on behalf of the purchaser's resident population:

- all completed consultant inpatient episodes occurring during the period of the agreement;
- all completed consultant day case episodes occurring during the period of the agreement;
- all outpatient attendances and treatments including ward attenders occurring during the period of the agreement;
- the provision of diagnostic, therapeutic, paramedical, hotel and ancillary services for such patients;
- diagnostic, laboratory and other services accessed directly by GPs for or on behalf of the Board's residents.

6.3 In addition the agreement will cover the provision of all Accident & Emergency attendances and treatments and all Genito-Urinary Medical outpatient attendances and treatments occurring during the period of the agreement.

6.4 The agreement is not intended to be a legally binding document but is designed to formalise a set of conditions which both partners will agree to abide by.

7 Agreement Period

7.1 The agreement is effective from 1 April 1999 and will continue in force for a period of three years up to 31 March 2002.

7.2 Throughout the period covering the agreement it will be necessary to keep activity levels and funding arrangements under close review. There will be an opportunity to formally renegotiate the terms of the agreement on an annual basis in order to ensure that the conditions continue to reflect changing circumstances as appropriate.

7.3 Where it is decided to implement planned change(s) to existing patterns of service provision it may become necessary to take future resource implications into consideration in terms of investment/disinvestment consequences.

8 Activity Levels

8.1 The indicative hospital service activity levels set out at Schedule 2 of this agreement are intended to reflect the anticipated workload to be dealt with by the provider. These take account of key issues such as needs assessment and current referral rates/patterns.

8.2 Every effort has been made to set realistic target volumes which take account of emergency and elective activity levels as appropriate. If during the course of the year a significant over/under performance in activity is projected, suitable risk-sharing arrangements will be agreed for handling the variance.

8.3 It is recognised that these indicative volumes may have to be further refined over time to take account of changes taking place in referral preferences and the availability of service provision. As new referral pathways emerge the purchaser and the provider will undertake to keep variations in planned activity under close review and discuss them fully.

9 Extra Contractual Referrals (ECRs)

9.1 In the case of non-emergency referrals made to a specialty not covered by this agreement, the provider will be required to comply with the arrangements contained in the HSS Executive's guidance on Extra Contractual Referrals (November 1995).

9.2 Paragraphs 30 and 31 of Circular PCCDD 26/98 refer to the abolition of ECRs in England. It is understood that the Executive is encouraging, where possible, Boards and Trusts to comply with the GB arrangements.

9.3 In the case of tertiary ECRs being arranged by the provider to hospitals situated elsewhere in Northern Ireland or in Great Britain, it will be necessary for consultant staff initiating such referrals to ensure that the purchaser is informed when the referral is taking place. Tertiary extra contractual referrals will be processed in accordance with the arrangements contained in the HSS Executive's guidance (May 1993).

10 Service Fee

10.1 The purchaser will pay the provider a service fee of £[redacted] in 1999/00 as shown in Schedule 1 [To Follow]. Schedule 2 [To Follow] sets out the activity against which the agreement will be monitored.

10.2 The service fee does not take account of the impact of General Practitioner Fundholding changes/developments for 1999/00. The impact of GPFH changes shall be forwarded to the Trust (Schedule 3) and the final hospital service activity levels after adjustment for GPFH will be set out in Schedule 4.

10.3 The various terms and conditions relating to specific financial/ information requirements are set out in detail at Appendix 1 of the agreement.

11 Financial Plan

11.1 In view of the provider's current and projected position in terms of its overall financial situation, it has become necessary for an appropriate recovery plan to be jointly developed and agreed between the Board and the Trust. This recovery plan will have to be implemented over a three year timeframe during which period the provider's financial situation will be brought back into balance on a phased arrangement. Details of the staging associated with the recovery plan are set out as follows:

PROPOSAL

	1999/2000 £'000	2000/2001 £'000	2001/2002 £'000	TOTAL £'000
DEFICIT brought forward	[redacted]	[redacted]	[redacted]	[redacted]
RECURRING DEFICIT (estimate)	[redacted]	[redacted]	[redacted]	[redacted]
WHSSB - Additional Funding (Recurring)	[redacted]	[redacted]	[redacted]	[redacted]
WHSSB - Additional Funding (Non Recurring)	[redacted]	[redacted]	[redacted]	[redacted]
ALTNAGELVIN - (Non Recurring Funding)	[redacted]	[redacted]	[redacted]	[redacted]
CARRIED FORWARD	[redacted]	[redacted]	[redacted]	[redacted]

11.2 In the course of developing this recovery plan the purchaser and the provider agreed to a number of conditions being incorporated into the service agreement. These relate to the following key commitments:

- the Board has agreed to find the necessary funding, as set out above, to deliver on its share of the joint recovery plan
- the Trust has agreed to meet the balance of funding required to implement the recovery plan
- the Trust has agreed to manage its financial affairs in such a way that the recovery plan is not compromised in anyway
- the Board and the Trust have jointly agreed that future proposed investments in service delivery which have a financial implication will be agreed in advance through the established planning mechanisms.

12 Waiting List Management

12.1 Common waiting time standards should be adhered to which reflect the guarantees laid down in the current Charter for Patients and Clients. Patients should be admitted for investigation/treatment on the basis of clinical need, regardless of whether or not their GP is a fundholder

12.2 The provider will make every effort to ensure that no Western Board patient has been waiting more than 18 months for inpatient or day case treatment or 13 weeks for an initial outpatient appointment.

12.3 In the event that the provider is not in a position to meet this commitment, it may be necessary for suitable waiting list initiative proposals to be developed in consultation with the purchaser.

12.4 The provider must ensure the accuracy of waiting lists and that patients who have already been treated or have died are removed from their lists. A validation exercise will be required for all patients prior to reaching twelve months inpatient/day case waiting time.

13 Monitoring Arrangements

13.1 The purchaser and the provider will work in close co-operation to review the performance of the agreement. A monthly review meeting will be held but both parties may decide to meet more frequently if this is deemed appropriate.

13.2 The provider will submit regular monitoring reports on activity levels and quality initiatives to the purchaser. Information on inpatient, day case and outpatient activity levels will be required on a monthly basis (see Appendix I for further details). Inpatient activity should be reported by specialty on a finished consultant episode basis as well as indicating the corresponding levels of discharges and deaths.

13.3 Monitoring reports should include details of any cancelled admissions, complaints received from Western Board patients and the action taken to remedy them. As information systems become further developed the provider may be asked to supply details in respect of cancelled operations and clinics by specialty.

13.4 The provider will be required to furnish appropriate information on all cases identified with cancer to the Northern Ireland Cancer Registry.

14 Quality Enhancement

14.1 The provider will ensure that services provided are of the highest standard of quality achievable within available resources. A major objective of this agreement will be to secure an improvement in the quality and responsiveness of patient treatment/investigation/care. The purchaser may also wish to negotiate other specific quality improvements in discussion with the provider over the period covered by this agreement.

14.2 The provider will share details of its quality framework with the purchaser. This document should set out the various professional guidelines and policies being adhered to, together with details of internal arrangements which are in place in respect of key activities such as:

- admission/discharge policies
- medical, nursing and clinical audit
- procedures for handling complaints

- relevant staff training/development programmes
- any other relevant quality initiatives

14.3 Each specialty will be required to participate in clinical audit on a multi-disciplinary basis as appropriate. Individual professions will also be required to initiate audit projects in relevant circumstances. Audit projects should be designed to develop suitable guidelines and treatment protocols from which outcomes can be measured.

14.4 The provider will be required to carry out consumer surveys in collaboration with the purchaser in order to avoid unnecessary duplication. Views on the quality of service delivery will also be obtained from local General Practitioners and the Western Health and Social Services Council.

14.5 The provider will be required to adhere to current health, safety and relevant firecode procedures/policies as appropriate.

15 Patient Discharge/Transfer Arrangements

15.1 The provider will be responsible for ensuring that appropriate arrangements have been made to facilitate the smooth transfer of a patient to another provider. In particular this will necessitate timely/proper consultation and notification between providers about the agreed handover of clinical responsibility/management.

15.2 Discharges from hospital to the community must be properly planned and co-ordinated. To this end the provider will be expected to have a written discharge procedure which is regularly reviewed and updated in consultation with purchasers, GPs and other relevant parties. This procedure should cover key issues such as:

- protocols for communication with receiving provider, GPs, community care staff, relatives/carers etc.
- information provided to patients about their condition, medication needs and any follow up appointments.

15.3 The provider will ensure the prompt dispatch of clinical discharge letters to GPs. The provider will be required to report on a regular basis to the purchaser about delays in issuing such letters.

16 Unsatisfactory Performance

16.1 The purchaser and the provider will adopt an open and constructive approach in terms of resolving any problems which may arise in relation to performance. Such issues will be resolved through discussion and negotiation with agreement being reached on a suitable course of action to remedy the problem.

16.2 In the unlikely event that there is significant or repeated failure on the part of the provider to meet agreed standards of performance or to implement an agreed course of action, it may become necessary for the purchaser to review the basis of the agreement.

17 Evaluation

17.1 Prior to completion of the agreement it will be necessary for the purchaser and the provider to agree suitable arrangements for jointly evaluating that services have been delivered to the standards and levels detailed in this agreement.

SIGNED: Thomas Frawley ***DATE:*** 19th July 1999

T J FRAWLEY
GENERAL MANAGER
[WHSSB]

SIGNED: S Burnside ***DATE:*** 8th June 1999

S BURNSIDE
CHIEF EXECUTIVE
[ALTNAGELVIN HSS TRUST]

APPENDIX I

WESTERN HEALTH AND SOCIAL SERVICES BOARD

FINANCIAL AND INFORMATION REQUIREMENTS

WHSSB/Altnagelvin HSS Trust

1 Service Fee

1.1 The service fee is net of capital charges, the accounting treatment of which will be subject to whatever arrangements are determined by the HSS Executive. Pay and price inflation for 1999/00 are included in the agreement at 2.6%.

1.2 The prices quoted will remain constant for the duration of the agreement and will only be adjusted by agreement in writing. Adjustments will only be made for in-year variations resulting from national or local approvals/ negotiations which impact on service costs and the related value of the agreement.

1.3 The provider will be responsible for managing the activity within the overall sum available. This will require the provider to monitor carefully the number of patients treated throughout the year and may necessitate the phasing of elective admissions - having regard to Charter guarantees - in order to remain within the maximum financial value of the agreement.

2 Variation to Service Fee

2.1 Where practicable the provider will endeavour to manage the workload levels set out in Schedule 2 [To Follow] in such a way that each month accounts for about one twelfth of the indicative activity levels and around one twelfth of the total agreement value. This will be particularly important given the significant resource constraints being faced by the purchaser because of the 1% cost improvement target imposed by Government.

2.2 Any under performance on elective referrals will be offset against over performance on emergency referrals.

2.3 Regular monitoring reports will be required from the provider so that variations of the service fee can be identified at an early stage, and any remedial action agreed with the purchaser.

3 Billing and Payment Arrangements

3.1 The purchaser will require the provider to submit a monthly invoice for payment of one twelfth of the agreed service fee. Invoices must include sufficient information to enable the purchaser to properly authorise payment and should include the following information as supporting documentation:

- service level agreement reference number
- period covered by invoice
- numbers of patients treated by specialty (see monitoring arrangement)
- charge per patient
- detailed patient related information including name, address, post code, date of birth, details of registered GP, date of consultation, date of admission, date of discharge, diagnostic code, OPCS

code, consultant details etc.

3.2 The purchaser will make prompt payment in respect of all valid accounts submitted by the provider. However in the event that the provider fails to furnish a full and accurate minimum data set within six weeks of the end of the month of treatment/discharge for any inpatient, outpatient or day case treatments discussion will have to take place with the purchaser on the issue of liability.

3.3 In accordance with Departmental guidance on exceptions to Charter waiting list guarantees patients who meet the criteria described for medical and self-deferrals will be separately identified and accounted for on the waiting list. These patients will not be subject to the 18 month inpatient/day case stipulation referred to at paragraph 12.2 of the main agreement.

4 Waiting List Information

4.1 During 1997/98 the four Boards and the Trusts worked to develop an anonymised waiting list data set extract for inpatient and daycase lists. The purpose of this exercise was to standardise the existing waiting list information flows between Trusts and Boards and thereby reduce the workload for all parties. From 1 April 1999 the provider will be required to provide the standard waiting list data set extract within the timescales agreed with individual Boards. During 1999/00 the Trusts along with the Boards will work to develop a similar standardised extract for outpatient waiting lists.

5 Monitoring Requirements

5.1 The provider will submit regular monitoring reports on activity levels and quality initiatives to the purchaser. Information on inpatient, day case, outpatient activity levels and waiting list returns will be required on a monthly basis (by the 15th working day of each month). In addition the Provider will work with the Board on projects to develop electronic data transfer.

6 Charter for Patients and Clients

6.1 The provider will strive to comply with all appropriate requirements and standards contained in the NI Charter for Patients and Clients. In addition the provider will be required to confirm the extent of its compliance with the purchaser's own Charter document 'Better Care'.

7 Complaints Procedure

7.1 The provider will be required to implement the HSS Complaints Procedure and to ensure that arrangements for the local resolution of complaints are put in place. These arrangements should be described in a written Procedure and should be brought to the attention of the service users. Staff should receive appropriate training and support in the handling of complaints.

8 The Protection and Use of Patient and Client Information

8.1 The Provider will be expected to follow DHSS Guidance on the Patient & Use of Patient and Client Information and the recommendations of the Caldicott Committee Report. Arrangements should be continually reviewed to ensure ongoing compliance with above named guidance and any further guidance issued. In addition the provider will be required to comply with the Data Protection Act 1994 and Data Protection Act 1998 when implemented.

9 Public Access to Information about the HPSS

9.1 The Provider will be required to adhere to the principles outlined in the recent 'Code of Practice on Openness in the HPSS' published by HSS Executive.

9.2 In particular the provider will be expected to ensure that the following key aims of this Code are adhered to:

- people have access to available information about the services provided by the HPSS, the cost of those services, quality standards and performance against targets;
- people are provided with explanations about proposed service changes and have an opportunity to influence decisions on such changes;
- people are aware of the reasons for decisions and actions affecting their own treatment and care;
- people know what information is available and where they can get it.

10 Conciliation and Arbitration

10.1 Both parties will endeavour to avoid the need for conciliation and arbitration having to take place through regular and constructive dialogue. However in the event of any dispute or failure to agree on any matter in relation to the agreement, the matter shall be referred for conciliation or, if necessary, arbitration in accordance with the machinery set out in the HSS Executive's guidance 'Resolution of Contractual Disputes' (June 1993).