NAME OF CHILD: LUCY CRAWFORD – DECEASED (RAYCHEL FERGUSON)

Name:	Thomas Jude Joseph Frawley
Title:	Dr
Present position and institution:	Assembly Ombudsman and Northern Ireland Commissioner for Complaints
Previous position and institution:	General Manager, Western Health and Social Services Board until 31/8/2000
Membership of Advisory Panels and Committees:	Trustee of National Association of Health Authorities and Trusts from January to June 2000. NB: Resigned from all bodies, advisory panels and committees on taking up post of Northern Ireland Ombudsman on 1 September 2000.
Previous statements, depositions and reports:	None
List of previous statement, depositions and reports attached:	N/a

I. Questions relating to your qualifications, experience, career background and duties.

(1) Please address the following questions with regard to your qualifications, experience and occupation/post as of April 2000:

(a) State your professional qualifications and the date on which they were obtained.

BA (History, Philosophy, Geography) Degree – Trinity College, Dublin, 1971

National Graduate Training Scheme – Manchester Business School 1971-73

Certificate in Health Economics – Aberdeen University 1981-82

Honorary Doctorate awarded by University of Ulster in 2005 in recognition of contribution to public service in Northern Ireland.

(b) *State the date of your appointment to the post of General Manager of the WHSSB, and provide a description of all the professional posts held by you before and since that date, giving the dates of your employment in each case.*

1 April 1985 to 31 August 2000	Appointed Area General Manager of WHSSB – I had overall responsibility for ensuring the Western Board fulfilled its statutory duties and managerial responsibility for all health and social services and staff working in the geographical area served by the Board. I was accountable to the Chairman of the Board and through him to the Board appointed by the Minister. I was also 'accountable officer' for financial resources allocated to the Board.
1981 - 1985	Chief Admin Officer of WHSSB – accountable as a member of corporate multi-professional team for providing health and social services to a population of circa 275,000 with a budget of £180m. I had responsibility for administration of all health and social services including finance.
1980 -1981	District Admin Officer of Londonderry, Limavady and Strabane District – head of administration of health and social services across three District Council areas including Gransha, Stradreagh and Altnagelvin Hospitals.
1978 -1980	Acting District Admin Officer Lisburn HSS District – acting head of administration and member of a corporate team responsible for managing all health and social services in Lisburn Health and Social Services District. I had overall administrative responsibility, including financial accountability for all facilities in the District.
1975 -1978	Administrative Officer of North and West Belfast District – accountable for community services in north and west Belfast.
1973 -1975	Unit Administrator, Ulster Hospital, Dundonald – responsible for all administrative services in the hospital and a number of health and social care facilities in East Belfast and Castlereagh HSS District.
July 73-Oct 73	Senior Administrative Officer – was part of administrative support to (Shadow) Southern Health and Social Services Board.
1971-1973	National Graduate Trainee, Manchester Business School

(c) *Describe the duties you were required to undertake in the post of General Manager of the WHSSB, and provide a copy of your job description in respect of the period commencing April 2000.*

I was appointed as General Manager of the Western Health and Social Services Board in 1985. I enclose a job description dated August 2000 which records my duties in April 2000 (see Document 1). An earlier job description is also attached for the sake of completeness but this does not reflect my duties in April 2000.(see Document 2)

Over the period (1985-2000) (until I took up post of NI Ombudsman in September 2000) the statutory functions of the Board went through a number of changes and my role evolved in response to those changes. The most significant of the changes was the creation of 3 autonomous, entirely separate, legal entities ie Trusts in the Western Area on 25 March 1996. This was the final stage of a policy introduced to create an internal market for health and social care by separating the commissioning of services from the provision of services. The Trusts were the providers established as a central part of this change and were placed in a direct reporting relationship with the DHSSPS.

My core responsibilities as General Manager of the WHSSB in 2000, recorded in the job description dated August 2000, are as set out in the job description under four key areas of responsibility and are as follows:

- ensuring that the Board met its statutory responsibilities;
- accountable officer for the financial performance of the Board;
- strategic leadership of the Board;
- as secretary to the Board responsible for the administrative services that supported the Board;
- accountable for the overall performance of the Board in commissioning sustainable services;
- ensuring Board operated within the finances allocated to it;
- oversight of the core processes of strategic and operational planning;
- ensuring Board operated within Departmental policies and priorities;

- responsible for all corporate services in the Board including human resources, finance, IT etc.;
- oversight of independent contractor services (ie dentists, community pharmacists and optometrists) operating within the Board area;
- liaising with all stakeholders to improve the health and wellbeing of the resident population.

(d) *In your capacity as General Manager of the WHSSB, please indicate whether you had any responsibility for the operation, management, supervision or control of the services provided by the Sperrin Lakeland Trust and Erne Hospital and, if so, state where that responsibility derived from and how you exercised that responsibility.*

As General Manager of the WHSSB, I ceased to have any responsibility for the operation, management or supervision of the services provided by Erne Hospital with the creation of the Sperrin Lakeland Trust in the Western Area on 25 March 1996. At that time, the Western Board ceased to have any operational, managerial or supervisory responsibility for the 3 Trusts established in the Western Board area on that date.

In relation to the 'control' of services, as General Manager I was responsible as Accountable Officer for the commissioning of services and signing the Service Agreements (SAs) as well as leading on the monitoring of the performance of the Trusts under the SA. As a commissioning authority the control exercised by the Board was through the Service Agreements (SAs) that had been entered into with Trusts. The three core functions fulfilled by the Board as a consequence of this major change were:

- Assessing the health and social care needs of the population living in the designated catchment area of the Western Board.

- Developing a portfolio of SAs with a range of providers including the three local Trusts to address the needs that had been identified through a needs assessment process. These SAs involved negotiating the levels of health and social care that would be delivered against agreed financial allocations by each provider. Service Agreements also provided the framework against which the Board would monitor the content, quantity and quality of the service that was provided.

The primary focus of the Board therefore was on commissioning health and social care for the resident population across a number of programmes eg acute hospitals, mental health, learning disabled, elderly, child care etc.

- The third core function was to oversee all aspects of the contracts delivered by independent contractors working in the Board's area. Independent contractors included medical, pharmaceutical, dental and ophthalmic professionals. The Board also had a responsibility to 'sign off' on the claims and payments made by and to contractors by a third party, the Central Services Agency. The Board's responsibilities in this area included organising and managing the out-of-hours services for GPS while investing in and supporting the development of suitable infrastructure and facilities for the delivery of primary care.

The Board derived its authority principally from the Health and Personal Social Services Order (NI) 1972 and subsequent amendments/updates to that Order. I derived my responsibilities from the Board's legal powers and the SAs with the Trust and I was accountable to the Board for meeting the responsibilities set out in my job description.

(e) *In circumstances where a health and social services Trust notified you or your office of an unexpected and unexplained death, what were your particular responsibilities and where did those responsibilities derive from?*

When the Trusts became separate autonomous public bodies, their primary reporting relationship moved from the Board to the DHSSPS. In 2000 the Trust had no explicit (policy based) responsibility for notifying the Board of unexpected or unexplained deaths.

However, were an unexpected and unexplained death to be brought to my attention in 2000 by a Trust, my response would have been as follows:

- seek assurances that an investigation had been initiated;
- ensure that the relevant professional leads in the Board had been advised;
- where the investigation and its conclusions resulted in the preparation of a formal report, I would have had an expectation that the report would be shared with the Board in order to enable the Board to consider whether the Board needed to initiate any action in light of the report. In making such a judgement, I would seek the views of the relevant professional leads in the Board on whether the findings, conclusions and recommendations proposed by the Trust were a proportionate and appropriate response to the incident that had been investigated.

My responsibilities derived from the Board's statutory obligations and from my role as the Statutory Accountable Officer for the Board as indicated in the job description (see Document 1).

(2) Please explain the organisational structure of the WHSSB as of April 2000 and in particular outline how your role as General Manager related to the roles performed by Dr William McConnell and Mr Martin Bradley.

In April 2000 the overall structure of the Western Health and Social Services Board was:

- Board;
- Health Care Committee, Social Care Committee, and Administrative Services Committee and Audit Committee;
- Board comprised of 6 non-Executive Directors including the Chairman and up to 6 Executive Directors;
- Senior Management Team (Executive Directors and a number of senior managers).

In 2000, as General Manager I was the statutory Accountable Officer for the Board, an Executive Director and also Secretary to the Board. I attended all Board Committees including the Audit Committee. I had line management responsibility for both Dr McConnell and Mr Bradley and for all other executives and senior managers employed by the Board. However, because the Board operated as a corporate entity, at Board meetings Directors were free and encouraged to offer comment and advice.

The Board was committed to a consensus model of decision making. Martin Bradley (in his role as Chief Nurse in 2000) attended the Board and Committees, as did Dr McConnell in his capacity as Director of Public Health (DPH). Mr Bradley, as Chief Nurse, provided the Board with advice on professional nursing and midwifery matters and Dr McConnell, in his capacity as Director of Public Health, advised the Board on professional, clinical, medical and public health matters. Both officers along with the Director of Social Care were the lead professional contacts with all providers, including Trusts. They also provided professional advice where appropriate in relation to primary care. They

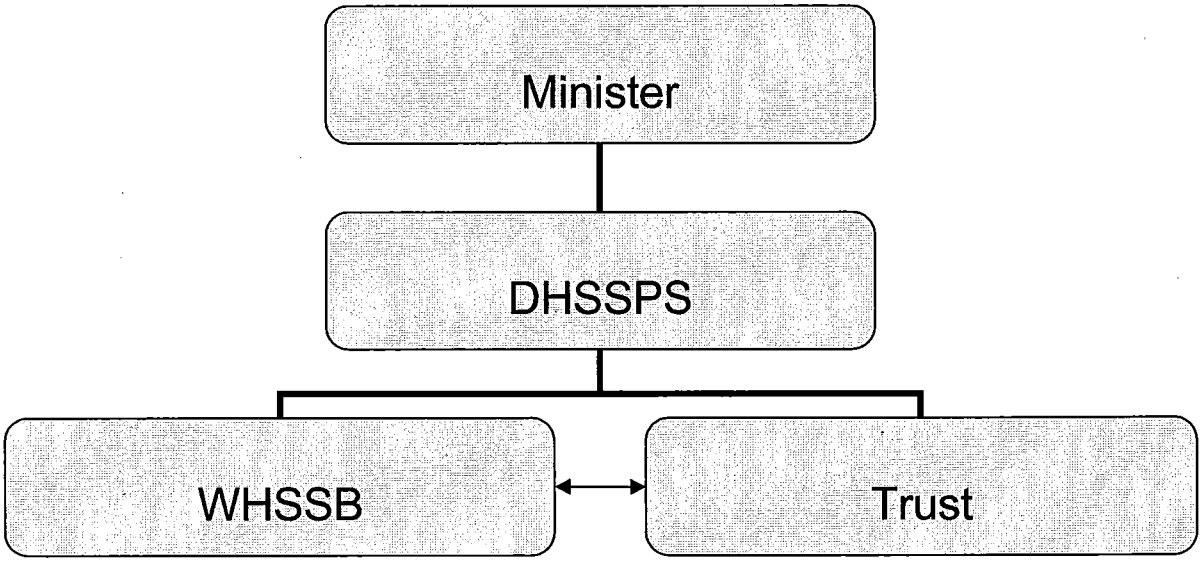
led the Board in its discussions relating to quality of care and issues affecting the health and social care status of the population. The Director of Public Health also had a number of specific statutory duties including:

- Control of communicable disease;
- Emergency planning;
- Prevention of chemical, biological, radiation and nuclear hazard.

II. Steps taken following the death of Lucy Crawford.

(3) Please explain your understanding of the nature of the organisational and management relationships, roles and responsibilities between the Western Health and Social Services Board, the Sperrin Lakeland Trust (including the Erne Hospital) and the DHSSPS, as of April 2000. Provide to the Inquiry any documentation which sets out the nature of relationships, roles and responsibilities.

My understanding of the organisational and management relations is illustrated in the diagram below:



My understanding of the roles and responsibilities of the DHSSPS were:

- supporting Minister in setting policy, strategic direction and priorities for health and social care in Northern Ireland;
- leading on and responsible for drafting legislation;
- securing and allocating finance;
- holding whole system to account.

The roles and responsibilities of the WHSSB were:

- to assess the health/social care needs of the resident population;
- to commission services;
- to ensure Board met and operated within resources allocated to it;

- to ensure services were consistent with DHSSPS policies and priorities;
- to oversee independent contractor services.

I refer to the WHSSB document numbered 3 which was provided to the Inquiry which explains the organisational and management roles and responsibilities between the WHSSB, Sperrin Lakeland Trust and DHSSPS. In relation to the particular relationship between the WHSSB and the Trust, I attach the Service Agreement (see Document 4) between both bodies (see Document 3). Sperrin Lakeland Trust was one of 3 Trusts located in the Western area in 2000. The two other Trusts were the Altnagelvin Group of Hospitals and the Foyle Trust.

The roles and responsibilities of Trusts are set out in Document 3.

In relation to the respective roles of the WHSSB and Trust, the Board was responsible for the health and social care needs of its resident population, and the Trust was responsible for providing services to the individual patients and clients.

In relation to accountability, it should be noted that the Board and Trust as depicted in the diagram are not in a hierarchical relationship. The relationship between them was informed by a Service Agreement (Budget and SA) depicted by an arrowed line in the diagram above.

(4) In the event of an untoward/unexpected death of a child in the Erne Hospital, were there any procedures in place as of April 2000 which governed the reporting of that death by the Hospital/Sperrin Lakeland Trust to:

(a) The Western Health and Social Services Board; or
(b) The Department of Health and Social Services and Public Safety.

If so, fully outline what was required by those procedures, and state whether the Hospital/Trust complied with them in the case of Lucy Crawford. Please arrange for the Inquiry to be provided with a copy of these procedures.

(a) There were no formal procedures in place for the reporting of an untoward death by the Hospital/Sperrin Lakeland Trust to the WHSSB. However, as outlined in my response to Q1(e), the process would in 2000 have involved the Trust notifying the lead professional officers in the WHSSB of an untoward/unexpected death. As far as I can recall, the Trust did comply with the arrangements as outlined for reporting untoward incidents. The expectation of the WHSSB, as commissioner in relation to clinical governance, was outlined at Section 5 of the SA (see Document 4). I have been provided by the HSC Board with a copy of Mr Mills' note of two update meetings (Document 5 - Inquiry Reference: 036b-002-002) in which he records that he informed me, on 3 May 2000, and subsequently again on 14 June 2000, of the untoward/unexpected death of a child. I do recall Mr Mills informing me of the event and that may have happened on two occasions. I would also ask the Inquiry to note Mr Mills' timeline of events (see Document 6 - Inquiry Reference 030-010-017 & 018 provided to me by the HSC Board) in which he records speaking to Dr McConnell on Fri 14 April 2000 and Mr Bradley on Wed 19 April 2000. This note also indicates that between 14 April and 11 May Mr Mills spoke to Dr McConnell on two other occasions.

(5) If there were no formal procedures in April 2000 requiring the Hospital/Trust to report in the circumstances referred to in the above question, would you have nevertheless expected the Hospital/Trust to have reported the death to:

(a) The WHSSB;
(b) The DHSSPS.

Please give reasons to explain your answer.

Yes, I would have expected the Board to be notified.

(a) I would have expected the Trust to notify the WHSSB of an 'untoward death such as that of Lucy Crawford because she was a resident of the Western area and therefore her care was covered by the SA between the Board and the Trust.

(b) I would have expected the Trust to notify the DHSSPS of an 'untoward death' such as that of Lucy Crawford because the Trust's line of accountability was to the DHSSPS.

(6) Did the Hospital/Trust report Lucy's death to the WHSSB in accordance with the extant formal procedures, or in accordance with your expectations?

The Trust reported Lucy's death to the Board in accordance with my expectations.

Arising out of the above question, please address the following matters:

(a) If there was any departure from the requirements of the extant formal procedures in terms of the report that was made by the Hospital/Trust to the Board, please explain what those departures were, and whether you addressed them with the Hospital/Trust.

As already explained, while there was no extant formal procedure in place in 2000 for reporting an untoward death, the SA in place (Document 4) placed an expectation on the Trust that the Board would be advised.

(b) Outline in chronological order all reports that were made by the Hospital/Trust to the Board, and state:

(i) What information was provided to the Board by the Hospital/Trust in relation to the death of Lucy Crawford?
(ii) Who provided this information to the Board on the occasion of each report?
(iii) Who received this information on behalf of the Board on the occasion of each report when it was provided?

While I do recall Mr Mills informing me of the death, in relation to other reports I have no direct knowledge of the chronology of all reports made by the Trust to the Board. I note from documentation provided by the HSC Board that Dr McConnell and Mr Bradley were notified as follows:

- I note that the document 03C-010-017 produced by the Trust indicates that Dr McConnell (DPH) was notified of the death of Lucy on 14 April 2000.

- The note referred to above indicates that Mr Mills (CX of Trust) spoke with Mr Bradley (CN) in relation to Lucy's death on 19 April 2000;
- In relation to my own knowledge of the incident, the note shared with me by the Inquiry indicates that as part of my update with Mr Mills on 3 May 2000 he appraised me of the untoward death of an 18 month old child. Subsequently, on 14 June 2000, as part of our next update meeting, he provided me with a verbal update on the ongoing investigation.

On 8 May 2000 my PA sent an email on my behalf to Dr McConnell and Mr Bradley stating:

'*I am aware from conversations that you have received background on [an untoward infant death] from Hugh Mills. I think it is important we get some definitive advice and I would be grateful if you could keep me appraised. Many thanks'. Signed TJF (my initials).* (Document 7)

I have no recollection of Dr McConnell's or Mr Bradley's ongoing contact with Trust colleagues in relation to the developing investigations, however I would anticipate that such contact did occur and this is confirmed in the files that I have received following a request to the HSC Board.

I have been provided with an incomplete draft copy of the report by Mr E Fee dated 5 July 2000 (033-102-262) on the review by the Sperrin Lakeland Trust of Lucy Crawford's case.

This draft report dated 5 July contains a memorandum dated 5 July 2000 from Mr Fee to Dr T Anderson which states that '*a draft report is enclosed for Mr Anderson's review'.* On the face of the actual

report there are three different handwritten notes: one note indicates the report was sent to Dr Anderson on 10 July 2000; a second note refers to an amended copy sent to Dr Anderson on 31 July 2000; a third note refers to a missing page on the sequence of events. I have no recollection of receiving or having sight of a draft or any of these amended papers that relate to Sperrin Lakeland Trust's review of the Lucy Crawford case.

I note that a draft report on Lucy's death was completed on 31 July 2000.

(7) What procedures or arrangements did the WHSSB have in place as of April 2000 regulating the action that should have been taken by the Board when a Hospital/Trust reported an adverse incident to the Board such as an unexpected/unexplained death? Please make arrangements to provide to the Inquiry a copy of any relevant procedures.

I would refer you to my answer at question 1(e) and question 8 for the procedure I would have expected to be followed.

(8) Under the procedures or arrangements then in place, what steps should the WHSSB have taken in circumstances where the Hospital/Trust had reported an adverse incident to the Board, and who was responsible for taking those steps?

Although there was no formal procedure in place, the arrangements that would have been followed are outlined in my response to Question 4. The Trust would have been responsible for those steps.

(9) Describe in order of chronology the steps that were taken by the WHSSB in connection with any reports that were made to the Board by the Hospital/Trust in relation to the death of Lucy Crawford. If particular steps weren't taken, please explain the omission to do so.

I would refer to the answer at questions 6(b) and 8.

(10) Insofar as you are aware, did the Hospital/Trust report Lucy's death to the DHSSPS in accordance with the extant formal procedures, or in accordance with your expectation? Outline what you know about any report made by the Hospital/Trust to the DHSSPS in relation to Lucy's death.

I have no personal knowledge of the Trust submitting a report in relation to Lucy Crawford's death (or its findings) to the DHSSPS.

(11) Notes contained on the files of Mr Hugh Mills (Chief Executive, Sperrin Lakeland Trust) relating to a meeting on 3 May 2000 state as follows:

'Wednesday 3rd May – provided briefing to Mr Frawley on issues.' (Ref: 030-010-018); and 'Meetings with Mr Frawley AGM 3/5/00 Untoward death re 18 month old child' (Ref: 036b-002-002); and the agenda at (Ref: 036b-059-096 to 036b-059-098) at item 11 'untoward death re 18 month old child'.

Arising out of these notes, please address the following matters:

(a) What was the purpose of the briefing which took place with Mr Mills on 3 May?

The meeting on 3 May was one of the regular update meetings I had with the Trust CX, Mr Mills, and the two other Trust CXs in the Western area every 6/8 weeks. The purpose of the meetings was to share information on a wide range of matters, regional, area and local. Part of the discussions would focus on the performance of the Trust against the Service Agreement.

(b) Where did this briefing take place, and for how long did it last?

While I cannot recall the actual location, these meetings usually took place in Mr Mills' office in the Trust or in my office in the Board. I do not recall the duration of this specific meeting but they usually lasted around 2 hours.

(c) Who attended this briefing, apart from yourself and Mr Mills?

No-one.

(d) What did Mr Mills tell you when he briefed you, and what issues were covered?

Mr Mills indicates that at the AOB section of our meeting he advised me of Lucy Crawford's death and my recollection is that he confirmed that an investigation was underway and that Mr Bradley and Dr McConnell had been advised.

(e) If you made any record of your discussion with Mr Mills, please arrange to provide it to the Inquiry.

I have asked the HSC Board for any notes I may have made of these update meetings although to date none have been traced. It was my practice to write action points against subjects that were discussed.

(f) Having received a briefing from Mr Mills about this adverse incident, what were your responsibilities as General Manager of the WHSSB and where did those responsibilities derive from?

As General Manager of a Board whose role was to commission services for the local population, my managerial responsibility would have been to ensure that the relevant professional leads had been informed and were aware that an investigation had been initiated; to await the final report of the investigation and in light of that report and my professional leads assessment of its conclusions decide whether it was necessary for the Board to take any further action.

(g) Did you take any action on foot of the briefing you received from Mr Mills? If so, what did you do?

I cannot recall what specific action I took on foot of the briefing from Mr Mills but I note from the records provided to me by the HSC Board that my PA sent an email dated 8 May 2000 to Dr McConnell and Mr Bradley (see Document 7) asking to be kept informed.

(h) Did you report to anyone else the information contained in the briefing from Mr Mills? If so, who did you report to and what did you report?

I do not recall reporting the information to anyone else, as I would at that stage have awaited the outcome of the investigation. I refer you to my answer to 11(g) above and the email dated 8 May 2000 that I sent to Dr McConnell and Mr Bradley (see also answer to question 6(b)).

(12) Notes contained in the files of Mr Mills relating to a meeting on 14 June 2000 state as follows:

Meetings with Mr T Frawley...14.6.00 Consultant Paediatrician progress with review. Updated re examin. (sic) on untoward death. Provided advice on info emerging from SGs Dr Asghar...'. (Ref: 036b-002-002); and the Agenda at (Ref: 036b-058-094 to 036b-058-095) at item 7 contains the same text. Arising out of these notes, please answer the following questions:

(a) What was the purpose of the briefing which took place with Mr Mills on 14 June?

As indicated in response to question 11(a).

(b) Where did this briefing take place, and for how long did it last?

I cannot recall, but either in my offices in WHSSB HQ or Mr Mill's office in Trust HQ in Omagh. The meetings usually lasted about two hours.

(c) Who attended this briefing, apart from yourself and Mr Mills?

Mr Mills and myself.

(d) What did Mr Mills tell you when he briefed you, and what issues were covered?

With the passage of time I cannot recall the detail of this part of the discussion, but my assumption on reviewing the note is that Mr Mills was advising me that the investigation was continuing and that further background to the incidents had emerged from interviews with Staff Grade Doctors, Dr Ashgar and Dr Duffy.

(e) If you made any record of your discussion with Mr Mills, please arrange to provide it to the Inquiry.

I have asked the HSC Board for any notes that may have been retained by the legacy Board.

(f) Having received this briefing from Mr Mills, what were your responsibilities as General Manager of the WHSSB and where did those responsibilities derive from?

As indicated in response to question 11(f).

(g) Did you take any action on foot of the briefing you received from Mr Mills? If so, what did you do?

I do not recall taking any action on foot of the briefing with Mr Mills on 14 June 2000. I would have confirmed with Dr McConnell and Mr Bradley that the investigation was ongoing. I would have awaited the outcome of the investigation before deciding if any further action was required.

(h) Did you report to anyone else the information contained in the briefing from Mr Mills? If so, who did you report to and what did you report?

Not that I can recall.

(13) Starting from the time at which you were first informed about the death of Lucy Crawford, outline chronologically all of the steps that you took in the exercise of your responsibilities in order to address any matter associated with the treatment and death of Lucy. For the avoidance of doubt, you should refer to all discussions, investigations or inquiries which you raised or undertook, any reports to other persons or organisations that you made, as well as any steps taken by you to obtain relevant documentation.

As stated in answer to 1(d), the responsibility transferred from the Board when Trusts came into being on 25 March 1996. However, from the records provided by the HSC Board, the chronology of the Board's involvement is as follows:

- in mid April 2000, I was verbally advised by either Dr McConnell or Mr Bradley about the death of Lucy Crawford. I was also advised that an investigation was underway;

- on 3 May 2000 Mr Mills' note given to me by the Inquiry Team indicates that as part of regular update meetings, he advised me of the death of Lucy Crawford, and the steps the Trust had initiated in response to the event. I would again refer to my email dated 8 May 2000 to Dr McConnell and Mr Bradley (see Document 7);

- on 14 June 2000 Mr Mills' note indicates that at my next 'update' meeting with him he briefed me on the continuing investigation;

- I note from papers I have received following a request to the HSC Board that the Trust's draft report into the death of Lucy has dates of 5 and 31 July 2000. However, despite a continuing search, no record can be found of the report into Lucy's death having been formally sent to the WHSSB or myself as General Manager and I have no recollection of having received it;

I was on annual leave in the latter part of July/early August 2000, I took up my position as Northern Ireland Ombudsman on 1 September 2000.

III. Other Matters

(14) How was clinical governance introduced across the Western Health and Social Services Board area following the publication of 'The New NHS: Modern and Dependable' (White Paper December 1997)?

The background to the development of clinical governance in NI and the Western Board in particular as it relates to the new 'NHS: Modern and Dependable' as I recall it is as follows:

- the 'Modern and Dependable' White Paper was introduced and implemented in England in 1997;

- in 1998/99 the health services in Scotland and Wales implemented arrangements based on the initiative in England;

- in 2001, the Management Board of DHSSPS(NI) launched a consultation on proposals for clinical governance arrangements in NI;

- in 2003 formal arrangements were implemented in Northern Ireland by DHSSPS. Under those arrangements, Chief Executives of all HPSS organisations were made explicitly responsible for implementing and overseeing clinical governance in their organisations;

(15) What steps had been taken by April 2000 to implement a clinical governance strategy in the Western Board area?

I have some recollection of the steps taken to implement a clinical governance strategy in the Western Board area. From records provided to me by the HSC Board, I note that the statutory basis for clinical governance was not implemented in Northern Ireland until 2003 (see question 14).

While clinical governance did not have a statutory basis in Northern Ireland, from the mid 90s onwards, responding to developments elsewhere. a number of initiatives were taken to develop an awareness of the value and importance of clinical governance. On 8 October 1999 the four Boards in Northern Ireland held a joint workshop to examine how an accountability and governance framework might be developed for the HPSS. As a result, a working group was established with the following terms of reference:

1. Produce a paper setting out the current position with regard to accountability and governance in the HPSS, identifying any gaps with a plan to address them.

The Western Board had two members of staff on the working group, one acting as the project manager. The report that resulted was submitted to the Board Chief Executives (see Document 8).

Section 3 of the report focuses on clinical and professional governance and the working group indicate *'this section contains significant challenges and must be addressed if effective governance and accountability is to be secured in all parts of the service'.*

The Section on clinical governance sets out a challenging agenda for all HPSS organisations and it highlights the importance of detecting/investigating/correcting adverse events.

The paper then sets out the key elements of a framework:

- a comprehensive framework of quality improvement activity in which internal scrutiny is supplemented by open and external review;
- clear policies aimed at managing risk, including procedures that support professional staff in identifying poor performance;

- clear lines of responsibility and accountability for the overall quality of clinical care;

- procedures to remedy poor performance.

Finally, the report set the following challenges for the HPSS:

- to strengthen and modernise professional regulation;
- to strengthen existing systems of quality control based on clinical practice, evidence based practice and learning lessons of poor performance;
- identify and minimise risk;
- identify problems as they arise and ensure lessons are learnt;
- support professionals in delivering quality care.

This was the platform on which the Western Board developed its approach to engaging with Trusts who were central to the introduction of clinical governance. At this point, many Trusts were already exploring systems of clinical governance building on structures which were already in place that had been introduced with the objective of ensuring doctors were effectively involved in the management of clinical services.

The mechanism developed to put clinical governance at the centre of the relationship between Trusts and the Board in the Western Area was the Service Agreement (SA), note SA with Sperrin Lakeland Trust 1999-2000 (see Document 4). Section 5 of the SA outlined the framework of

clinical governance the Board expected the Trust to evidence. The narrative underpinning the agreement signals that the Board would be 'adopting a proactive approach to the initiative to ensure that a structured and coherent clinical governance programme is in place' within Trusts. Specifically, the first key element identified in Section 5 of the SA is '*processes for recording and deriving lessons from untoward incidents, complaints and claims'*. Finally, the Board gave notice that clinical governance will feature prominently in our discussions with providers.

I do recall that alongside these practical steps Board staff participated in seminars and workshops to develop their knowledge and expertise around clinical governance (see Document 9 - 3 November 1999 Clinical Audit Acetates).

(16) What was the responsibility of the Western Health and Social Services Board to ensure that the Sperrin Lakeland Trust (and in particular the Erne Hospital) provided quality care?

As commissioner of the services, the WHSSB was responsible for assessing needs and commissioning safe and sustainable services to meet those assessed needs within available resources and Departmental policies. The Board's responsibilities are outlined in Service Agreements (SAs) with the Trusts and a range of other providers (I have enclosed a copy of an SA – Document 4). The Board monitored the services provided by Trusts informed by the SA through regular visits, meetings and reviews.

The Trusts – as independent organisations - were responsible for the quality of the services provided to the individual patients by their clinical professionals including doctors and nurses, and were accountable directly to the Department.

In commissioning services, the Western Board sought to build improvements into SAs as resources allowed. Site visits, the views of GPs, information from complaints, the views of patients and the perspectives from Royal Colleges and medical schools all offered insights into the quality of services that were being provided.

The Board's accountability meetings with a Trust did not deal with specific cases, although any conclusions/recommendations arising from reports and service reviews would have been discussed.

The emerging system of clinical governance was viewed as important by the WHSSB because it was concerned with addressing some of the major challenges involved in commissioning an appropriate safe, viable and affordable model of acute hospital service. At 2000 the Western Board had three acute hospitals located across a very wide and difficult geography; Altnagelvin in Derry, the Tyrone County Hospital in Omagh and the Erne Hospital in Enniskillen. It was considered by the Board to

be essential that all services provided by hospitals from which it commissioned services had a commitment to developing clinical governance schemes that would provide assurance to the relevant Trust Board, and through it to the Western Board that its resident population were receiving services that were safe and of good quality. An important milestone developed by the Board and the Sperrin Lakeland Trust to establish a baseline for this approach was the Clinical Risk Assessment Survey completed by independent consultants in 1999 (see Document 10).

(17) What actions did the Western Board routinely take to monitor the quality of care provided at the Erne Hospital?

The WHSSB established its monitoring role through the SA attached (see Document 4). I asked the HSC Board to provide me with records of monitoring meetings/discussions with Trusts from around that time. At the point of finalising this statement, the HSC Board has been unable to locate copies of the notes that would have been developed following the regular monitoring meetings that were an integral part of the engagement between the Board and the Trusts. These discussions would have included a review of the activity completed against projected activity, the financial performance against budget and issues of quality that had been highlighted through monitoring arrangements outlined earlier (See answers to Questions 2 and 16).

(18) Please outline the criteria or factors which you would have taken into account when determining whether issues identified as a result of a critical incident needed to be disseminated to others in the NHS in Northern Ireland?

While there was no formal policy, my expectation would have been that the relevant Trust would have raised the incident with the Department. If a report of a critical incident was received by the Board – through its professional advisers – the final report would have been tested against the following questions:

- was the critical incident a 'one off'?;
- were there training or competency issues involved in the specific incident?;
- did Board's SLAs/commissioning plans need to be reviewed in light of the incident?;
- did the incident highlight any systemic problems that should be addressed and require action to be disseminated across the wider HSC system?

If the issue was identified as having wider implications across the HSC, the relevant Trust should be advised that the matter should be raised with the DHSSPS, if this had not already been done. It is the Department's responsibility to make a judgement on whether the issues highlighted had implications for the wider HPSS system. The line of communication into the DHSSPS would have been through the professional lines:

Medical – Chief Medical Officer
Nursing – Chief Nursing Officer
Social Services – Chief Social Work Advisor
Management/Administration/Finance – Permanent Secretary

(19) Did you give any consideration to whether any of the issues arising out of Lucy Crawford's case warranted dissemination to a wider audience in the NHS in Northern Ireland? If so, please explain the consideration you gave to this matter, the conclusions which you reached and any action that you took.

I do not recall giving any consideration to the issues because my employment with the WHSSB ended on 31 August 2000 and I do not recall having seen the Trust's final report prior to that.

(20) Have you or the Western Health and Social Services Board learned any lessons or changed any practice arising out of your experience of involvement in the processes of inquiry into the treatment and death of Lucy Crawford, or any other matter related to her death? If so, fully describe the lessons that have been learned or the changes in practice which have occurred.

I would refer you to the answer to question 19.

(21) Provide any further points and comments that you wish to make, together with any documents, in relation to:

(a) The cause of Lucy's death;

I am not qualified to comment on this question.

(b) The role performed by you, the Sperrin Lakeland Trust or the Western Health and Social Services Board when reviewing or investigating issues relating to the cause of Lucy's death;

I have no further comment to make.

(c) The procedures which were followed when reviewing or investigating issues relating to the cause of Lucy's death;

I have no further comment to make.

(d) Lessons learned from Lucy's death and how that affected your work;

Given that I left the Board on 31 August 2000, I have outlined my involvement in this case to the best of my recollection of events that occurred nearly 13 years ago.

(e) Any other relevant matter.

In developing my responses to the questions in this statement, I am conscious of the significant passage of time and the extensive changes that have been introduced to the HSC over the 13 years that have elapsed. It is therefore important that the detail is examined against the knowledge and arrangements that were in place in 2000, and not judged against the organisational systems and clinical knowledge of 2013.

This statement is true to the best of my knowledge and belief.

Signed: Thomas Frawley. **Dated:** 5th February 2013.

T J FRAWLEY

WESTERN HEALTH AND SOCIAL SERVICES BOARD

CHIEF EXECUTIVE

JOB DESCRIPTION

Title: Chief Executive

Reports to: The Chairman

Accountable to: The Board

The term "he" has been used throughout the job description for ease of reference; it should be taken as meaning he or she.

An Overview

The Chief Executive is expected to provide executive leadership, clear vision, direction and strategic management for the Western Health and Social Services Board in leading and shaping the local health and social care economy.

The Chief Executive is an Executive Director, a member of the Western Health and Social Services Board and is the statutory Accountable Officer for the Board.

The Chief Executive is responsible to the Chairman and accountable to the Board for the overall performance of the organisation's activities in order to ensure improvement in the health and social well-being of the population living in the Western area.

The Chief Executive is responsible for leading the further development of the HPSS system and for motivating managers and professionals as they develop. The developing duty of partnership with organisations within and outside the HPSS will be a significant responsibility for the Chief Executive as will be leading the Board's response to the Equality legislation.

Key Responsibilities

The Chief Executive will have key responsibilities in relation to:

Strategic Leadership and Planning

The role of the Chief Executive is dependent on an ability to effectively provide leadership and planning for the whole HPSS system in the Western Area. This will require him to:

- Facilitate the development of a vision for health and social care in the West;
- Ensure the development of Board and its staff;
- Work with Executive and Non-Executive Directors to agree a corporate agenda for the Board;
- Develop and deliver a strategic plan for the Board based on a comprehensive framework of needs assessment;
- Introduce and implement principle of best value;
- Prioritise and implement the social inclusion and equality agendae within the Board;
- Ensure the Board develops a focus on outcomes;
- Ensure Primary Care is given the focus and support to enable it to fulfil its role within the HPSS system.

Performance Management

The Board, as a statutory body, has a major responsibility for the effective use of public money. To that end, the Chief Executive must demonstrate an ability to deliver sound Performance Management by:

- Translating the Board's vision for health and social care in the West into clear targets and plans;
- Ensuring the delivery of national and regional targets/policies in the West, particularly those around Waiting Times and Winter Pressures;
- Ensuring effective performance systems are in place that will enable the Board to fulfil its public stewardship and statutory responsibilities;
- Setting and achieving financial targets;
- Setting and achieving activity/quality targets both 'internal' and 'external' to the Board through relevant and effective commissioning arrangements;
- Maintaining and developing an appropriate management structure;
- Maintaining and developing appropriate financial systems consistent with public accountability and Corporate Governance;
- Maintaining and developing appropriate information systems.

Partnership/Working Relationships with Others

The essential improvement in the health and social well-being of the population served by the Board will only be achieved if effective relationships are developed with other key partners in the public, private, voluntary and community sectors. The key requirements will be to:

- Develop effective HPSS partnerships with Trusts/independent contractors/other providers and the Western Health and Social Services Council etc;

- Form and develop key partnerships beyond the HPSS system with the statutory, private, voluntary and community sectors;
- Secure within the Area served by the Board a strong commitment to Community Development;
- Specifically develop and build on cross border working, particularly with the organisations which are in membership of CAWT (Co-operation and Working Together).

Statutory Obligations

As a public authority, the Board must fulfil key statutory obligations. The Chief Executive must:

- Ensure these are complied with, particularly the areas of mental health, child care, public health, equality, fair employment and health and safety;
- Fulfill all responsibilities described under Standing Financial Regulations and in particular the duties described within the relevant circulars on the role of the Accountable Officer. This will form the core of a robust Corporate Governance framework for the Board;
- Work with others to ensure that the whole HPSS system in the Western area, including the Board, is working to agreed Clinical Governance requirements.

Communications and Advocacy

The Board works within a complex system of health and social care and must relate closely to the population it serves. The Chief Executive must play a key role to:

- Maintain and enhance public confidence in the Board;
- Represent the Board externally;
- Develop and promote a positive corporate image;

- Promote and explain the Board's plans and strategies;
- Influence and inform national and regional strategies and policies;
- Seek regular, structured feedback from the community and put in place effective consultation arrangements;
- Manage the interface with politicians, interest groups, the public and media.

General Management Responsibilities

- Review individually, at least annually, the performance of immediately subordinate staff and provides guidance on personal development requirements;
- Maintain staff relationships and morale amongst staff reporting to him;
- Review the organisation plan and establishment level of the service for which he is responsible to ensure that each is consistent with achieving objectives, recommending change where appropriate;
- Delegate appropriate responsibility and authority to staff within his control consistent with effective decision making, whilst retaining overall responsibility and accountability for results;
- Participate, as required, in the selection and appointment of staff in accordance with Western Health and Social Services Board policy;
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down and approved by the Western Health and Social Services Board.

NB: This job description summarises the main duties but is not exhaustive. It will be regularly reviewed and updated in discussions with the postholder. The postholder will be subject to regular performance reviews.

August 2000

DOCUMENT 2

WESTERN HEALTH AND SOCIAL SERVICES BOARD

GENERAL MANAGER

JOB DESCRIPTION

Background

Circular HSS(P) 2/84 outlines decisions on the improvement of general management in the Health and Personal Social Services in the light of the NHS Management Inquiry Report. The post of General Manager is intended to facilitate this process. The essence of the general management function is the bringing together of responsibility for the planning, implementation and control of the Board's performance. The General Manager will carry personal responsibility for this and be personally accountable to the Board for its discharge. It is against this background that this job description should be read.

1. Job Title: General Manager

2. Purpose of Role: To be directly accountable to the Board for:-

(i) securing the strategic direction of the Western Health and Social Services Board;

(ii) ensuring effective co-ordination and integration of the Board's Managers;

(iii) identifying key issues arising from the Board's operations and developing action plans to deal with these key issues.

3. Key Organisational Relationships:

3.1 The General Manager will report to the Board and will be directly and personally accountable to it for the general management function and overall management performance.

3.2 The following staff will be managerially accountable to the General Manager:-

Chief Administrative Officer
Chief Administrative Medical Officer
Chief Administrative Nursing Officer
Director of Social Services
Area Treasurer
Chief Administrative Dental Officer
Chief Administrative Pharmaceutical Officer

3.3 The General Manager will work with the Board membership and in particular will work with the Chairman and Vice-Chairman of the Board.

3.4 The General Manager will liaise with senior staff at the Department of Health and Social Services and other relevant agencies.

3.5 He will liaise with the General Managers of the other three Boards and the Heads of the Training Council and C.S.A.

4. Responsibilities:

4.1 Interpersonal:

The General Manager will liaise with the Chairman and when requested will act as spokesman for the Board on matters of Board strategy and policy.

He will have a responsibility for the motivation and development of those staff accountable to him.

He will establish a system of performance review for those staff directly accountable to him. He will review individually and at least annually the performance of those staff, providing guidance on personal development requirements and advise or initiate, where appropriate, further training.

He will establish performance criteria for Managers in carrying out their managerial responsibilities.

He will participate in the selection and appointment of staff in accordance with the agreed procedure.

He will assist the Board in the establishment of effective relationships between the Board and other groups and individuals with relevant concern in care.

He will define clearly the co-ordinating role of the Group Administrators at Unit Level and ensure that this co-ordination function is effectively performed.

4.2 Information:

The General Manager will be responsible for the generation and provision of advice and information to the Board so that it can formulate policies, decide priorities, set objectives, allocate resources and monitor progress.

He will provide professional advice of a managerial nature to Chief Officers accountable to him.

He will be expected to give attention to ascertaining the needs and expectations of the consumers in using Health and Personal Social Services.

4.3 Decision Making:

He will be responsible for the leadership of the Area Executive Team and the effective co-ordination and integration of its activities.

As the Board's Accounting Officer, he will secure the allocation and control of resources in accordance with the Board's policies and the promotion of greater efficiency, improved cost-effectiveness and better quality services. In order to effect this task, he will through the Treasurer, establish a programme of audit.

He will be responsible for the implementation and monitoring of the Board's policies and strategic and operational plans.

The General Manager will co-ordinate the views of Chief Officers in formulating the Board's response to matters raised by the Department in the annual Accountability Review and will develop mechanisms for reviewing the performance of Unit Management Groups.

He will have responsibility within the Board's policy for the promotion of improved personnel and management development policies.

He will be responsible for the Board's management structure and the promotion of maximum possible delegation of decision making at all levels.

He will be required to examine the potential of new and innovative ways of achieving the Board's objectives and to encourage well-founded initiatives in the delivery of care and services.

5. Performance Review:

The performance of the General Manager in relation to the foregoing defined activities will be reviewed by the Board on an ongoing basis.

(NOTE: The term 'he' has been used throughout the job description for ease of reference. It should be interpreted to read 'he/she')

DOCUMENT 3

WHSSB Draft Response to the O'Hara enquiry

Draft Response to the O'Hara enquiry

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

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

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 provides an illustration of 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.

At the time of the incident, 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

Doc 3.

SERVICE AGREEMENT FOR ACUTE HOSPITAL SERVICES [POC 1]

PURCHASER	**Western Health and Social Services Board**
PROVIDER	**Sperrin Lakeland Health and Social Care Trust**

JUNE 1999

WESTERN HEALTH AND SOCIAL SERVICES BOARD
SERVICE AGREEMENT WITH
SPERRIN LAKELAND HSC TRUST

Introduction

1 On 15 December 1998 the Health and Social Services Executive issued Circular PC CDD 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.

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 and well-being
- quality
- a local focus
- partnership
- efficiency and openness
- accountability

3 There is a continued emphasis 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.
- adopting a shared approach to the management of financial risk

4 **Strategic Context**

4.1 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.

4.2 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.

4.3 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.

5 Clinical Governance

5.1 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.

5.2 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.

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

6 Year 2000 Compliance

6.1 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.

6.2 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.

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

6.4 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.

7 Partners to the Agreement

7.1 The partners to this agreement are the Western Health and Social Services Board (the purchaser) and the Sperrin Lakeland HSC Trust (the provider).

7.2 The term 'purchaser' will be used to refer to the Western Health and Social Services Board and the term 'provider' will mean the Sperrin Lakeland HSC Trust.

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

8 Scope of the Agreement

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

8.2 This agreement will cover the provision of the following services by the provider to or on behalf of the purchasers 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.

8.3 In addition the agreement will cover the provision of all Accident & Emergency attendances and treatments occurring during the period of the agreement.

8.4 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.

9 Agreement Period

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

9.2 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.

9.3 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.

10 Activity Levels

10.1 The indicative activity levels set out at Schedule 1 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.

10.2 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.

10.3 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.

11 Extra Contractual Referrals (ECRs)

11.1 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).

11.2 Paragraphs 30 and 31 of Circular PC CDD 26/98 refers to the abolition of ECRs in England. It is understood that the Executive is encouraging, where possible, Boards and Trusts to comply with the Great Britian arrangements.

11.3 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).

12 Service Fee

12.1 The purchaser will pay the provider an overall annual service fee of [redacted] The sum relating to acute hospital services has been calculated on the basis of the indicative activity levels and corresponding prices specified in Schedule 1 of this agreement. The service fee does not take account of the impact of General Practitioner Fundholding changes/developments for 1999/2000.

12.2 The sum relating to Acute Hospital Services has been calculated on the basis of the following:

POC No	Programme of Care	Sum Allocated £
1	Acute Services (Calculated on the basis of the indicative activity levels specified in Schedule 1)	[redacted]

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

13 Waiting List Management

13.1 The provider should only admit patients from the waiting list on the basis of clinical priority. 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

13.2 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.

13.3 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.

13.4 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.

14 Monitoring Arrangements

14.1 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.

14.2 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.

14.3 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.

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

15 Quality Enhancement

15.1 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.

15.2 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

15.3 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.

15.4 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.

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

16 Patient Discharge/Transfer Arrangements

16.1 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.

16.2 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.

16.3 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.

17 Unsatisfactory Performance

17.1 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.

17.2 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.

17.3 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.

18 Evaluation

18.1 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:** 2/8/99.....

T J FRAWLEY
GENERAL MANAGER
[WHSSB]

SIGNED: Hugh Mills ..... **DATE:** 22nd July '99...

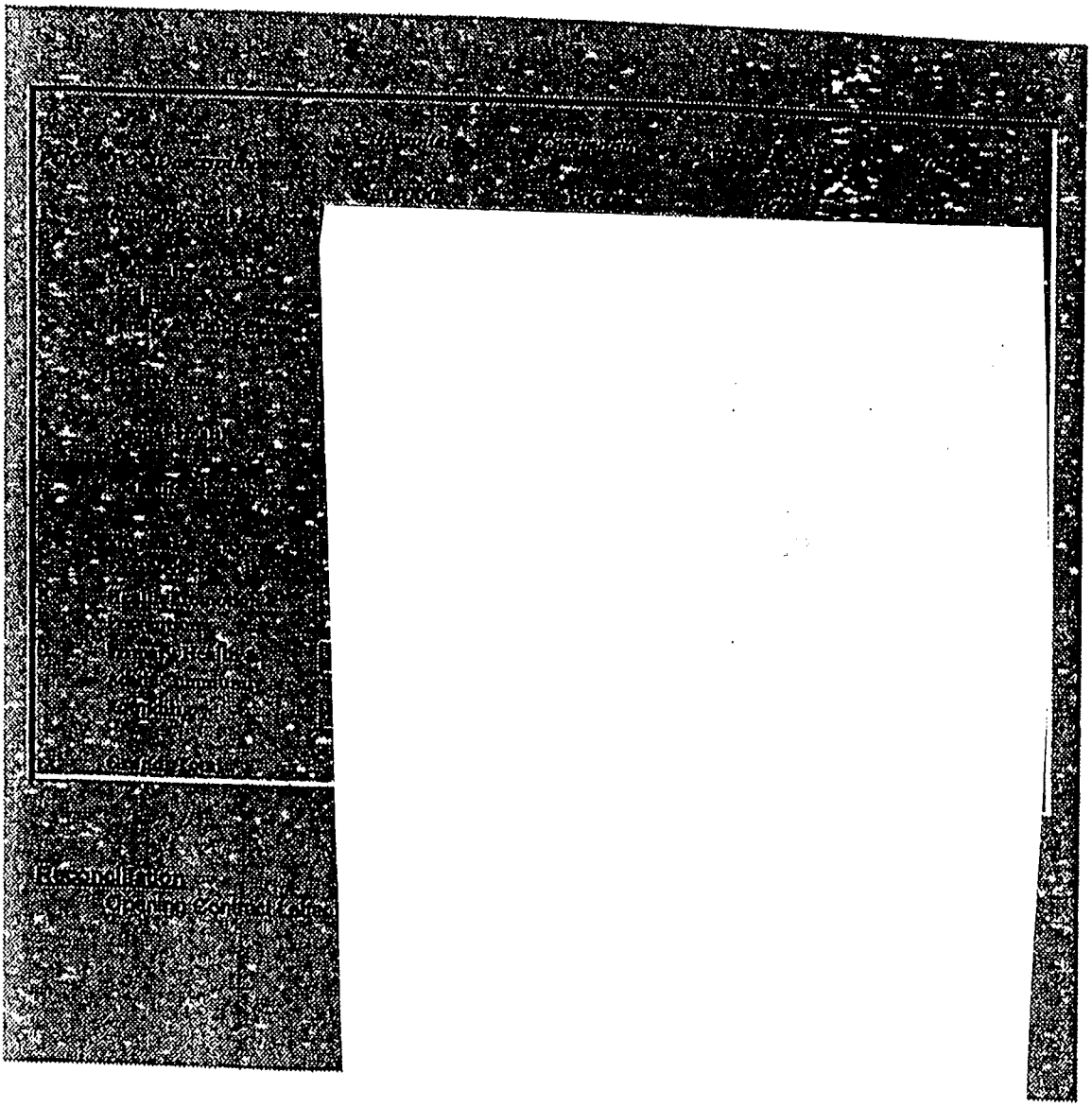
H S MILLS
CHIEF EXECUTIVE
[SPERRIN LAKELAND HSC TRUST]

SUMMARY

Sperrin Lakeland HSS Trust

1999/2000 Western Board Contract

Summary by Programme of Care



Sperrin Lakeland HSS Trust
Hospital Services
1999/2000 Contract before GPFH

	Hospital Specialities		Volumes			Cost			Total Cost			
POC	Main Group Speciality	Sub-Group Sub Speciality	Inpatient	Day Case	Outpatient	Inpatient £	Day Case £	Outpatient £	Inpatient £	Day Case £	Outpatient £	Total £
1	A&E											
1	Chronic Pain											
1	Cardiology	General										
1	Dermatology	Pulse Dye Laser										
1	Dermatology											
1	ENT											
1	General Medicine	DA Endoscopy										
1	General Medicine	NOTE 1										
1	General Surgery	DA Minor Surgery										
1	General Surgery	Breast Lump Clinic										
1	General Surgery											
4	Geriatric Medecine	NOTE 2										
1	Gynaecology	Colposcopy										
1	Gynaecology	General										
1	Haematology	Anti-Coagulant										
1	Haematology											
1	ICU											
1	Neurology											
2	Obstetrics	General										
1	Opthalmology											
1	Oral Surgery											
1	Orthodontics											
1	Paediatric Medicine											
1	Pain Management											
1	Renal											
1	Rehabilitation											
1	Rheumatology											
1	Trauma & Othopaedics	General										
1	Trauma & Othopaedics	Orthopaedics										
1	Sick Babies,NNICU	Col Days										
	Final Price Adjustments											

Sperrin Lakeland HSS Trust
Hospital Services
1999/2000 Contract before GPFH

Programme Of Care Analysis

Volumes		
Inpat.	Day Cases	Outpat.

Total Cost			
Inpatient Cost £	Day Case Cost £	Outpatient Cost £	Totals £

1 Acute
2 Maternity & Child Health
3 Family & Child Care
4 Elderly care
5 Mental Health
6 Mental Handicap
7 Physical & Sensory Disability
8 Health Promotion
9 Primary Health & Adult

Sperrin Lakeland HSS Trust
Hospital Service-Inpatient Elective Emergency Split
1999/2000 Contract after GPFH

	Hospital Specialities		Inpatients Elective/Emergency Split						
POC	Main Group Speciality	Sub-Group Sub Speciality	Elective	Emerg.	Total	Emerg. %	Cost £	Total Cost Elective £	Emerg. £	Total £
1	A&E									
1	Chronic Pain									
1	Cardiology									
1	Dermatology	General								
1	Dermatology	Pulse Dye Laser								
1	ENT									
1	General Medicine	General								
1	General Medicine	DA Endoscopy								
1	General Surgery	General								
1	General Surgery	DA Minor Surgery								
1	General Surgery	Breast Lump Clinic								
4	Geriatric Medecine									
1	Gynaecology	General								
1	Gynaecology	Colposcopy								
1	Haematology	General								
1	Haematology	Anti-Coagulant								
1	ICU									
1	Neurology									
2	Obstetrics									
1	Opthalmology	General								
1	Oral Surgery									
1	Orthodontics									
1	Paediatric Medicine									
1	Radiotherapy									
1	Renal									
1	Rehabilitation									
1	Rheumatology									
1	Trauma & Othopaedics	General								
1	Trauma & Othopaedics	Orthopaedics								
1	Sick Babies,NNICU	Cot Days								

APPENDIX I

WESTERN HEALTH AND SOCIAL SERVICES BOARD

FINANCIAL AND INFORMATION REQUIREMENTS

WHSSB/Sperrin Lakeland HSC 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 1999/2000 are included in the agreement at [redacted]

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 1 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 [redacted] cost improvement target imposed by Government.

2.2 There will be no variation to the service fee where inpatient/day case outturn activity levels, after allowing for differences across specialties, represent no more than [redacted] of the service fee.

2.3 Where outturn activity levels account for more than [redacted] of the service fee then any increase/decrease to the service fee payable will be calculated using an average marginal rate of [redacted] This agreed average marginal rate (%) will be applied to any sum in excess of [redacted] of the original service fee. An example of how any such variation will be calculated is shown in the Appendix to this agreement.

2.4 Regular monitoring reports will be required from the provider so that variations in excess of [redacted] 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 10.2 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 1999/2000 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 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 1984 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).

DOCUMENT 5

Meetings with Mr T. Frawley AGM.

3/5/00 Untoward death re 18 month old child
14/6/00 Consultant Paediatrician - progress with review
Updated re examin. on untoward death
Provided advice on info emerging from S.G.'s Dr Ashgar / Dr Duffy.

[redacted]

LC-SLT 036b-002-002

[redacted]

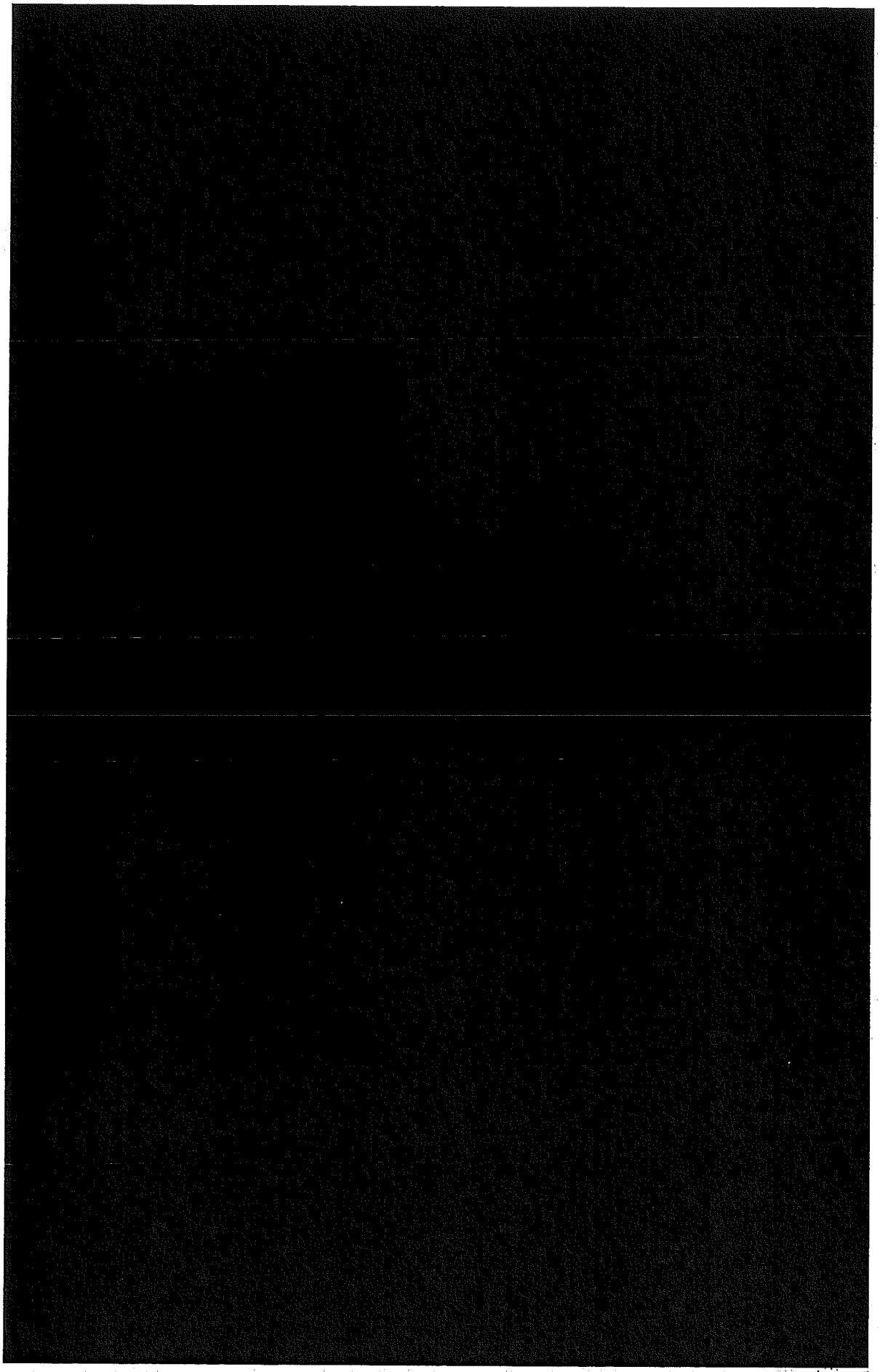
MEETING WITH MR MILLS

WEDNESDAY 3 MAY AT 10.00 AM 2000

AGENDA

[redacted]

LC-SLT 036b-059-096



036b-059-097

LC-SLT

[redacted]

11	Any Other Business	[redacted] – Untoward death. re 18 month old child.

[redacted]

LC-SLT 036b-059-098

[redacted]

MEETING WITH MR MILLS

WEDNESDAY 3 ~~MAY~~ 14 June AT ~~10.00~~ 2.30 AM

AGENDA

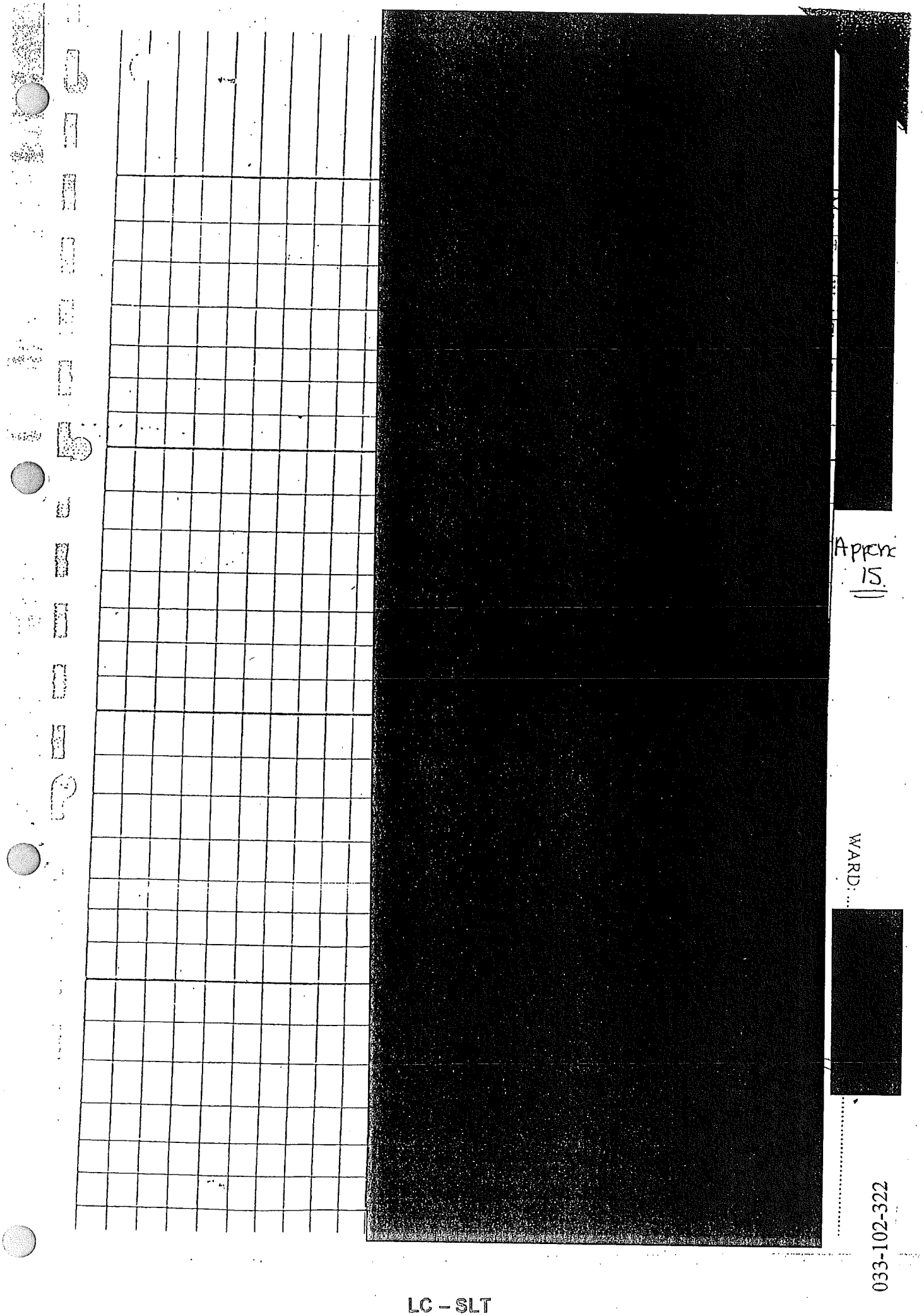
[redacted]

LC-SLT 036b-058-094

[redacted]

7	Consultant Paediatrician – progress with review Updated re examin. on untoward death.	Provided advice on info emerging from S.G.'s Dr Asbyn/Duffy	

[redacted]



LC – SLT

[redacted]

MONTH: March - April 2000

033-102-323

LC – SLT

MONTH ..... March / April 2000

033-102-324

LC – SLT

DOCUMENT 6

CONFIDENTIAL

Lucy Crawford - 18 month old child admitted to Erne Hospital with suspected Gastro-enteritis

Friday 14 April 9.00 am

Dr Kelly advised me of an adverse incident regarding the illness of Lucy Crawford. He advised that there could be a situation where the wrong drug or incorrect dose/level of fluids may have been prescribed, although blood tests were not confirming this. Child had been transferred to Royal Belfast Hospital for Sick Children however, was reported as 'brain dead'. Dr O'Donoughoe had been asked to obtain a copy of the patient's notes. I agreed I would advise Dr McConnell.

Advised Ms O'Rawe through Janet Hall given adverse incident and potential for press interest. Provided information to Dr McConnell, who stated he would advise Martin Bradley.

Monday 17 April

Janet Hall advised me of Press interest. We felt if response could confirm cause of death did not relate to an infectious disease this may be useful information for the public. Mr Fee recommended as cause of death was still unknown it would be unwise to make this statement. General statement provided. Chairman briefed about issue.

Tuesday 18 April

Mr Fee provided an update of discussions with nursing and medical staff. They were generally upset given suddenness of death and another recent death of chronically ill child. He was meeting Dr Anderson to examine the case notes on Wednesday pm. He could not be definitive about circumstances from the information collated so far.

Wednesday 19 April

Met with Martin Bradley and advised him of the issues. Dr McConnell also advised circumstances were still being examined.

Thursday 20 April

Mr Fee advised that the patient's notes recorded a comment from Dr O'Donoughoe that he was uncertain about the instructions he gave staff about the rate of flow of I.V. fluids. Child had been given 100 mls per hour for 4 hours. He states he meant this to be 100 mls per hour for the first hour and 30 mls per hour thereafter. However, when child collapsed anaesthetic support had prescribed more fluids. Post mortem results indicated cerebral oedema. Mr Fee felt he required advice from a Paediatrician. I agreed I would arrange this. I enquired if Dr Anderson and Mr Fee had considered if

Dr O'Donoughoe should continue to see and treat patients. He confirmed it was their opinion he should continue. Mr Fee advised that written reports had now been requested from six members of staff. We discussed how best we should communicate with the family to advise that the circumstances were still being examined. We agreed it would be preferable if the family's Health Visitor could call with the parents rather than send a letter. Mr Fee agreed to contact manager to identify relevant health visitor.

I spoke with Dr Murray Quinn, Altnagelvin Hospital, who agreed he would look at the notes and provide his advice.

Friday 21 April

Requested Mr Fee to contact Dr Quinn to advise him of main issues we need to examine and forward case notes to him. I requested Mr Fee to ensure that Dr O'Donoughoe is advised he is aware of involvement of Dr Quinn. Mr Fee advised that the Health Visitor had been identified and he would make contact with her to speak with the family.

Rang Dr McConnell, left message to advise I had requested Murray Quinn to provide the Trust with advice on the case.

Thursday 27th April

Mr Fee confirmed he had spoken with Dr Quinn. He also advised he had identified and spoken with the Health Visitor. Although she was on leave this week (Easter week) she stated she would call and speak with the family.

Wednesday 3rd May

Provided briefing to Mr Frawley on issues.

Thursday 4th May

Discussed case with Dr Kelly. Requested that when reports were available that he should convene a discussion involving Dr Quinn, Mr Anderson, Mr Fee and himself to decide the way forward. Dr Kelly advised he was asking for report on tests carried out in connection with post mortem.

Friday 5th May

Mr Fee advised that parents had met with Dr O'Donoughoe.

Thursday 11th May

Mr Fee still awaiting one report from a member of staff. Dr Quinn had provided verbal advice that fluids may not have been excessive. Confirmed with Mr Fee my request to Dr Kelly.

DOCUMENT 7

Carmel Ming

From: Mooney Carol
Sent: 08 May 2000 11:04
To: Bradley Martin (ABHQ); McConnell Bill
Cc: Barber Barbara; Ming Carmel
Subject: UNTOWARD INFANT DEATH

I am aware from brief conversations that you have received some background on the above from Hugh Mills. I think it is important that we get some definitive advice and I would be grateful if you could keep me apprised. Many thanks.

TJF

Executive Summary

The origins of this Report lie in the Joint Board Workshop held on 8 October 1999, when it was agreed that the Boards would commission and co-operate on four Projects designed to address aspects of HPSS organisational arrangements.

A Group was set up to produce a Report on Accountability and Governance under the Chairmanship of Sean McKeever (SHSSB) with Michael Gormley (WHSSB) as Project Manager. The other Group members were Stanton Adair (EHSSB), Jim McCall (EHSSB), Courtney Crutcheley (NHSSB), John Watson (NHSSB) and Seamus Wade (WHSSB).

The Group was tasked with the following:

1. ***To produce a position paper setting out the current position with regard to Accountability and Governance in the HPSS and identifying gaps, with a plan to address them.***

2. ***To take a wide spectrum approach which provides a generic model not tied to any specific future organisational scenario.***

The resulting Report is in five main Sections. **Section 1** describes the key elements of an effective Accountability and Governance Framework and identifies a number of Principles which the Group feels should underpin such a Framework.

Section 2 sets out the elements of Public Accountability in terms of Corporate Governance arrangements and the Financial Control environment. The Section

draws together the systems and arrangements which must be reflected in all parts of the HPSS if public confidence is to be secured.

Section 3 examines Clinical and Professional Governance under the three headings of Clinical Governance, Professional Governance in Social Care and Governance in Primary Care. It should be emphasised that this Section contains significant challenges which must be addressed by the HPSS if effective Accountability and Governance is to be secured in all parts of the service.

Section 4 outlines elements of the Framework of Internal Management Accountability and this Section is still in development at the time of writing (30 June 2000).

Section 5 highlights the Issues which the Group feel require initial consideration by the four Board Chief Executives. The feedback will then be used by the Group to focus and strengthen the final Report which we propose to complete following the Workshop planned for 14 September 2000.

The Appendix outlines a Template of Accountability and Governance arrangements for the HPSS and it is our hope that this can be developed to provide a practical "Checklist" for use across the service, subject to ongoing updating in the light of changing circumstances both in organisational arrangements and in the general climate of Accountability and Governance.

Section 1: ACCOUNTABILITY AND GOVERNANCE; DEFINITIONS AND PRINCIPLES

1.1 Introduction

Those who work in the HPSS manage and prioritise the application of resources within Government policy on behalf of the public which funds the service and which expects the highest standards of quality and probity. This imposes an obligation on the service to secure and demonstrate the highest possible levels of conduct and performance through a system of Accountability and Governance.

The HPSS is committed to adhering to the principles of public life put forward in the Nolan Report:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

The aim of this Report is to support the development of a set of arrangements and mechanisms designed to ensure public confidence in the health and personal social services through effective Accountability and Governance. The Report

builds on the systems already in place and identifies gaps and challenges which must be addressed, whatever the organisational arrangements in place within the HPSS.

The Framework of Accountability and Governance must apply across all aspects of the HPSS. It should also be stressed that arrangements for Accountability and Governance must be underpinned by continuous Risk Assessment and performance review and that Accountability and Governance is not a static process.

An effective Accountability and Governance Framework for the HPSS must provide public, clinical and professional, managerial and financial accountability within a highly complex system which plans and commissions services and delivers them in a wide-range of settings in line with Government policy through professions who often operate in context where traditional models of hierarchy and accountability have not applied. It must also address variations in performance across the HPSS system.

The Permanent Secretary of the Department of Health, Social Services and Public Safety is the Accounting Officer and as such is accountable for performance and expenditure in the Health and Social Services, including Primary Care within a policy framework determined by Government. The Permanent Secretary is at the pinnacle of a system of Accountability and Governance which must ensure that all those within the service can discharge their responsibilities in accordance with a clear set of Principles and practical arrangements which underpin and describe responsibilities for Accountability and Governance in all parts of the HPSS.

The Permanent Secretary delegates responsibility to Accountable Officers i.e. Board and Trust Chief Executives.

This Report takes a broad view of Accountability and Governance. It includes all aspects of internal control (i.e. the system of controls which has been established to provide assurance, including Standing Orders and other financial and non-financial control arrangements), clinical and professional governance and arrangements for securing probity and openness. It also recognises that new legislation on Equality and Human Rights must be enshrined within Accountability and Governance arrangements.

1.2. Types of Accountability and Governance

In order to provide a Framework for considering Accountability and Governance, the Report identifies three broad types of Accountability and Governance. These are:-

- **Public Accountability** which refers to the responsibility of the HPSS to inform, consult and involve patients and clients and to operate in ways which are open and transparent. It also includes mechanisms such as complaints procedures, codes of openness and the production of corporate reports which provide information and redress to the public. There are two elements to Public Accountability:

  - Corporate Governance which describes arrangements to secure "the management of the management"

  - The Financial Control Environment which is about ensuring that appropriate mechanisms are in place to secure control over the application of Public Funds.

- **Clinical and Professional Governance and Accountability** is about ensuring that services are planned and provided to clear standards. There is a responsibility on all professionals to engage in audit and to review performance against these standards. There is also a requirement in each part of the HPSS to ensure that continuous Risk Management is in place so that issues can be identified and addressed. This report deals with three major areas encompassed within Clinical and Professional Governance:

- Clinical Governance
- Professional Governance in Social Care
- Governance in Primary Care

- **Internal Management Accountability** requires arrangements for demonstrating progress towards targets, priorities and standards agreed at national and local levels and for demonstrating effective management arrangements in accordance with VFM principles. Management Accountability also refers to the need to ensure that Statutory Duties are met.

1.3. Principles of Accountability and Governance

A number of key principles have been identified as essential in securing effective Accountability and Governance. These are:-

Responsibility. All those working within the HPSS are required to play their full part in delivering the priority aims and objectives identified in strategies and management plans relating to health and social care and to meet the requirements of their registration authorities.

Partnership. In working within the Accountability and Governance Framework, the different parts of the integrated health and personal social services organisation must understand and accept each others roles and responsibilities. They need to work together in partnership within a clear accountability framework to ensure that patients and clients obtain high quality,

cost-effective services when they are needed. It will, for example, be important to involve all partners, including primary care services, in the development and implementation of local strategies for health and social services within an agreed Regional Strategy for the HPSS.

Openness. It is important to ensure that the public is consulted and that decisions are taken publicly and transparently and that as much information as possible is available to the public about how decisions are taken and resources allocated. The public also has a right to expect that the resources used within the health and social services are soundly managed. Health and Social Services Councils have an important role to play in representing patients and clients and arrangements for openness must secure their confidence and support.

Clarity. Accountability and Governance arrangements must be clear and must show how different professions and parts of the service are responsible for discharging Accountability responsibilities.

Simplicity. The Accountability and Governance Framework should be designed and operated in such a way as to not impose unreasonable administrative and bureaucratic burdens on those working within the service. It should also be understandable to service users and this is a particularly difficult challenge in such a complex organisation as the HPSS.

Consistency. The framework must be capable of application across all parts of the HPSS and be robust enough to meet the needs of new organisations and of new requirements for accountability and governance which may emerge as a result of policy or organisational change within the service.

Section 2: PUBLIC ACCOUNTABILITY IN PRACTICE

2.1. Introduction

If any HPSS organisation is to demonstrate that it satisfies its obligation to be fully accountable to the public, there are two fundamental aspects which must be addressed. These are General Governance arrangements and the Financial Control environment and these are discussed in more detail in this section.

2.2. Corporate Governance Arrangements

Over recent years there has been considerable discussion about the need for clear corporate governance arrangements within health and social care organisations. This has been prompted by an increasing public perception that there is insufficient control over some senior managers and professionals who appear to have been able to act without restraint and where, in exceptional cases, inadequately designed systems have failed to prevent fraudulent or inefficient behaviour and indeed, may have contributed to variations in clinical or professional standards.

Corporate Governance is about "the management of the management" and has been defined in the "Report of the Committee on the Financial Aspects of Corporate Governance" (the Cadbury Report, December 1992) as:

"The system by which organisations are directed and controlled".

Corporate Governance is therefore concerned with the structures and processes for decision making and accountability, controls and behaviour at all levels of organisations.

Irrespective of what new structure may be introduced to the HPSS in Northern Ireland, it is reasonable to assume that the resulting organisations will each have a "board" which will have responsibility for:-

- Giving leadership and strategic direction;
- Defining control mechanisms to safeguard public resources;
- Supervising the overall management of the body's activities; and
- Reporting on stewardship and performance.

Each "board" when designing its Corporate Governance arangements to encompass the key principles of openness, integrity and accountability, will wish to give consideration inter-alia to the following aspects:-

Role Definition and Accountability Arrangements

It is essential for an organisation to define the respective roles and accountability of its "members and officers" and to ensure that this is fully understood by all parties concerned. This helps to facilitate the efficient discharge of the organisation's business and also guides the preparation of submissions, so as to ensure that the "board" meetings deal only with appropriate business and in a level of detail consistent with members requirements.

Standing Orders

The Standing Orders should describe not only how meetings of the organisation are to be conducted but also the admission of deputations, representatives of other organisations and members of the public; the facilities provided for the media; the arrangements for the establishment of committees and sub-committees and the approval/accountability mechanisms for all corporate governance arrangements.

They should also describe how the organisation will meet its commitments in respect of transparency and openness. For example, the presumption is that all "board" meetings are held in public.

Committee Structure

To function efficiently and effectively, a "board" must consider how its business will be conducted and may determine to establish committees or sub-committees to deal with particular areas of interest outside of main board meetings. Examples of typical committees are general purposes, audit and remuneration and it will be essential for the board to determine for each the remit, membership and reporting arrangements as well as, if appropriate, the extent of any delegated authority in line with the relevant legislative framework.

Schemes of Delegation

Essential to the efficient operation of any organisation is the establishment of clear lines/levels of delegation. In developing a scheme of delegation the organisation will wish to ensure that the levels and nature of its delegation to its

committees and senior managers are clear, as are the associated reporting arrangements on the exercise of such delegation. The scheme of delegation should specify the extent to which officers can commit the organisation to expenditure or liability in relation to ordering, making payment, contracting and decision making.

The ability of the organisation to delegate will significantly be determined by the legislation under which it has been established.

Submissions

The nature and clarity of the reports, papers and minutes of an organisation provide an important measure of its openness as well as its comprehensiveness and responsiveness. Clear precise submissions facilitate both the members of the board in arriving at decisions and the media and public in the understanding of the issues involved and the reasons underpinning particular decisions. To facilitate this, clear guidance should be established for all staff in the preparation of such submissions and in securing ownership at senior officer level prior to board consideration.

Communications and Public Involvement Strategy

The establishment of a comprehensive strategy for dealing with the media and communicating significant decisions to the public is essential in the pursuit of openness and enlisting public co-operation. This strategy should be pro-active and designed to assist both members and officers, as and when appropriate.

The Modernisation agenda within the service, the TSN/Social Inclusion imperative and the Equality legislation re-inforce the need for effective public involvement in decision-making and HPSS organisations must reflect this in their arrangements for Public Accountability.

Complaints Procedures

HPSS organisations, including FPS representatives support the agreed HPSS Complaints Procedure and this has an important role to play, both in providing responses and redress in respect of complaints and as a rich source of information about service quality and standards.

Code of Practice on Openness in the HPSS

All HPSS organisations have a duty to provide information to the public in a form which is accessible. This information includes details of services, costs, proposals and plans which affect services and information on how to access personal health and social services records.

Conduct

Any HPSS organisation requires high standards of business conduct from both its members and officers and it is essential that these requirements are set down in detail and their application monitored. It is imperative to be able to demonstrate that decisions are taken objectively and free from members' social or private business relationships. This can be partly achieved by establishing a Register of Interests where senior officers should record details of all private, voluntary or business interests which are material and relevant to the business of

the HPSS body. Where a conflict of interest arises, the officer should declare the interest and withdraw and play no further part in the relevant discussions or decisions. Particular attention should be given to aspects such as the receipt of gifts and hospitality where actions, while innocent in nature or intent, could be open to misinterpretation and could easily bring the organisation into disrepute.

Public Interest Disclosure (Whistleblowing)

There should be a culture and environment throughout the HPSS which encourages staff to feel able to raise concerns about health and social care matters without fear of victimisation and HPSS organisations should have in place local policies and procedures which comply with the 1998 Public Interest Disclosure Order.

Performance Review

Fundamental to the organisation will be the establishment of comprehensive monitoring arrangements for ensuring that it is meeting its central role and responsibilities across the range of services which it provides. This will involve the detailed specification of the information it wishes to receive and the associated frequency; regular visitation by members across all aspects of service delivery; meetings with representatives of both users of its services and the general public; the monitoring of complaints and the regular review of the performance of its staff.

The magnitude and range of services provided by an HPSS organisation creates particular challenges for the development of a comprehensive monitoring system and can result in disproportionate concentration being given to new

elements of service delivery which may account for only a very small percentage of total expenditure.

Challenges

There is still a considerable challenge to ensure that the arrangements and requirements described within this section are applied throughout the HPSS "family", in particular with regard to the pivotal and developing role of independent contractors and other clinical and professional staff. Future accountability and governance arrangements must apply to these groupings.

2. 3. The Financial Control Environment

The HPSS is entrusted with responsibility for assessing the health and social care needs of its population and for committing public monies to meet these needs.

Health and Social Services managers must ensure that appropriate measures are in place to allow them to discharge their stewardship function effectively.

These measures will include the formulation of a set of standards and rules, which the service can expect all health and social care employees to abide by.

Central to successful discharge of the stewardship role is a strong financial control environment. This encompasses standards, procedures and protocols, management style, culture and values and provides the backdrop against which

the control measures will operate. The building blocks of a strong control environment are as follows:

Standing Financial Instructions

Standing Financial Instructions are issued for the regulation of the HPSS body, its directors, officers and agents in relation to all financial matters. They should cover the complete range of the organisations activities and should include arrangements for contracting, purchasing, collection of income, making payments, security of assets and audit. Through Standing Financial Instructions, the Board will be enabled to exercise financial supervision and control.

Budgetary Arrangements

HPSS bodies must operate within a finite level of resources. To maintain strong financial control, it is fundamental to have a robust budgetary control system with clear reporting and responsibility lines. The system should ensure that budgets are established for all significant areas of income and expenditure which will allow the organisation to meet its statutory financial targets.

The organisation's budgetary process should ensure that out turn is regularly measured against budget, variances discussed with budget holders on a timely basis, and remedial action taken.

Annual Accounts and Reporting

Key contributors to the financial control environment are the production of annual accounts and the adoption of a professional approach to financial reporting in accordance with generally accepted accounted principles and practice. The financial performance of the organisation should be reported regularly to the Board to facilitate proper decision making.

Asset Management

HPSS bodies should instigate systems of control to provide adequate physical security over their assets and limit exposure to loss whether unintentional, by misappropriation or by theft. All assets of significant value belonging to the body should be recorded in an asset register and appropriate mechanisms established to ensure additions, disposals and movements are properly captured. The organisaiton should seek to promote a culture where responsibility for safeguarding assets is assumed by all staff.

Financial Procedures Manuals

Clear, concise, well documented financial procedure manuals assist in securing strong internal control by serving as a point of reference for staff in carrying out their day to day duties.

Availability of documented procedure manuals should lessen the impact of staff turnover and lead to consistency in approach over time and provide assurance that the organisation is complying with applicable laws, regulations and Department of Health, Social Services and Public Safety directives.

Anti-Fraud Measures

Fraud is a generic term for a range of offences normally involving either theft, obtaining property or services by deception, or false accounting. HPSS bodies exist in a climate of scarce and competing resources and management has a responsibility to ensure funds are spent as intended. It is important that adequate arrangements are in place to prevent fraud from occurring or to detect it on a timely basis. Proper segregation of duties and supervision of activities help prevent fraud but will not eradicate it completely. It is essential that HPSS bodies cultivate an environment where fraudulent activity is understood to be unacceptable and all suspected incidents are fully investigated.

HPSS organisations should have a clear policy on how fraud is dealt with when suspected or detected. A fraud response plan should be established which specifies the officers charged with the responsibility for investigation and the procedures to be followed. Any incident involving criminality should be reported to the Police.

Audit Arrangements

To maintain public confidence in the Service, Health and Social Care organisations must be able to demonstrate publicly that they have taken adequate steps to minimise financial risk, safeguard public resources and apply funds for the intended purposes. This can be achieved by instigating systems of regular independent monitoring and verification. These systems should include review by internal and external auditors who should have unrestricted access to all of the organisation's books, records, assets, premises and staff as considered necessary. Both sets of auditors should have undergone appropriate

professional training. They should have clearly defined terms of reference and should report their findings to the Board through the Audit Committee. Internal Audit should have sufficient standing within the organisation to ensure its recommendations are acted upon.

In exceptional cases the auditors should have the right to bypass these procedures and inform the relevant Board Chairperson.

Remuneration of Senior Officers

To ensure high calibre staff can be recruited, retained and motivated the organisation must have appropriate remuneration arrangements for senior officers. However, the organisation is a public body and the remuneration of its employees must also be publicly defensible. To ensure public confidence and equity for staff, the pay and conditions for all staff should be centrally determined.

Challenges

As with Corporate Governance arrangements there are particular challenges associated with the provision of a strong financial control environment where service providers and commissioners are not direct employees of the organisation. These should also be addressed in the same manner as for directly employed staff as detailed above.

Section 3: CLINICAL AND PROFESSIONAL GOVERNANCE IN PRACTICE

3.1. Introduction

Clinical and Professional Governance provides a framework within which Health and Social Care Organisations and individuals are accountable for continuously monitoring and improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical and professional care will flourish within clear and explicit standards.

Governance is the means by which HPSS organisations ensure the provision of quality clinical and professional care by making individuals accountable for setting, maintaining and monitoring performance standards. This Report addresses the three main components of Clinical and Professional Governance, namely:

- Clinical Governance
- Professional Governance in Social Care
- Governance in Primary Care

For Clinical and Professional Governance to be effective there must be an open and participative culture in which continuous professional developement, education, research and the sharing of good practice are valued and expected.

There should be a fundamental commitment to quality at all levels of the service such that quality infuses all aspects of Health and Social Care provision.

The basic objective of Clinical and Professional Governance is to secure a safe and effective service in accordance with clear and explicit standards and to ensure that where deficiencies are identified appropriate action is taken to address them in a transparent way.

Under Governance arrangements HPSS organisations must ensure and demonstrate that:

- Quality improvement processes (eg clinical and professional audit) are in place
- Leadership skills are developed across all professions
- Evidence-based practice is in day-to-day use
- Good practice, ideas and innovations are disseminated
- Clinical risk reduction programmes are in place
- Adverse events are detected/investigated/corrected
- Lessons for clinical and professional practice are learned from patient/client complaints

- Early recognition and action related to problems of poor clinical performance

- High quality of data is collected and made available to monitor care

Key elements of the framework must include:

- **A comprehensive programme of quality improvement activity in which internal scrutiny is supplemented by open and external review.** This must include full participation by all relevant clinical staff in audit programmes, the routine use of evidence-based practice, appropriate safeguards to govern access to and use of patient and client information and high quality clinical record and information systems

- **Clear policies aimed at managing risk, including procedures that support professional staff in identifying and tackling poor performance.** This must include controls assurance arrangements which promote self-assessment and peer assessment to identify and manage risk and the systematic and ongoing assessment of clinical risk.

- **Clear lines of responsibility and accountability for the overall quality of clinical care.** This includes arrangements which ensure that the relevant Accountable Officer carries ultimate responsibility for assuring the quality of services and care and a robust and rigorous reporting system on clincal care standards. This must include the authority to take the necessary action to ensure that the quality of services and care is maintained ti the required standards.

- **Procedures for all professional groups to identify and remedy poor performance.** This will include critical incident reporting procedures, complaints procedures, professional performance procedures which help staff to improve their performance and support for staff in raising concerns.

3.2. Clinical Governance

Clinical Governance has a vital role to play in ensuring public confidence in the HPSS and is a key part of the overall Governance framework..

The Clinical Governance framework for the HPSS must address the following challenges:

-To strengthen and modernise professional self-regulation, building on the principles of performance review discussed in Section 2 of this Report

- To strengthen existing systems for quality control, based on clinical standards, evidence based practice and learning the lessons of poor performance.

- To identify and minimise risk

- To investigate problems as they arise and ensure lessons are learnt

- To support professionals in delivering quality care

- older people and their carers;
- people with physical disabilities or learning disabilities;
- people with mental health problems;
- people with drug or alcohol abuse problems;
- families, particularly where children are in need, including children with a disability ;
- children who are "looked after" (in public care);
- carers.

1.2 Health & Social Services (HSS) Boards and Trusts have to balance the needs and demands of the communities they serve, and the resources available when planning or commissioning social services. The priority must always be the protection of vulnerable people. Eligibility criteria are used to identify who can access help and in what circumstances, and to ensure that everyone in a locality is treated fairly. These criteria must also embrace the issue of charging where there is the requirement to pay for services.

2 Community Care Services for Adults

Principles and Objectives

2.1 Social care is predominantly provided by family, friends and neighbours. It is important that where people require support to live at home or in independent living settings that social care provision is available to enable them to do so.

2.2 In recognition of this the following principles and objectives are identified:-

(i) services should be provided to people in a way that supports their independence and respects their dignity. People should be able to receive the care they need without their lives having to be taken over by the social care services;

(ii) social care services should meet individual needs, bringing together as appropriate social services, health, housing and education. People should have a say in what services they receive and how they are delivered;

(iii) social care services are organised, accessed, provided and financed in an open and consistent way in every part of the province;

(iv) social care services should safeguard people against abuse, neglect or poor treatment whilst receiving care. Where abuse does take place, the system should take firm action to put a stop to it;

(v) people who receive social care services should have an assurance that the staff they deal with are sufficiently trained and skilled for the work they are doing. Staff themselves should feel included within a framework which recognises their commitment, assures high quality training standards and oversees standards of practice.

2.3 The DHSS&PS Regional Strategy 1997-2002 requires HSS Boards and Trusts to assess the needs of the population and identify:

- the prevalence of the particular conditions or social circumstances, including variations associated with factors such as socio-economic status, social grouping, lifestyle, personal mobility, location, age, sex and community background;

- the efficiency and cost effectiveness of services in general;

- the availability of resourcing;

- the views of users and potential users of services, their carers and representatives and service providers;

- outcome measures and targets for improvements in the population's social well-being and for reductions in any variations.

3 Services for children and their families

The Children (NI) Order 1995 is based on a clear and consistent set of principles designed to promote the welfare of children. These are as follows:-

- the welfare of the child is the paramount consideration in court proceedings;

- wherever possible, children should be brought up and cared for within their own families;

- children should be safe and be protected by effective intervention if they are in danger, but such intervention should be open to challenge;

- when dealing with children, courts should ensure that delay is avoided, and may only make an order if to do so is better than making no order at all;

- children should be kept informed about what happens to them, and should participate when decisions are made about their future;

- parents continue to have parental responsibility even when their children are no longer living with them. They should be kept informed about their children and participate when decisions are made about their children's future;

- parents with children in need should be helped to bring up their children themselves and such help should be provided in partnership with parents;

- services provided to children and their families should draw on effective partnerships between Health & Social Services Boards and Trusts and other agencies.

4 The role of Board members

4.1 Board members, executive and non-executive, have a crucial role. They must ensure that the interests of the children come first. As Board members they set the strategic direction of services and determine policy and priorities for local communities within the overall objectives set by Government.

4.2 Trust Board members need to make sure they receive the right information so that they can ask questions about the services and resources for children in their community. They need to know:

- how the overall needs of children in their community, and the likely demand for services, have been estimated;

- what services are being provided and how much is being spent on them;

- how to judge the quality and effectiveness of services and whether they achieve good outcomes for children.

Role and responsibilities of corporate parents

4.3 Members of Boards and Trusts have particular responsibility for children in the Trusts care, i.e "looked after children" in terms of the legislation. Boards have delegated the discharge of these functions to HSS Trusts. Boards nevertheless remain enjoined in this responsibility through commissioning activities.

The key points are that ;

- children who for whatever reason need to be looked after in public care should have the same opportunities to make a success of their lives as any child, including a decent education;

- children in the public care must be the primary focus for the resources and accountability of the Trust which has accepted parenting responsibility for them;

- children who have spent a significant time being "looked after" by
- the Trust should afterwards be given the kind of support that responsible
- parents would give to their own children;

- children in public care and other children in need, including disabled children, should be provided with necessary support services, in partnership with health and education services.

5 Other agencies

5.0 Other agencies with statutory powers and responsibilities in respect of the care of children include:

5.1 The Northern Ireland Guardian ad Litem Agency (NIGALA), an independent agency established under the Children (NI) Order. The role of NIGALA is to safeguard and promote the interests of children by independent social work investigation and advice to the court in specified proceedings under the Children (NI) Order 1995 and the Adoption (NI) Order 1987;

5.2 Two voluntary organisations: the Family Care Society and the Church of Ireland Board of Social Responsibility are registered adoption agencies;

5.3 The National Society for the Prevention of Cruelty to Children (NSPCC), uniquely amongst voluntary bodies has a power to bring care proceedings in its own right under Articles 49 and 50 of the Children (NI) Order.

5.4 The Probation Board for Northern Ireland provides services for young offenders;

5.5 The Royal Ulster Constabulary (RUC) along with Social Services and the NSPCC are primarily responsible for the investigation of child abuse. There is a Joint Protocol which requires the Agencies to work together in a way that primarily addresses the needs of the child concerned and must make the child's welfare the first priority.

5.6 Most of these services make use of specialist skills. Careful planning, management and monitoring arrangements are required to minimise to risk to children who are particularly vulnerable, such as those who are "looked after" and children on Child Protection Registers.

6 Inter-Agency and Organisation Context

6.0 Guidance issued by the Department of Health, Social Services and Public Safety (DHSSPS), the Department of Education Northern Ireland (DENI), and the Northern Ireland Office (NIO), provides a framework within which children's services can be developed on an inter-agency basis

6.1 HSS Boards have responsibility to produce Children Services Plans, which reflect local circumstances, and which engage a wide range of organisations and individuals in the planning process. The planning process is progressed by each Board's Children and Young People's Committee, comprising representatives from health, education, criminal justice, the voluntary sector and social services. It is also expected that relevant people from other disciplines and user representatives will be fully consulted and enabled to contribute to this task. Children's Services Plans form the basis of the commissioning of services by Boards and the

delivery of children's services by Trusts and where appropriate, voluntary and private sector organisations.

6.2 Relationships with other disciplines and agencies

The integrated service designed to promote the health and social welfare of the population of Northern Ireland provides channels for communications and co-operation between different groups of professionals enabling social services to act in partnership with:-

- **health care professionals** including GPs, nurses and professionals allied to medicine who have responsibility for improving the health of their resident population. Primary care is the first port of call for most people when they need either health or social care. Professionals working in co-operation play a major part in providing the right care in the community by assessing the extent of the problem, and recommending what care is needed.

  Care may be provided by primary care professionals or the patient or client may be referred for more specialised diagnosis or assessment and care in the community. In the context of improving care in the community, effective links between primary care professionals and those responsible within HSS Trusts for assessment and care management arrangements are essential.

- **Voluntary Organisations** meet specialised needs in ways that are both different and essential to the health and social welfare of individuals and

communities. Many voluntary groups provide support services which mitigate the need for statutory or other formal interventions.

- **Housing Executive and Housing Associations** have an important role to play particularly in the context of community care. Social services co-operate with housing agencies to ensure housing strategies take into account community care and child care issues.

7.0 Purchasing services from other agencies

7.1 The Government continues to encourage Boards and HSS Trusts to develop their roles as "enablers" to increase the proportion of services purchase from external providers. Social services work closely with independent providers to encourage the development of good quality day care, domiciliary provision and residential accommodation.

8.0 Users and carers

8.1 The importance of gaining users' and carers' perspectives in all aspects of service is of central importance to the achievement of the Government's objective for Health and Social Services in Northern Ireland.

8.2 User involvement through proper representation and consultation at strategic, operational, and individual levels, ensures that services are continually improved, designed to achieve the highest possible quality of care, and optimising user choice and independence.

3.4. Governance in Primary Care

All staff working within the Primary Care environment should be subject to the same clinical and professional accountability requirements as described in this section. Even though the contractual arrangements of independent practitioners providing FPS services are different from other directly employed staff, the same requirements for clear and unambiguous accountability and governance arrangements should apply in this area.

In any organisational arrangements with a strong local focus general practitioners, dentists, community pharmacists, and optometrists (opticians) may expect to be involved both as providers and commissioners of service and accountability and governance arrangements should clearly recognise this duality of function and the potential conflict of interest which may arise.

The accountability arrangements should recognise the independent status of these professions but still be framed in such a way as to facilitate strong Accountability and Governance within a clearly defined contractual relationship in a manner which inspires public confidence. A further requirement is the need for transparency and contestability.

Key issues to be addressed in a framework of Accountability and Governance include:

- To address the ambiguous and nebulous nature of the current contractual arrangements that pertain to independent contractors necessitates the introduction of a formal contractual relationship with a commissioning

organisation in which independent contractors are clearly accountable to that organisation. This relationship should define the roles, responsibilities, standards and accountability requirements for each party. It should also include the provision for either party to formally withdraw from the contract provided that justifiable grounds are given. Terms of Service are fundamental in the area of FPS and the Contracts should make particular reference to the Terms of Service and should clearly detail the specific requirements of the Contract in relation to them.

- The formal Contract between the Independent Contractor and the Commissioner should clearly specify that all staff employed directly by Independent Contractors will be bound by the same Accountability and Governance arrangements as apply throughout the HPSS.

- The current system for dealing with potential disciplinary issues (including fraud and malpractice) is overly complicated. There is a need to introduce a disciplinary system which will structure the process and the penalties and sanctions that can be imposed when cases of fraud or malpractice are suspected and/or proven. These sanctions include areas such as training, penalties and repayments and if necessary, suspension. The sanctions should be clearly defined within the formal Contract and the power to impose them should rest with the Commissioning organisation. The current protocal by which disciplinary action can only be taken within 13 weeks from the date that the incident occurred (except in cases of fraud) inhibits effective Accountability and Governance and should be reviewed as a matter of urgency.

- The introduction of a holistic approach to Accountability and Governance across the HPSS means that the present mainly uni-professional nature of postgraduate education and professional development for FPS will require modification to encompass a team approach

- In order to demonstrate improving standards it will be important to develop and introduce meaningful outcome indicators within the Primary Care setting

- Clinical audit has been shown to lead to improved quality and should be a professional and contractual obligation for all staff

- As in all of the HPSS continuous performance appraisal agreed between practitioners and those who hold their contracts should be a requirement

- The introduction of a formalised contractual relationship could also make a significant contribution in VFM terms by ensuring that there is no duplication of payments (e.g. ante-natal and post-natal care, immunisations etc). It is not sustainable to be paid for work carried out by others (e.g. Trust staff).

The introduction of the above arrangements recognise the value of independence in the provision of FPS services, would have a significant impact in terms of improved Accountability and Governance and would assist Accountable Officers in discharging their duties and demonstrating to the public that the entire HPSS system was transparent and accountable.

SECTION 4: INTERNAL MANAGEMENT ACCOUNTABILITY IN PRACTICE

4.1. Introduction

In accounting for the management of the resources (financial, non-financial and staffing) they use and deploy managers at all levels must work within a publicly transparent system which has clear decision-making processes and in which performance and probity can be secured and monitored. The Management Accountability framework for the HPSS includes:

- Organisational arrangements and management structures which specify how each part of the organisation will conduct its business
- Self Assessment and Risk Management
- Health and Safety
- Human Resources
- Emergency Preparedness
- Continuing Professional Development/Training
- Industrial Relations Policies
- Equality, Human Rights and Related Legislation
- Targeting Social Need
- Data Protection
- Access to information, including personal records

(NOTE: This section still to be further developed)

SECTION 5: ACCOUNTABILITY AND GOVERNANCE; KEY ISSUES

This Report sets out the framework which should be in place to ensure that any HPSS organisation has sufficiently robust Accountability and Governance arrangements in place to meet the requirements of public, clinical and professional, financial and internal managerial accountability.

There are a number of Key Issues identified throughout the Report which will require initial consideration by the four Board Chief Executives in the first instance at the September Workshop and which will then need to be discussed and debated within the wider service.

These are as follows:

1. **Does the Report address the key elements of Accountability and Governance as they relate to the HPSS and are they sufficiently "ideology neutral" as to suit any likely organisational design for the HPSS? (Section 1.2.)**

2. **Are the Principles identified in the Report relevant and complete and are they likely to attract broad support in the HPSS? (Section 1.3.)**

3. **Do the Corporate Governance arrangements provide a robust template for "boards" and their organisations across the HPSS? (Section 2.2.)**

4. **Is there an issue around the role of DHSSPS in its accountability to the HPSS?**

5. **Do the elements in the Financial Control environment provide a robust set of controls to ensure the effective discharge of financial stewardship across the HPSS? (Section2.3.)**

6. **With regard to Corporate Governance and Financial Control does the Report establish the challenges which are associated with those services within the Independent Contractor sector (FPS)? (Sections 2 and 3).**

7. **Is the clarification between 3 types of Clinical and Professional Governance helpful and does the Report capture the key elements necessary for and challenges associated with effective Clinical and Professional Governence? (Section 3).**

8. **Does the revised Section 3.4 capture the key issues in relation to Primary Care?**

9. **Is it acceptable/clear that Accountable Officers are also accountable for clinical governance?**

10. **Has the Report identified the main elements necessary in securing effective Internal Management Accountability for the HPSS? (Section 4).**

11. Has the Report provide a clear picture of the "Deficiencies and Gaps" within the current system of Accountability and Governance and can work now be commissioned which will lead to the development of Proposals aimed at building understanding and at addressing them?

12. Does special consideration need to be given to circumstances where "shared governance" arrangements may operate eg in a HWIMP?

13. Overall, does the approach adopted provide the basis for a holistic HPSS-wide Accountability and Governance framework?

14. Other issues of interest/concern to the Chief Executives?

APPENDIX: ACCOUNTABILITY AND GOVERNANCE TEMPLATE

Has your HPSS organisation addressed the following?

NOTE: The elements outlined below are described in greater detail in the text of this Report.

1. A system of Accountability and Governance which applies to all staff and Independent Contractors and which is underpinned by continuous Risk Assessment and Performance Review.

2. A set of Principles which underpin your system of Accountability and Governance and which are agreed and applied by your senior management and your "board".

3. Clear definitions of Roles and Accountability for all staff.

4. Standing Orders for meetings.

5. An effective Committee structure.

6. Clear lines of delegation described within a Scheme of Delegation.

7. Guidance on Submissions.

8. Strategies for Communications and Public Involvement.

9. A Complaints Procedure which is genuinely accessible and fair.

10. A Code of Practice on Openness.

11. A Register of Interests and other arrangements aimed at securing the highest standards of Conduct.

12. Arrangements for Public interest Disclosure (Whistleblowing).

13. Monitoring and Performance Review for all staff and Independent Contractors.

14. Standing Financial Instructions.

15. A robust system of Budgetary Control

16. A system of Annual Accounts and Reporting.

17. Asset Management arrangements.

18. Financial procedures Manuals.

19. Anti-fraud Measures.

20. Audit Arrangements (Internal and External elements).

21. A Remuneration Committee.

22.A clear system of Clinical Governance.

23.A clear system of Professional Governance in Social Care.

24.Effective Governance in Primary Care, including clear lines of accountability.

25.A set of internal management arrangements and structures which take account of relevant current legislative arrangements and management/staff agreements.

26.Human Resource policies which cover such issues as:

- Appointments
- Checking of Professional Qualifications
- Revalidation
- Continuous Professional Development
- Discipline Procedures
- Clinical Supervision
- Clear professional and managerial lines of accountability

DOCUMENT 9

Carmel Ming

From: Mooney Carol <WHSSB/ABHQ/MOONEYC>
Sent: 03 November 1999 12:55
To: Doherty Helena
Subject: CLINICAL AUDIT ACETATES
Attachments: CLINGOV.PPT

CLINICAL GOVERNANCE/AUDIT/ EFFECTIVENESS

What we are trying to deliver:

- Effective organisations
- Effective clinical practice
- Effective staff

Through

- changing behaviours
- research and evidence
- creating the climate
- a living process

Clarity about the role of the Board:

- Leadership
- Structure for accountability and decision making
- Communication and information flows

The successful introduction of clinical governance at a practice level will depend on a number of factors within the organisation:

- A clear sense of purpose
- An appropriate culture
- Good systems
- Resources to support the process

What I would like to see from today:

- agreeing strategy for quality and clinical governance (whilst individual organisations remain responsible for operational activities)
- learning lessons which may be relevant to other organisations, or which concern the relationships between organisations

- developing shared infrastructures and processes where appropriate
- developing a shared approach to training and professional development
- consideration of issues which require a county-wide approach, such as manpower planning

- taking an overview of activities across organisations and links to non-NHS organisations
- to consider the patient's perspective, for whom organisational boundaries are irrelevant

DOCUMENT 10

SPERRIN LAKELAND HEALTH AND SOCIAL CARE TRUST

RISK REVIEW OF ACUTE HOSPITAL SERVICE PROVISION THROUGH THE SPERRIN LAKELAND MODEL

HEALTHCARE RISK RESOURCES INTERNATIONAL

FEBRUARY 2000

HRRI

CONTENTS

SPERRIN LAKELAND HEALTH AND SOCIAL CARE TRUST

INTRODUCTION

1. The intention of this risk review of acute hospital service provision through the Sperrin Lakeland model is to provide a clear practical plan of action for the Trust staff members to develop a more focused and systematic risk management process for the interim period of the next 10 years.

PROJECT OBJECTIVES

2. Accordingly, the project objectives are to:

   (i) undertake a detailed risk review of the proposed Sperrin Lakeland model service configuration of "Altnagelvin and One Hospital Service on Two Sites" in the Southern Sector;

   (ii) analyse and assess the risks identified from (i), in relation to both using the model as the interim solution and for a period of approximately 10 years – the long term.

PROJECT ACTIVITY

3. In undertaking the activity associated with the risk review project, the HRRI team focussed on the **clinical** risk profile of the model and the "knock-on" effects related to the following arenas:

   - health and safety at work risks;
   - risks in the operational support services;
   - organisational and business-type risks.

4. More specifically, the project team reviewed from a risk perspective, the following building blocks which were identified by the Steering Group as central to the eventual achievement of whichever long term model is agreed:

   - emergency response arrangements;
   - effective human resource strategies;
   - formal 'managed clinical networks';
   - developments in primary care.

5. In addition, the project team undertook an in-depth risk analysis of the weaknesses identified by the WHSSB Steering Group, of the Altnagelvin and "One Hospital on Two Sites" model, as follows:

   - "cannot provide the numbers of patients on both sites needed to maintain skills, e.g. in Accident & Emergency

- results in some duplication and some splitting of facilities/equipment
- makes sub-specialisation and teamwork difficult
- requires some consultants to work unacceptable rotas
- training standards unable to be met
- likely to be gradual breakdown in balance of services between sites
- clinical networking more difficult across 3 sites
- likely increasing difficulties in recruiting top quality medical, nursing and paramedical staff".

6. Finally, in conducting the risk review the following risk features, which the project team examined, were in relation to the particular focus of clinical services:

- standards of service and care delivered
- availability and range of services
- adequacy of policies, procedures and guidelines
- junior medical staff activity
- adequacy of medical supervision
- adequacy, integration and competencies of existing staff
- clinical audit arrangements
- communication systems
- integration of professional inputs to the treatment and care processes
- near miss and incident reporting culture and systems
- the interface between health care, social care and other public services.

7. In progressing these reviews, the HRRI project team worked with the Trust staff members to:

- examine thoroughly the report of the Steering Group;
- interview a range of clinicians, managers, members of the Steering Group, WHSS Council, WHSSB, NI Ambulance Service Health & Social Services Trust, GPs and representatives from Altnagelvin Hospitals Health & Social Services Trust;
- undertake limited visits to the clinical sites;
- review the draft remits of the "Essential Building Blocks".

PROJECT OUTCOMES

8. As a result of the review, this single report was compiled and will be submitted for the consideration of the Trust Board and Chief Executive. This will include the following elements:

- a risk profile of the Sperrin Lakeland model services for the interim period;
- a risk profile of the Sperrin Lakeland model services, as the long-term solution.

9. The information elicited, through the snapshot of time spent within the Trust, was used to devise a number of action points through which the Trust can implement measures to reduce the risks identified. Corroborating reports received from more than one source has carefully checked these. In view of the limited time available for

the on-site work, it is recognised that the Trust may be privy to additional information, to which the Project Team did not have access, which may affect the recommendations made in this document.

10. Prior to the finalisation of this document, a process of consultation will take place with Trust managers. A key part of this will be a sharing of views about the prioritisation of the action points, with the aim of identifying those requiring the most urgent action.

Documents Reviewed:

11. A number of DHSS, Trust, WHSSB and Working Group specific documents were made available for the professional advisors to review. These included the context documents outlining the strategic direction for Northern Ireland which included:

Health and Well Being: Into the Next Millennium, 1996
Well into 2000 A Positive Agenda for Health and Wellbeing, 1997
Fit for the Future, 1998
Putting It Right, 1998
Acute Services in the Future, 1996
Fit for the Future Summary of Responses to the Consultation, 1999
Sustainable Services: Quality Care, March 1999
Sustainable Services: Quality Care The Way Forward, September 1999

People Interviewed:

12. A number of individuals within each of the specific services were extremely generous in the time they gave during our site visits. We are grateful to them for giving their time and being frank with their responses. These are included in Appendix A.

13. The relevant discussions with these individuals and the documentation reviewed have been summarised in this report and specific clinical quality, Health and Safety improvement and risk reduction recommendations identified. These recommendations are not intended to be legal advice, but should be used to assist the Sperrin Lakeland Health and Social Care Trust in improving clinical quality and reducing areas of potential or actual risk.

14. This report should be viewed as a confidential communication for the purpose of improving the delivery of patient care. The Trust may wish to share this report with appropriate individuals with a need to know and use it as a mechanism to stimulate discussion at medical, midwifery, nursing and clinical audit meetings; for education purposes; and to minimise and eliminate potential risk exposures in services provided by the Sperrin Lakeland Health and Social Care Trust.

Positive Practices to Reinforce:

- The development of the Community Paediatric Nursing Services;
- Multi-professional Audit including annual audit days/workshops, presentation and reports;
- The junior doctors audit competition, participation and commitment to Confidential Enquiry into Perioperative Deaths /results, and the participation in the National stroke audit;
- The standardisation and leadership of the laboratories bringing about integration;
- The Trust's Resuscitation training with Advanced Life Support and Paediatric Advanced Life Support, the resuscitation committee and the Do Not Resuscitate policy. The provision for the inclusion of Living Wills would enhance this;
- The joint working and developments within radiology with the minimisation of invasive procedures due to new techniques and technology;
- Expanded roles of the Radiographers to maintain service provision;
- The phlebotomy service provided at the Erne Hospital;
- Fully Consultant provided anaesthetic services;
- The ambulatory care services and facilities provided on the Tyrone County Hospital site;
- COSHH and Workplace Risk Assessments which are up-to-date in the Tyrone County and being updated on the Erne Hospital;
- Examples of cross border collaboration in mental health and ear nose and throat services;
- The development of Tele-Radiology links in trauma/orthopaedics with Altnagelvin and video conferencing for neurology with the Royal Group of Hospitals;
- Multidisciplinary team working for stroke care;
- Review of overdose patients by a psychiatrist within 24 hours;
- Mandatory training for community staff on moving and handling together with yearly up dates;
- Use of a risk assessment tool for moving and handling;

- Policies on do not resuscitate within the elderly care unit and involvement of the multidisciplinary team and relatives;
- The bi-annual international workshops on ear, nose and throat surgery over the last 7 years;
- The infection control committee and its membership which includes a representative from the Registration and Inspection Unit ;
- The use of the Scrutiny Committee to review claims.

15. The effective management of clinical risk of liability exposure requires co-ordinated, integrated teamworking processes which focus on providing safe, high quality patient care. This report highlights issues raised during the review and areas for continuous quality improvement.

Issues Raised and Identified:

16. The discussions focused around the Sperrin Lakeland model with Altnagelvin and one hospital on two sites. Inevitably different options of achieving this were put forward from a clinical risk, patient and staff safety and a quality perspective. These included inpatient acute services on one site (either Tyrone County or the Erne) and day case, minor injuries unit, outpatients and elderly care on the other. In light of the discussions the report will address each of the clinical specialities in turn. The focus of the discussions was around the need for viability; affordability and sustainability of high quality effective care in appropriate healthcare setting. This will provide:

- a risk profile of the Sperrin Lakeland model services, related to the interim period in improving service delivery;
- a risk profile of the Sperrin Lakeland model services, as the long-term solution which will be viable in the face of change and sustainable for at least 10 years;

ACUTE HOSPITAL SERVICES

17. The Trust provides essential emergency and elective care to its local community. An indication of the volume is given by the following summary statistics. These indicate a significant volume of activity provided locally in an area geographically removed from larger centres of population:-

Number of acute hospital completed inpatient episodes in 1998/99 – 17,036
Number of new and review outpatient attendance in 1998/99 – 48,010
Number of acute hospital completed day cases in 1998/99 – 4,937
Day Case attendances at the Tyrone County Hospital 1998/99 – 2884 with 66 overnight stays.
Day Case attendances at the Erne Hospital 1998/99 – 1720 with 36 overnight stays.

17.1 **The WHSSB recommends:**

Following the period of public consultation on the recommendations on the future of the Acute Services Review Steering Group the WHSSB reached two recommendations on the future of acute services in the South West of the Province. The second recommendation is particularly relevant to this review of risk assessment and is detailed below. These recommendations were reached at a meeting on 2nd September 1999 which was subsequent to the bulk of interviews with the staff listed in Appendix A.

'That the Western Board works urgently with the Sperrin Lakeland Trust and other key stakeholders to secure a pattern of acute services in the Western area based around Altnagelvin and acute services in the Sperrin Lakeland Trust that will become the bridge to the implementation of the sustainable Model recommended by the Board. The aim will be to ensure that this interim pattern of service provision meets appropriate quality standards, is compatible with the achievement of the sustainable Model and is within the overall resources available to the Board'.

ACCIDENT AND EMERGENCY SERVICES

18. The A&E Services receive patients from a widespread, largely rural and sparsely populated area. The distances involved and the poor quality of the roads have a major bearing on travel times.

36,414 total attendances in 1998/99 across both units with Consultant coverage from the General Surgeons and led by the Associate Specialists/Staff Grades. There are no developments or role enhancements for Emergency Nurse Practitioners with nursing services led by an A&E sister being provided by a core of accident and emergency nurses and care assistants. The staff grades run the departments supported by one accredited SHO training post which is integrated within the surgical rota to provide night and weekend cover at the Erne Hospital while at the Tyrone County the A&E Department has an independent Medical rota.

19. There is no orthopaedic provision on site with fractures and orthopaedic trauma being stabilised and referred to Altnagelvin from the Tyrone County Hospital and Belfast City Hospital from the Erne Hospital. There is no consultant led Accident & Emergency Services and no orthopaedic input to support emergencies. There is no accredited consultant cover for Accident and Emergency. With changes in the responsibilities of the General Surgeons this work should transfer to accredited consultant coverage for all Accident and Emergency Services. Under the Managed Clinical Networks Working Groups the Accident and Emergency Services are being targeted as a pilot managed clinical network with Altnagelvin. Clinical guidelines (British Association for Accident and Emergency Medicine 1993) recommend having an Accident and Emergency Consultant leading the accident and emergency team, with trained accident and emergency nurses and the 24 hour availability of trained paediatric nurses within the department.

20. The core service requirements for a fully functional Accident and Emergency Department is to have a consultant-led assessment, resuscitation, treatment and onward referral of acute medical, surgical, trauma and psychological emergencies in patients of all ages by appropriately trained and experienced staff according to national and local standards and available continuously 24 hours a day. There is an urgent need for 24 hour Consultant cover which would mean a minimum of 3 accredited accident and emergency consultants to provide clinical leadership, development of policies, procedures and clinical guidelines and multidisciplinary standards of practice. The Trust would also need to build up an infrastructure of middle and junior grades to allow full coverage of the departments, including supervision, training and overlap between shifts. Even with the planned managed clinical networks, multidisciplinary pathways of care and the pre-hospital emergency care developments, urgent developments are needed to maintain a safe and quality service for patients and staff and to reduce the current high risk exposure.

21. These developments are going to take time and in the short to medium term from a clinical risk perspective it may be better to concentrate on one Accident and Emergency Department and to build up a minor injuries unit led by an associate specialist in the interim. There are approximately 14,000 new attendance at each Accident & Emergency department per year, a figure of 35,000 new attendances has been suggested as the lower threshold for a fully staffed and functional department. This volume makes it difficult to justify full Accident & Emergency services and staffing. It is not possible from a clinical risk and quality stances to sustain full Accident and Emergency services across both sites. The proposed building blocks and support from Altnagelvin with the managed clinical networks could enhance the development and minimise the risk exposure.

22. **Risk Profile in the Interim**

- Appointment of the Accident and Emergency Department Consultants.
- Development of telemedicine across the three sites to improve with orthopaedic consultant appointments and further staff training.
- Development of Emergency Nurse Practitioners and a Minor Injuries Unit within both sites.
- Setting up of a Managed Clinical Network pilot across the three sites.
- Development in primary care to enhance the pre-hospital emergency care and the role of community paediatric nurses.

23. **Risk Profile in the Long-Term**

- Rationalisation of the Services.
- Consider retention of a Minor Injuries Unit on one site.

GENERAL SURGERY

24. This service is currently run by 4 Consultants and 2 Locum Consultants with 3 Consultants on each site. The WHSSB have recently agreed the Trust should proceed to fill the two locum posts. It was reported that if one of the surgeons replacing a

general surgeon was to be a Specialist in Urology it would further exacerbate the on-call arrangements in Surgery. The Consultant Surgeon has an interest in urology. The plan is to support the consultant with a staff grade to enable him to continue with urology and general surgery and therefore continue the on call rota.

25. The on-call cover and back-up arrangements are onerous on the individuals and results in little time for personal life, update and maintenance of qualifications and training and adequate time away from the Trust. The split site working does not allow achievement of the necessary sub-specialisation of care and the volume of patients is too small to support maintaining the skills and competency levels of the consultants involved. Consultants are supported by SHOs and JHOs with no middle grades. This results in more direct involvement of Consultants in patient delivered care and supervision and training of junior staff. The absence of middle grade staff can be perceived as resulting in poorer training placement and may effect recruitment, retention and sustainability of junior staff.

26. There is currently limited urology expertise with procedures being carried out by a general surgeon with an interest in urology and by an associate specialist in Accident & Emergency. 1 Urologist is required to 80,000 population which would equate to 1.5 qualified urologist for Sperrin Lakeland (115,000 catchment area). This should be in addition to Surgery where one surgeon is required for 30,000 population which equates to 4 surgeons minimum without any two-site cover. However, the viability in the short term of having more surgeons would have to being weighed up against the constraints due to physical capacity.

27. **Risk Profile in the Interim**

- Replacement of the Locum Consultants with full-time appointments
- Appointment of a Urologist to develop the urology services
- Further utilisation of day case procedures with appropriate selection and less use of overnight beds as backup facilities.
- A Theatre Users Group should be established across both sites with wide representation of the theatres and ward areas to review theatre utilisation, day case and staff wellbeing/fitness to practice.
- Review the implications of capital requirements, consultant on-call cover, travel involved and 'knock-on' effect on other specialities in the rationalisation of emergency and elective services. The emergency services should link with the Accident and Emergency Department. Emergency work could be undertaken on one site with all elective work on the other. However whether or not this would address the on-call requirements for Surgeons and Anaesthetists along with other factors such as the capacity of the emergency site would need to be given careful consideration.

28. **Risk Profile of the Long-Term**

- In order to build up the expertise and subspecialisation, meet the college recommendations, have a more sustainable on-call rota and have an infrastructure to support the surgical department on a new Green field site; and in line with

patient safety, quality of care and clinical risk management it would be better to have all inpatient services on one site (alongside A&E, anaesthetics, radiology and ICU/HDU) and supported by day case on both sites.

- The utilisation and development of managed clinical networks could be very proactive within the surgical services with good teamworking, skills and competency maintenance and primary care developments and should be considered alongside the rationalisation of services.

ORTHOPAEDICS

29. Orthopaedic reviews are provided by a visiting Consultant from Altnagelvin to the Tyrone County and a consultant from Green Park to the Erne. Minor fractures are treated at the Sperrin Lakeland Hospitals with advice being obtained from an Orthopaedic Specialist when required. The orthopaedic surgical procedures are carried out at Altnagelvin and Belfast. All orthopaedic and trauma services should be managed and supervised by specially trained orthopaedic/trauma specialists. With the telemedicine links and the supportive managed clinical networks this seems to be a sustainable service in terms of clinical risk. Some orthopaedic surgery which remains at Tyrone County Hospital should be transferred to Altnagelvin as soon as possible under the transition plan for the transfer of all orthopaedics and bony trauma to the care and supervision of the consultant orthopaedic surgeons.

30. **Risk Profile in the Interim**

- Plans should be fully implemented to ensure specialist care is provided or supervised by fully accredited Orthopaedic and Trauma Specialists. The further development of telemedicine links will assist in this.
- Clinical audit should be undertaken to monitor response times, local treatments and mortality and morbidity.
- Within the managed clinical networks there could be more developments in rehabilitation and ambulatory care, supported by multidisciplinary pathways of care and early discharge back to the Sperrin Lakeland Hospitals.

31. **Risk Profile of the Long-Term**

- Decisions need to be made with the proposed new hospital with regard to the level of provision of Trauma/Orthopaedic Services and the appointment of Consultants to support the Accident and Emergency Department.

UROLOGY

32. Currently urology procedures are being carried out by a general surgeon with an interest in urology and an associate specialist from accident and emergency. The consultant works across both sites covering outpatients, theatres and the ward areas. There are no standard or outcome measurements to benchmark the results from procedures undertaken with other centres. The Trust should ensure that outcomes are similar to other centres that employ dedicated consultant Urologists. The present post-holder also maintains his general surgical patients, endoscopies and some

chemotherapy services. He also participates on a 1 in 3 on call rota which reduces to 1 in 2 for 12 weeks of the year during periods of annual leave.

33. One Urologist is required to 80,000 population which would equate to 1.5 qualified urologist for Sperrin Lakeland (115,000 catchment area). It was reported that one of the surgeons replacing a general surgeon would have a urology background and will be unable to provide general surgery on call further exacerbating the crisis in surgery. The Consultant Surgeon has an interest in urology. The plan is to support the consultant in the interim with a staff grade to enable him to continue with urology and general surgery and therefore continue the on call rota.

34. **Risk Profile in the Interim**

- Clinical audit and benchmarking should be undertaken to compare the outcomes of the current service provision with similar work at other centres.
- As part of a managed clinical network an appointment should be made of an accredited Consultant Urologist to lead the sub-speciality and not be part of the general surgical rotation.

35. **Risk Profile of the Long-Term**

- Training and supervision needs and the service provision should be addressed in terms of college recommendations and managed clinical network supports. If urology services are to be maintained they need an infrastructure with appropriate skills, competency and nurse practitioners to support them.

EAR, NOSE AND THROAT SERVICES

36. Provided by two full time Consultants with outpatient services across both sites and all surgical procedures and paediatric care being provided at the Tyrone County Hospital. Ear nose and throat services have a third consultant locum surgeon on their rota, which is paid for from the Cavan/Monaghan contract. We support the recommendation that this long-term locum should also be filled on a permanent basis. The on-call cover and back-up arrangements are onerous on the individuals and results in little time for personal life, update and maintenance of qualifications and training and adequate time away from the Trust. Some concerns were suggested about the proposal in the Sperrin Lakeland model to undertake day casework on both sites. Care should be taken to ensure rotas provide sufficient cover on the in-patient site when this development is being planned. 27% of the current inpatient workload is undertaken on children with limited paediatrician input as the 16 paediatric beds are in a separate area on the adult ward.

37. The services are provided through multidisciplinary clinics with audiology, including paediatric audiology, combined clinic with radiotherapy, speech and language therapists and KTP laser equipment and CT Scanner for enhancing access to diagnosis.

38. **Risk Profile in the Interim**

- The locum position should be made substantive and day case provision across two sites should be reviewed.
- There should be a number of clinical audit projects undertaken to demonstrate results, clinical outcomes and to maintain the high profile of the service provision.

39. **Risk Profile of the Long -Term**

- With the rationalisation of acute services provision, Ear, Nose and Throat services should remain on one site with the inpatient services and the Accident and Emergency Department. As 50% of the total workload is paediatric based, it should be incorporated within Children's Services for day and inpatient facilities and nursing care.

OBSTETRICS, NEONATAL AND GYNAECOLOGY SERVICES

40. Currently based on the Erne site with day case procedures and clinics on both the Erne and the Tyrone County sites. Outpatients clinics are also provided at Castlederg. The inpatient services have already been rationalised onto one site supported by neo-natal service and improving rotas and training for medical staff. This service should be maintained with support from anaesthetics, surgery and high dependency care provided. The services are based on achieving the choice of women and providing continuity of care for women and their babies. There are 6 neonatal cots with facilities for two intensive care (for stabilisation and transfer within 48 hours) and a transfer policy for gestations under 30 weeks. With current on call provision of staff for emergencies, there should be clinical audit undertaken to ensure the Trust is achieving the standard of a maximum of thirty minutes from decision to proceed with a Lower Segment Caesarean Section (LSCS) delivery to commencement of the operation. (Royal College of Obstetricians and Gynaecologists, "Towards safer Childbirth" February 1999, Appendix 4, standard 12b). The clinical audit should indicate the reasons and extent of the problem is the standard is not achieved and should include an examination of available theatre capacity.

41. **Risk Profile in the Interim**

- An ongoing multiprofessional audit and use of clinical indicators should be commenced as a matter of urgency to demonstrate effectiveness of obstetric emergencies and response times for LSCS.
- Reviews of access to the emergency theatre/staff and links to the Theatre Users Group should be established and maintained.
- Maintenance of skill, competencies and confidence in Advanced Neonatal Life Support should be mandatory for all obstetric staff.
- Cardiotocograph (CTG) training and dealing with obstetric emergencies should also be mandatory and occur at least annually.
- Midwifery led care and user forum workshops should continue to be developed with women centred services.

- There should be extensions of the availability towards 24 hours for epidural anaesthetics to allow mothers choice and reduce outflow of future deliveries.

42. **Risk Profile of the Long-Term**

- With the rationalisation of acute services this directorate should be located with paediatrics, anaesthetics, general surgery and accident and emergency.
- Further development of the services and the infrastructure to meet the Royal College of Obstetricians and the Royal College of Midwives minimum standards and guidelines in building up services in light of potential closure of other units in the province.

CHILDREN'S SERVICES

43. The in-patient service is linked with Obstetrics and Neonates on the Erne Hospital site and there is a day unit with outpatient sessions on the Tyrone County Hospital site. There is a requirement to develop integrated child health services which are better co-ordinated and clinically led and include the child protection awareness, education, training and register maintenance. The Trust should review patient administration information regarding possible placement of children on adult wards. Should there be such placement then the Trust should ensure that its policy is adhered to.

44. The Trust is to be commended on the development of the paediatric ambulatory care service from Tyrone County Hospital with the associated community care support. Similar development at Erne Hospital should be further supported. With the changes from hospital to a community based paediatric service, care should be taken to ensure that paediatric nursing skills are maintained by appropriate use of rotation and secondment between community and hospital care environments.

45. **Risk Profile in the Interim**

- Development of outreach services and full utilisation of community paediatric nurses to support primary care services and to triage and treat children at home. This should include more preventative and health promotional activities and the development of multidisciplinary pathways of care for chronic disabilities and illnesses.
- Paediatric nursing support should be developed within the Accident and Emergency Services and the proposed minor injuries unit.
- Managed clinical network developments in children's services should incorporate all aspects of primary and mental health care and full affiliation with larger paediatric units.
- Infrastructure of medical staffing to support education, training, development and clinical supervision with middle grades being responsible for acute paediatric care.
- More input to surgical services especially Ear, Nose and Throat, Theatres and Accident and Emergency Departments.

- Extend development of paediatric ambulatory care services to the Erne Hospital and surrounding community.

46. **Risk Profile for the Long-Term**

- Training and development of paediatric nurses to maintain the skills, competency and confidence of caring for children in the community. This may involve some rotation and training in larger units on an ongoing basis.
- Development of Paediatric Services to provide good provision for the new hospital with a good infrastructure of medical, nursing and therapy staffing.

INTERNAL MEDICINE

47. Currently available on both sites with 5 Consultants at the Tyrone County and 3 at the Erne Hospital. These are supported by 1 Staff Grade, SHOs and JHOs. The Trust is to be commended for the developments of the sub regional dialysis/renal unit at the Tyrone County Hospital. There is one accredited Cardiologist and an expressed need for a Respiratory Physician supported by Respiratory Nurse Practitioners at the Erne Hospital site. There is a lack of available beds with many patients being boarded out as outlyers to other wards. There are well-established stroke units in both hospitals with functioning multidisciplinary services. The Tyrone County Hospital is always experiencing bed difficulties and problems in maintaining rehabilitation of patients and accepting new referrals.

48. Visiting consultant clinics are held in many of the subspecialties including dermatology, rheumatology, haematology and neurology. The oncology/radiotherapy clinics have recently been withdrawn, removing access to this expertise by local clinicians. Most of the admissions to the Sperrin Lakeland Hospitals come through the GPs and the Accident and Emergency Departments.

49. **Risk Profile in the Interim**

- Review bed requirements in the light of Omagh General replacement Business Case and the outcome of the Acute Services Review. Conduct an audit of bed utilisation and discharge planning and implement a bed management policy.
- Allow direct access for medical admissions from GPs without going through the Accident and Emergency Departments.
- Proceed with the appointment of a fourth Consultant Physician at the Erne Hospital with a special interest in Respiratory Medicine.

50. **Risk Profile of the Long-Term**

- Continue the ongoing developments of sub-specialisation with the medical infrastructure to support them.
- GPs can have direct referrals to the wards and to the Accident and Emergency Department and Minor Injuries Unit.

- Development of managed clinical networks and pre-hospital emergency care could result in fewer admissions and more care within the community supported by the GPs and specialist nurses.

CARE OF THE ELDERLY

51. Acute care and rehabilitation for the elderly is provided on both sites. There are ten continuing care beds on the Erne Site and a separate continuing care facility at the Tyrone and Fermanagh site for the Tyrone County Hospital. There is one Consultant Geriatrician with GP cover being provided for continuing care. Community developments have included the increase in Nursing Home provision and Rehabilitation Service. Concerns were expressed at Tyrone County Hospital regarding the continuing care of the frail elderly being off the main site and issues raised included acute service access, laboratory results, resuscitation, ambulance and staffing levels/skill mix.

52. **Risk Profile in the Interim**

- Close relations and continuing care of the elderly in the community is very important and could be driven by the managed clinical networks across health and social care.
- Review bed requirements in the light of Omagh General replacement Business Case and outcome of the Acute Services Review. If there are insufficient beds to provide care and rehabilitation to elderly patients this restricts the development of integrated services and results in patients inappropriately placed on to medical and surgical wards.
- Continued development of rehabilitation services and review of the supporting multidisciplinary team workforce requirements to support them.
- Introduction of a workload methodology to examine the quantitative and qualitative aspects of patient needs and the supply of staff by grade and skill mix to meet these increasing needs and dependency.

53. **Risk Profile of the Long-Term**

- Increases in the number of elderly in the population with increased demands for care and rehabilitation need to be provided for.
- Continuing care of the elderly needs to be on the same site as acute care, diagnostic services and the therapy professionals.

ANAESTHETICS

54. A consultant provided service with 4 Consultant Anaesthetists on each site with no supporting infrastructure of middle or junior medical staff. A full range of inpatient and ambulatory care services are provided with limited acute and chronic pain control and palliative care. The Trust participates in CEPOD audit with the reporting provided by the Anaesthetic department. Services provided to Obstetrics are limited unless there are clinical requirements, as the epidural service is currently only provided Monday to Friday 09-00hrs to 17-00 hrs due to no in-house anaesthetist/no

junior staff. Anaesthetic support for emergency obstetric procedures including LSCS is obtained by calling the anaesthetist to the hospital from his/her home, this can lead to delays. Transfers requiring airway or critical care support from Accident and Emergency, ICU/HDU or the acute wards are undertaken by the anaesthetist on-call which results in a second anaesthetist who is not on call being asked to cover the hospital site. The transfer rate is running at about three per month and there have been three incidences recently were junior staff have had to transfer critically ill patients because of the unavailability of anaesthetic staff. The back up arrangements for on call is not sustainable and the suggested regional retrieval system for critically ill patients should be pursued.

55. **Risk Profile in the Interim**

- Development of a managed clinical network for critically ill patients to be moved by the most appropriate route with the best skilled personnel to units with recognised Intensive Care Beds.
- A multidisciplinary audit should be undertaken to review the attendances, waiting lists and the outcomes of patients attending pain clinics and receiving palliative care on both sites.
- The role of the Anaesthetist in the Trauma Team and the provision of regional retrieval transfer arrangements for critically ill patients should be considered.
- Resident arrangement for anaesthetic staff to cover resuscitation and obstetric emergencies should be reviewed.
- Developments of patient needs led services such as acute and chronic pain relief and palliative care are being curtailed and should be further developed to provide sustainable high quality services.

56. **Risk Profile of the Long-Term**

- The function, usage and criteria for admission and 'treat and transfer' of patients requiring intensive care should be reviewed in the light of intensive bed facilities across Northern Ireland and the proposed new hospital.
- The training, education and supervision requirements to build up an infrastructure to provide anaesthetic services in accordance with the Royal College of Anaesthetists recommendations.
- Managed clinical networks with more input from primary care and pre-hospital emergency care and surrounding Trusts could help with support provision, developing skills, competencies and expertise and better team working. The role of Pain Control nurse specialists should also be reviewed as a support mechanisms for both acute and chronic pain.

COMMUNITY SERVICES

57. There is a need for much more integration and development of services across the sector of care. Although the focus of this review is on acute hospital services, the assessors gained the impression that the Trust had not got clear leadership for progressing community developments. There were particular concerns that children's services in the community should have a higher profile than was apparent from the

brief discussions on these. There is a need for a clear strategy with key issues and an action plan to outline the consolidation, development and training needs to provide a more cohesive, collaborative and co-ordinated service across all sectors of the Trust. Successful management of both the interim and long term development of community services will be as critical to minimising risks for patients as the hospital provision.

58. **Risk Profile in the Interim**

- A strategy for community services should be developed in light of the acute service review.
- The confidence of the public could be maintained through assurances of improvements in integration of services and teamworking across all sectors of care.
- The continued development of Pre-Hospital Emergency Care Services together with the supporting managed clinical network of integrated care.

59. **Risk Profile of the Long-Term**

- The Trust should further develop the advantages of having combined primary and secondary care to reduce clinical risk exposure by planning services in partnership ensuring they are seamless, collaborative and co-ordinated in the best interest of the patient. Full utilisation of integrated care through multidisciplinary pathways could enhance these developments by improving communication and documentation of patient care.
- Training and development to provide skills, competency and confidence to nursing, medical, social and therapy staff to work across the different sectors to provide patient centred care supported by technological advances including telemedicine.

CLINICAL SUPPORT SERVICES

60. More integration and infrastructure is required to bring the services together under one management head across both sites similar to arrangements in Radiology, Pharmacy/CSSD and the Professions Allied to Medicine. There should also be some exploration within pathology services of consolidation on one site. Services and capacity exists on the Tyrone County site, and with an increase in near patient testing on the Erne site, the infrastructure is there to support a single service across the Sperrin Lakeland Trust. This would cut down on duplication of expensive equipment and allow for a more manageable commitment to on-call rotas in line with the European Working Time Directives.

61. **Risk Profile in the Interim**

- Training and education of clinical staff in near patient testing, with an increase in equipment for basic procedures at the Erne Hospital site.
- Less duplication of equipment and resources at both sites in trying to provide an unsustainable 24-hour cover.

- Pathology service provision on the Tyrone County site with all emergency on-call cover provided on one site to reduce the onerous, unmanageable, voluntary current coverage, which maybe in breach of the Working Time Directive. This would also allow the laboratories to apply for Clinical Pathology Accreditation (CPA).
- Managed clinical networks could provide integrated management of support services with better accessibility for patients and rationalisation of services to cut down on the amount of duplication and allow resources for equipment replacement in radiology, pathology and other support services.
- Consolidation of support service on one site where appropriate in line with speciality service location would increase job satisfaction, and improve recruitment, retention and training of support staff.

62. **Risk Profile of the Long-Term**

- More co-ordinated service provision across all sectors of care with easier access and equity of services for patients.
- The rationalisation of services would determine where the support services should be located to avoid duplication, rework and allow resources for equipment replacements and consolidation of staff expertise.

A RISK PROFILE OF SERVICE PROVISION DURING THE INTERIM PERIOD OF SERVICE PROVISION WITHIN THE SUSTAINABLE MODEL OF CARE DELIVERY

General Issues which have implications across the Trust will be grouped, for the convenience of the Trust, into the following three areas:

- **Organisation/Management Issues**
- **Services/Systems Issues**
- **Workforce Issues.**

ISSUES RAISED

ORGANISATIONAL/MANAGEMENT ISSUES

Recommendation:

1. **The Trust need to identify the infrastructure, business requirements and resources which are required in order to sustain the local high quality services outlined within the Sperrin Lakeland model.**

Issues Raised:

The Trust has a robust Business planning process that has been developed over the last ten years. This bottom-up/top-down approach has proven invaluable in preparing for change. Against this process one must recognise the difficulty of achieving its goals in such an environment of uncertainty. Hence, it is recommended that the comments below be used as a signpost for the Trust in developing its future strategic plans.

Concerns were repeatedly expressed with regard to accessibility –v- quality of patient care. The ultimate aim should be to sustain the local high quality services in primary and secondary care.

The business and patient need elements should be considered in light of the decision for a new hospital on a green field site. The interim arrangements could effect ongoing referral patterns and direct patients to other services, which could ultimately have an impact on the casemix and client population of the future. The staffing levels in specialities need to be built up and succession planning should be considered in the light of trainees and juniors that will be required on a single site. There could be more growth and development in ear, nose and throat services with the excellent service provision and training opportunities. There is a need for major investment to meet these needs with the provision and adequacy of services on two sites. During the bridging period provision should be made of the use of staff grades where the appointment of too many consultant posts for the longer term may not be appropriate (due to insufficient volume of patients). Structure should be established to meet College recommendations for training and junior medical grades.

Concerns were raised with regard to the limited view of The Health Board –v- the bigger picture across Northern and Southern Ireland with the siting of acute hospitals and the reconfiguration of services to meet patient needs, demands and quality agenda. The delay in developing the future structures for Boards and Trusts and Primary Care Commissioning in Northern Ireland as outlined in the "Fit for the Future" document was causing some frustrations and anxieties especially with the clear pictures which have been painted with "Health and Wellbeing: into the next Millennium" and "Well into 2000 A positive agenda for Health and Wellbeing". Recognition was given to the current political climate and limited cross border workings, but it was felt that healthcare could lead the way across the whole country of Ireland instead of just concentrating on the Province.

The Trust has an IM&T strategy and this has been widely disseminated. It is dependent on significant capital and revenue support over the next three years. There has been slippage because of Y2K requirements and cost efficiency reductions within the Trust. It will be necessary for the Trust to ring fence its financial commitment to the strategy if it is to be positioned to meet the information requirements needed for clinical governance and to support developments with the Primary Care commissioning and community care.

The Trust appears to be on track with Y2K compliance. The present activity is around contingency planning and maintaining continuity of services. External audit gave the Trust high amber and then blue status (relatively good).

There have been delays in the implementation of developments submitted by the Trust in business plans due to lack of acceptance and decisions on the Sperrin Lakeland model. Cash releasing and lack of new funding development have also contributed to these delays.

Concerns were expressed regarding the continuing care of the frail elderly being off the main site and issues raised included acute service access, laboratory results, resuscitation, ambulance and staffing levels/skill mix. The business case to locate these beds on the Tyrone County site was not supported by the commissioners, as the outcome of the acute services review was still to be determined.

Discussion:

The Trust can only build the infrastructure once the staff have clear direction and have reviewed the risk profile in the best interest of providing a sustainable interim period of service provision which meets appropriately set multidisciplinary standards, patient needs and the quality criteria set by the key stakeholders. Some hard choices have to be made to meet some of the issues, which have been raised, and to allow for ongoing clinical and business development, which seem to be currently stifled.

The Trust Board need to look at the wider picture of integrated care across all sectors of care which has to be supported by information technology, telecommunications and technological developments. There are many dedicated, motivated, well-educated professional staff who need clear direction and leadership to sustain high quality services and acceptance of the model.

Recommendation:

2. **The Trust should review the community care provision and the impact of primary care developments alongside the acute services review to ensure better continuity of patient care across all health and social care sectors.**

Issues Raised:

Further developments should be considered in all aspects of community care and services to further enhance those made within diabetes liaison, Macmillan nursing, breast and stoma care, wound management, midwifery led antenatal clinics and with out-reach cardiac support/rehabilitation. The Trust is very focussed on acute care delivery, sometimes at the detriment of community developments for more shared care provision, when ideal opportunities exist similar to children's services.

The Trust is able to cite some initiatives in community care, but there does not appear to be adequate preparation and development of the community services to support the changes taking place in hospital care and in particular to facilitate rationalising services between Erne and Omagh. Two of the building block groups, for primary care and pre-hospital emergency arrangements, will be examining these requirements.

The need for rapid development and enhancing of the community services, in line with some of the early developments in paediatrics and stroke care, in areas such as ambulatory care for surgical patients and elderly rehabilitation.

Whilst the Manager for health visiting, school nursing and family planning for Fermanagh attends case conferences and has Child Protection brief on behalf of nursing, it was reported by both a community manager and a social work manager that the Trust was not fulfilling its legal requirements under the Children Order 1995 for a child protection specialist. It was reported that there was no nominated nurse advisor to provide ongoing support, education and training. This lack of provision provides clinical risk exposure which needs to be addressed across both sites in the proposed Sperrin Lakeland model. The Trust has included this requirement in their development bids, however to date this has not been funded by the WHSSB.

Concerns were raised with regard to the relatively low level of referral from within the hospitals, for example from A&E, of possible concerns of child abuse.

Discussion:

The Trust needs to incorporate primary and community care developments into the wider picture of the acute services review. There needs to be much stronger networks

of care to have more shared care provision, more care provided in the patients' own home environment and better integrated care with clearly defined standards and measurable outcomes of care.

Some of the resistance to change within the hospital could be overcome with a better understanding for the staff and the public if they realised many of the developments are to provide building blocks of home/community care. Resources need to be aligned with the developments to provide more primary care services through primary care commissioning, practice nurses, social workers, community psychiatric nurses, therapy professionals and specialist nurses.

The child protection issues should be reviewed in light of the DHSS guidelines on the Welfare of Children and Young People in Hospital. There should be a combined child health service to provide all aspects of integrated care and to work in partnership to provide protective services in line with the Children Act and the Children Order of 1995.

Recommendation:

3. **There is a need for the Trust to review its Communication Strategy to provide clarity on standards and audit criteria to monitor and measure effectiveness.**

Issues Raised:

The Trust does have monthly core team briefings, which are used to disseminate information, and should be audited to ensure the two-way passage of information. The Trust Chairman also hosts open forums and there have been adhoc briefing meetings for major issues such as efficiency savings targets. None the less poor communication and lack of information sharing leading to speculation and boundaries/barriers were sited as leading too much uncertainty, lack of security, rumour mongering and speculation. There were examples given of poor communication within the Trust. This was both within the Directorates and between the medical body and management. The professional advisors found this to be differing across the specialities, some of which were very good at cascading information.

There is a team brief approach to communicate to staff within the Trust. The monthly core brief is distributed to 180 Heads of Departments and Consultants across the Trust. Feedback suggests that this is patchy in implementation by managers with some circulating it and other discussing it with staff. Comments were made that often information may go to Directors within the Trust but there it would stop.

There is a requirement for more multidisciplinary meetings across both sites to breakdown the boundaries and barriers which have been artificially created due to fears of losing services or one of the hospitals.

There were many examples quoted which highlighted differences of opinion between the Trust Board and the Medical Staff on the long-term future arrangements. It was evident that for the longer term, the majority of medical staff opinion moved to support the 'Greenfield' hospital model during the preparation of the Steering Group's recommendations. The Trust had to balance this viewpoint with the views of other staff groups and the community given the earlier public consultation and support for the Manchester University recommendations in 1997. A perception emerged that some views expressed by the medical staff were not always considered.

The organisational structure across the Trust has recently been reviewed and the recommendations in the report "Which Direction for Directorates" are being acted upon in order to have meaningful Directorates and joined up working.

Discussion:

The quality of communication and interaction between healthcare providers themselves and between providers, management and their clients and/or families is often directly equated to the quality of care provided; thus the need to maintain open and active communication is essential. Staff should be continually reminded that the open, honest and effective communication strategies demonstrate a caring, well meaning and sympathetic attitude by all staff who are involved in care regulation and delivery. Good communication is seen as a necessary prerequisite for all healthcare professionals and is being taught in all forms of professional training and by external training bodies. Effective communication and clear concise documentation are the best forms of risk prevention and should be an integral part of every risk management strategy.

The Sperrin Lakeland Trust need to set up a more formalised internal and external two-way communication strategy to ensure all channels of communication are clear and understood. There is evidence of some good communication practice within the unit and this needs to be filtered into and expanded within the strategy.

Many of the issues raised related to no formalised communication or structure to ensure appropriate information is disseminated to stop speculation and rumour mongering. In our view, many of these issues could be minimised or eliminated with more proactive involvement and a discussion framework. This should be audited on a regular basis to monitor and measure the effectiveness and to counteract any blockages or miscommunication. Documentation control will ensure all staff have the appropriate information and are not using outdated information and there is more consistency of data control and communication.

Recommendation:

4. **With the expected decision to extend the concept of Clinical Governance to Northern Ireland with modification to include Social Care, it is recommended that the Trust staff are made aware of their requirements to its implementation and sustainability across the Trust.**

Issues Raised:

Clinical Governance Issues were raised with regard to lack of clarity of the working group structures within the Trust and full co-ordination/collaboration on clinical audit, quality and risk management issues. Clinical Governance has not yet been formally introduced to Northern Ireland, but is being implemented at various stages across the Province, and the Trust has commenced an awareness programme to involve staff in its development. A survey, which was part of the scoping exercise to inform the current position of Clinical Governance and the role of the quality management group, recently undertaken identified 15 different committees. Some of the staff on these committees suggested that the membership, roles and reporting mechanisms for these were reported to be largely unclear. It could be suggested that a more robust approach to clinical governance, with clear accountability, responsibility and reporting mechanisms, would be supportive to the clinical risk issues facing the Trust.

The Trust had to date had limited consultation on a framework to pull the governance and controls assurance issues together. Some staff were unclear as to how Corporate and Clinical Governance, Internal/External Audits and Controls Assurance all fitted together. The Trust Steering Group is to host a workshop to examine current activity and the way forward to find the best fit.

There is a need to review the Trust's sub committees needed to support the governance agenda and ensure a multidisciplinary approach where appropriate an example of such a group for early implementation would be within the operating theatres. Present issues relating to theatre utilisation should be addressed and reported on by the Theatre Users Group, particularly with the delays which have been highlighted in undertaking emergency LSCS. This should be one of the groups which has clear accountability, responsibility and reporting mechanisms to the Clinical Governance Group to ensure the smooth running and operation of the operating theatres and intraoperative care delivery.

There was some lack of clarity on the understanding of the mechanisms within the Trust for the provision to the Chief Executive and the Trust Board of resolved medical professional advice. The Medical Director will need to work closely through Clinical Directors and the Chairman of the Medical Staff Committee to ensure views on professional advice are suitably channelled. Linkages within Clinical Governance organisational structures will be necessary to ensure medical staff support for clinical management and leadership arrangements.

Discussion:

Clinical governance incorporates a number of processes, including clinical audit; evidence based practice in daily use supported within the infrastructure; clinical effectiveness; clinical risk management with adverse events being detected, openly investigated and lessons learned; lessons for improving practice are learned from complaints; outcomes of care; good quality clinical data to monitor clinical care with problems of poor clinical practice being recognised early and dealt with; good

practice systematically disseminated within and outside the organisation and clinical risk reduction programmes of a high standard being in place. This has much relevance for high-risk specialities and how it affects their operational working.

There will be an expectation for all clinicians to fully participate in audit programmes, including speciality and subspecialty national external audit programmes endorsed by the Commission for Health Improvement. The Trust participates in some of the external audit studies such as National Confidential Enquiries Still Births and Deaths in Infancy (CESDI), Perioperative Deaths (NCEPOD) and Maternal Deaths (CEMD). Clinical Governance places a duty of responsibility on all healthcare professionals to ensure that care is satisfactory, consistent and responsive, each individual will be responsible for the quality of their clinical practice as part of professional self-regulation. It will strengthen the current systems of quality assurance based on evaluation of clinical standards; better utilisation of evidenced based practice and learning the lessons from poor performance. The clinical governance framework builds upon professional self-regulation and performance review; it takes account of existing systems of quality control and includes all activity and information for quality improvements.

Recommendation:

5. **Patient and staff safety should be paramount during the interim period of service provision in considering appropriateness of care delivery, achievement of standards, quality criteria and outcomes.**

Issues Raised:

There has been increased travel for staff, patients, relatives and visitors with poor infrastructure and accessibility due to roads and public transport systems not being good between the hospitals. However, the Sperrin Lakeland model was reported to involve less travel disruption that any of the three preferred models.

There is a waiting list of over 18 months for pain clinics and low provision of acute and chronic pain management. Again no audit has been undertaken in this area to assess the priorities of patients on the waiting lists, the risks suffered by patients, the needs of patients and outcomes due to delays in treatment or the loss of reputation of the Trust due to long term patient sufferings. The patients attending pain clinics at both sites should be assessed in terms of follow-up arrangements and duration of treatments. The length of waiting lists in some specialities is an area where clinical audit could be directed by the Quality Management Group and the Commissioners of Care Delivery.

Concerns were raised with regard to getting key personnel within the Trust for Crash LSCS/Emergency Obstetric Surgery and it was stated that "decision to incision" to meet Royal College of Obstetrics standards for emergency LSCS was not always possible. There was no audit data available to back this up or to highlight the reasons for delays and the appropriateness of actions taken. The Consultant Anaesthetists

have to be called in from home and often backup theatre staff were required and these were cited as sometimes causing delays.

There is a perceived loss of public confidence in the service provision by the WHSS Health Board and the Trust and much public pressure to save hospitals and services. In such circumstances there was a perception among clinical staff that some of the issues relating to clinical safety and risk were subordinated.

Issues were raised with regard to the GP referral patterns and the lack of internal and external clinical networks. Some GPs on the Co-operative are already referring directly to Altnagelvin. Managed Clinical Networks are being addressed through one of the Joint Board/Trust/Primary Care building block groups being used to support changes in the acute service provision.

The criteria for cases/casemix of patients including selection criteria for day and major surgery should be agreed between surgeons and anaesthetists. The current arrangements need to be agreed as there are implications for the appropriate backup services due to the lack of infrastructure to cope with some surgery for example Ear, Nose and Throat referrals to Belfast due to the lack of back-up of ICU beds. The consultants are capable of the procedures but with inappropriate backup facilities referrals are made elsewhere. Hence when referrals are made to Belfast there are feelings of the patient's condition not being interesting enough compared to the receiving hospitals innovative and research based practices.

Accommodation for outpatients is said to be poor particularly with regard to access and equipment.

Some staff expressed concerns with regard to the problems they have experienced and perceived due to poor security arrangements with lack of night security and protection for staff and patients.

As paediatric medical cover is based at Erne Hospital, there is no on site paediatrician at Tyrone County Hospital, with implications for ear, nose and throat and support to Accident & Emergency. Paediatricians are undertaking clinics and day unit care at the Tyrone County Hospital between Monday and Friday within the hours of 9am to 5pm where they are available for consultations between patients and paediatric emergencies.

On-call services and difficulties of cross site cover were raised continually with concerns of the services being spread too thin and that good will is running out with too much expectation on over commitment to the Trust. On call rotas in some specialities are onerous and most services are site specific. On an out of hour on-call basis there is very little cross-site cover required in the current provision of services. Given the distances and the geography there is no expectation on the Trust's part for staff to provide cross-site cover out of hours.

There is no consultant led Accident & Emergency Services and no orthopaedic input to support emergencies. There is no accredited consultant cover for Accident and

Emergency. With changes in the responsibilities of the General Surgeons this work should transfer to accredited consultant coverage for all Accident and Emergency Services. Under the Managed Clinical Networks Building Block Group it is proposed to target Accident and Emergency Services as a pilot managed clinical network with Altnagelvin. Clinical guidelines recommend having an Accident and Emergency Consultant leading the accident and emergency team, with trained accident and emergency nurses and the 24 hour availability of trained paediatric nurses within the department. Clerical support to Accident & Emergency is Monday to Friday 9am to 5pm only; there is no clerical support outside this. This is a clinical risk issue as nursing and medical staff are having to undertake these duties out of hours which is detracting from patient care and causing delays in treatments and obtaining of patient records.

There needs to be acceptance of the provision of High Dependency Units (HDUs) as opposed to ICU, which according to Crest Guidelines cannot be provided without appropriate 24 hour medical staff cover. The unit is based on treat and transfer to a regional or tertiary centre.

Some of the clinical staff felt that from a risk, quality, efficiency and effectiveness viewpoint they would support a single site option for all acute services, prior to moving to a Greenfield site. They felt very strongly that all emergency and elective work should be on one site, with the other site being used for outpatients, ambulatory care and minor injuries unit.

Mortuary facilities, although not visited during the professional advisors time on site, are said to be inadequate at both sites, but especially at Erne Hospital.

There are said to be shortages of patient beds at Tyrone County Hospital. Whilst this is multi-causal in nature, two main reasons given, are the impact of the stroke patients and a low number of beds available. Concerns were expressed with regard to poor bed management and lack of a policy for sequencing of boarding out of patients and care of outlyers. There is a need for better bed management; with the inclusion of community care options as part of the solution.

Discussion:

There are many issues, which need to be addressed under this recommendation, which are causing concern and anxiety within the Trust. They need to be thought through and acted upon in order to provide a controlled environment of care. They are all things which can be reviewed and better managed to ensure patient and staff safety. They ranged from clinical concerns which are proving problematic, to security and use of facilities which are fit for the purposes of staff and patient wellbeing.

To meet the needs of all staff and the organisation, the Trust should aim to ensure that:

- staff development, education and training needs are prioritised and met on an ongoing basis in line with organisational requirements;

- staff are provided with a safe environment in which to work in accordance with relevant legislation;
- staff are offered support, assistance and specific counselling when required;
- staff continue to have access to Occupational Health Services;
- all staff receive mandatory training in manual handling and lifting techniques, Cardiac adult and paediatric resuscitation, fire safety training and the management of violence and aggression;
- mechanisms are developed to ensure that staff are consulted with regard to their vocational needs;
- staff are able to provide appropriate feedback to management with regard to the extent to which their needs are being met;
- staff are fully informed of Trust developments and change and have adequate opportunity to provide their professional input and comment.

The introduction of a workload methodology system should be introduced to look at the quantitative and qualitative aspects of care. Linked to standards this could be used as a monitoring tool to demonstrate quality of patient care. A workload system could be used within the different services to address a number of the risk issues, which were noted in relation to staffing, and staff and patient safety during the interim provision of care delivery.

Clinical supervision is important for all grades and disciplines of staff as a means of protecting the patient from unsafe practice. Systems should be in place to facilitate this, with staff provided with education and support in the principles of this process.

SERVICES AND SYSTEMS ISSUES

Recommendation:

6. **Innovations, development and continuation of high quality services for patients and staff should be encouraged throughout the interim period with clear direction for clinical audit, continuous quality improvements and full utilisation of multidisciplinary standard of care delivery. The Trust should review its arrangements for the conduct and support of clinical audit to clinical teams. It should also tighten up the process of sharing and dissemination of audit. There should be clear direction given to audit topics in the light of implementation of the Sperrin Lakeland Model.**

Issues Raised:

Perceived restricted clinical developments of services and innovations due to the waiting periods, lack of development funding and lack of decision making e.g. Pain management, urology, and fully integrated child health services.

Reduced equity and access to some services for some patients e.g. Maternity, paediatric, ear, nose and throat, trauma and cancer, with concerns raised regarding the differing standards and quality of care due to lack of joined up working e.g. Pain relief, epidural services during the intrapartum period, urology.

Health and social services staff outlined problems with discharge planning particularly from regional hospitals and provision of adequate packages of care due to lack of planning, poor communication, readmissions to hospital and poor bed profiling.

Unless there are clinical requirements the epidural service for obstetrics is currently only provided Monday to Friday 09-00hrs to 17-00 hrs due to no in-house anaesthetist/no junior staff.

There were preferences in most specialities, apart from orthopaedic referrals, for patients to be referred directly to Belfast rather than Altnagelvin. Referrals to Altnagelvin often resulted inpatient having to travel in a triangle to Belfast.

Issues were raised regarding concerns with split site working and referrals with faxing of information e.g. Cardiotocograms and Electrocardiograms, babies born in Accident & Emergency /on the roadside and equipment replacing. A telemedicine link through a workstation in the Tyrone County Hospital provides facilities for the downloading of CTs from the Erne. There have been 9 babies born in the Accident and Emergency at the Tyrone County in five years and support for these deliveries has been provided by the community midwives. Emergency births occur in other remote parts of the Trust's rural geography. Replacement of equipment has suffered due to available funding.

Since the findings of the NCPOD report (1989) there has been recommendation that 24-hour on-site trauma team supports Accident and Emergency departments. Such a team would include medical staff from anaesthetics, orthopaedics, and general surgery, together with nursing and radiographic support. At present, whilst there is support from these specialities, there is no rostered and identified trauma team at the Tyrone County Hospital. An anaesthetist and surgeon would attend if available. There are no rotas as to which members of the team would be available particularly the surgeon and anaesthetist who would be expected to direct and lead the trauma team. Accident and Emergency staff should lead the clinical arrangements for dealing with major incidents.

Problems with the sharing of patient records across the Trust and poor transport systems to get records for outpatient clinics. There are a significant number of duplicate registrations within the Trust for the same patient. It is possible for patient/client records not to be collated for a treatment episode. This is recognised by the Trust and there is a project to develop systems for a unique identifier within the

Trust. This will take time and there does not appear to be adequate 'flagging' of the existence of other records for a patient in the interim. A working group is currently examining how these arrangements could be improved.

There appears to be significant audit activity which is to be commended. Last year, within the Annual Audit Report, there were 120 audits reported upon. The Trust hosts an annual audit day and Trust audits have been selected for the Regional Audit Conference. The competition for the junior doctors' audit whilst commendable might discourage or divert from clinical and a multidisciplinary approach. Some examples of re-audits and closing the loop were given but these appear to be exception more than the norm. In discussion with nurses, health visitors and PAMs there were poorer responses on the use of audit for quality improvement, the lack of direction within the Trust from the Quality Management Group and externally from the Commissioners. Medical staff reported on the lack of direction for audit activity within the Trust and was disparaging of the audit topics given by the Western Board.

Health and Safety appears to be adequately structured, with workplace audits being undertaken. The Health & Safety committee is chaired by the Director of Corporate Affairs who has responsibility for the quality, complaints and risk management agenda. Although a minor point, the Trust needs to give attention to the need to separate pedestrian and vehicle access at Omagh. This is a Health & Safety requirement and one that the Health & Safety Executive is paying particular notice to at present in its visits.

There is a total of 48.75 hours of Control of Infection Nurse time available to the Trust, given the geography and responsibility for community developments this is likely to be inadequate. An example of this is the limitation on surveillance; the surgical infection rates are not available. An audit of post-operative infection rates was undertaken in 1998 and the results were said to be 'at least as good as nationally published rates'.

Discussion:

Clinical Audit should be seen, as a main component to Clinical Governance, which is an essential requirement of all medical staff and should involve all clinical staff. The Trust should be able to show demonstrable results in quality improvement and risk reduction from the clinical audit process. The role of clinical audit should be clearly identified within the Trust's Risk Management Strategy and should be seen as an important building block to managing risk and meeting the corporate/clinical governance requirements. There needs to be clear direction and clinical leadership to ensure topics and processes required by the Commissioners, Quality Management Group and Risk Management groups are undertaken. All audits should be published and shared in an annual report to ensure lessons are learned and best practices disseminated throughout the Trust and the Managed Clinical Networks.

An effective clinical audit programme helps to give necessary reassurance to patients, clinicians and managers that an agreed quality of service is being provided within available resources. It is performed to improve standards of care, to raise awareness

of costs, to eliminate waste and inefficiency, and as a valuable educational tool for peers, juniors and other professionals. It is an educational process for clinicians, identifying inappropriate and inefficient clinical practices and inadequate support. It can lead to increased consumer awareness and choices about healthcare, as information becomes more readily available about clinical activity, quality of services and health outcomes. Clinical audit has an important role in risk management in revealing where care is ineffective or below acceptable standards and in encouraging its replacement with effective care and improved clinical outcomes.

Regular audit of patient records allows opportunity for continuous quality improvement and aids in risk reduction and improved defensibility should legal action be taken against the Trust. A comprehensive, complete, consistent record of patient care is the best defence if anything untoward does happen. Accurate record keeping and documentation, with regular quality review and audit, is essential to this process, and facilitates the tracking of the patient and their care throughout the Trust. Improvements can be made in the documentation of patient care with good interdisciplinary plans of care. These should incorporate inbuilt standards, clinical outcomes and variance tracking. A system of well-integrated process and delivery of healthcare makes the patient feel they are receiving personalised, organised and co-ordinated care.

Evaluation of patient care should be undertaken and include, but not be limited to the following:

- completeness and legibility of patient records, care plans, informed consent and investigation results;
- accuracy of diagnosis, operations/procedures, treatment and follow-on care, including allergies and the care delivery processes across the care sectors;
- appropriateness of use of laboratory investigations, routine radiology procedures, antenatal screening and other services;
- decision to incision for all LSCS to estimate and evaluate the impact of delays in care provision;
- the safe and secure movement of patients throughout the Trust and the clinical networks of care ensuring adequate recording of information communicated between staff;
- outcome of care in the short, medium and long term;
- reviews of patients with a mental health history and those suffering from postnatal depression and acute mental illnesses being cared for across health and social care sectors.

The Trust should be able to show demonstrable results in risk reduction from the clinical audit process through regular patient record reviews. These should be developed by a multidisciplinary team through a clear monitoring, review and evaluation process, which should include, but not be limited to the following:

- clinically valid standards of care set by the team and ratified and adopted by the Trust;

- the standards of care set by the multidisciplinary team linked to Multidisciplinary Pathways of Care©, flow diagrams and practice guidelines;
- specific thresholds used to monitor compliance with established standards, guidelines and outcome measurements;
- defined methods for the collection and analysis of data, including reference to collection tools, sample size, time frame and staff responsibility;
- provisions for corrective action planning to include education opportunities, organisational modifications and behavioural changes;
- evidence of follow-up assessment to evaluate the effectiveness of the corrective action and ongoing results;
- recognition and maintenance of good practices.

High level support, stimulation and co-ordination of the clinical audit process are essential to meet the above requirements. The main purpose of audit should be to review current activity and to evaluate changes and most importantly to share best practices throughout the Trust.

Recommendation:

7. **Consider the use of Trust Wide and Speciality specific regularly updated multidisciplinary pathways and clinical guidelines, policies and procedures with input from other wards and departments as deemed necessary.**

Issues Raised:

There is a lack of clinical guidelines, policies and clinical procedures across the Trust and concerns were raised regarding inconsistencies of clinical standards and quality criteria. Many examples were quoted to demonstrate inconsistencies across the sites with no standard or outcomes measurements or evaluation as to what the best practices should be.

One of the key components of acceptance and driving the managed clinical networks will be through having multidisciplinary pathways of care supported by clear policies, procedures and clinical guidelines. These will help to set up a core set of principles which will underpin effective clinical networking between professional care givers and across the different sectors of primary, secondary, tertiary, social and community care.

Discussion:

The importance of up-to-date, easily understood policies, procedures, guidelines, treatment flow diagrams and agreed standards cannot be over-emphasised in relation to risk reduction and achieving clinical governance. Often, a major cause of risk is that members of staff are individually uncertain of what is expected of them, particularly in emergency situations. This can be compounded when other members of the same team have different understandings about what actions should be taken in such situations.

The Trust should ensure that policies and procedures are up-to-date; issued to those who need to use them; received and read by those people; understood by those people, and put into action by those people. Furthermore, regular audits will be undertaken to ensure staff awareness and compliance with them, within clear lines of accountability and evaluation of effectiveness.

The Trust should have a continuous programme for reviewing all of the Directorate policies, guidelines and procedures, to ensure they are clear, concise, dated and updated annually. Medical, nursing and other procedures should be evidence-based, and procedure manuals and documents will include a reference section. Too many policies, procedures and guidelines can be as risky as having none if they contradict and confuse staff due to overlap and inconsistency. It is better to have fewer relevant guidelines than hundreds which only serve to confuse staff and they find there are so many they do not bother or cannot find the time to read them.

The Trust should also ensure that the Directorate-wide policies, procedures, guidelines and pathways are sufficiently flexible to be of practical use in different services and departments, yet at the same time not lead to inconsistency in interpretation. Accordingly, all policies, will make clear what must be strictly followed, and what is open to managerial discretion. Consistency in the management and retention of obsolete or superseded documents should be developed to ensure there is always a core set kept for reference.

Clinical guidelines and multidisciplinary pathways of care produced by the multidisciplinary team based on reasonably selected criteria, evidence based and best practice can demonstrate a controlled environment of care. They can clearly state the actions, processes and expected outcomes of care for selected operations/procedures in priority order with performance measurements, staff skills and competencies to undertake them. They need to be regularly updated and reviewed to meet changing circumstances and they are no substitute for professional judgement. They can be used to guide the clinical team and develop a system of better team working particularly across the sectors of health and social care delivery.

Recommendation:

8. **The Trust should ensure it has a clear Patient Transfer Policy which is audited on a regular basis for compliance and appropriateness. This will be an essential policy which will need to link with existing policies across the managed clinical networks.**

Issues Raised:

Most staff were unaware if the Trust has a Patient Transfer Policy. Concerns were raised with regard to the Consultant Anaesthetist having to transfer critically ill patient to Altnagelvin or the Royal Group of Hospitals, as there is only one anaesthetist on call. The Royal College guidelines around treatment and transfer of patients with specific conditions are threatening the sustainability of the existing structures for some of the smaller Accident and Emergency Departments. This can be

further compounded by the onward transfer of patients which from any of the Accident and Emergency Departments can be delayed due to pressure on ambulance resources.

Other options to consider to support the Accident and Emergency Departments should include; improved communication and telecommunication across the sectors of care with more rapid diagnosis, joint consulting through telemonitoring and more remote interventions; enhancing the primary care role in the provision of emergency care; the training and usage of emergency nurse practitioners to run minor injury units and out of hours services with GPs.

A&E services are being provided without orthopaedic surgery available within the Trust. There have been no audits or evaluation of patient outcomes in terms of the appropriateness of backup care prior to transfer and the speed of transfers including the impact on the safety of patients.

Discussion:

There needs to be clear policies and guidelines of internal and external transfers, including who should accompany the patient and responsibilities between the two areas. Also the level of communication and documentation of care, including observations and investigation results. There is a similar need at regional level. At regional level there should be consideration of a retrieval system operating from regional centres for critically ill patients.

The outcome of the Ambulance Review which is imminent and could have an impact on the decision making, it is expected to recommend considerable change to the way ambulance services are delivered across Northern Ireland. The current standard for ambulance response times were set 20 years ago and they were based not on clinical need, but on times which were achievable at the time. Greater focus on more clinically relevant standards for shorter response times, especially for life threatening conditions, could save more lives. The Government has given commitment to the introduction of new ambulance performance standards, which has implications for recruitment, training and preparedness for ambulance personnel especially for paramedical grades. The current National standards require that at least one of the crew on any Accident and Emergency ambulance should be a paramedic. The WHSSB require a further three paramedics to reach this standard and these paramedics should be available shortly. The onward transfer of patients from any of the Accident and Emergency Departments can be delayed due to pressure on ambulance resources.

In response to cardiac emergencies there is a direct telephone access to coronary care units in Altnagelvin, the Tyrone County and the Erne Hospital by GPs, RUC and the Ambulance Service. The telephone number is also given to patients who are considered to be high risk. Mobile Coronary Care Units provide a first line emergency ambulance service to patients with acute chest pain and are staffed by a doctor and coronary care nurse. There is one based at Altnagelvin, Tyrone County and the Erne Hospital. Both Altnagelvin and the Tyrone County use front line

ambulances and the Erne Hospital use a dedicated car driven by medical staff. The system works well across the WHSSB. It is understood that with the amalgamation of Tyrone County and Erne that there could be two sites and consideration should be given to appropriate alternative plans to ensure support for coronary care for the distant rural communities.

Recommendation:

9. **Consider a system for regular monitoring and recording of occurrence, complaints, near misses, incident and clinical indicators to staff and patients. It would be also beneficial to have guidelines for recording the severity of incidence, action taken and their potential for complaints, claims and or pending litigation.**

Issues Raised:

There was no structure for clinical incident reporting given amongst those staff interviewed. Health & Safety incident reporting appeared to be satisfactory within Directorates. It was also stated by more than one that there was no sharing or learning across the Trust from clinical incidents that had occurred. The Trust is addressing this issue in the Trust Quality Strategy and near miss and incident reporting will be piloted in the Obstetric and Gynaecology Directorate.

Following discussion and consideration given to the hazards of lone working and potential incidents where staff are at risk, a policy on Violence to Staff has been developed by the Trust through a staff working group in conjunction with the Staff Side. This followed earlier training for staff in Care and Restraint training.

There is no system for checking that staff using their vehicles for work are properly insured. Although staff have to sign a declaration at the time of claim submission. A system should be introduced whereby all such staff are required to provide the above documentation to the Trust for view at commencement of employment and annually thereafter.

Discussion:

Incident reporting, investigation and follow-up are considered a minimum risk management standard, alongside the clinical complaints procedure which are a means of assessing areas where improvements need to be made. The reporting of near misses is also important as we can learn from these and put systems in place to stop them happening. A definition of a Near-Miss may be **"an occurrence which but for luck or skilful management would in all probability have become an incident".** As healthcare professionals we need to be prepared to share things that have the potential to go wrong and to have a learning culture to prevent patient accident or injuries from occurring in the first place. A clinical incident may be defined as **"any occurrence, which is not consistent with the professional standards of care of the patient or the routine operation/policies of the organisation".**

Consideration should be given to extending the provision of training in customer care to all clinical staff, ward and clinic clerks and consultants' secretaries.

Management of untoward patient outcomes should be undertaken on a proactive basis within an open, honest and supportive environment. The development of one, clear and easy to use, incident report form to be completed by any employee having knowledge of an untoward occurrence is essential. This would enable senior staff to be informed of all such instances and will allow them to mitigate any potential for a negative reaction from staff or patients. In addition to responding to individual events, this data collection process will enable identification of developing trends, which require intervention.

The Trust should afford the highest priority to developing and implementing a more robust incident, 'near miss' and clinical indicator reporting system to rectify any current inadequacies. This process will be accompanied by relevant training, definitions and communication that the Trust will be supportive in its stance to the management of near misses, incidents and errors reported.

In the experience of HRRI, there is a constant need for the Trust Board to reinforce its principles and values, in order to ensure there is a positive approach to the management of risk throughout the organisation.

There is no doubt that the Trust will have a lower-risk profile if it articulates and demonstrates the following values:

- openness and honesty within the organisation;
- supportive to staff rather than blaming or recriminating;
- positive attitude to problems;
- quick and decisive response to reported deficiencies;
- desire to learn from errors or mistakes;
- staff are given feedback on action taken in their reports of incidents.

The Trust should have an ethos of providing education and training and providing a learning environment. At present the Trust has not got specific statements on developing a 'just' culture or no blame culture that supports incident reporting and clarifies the relationship with the Trust's disciplinary policy. It is necessary to clarify that the Trust encourages reporting of incidents and near misses but that there are instances when disciplinary action may be taken.

The Trust Management should communicate the following statement in a suitable form to all employees:

'Staff who make a prompt, full and honest report regarding a particular near miss or incident will not be disciplined except under the following exceptional circumstances:-

- *Where the member of staff acted criminally, deliberately or in a malicious manner;*

- *where the member of staff is guilty of gross misconduct or carelessness with a potential for serious consequence and where the person could be reasonably expected to appreciate or foresee the results of their behaviour;*

- *where the incident or accident follows one or more previous incidents of a similar nature and where all appropriate training, supervision and counselling has been provided by the Trust.'*

The Trust encourages staff to raise concerns. Staff have made use of the Trusts' Policy for Raising Concerns, Policy on Harassment at Work and the Grievance Procedure. Staff have dealt with problems at the time by raising them with line managers, professional advisers, the Chief Executive and Chairman. The Trust does not operate 'gagging clauses' and responds openly to staff side issues through the monthly Joint Forum meetings.

The Trust should continue to extend an 'open' culture which will remove barriers to the effective implementation and function of the Trust's and Directorates' Risk Management Programme. It will be a continued challenge for the Trust to ensure effective systems and provide on-going support and assurances to all staff.
The development and expansion of the current Trust-wide usage of clinical indicators would help in highlighting high risk cases and examples of where deeper review is needed of particular cases. For example in obstetric, gynaecology and neonatal, specific clinical indicators will provide triggers and early warning signs of potential problems. The suggested minimum data set for these services use of clinical indicators are as follows: -

Maternal
- Third degree tear
- Anaesthetic problems
- Convulsions/eclampsia
- Delay in caesarean section over 30 minutes
- Drug errors
- Failure of equipment
- Hysterectomy
- Intensive care unit transfers
- Post partum haemorrhage of over 1000 mls
- Return to the operating theatre

Neonatal
- Apgar score less than 4/5 at five minutes
- Caesarean section after failed instrumental delivery
- Unsuspected congenital abnormality
- Stillbirth or neonatal death after 24 weeks
- Unexpected admission to Special Care Unit.

The Trust should also consider extending the role and membership of the Scrutiny Committee to investigate both specific critical incidents of a clinical nature, and incident trends. This would consist of a group of senior medical and nursing staff whose role would be to:

- Reviewing clinical claims as they arise with a view to ascertaining their educational and predictive value from a risk management perspective;
- evaluating the Trust's clinical policies and procedures with a view to incorporating up to date evidence based practice as appropriate;
- liasing as required with the Risk Management Group and specifically in relation to clinical risk priorities;
- reviewing clinical incident reporting data and instigating measures to address any specific trends highlighted.

This Group should be established and be accountable within the Trust's Clinical Governance framework and consist of a small number of respected clinicians who would meet regularly to review all potential claims and give a balanced view on whether these should be defended or settled. In making their judgements, they would seek expert advice from clinicians within the Trust and where appropriate externally.

WORKFORCE ISSUES

Recommendation:

10. **The Trust should develop without delay a robust Human Resources Strategy outlining ways of achieving safe organisational practice, through safe up-to-date clinical practices with healthy staff who are fit to practice.**

Issues Raised:

There is currently no human resource strategy which has been shared with all staff and being used as a working document to progress organisational developments. There is a need for a clear and concise human resources strategy as the Sperrin Lakeland model outlines high quality sustainable services, which are provided to a high standard for the local population. This demands good standards of staffing levels through grade and skill mix workforce planning, staff who are highly motivated, valued and enthusiastic, with some degrees of specialisation and availability of expertise to provide and maintain the highest possible quality of clinical care. The establishment of managed clinical networks may mean patients by-passing their nearest hospital completely, or being assessed locally and quickly transferred elsewhere. Staff must have career and structure opportunities to keep up-to-date in their area of special interest and in new developments.

In view of the present uncertainty about the configuration of acute services, staff morale was anticipated and reported as being low. Some staff felt they were undervalued and there was too much secrecy. A staff survey should be conducted without delay to assess the magnitude of the problem, to inform the human resources strategy and to allow an ongoing action plan to counteract the issues being raised.

It was said that the strategy needs to address the high level of stress within the Trust. Sickness absence was said to be 8-10% at Erne and 15% at Omagh. Occupational Health (OH) services are provided by Westcare (part of Foyle Trust) and several staff reported favourably on the services provided and support given. The Consultant in OH has stated that across the Trust 1-2% sickness absence may be attributable to the Omagh bombing incident and about 0.5% relates to issues of uncertainty causing anxiety. It was stated that the Trust has appointed an 'Attendance at Work Adviser' to support managers.

Although a national problem, of nurse shortages, issues sited as a particular problem in this Trust were due to theatre staff shortages, under recognition of nurses and feeling of being undervalued were all raised. "Heroes to Nothing" was being quoted. These issues should also be addressed through the Theatre Users Group to identify operational policies and the impact on the working practices.

Concerns raised with regard to staff being equipped/qualified to cope with workload/ casemix and meeting patient need. One example of the impact where these concerns are occurring is in elderly care where there has been increasing dependency levels of the patients with shorter lengths of stay making them more acutely ill and yet managed with the same staffing levels.

There were discrepancies with regard to the Trust Transfer of Staff Policy in moving staff across the Trust. This has worked well in the past and has helped with joined working. Recently with changes in the policy it was stated that full applications and recruitment processes had to happen in the future with perceived barriers to movement and full service provision. The draft human resources strategy should be reviewed in light of these comments.

A Regional human resources strategy has been contributed to since late last year. The information-gathering phase has been completed but the draft document is yet to be issued. Within the Trust there is a need to develop an underpinning strategy but its content will be influenced by the Regional Strategy. A separate initiative arising from the January 1999 Trust Development Day is being worked on and a scoping document has been prepared for consideration.

Discussion:

The organisational Human Resources Strategy should be developed and reviewed to reflect the current and future challenges that the Trust faces in the new NHS. This will be based upon an organisational development approach and address the wider Human Resources and related imperatives as outlined in the Department of Health's 'Working Together - Securing a Quality Workforce for the NHS' document.

From a risk management perspective, an effective and up-to-date Human Resources Strategy will reduce the risks associated with low moral, employment-related stress, Health and Safety risks and non-compliance with employment legislation. It aims to reduce sickness and absence rates by 20% of the present levels by the Year 2001.

On the positive side, proactive Human Resources planning and management will facilitate effective risk reduction measures. These are outlined in the 'Working Together' document under the following headings:

- a fair process for determining reward;

- enhanced job satisfaction through a sense of empowerment and active involvement in the decision-making process;
- equality of opportunity;
- individual skills development;

- positive and understanding management;
- staff well-being and security in the work environment.

The pace and scope of change has understandably contributed towards a culture in which some staff may feel threatened, uninformed and under-valued. Whilst the Trust itself is not always aware of the impact and 'sharp end' consequences of the Government's health care agenda, there is a need to ensure that all staff are kept as informed as possible. Timely communication with staff accompanied by supportive 'body language' from the organisation will assist in alleviating staff fears and maintaining positive morale. Failure to address this risk will result in poor behaviour amongst aggrieved staff and a reluctance to embrace the Trust's very significant short-term strategic challenges.

Much of the present anxiety may be rooted in the future demands that will be made on nearly all individuals in meeting the challenges of a new healthcare environment.

To a certain degree, the previous purchaser/provider arrangements precipitated a 'compartmentalised' management culture in which specific individuals assumed quite defined and specialist functions. There is now a requirement for all managers to adopt a far more expansive role. This necessity can create concern and a lack of confidence. The Trust recognises this potential source of instability and will address any perceived or actual skill deficits sensitively and promptly. A recurring theme within the Trust is the lack of organisational succession planning. This creates a significant risk exposure. From the corporate perspective, inadequate deputy cover and a failure to transfer specific skills to defined individuals expose the Trust to unwarranted risk. The loss of key individuals at short notice, unforeseen ill health and retirement can be better absorbed if appropriate organisational arrangements have been implemented in a timely manner.

Recommendation:

11. **Consider the development of a process by which the performance, in line with clinical governance of all the medical, midwifery, nursing, therapy and support staff will be measured based upon training, skills, competency and experience through individual job plans. A framework for the Scope of Professional Practice should be developed as a matter of priority.**

Issues Raised:

As discussed in recommendation 9, the Trust encourages staff to raise concerns. Staff have made use of the Trusts' Policy for Raising Concerns, Policy on Harassment at Work and the Grievance Procedure. Staff have dealt with problems at the time by raising them with line managers, professional advisers, the Chief Executive and Chairman. The Trust does not operate 'gagging clauses' and responds openly to staff side issues through the monthly Joint Forum meetings. Knowledge of the Trust's 'Policy for Raising Concerns' was variable and consideration should be given to ensuring that all staff, particularly clinical staff, understands the policy and its application.

There has been delegation of responsibilities for duties such as IV cannulation, phlebotomy, plastering, fine bore tube feeding and swallowing assessment. A training programme was developed in conjunction with nursing education to introduce these skills in nursing. This should be subject to on-going review and support. There was no overarching policy or Framework for the 'Scope of Professional Practice' issues. It was stated that the medical staff would approve increased Scope of Practice through the Medical Staff Committee.

Lack of staff empowerment and utilisation of skills of existing staff. There is no Trust Wide Scope of Professional Practice Framework to allow and support clinical developments and expanded roles.

There are no Nurse Practitioner roles within the Accident &Emergency departments. These roles should be developed without delay to allow the Sperrin Lakeland model to be sustained and to provide high quality nurse led care at the port of entry into the hospital for most patients.

The lack off skill mix review within Erne outpatients department and the need to increase the scope of practice of qualified staff.

Discussion:

To maintain high standards of care and service, it is necessary to ensure all Trust medical, midwifery, nursing, therapy, social work and support staff only provide the care they are qualified to provide. Activities and procedures undertaken should be based upon education, experience and demonstrated competence, in addition to initial qualifications. Initial employment should be based upon a complete review of qualifications, skills and competencies; and clinical competence on all staff members

should be documented through individual job plans on a regular basis. There should be evidence of continuing medical education, professional recognition and results of various clinical audits. In the case of the junior doctors it is also appropriate to outline which operations/procedures they may perform with or without supervision.

There should be clear lines of accountability and responsibilities as to which professional is in charge of the patient's care at all time. A revalidation process to ensure fail-safe mechanisms are in place to ensure that minimum standards are adhered to should be addressed. This could take the form of internal peer review which could be benchmarked against external standards.

Safe practice and therefore safe patient care can be achieved if:

- staff work to an agreed level of skills and competency as outlined within their individual job plan;
- supervision and support systems are used;
- care and treatment given is based, where possible, on research and evidence;
- workload and service demands are not exhausting.
- rotation of staff to develop expertise and skills of the casemix of patients being cared for by them e.g. Intensive and high dependency care units.

It is the responsibility of both the Trust and the individual professionals to ensure that each member of staff receives the appropriate education and training to equip them to fulfill the responsibilities of their post. This can be best achieved through having an on-going, mandatory core programme of education and training for all staff, with additional, individual needs identified through a system of appraisal/performance review and clinical supervision.

Recommendation:

12. **The Trust should review the working across sites and the on-call arrangements in terms of meeting patient needs and complying with the Working Time Directive.**

Issues Raised:

Medical staff cover and on-call arrangements across the Trust are not sustainable at the current levels and stresses/pressures are starting to show.

On-Call arrangements, some of which are voluntary, and personnel problems in the laboratory services, which are due to supervision, split site working and poor accommodation on one site require to be addressed. These are in breach of the EC Working Time Directive and clinicians are hindered from any form of near patient testing for fear of closure of laboratory services. Voluntary out of hours working and the need for near patient testing.

Within the Tyrone County Hospital there are two housemen within general medicine. There is a link between medicine and surgery (2 JHO posts in each) out of hours. At present this is approved by the college but would normally be inadequate to meet junior doctor requirements. A third in each speciality is likely to be required in the near future. It was reported that there has been long term usage of locum medical staff /juniors which compounds the on-call and cover arrangements making them even more risky in terms of continuity of care and inadequate handovers with temporary staff who are alien to the care delivery system.

There is one community-based paediatric nurse working Monday to Friday 9-5 therefore at other times services are given by general district trained staff.

Discussion:

The current on-call should be made more sustainable with extra support through appropriate infrastructures. The arrangements are unacceptable as they give staff very little time away from the Trust, no time for family life and can make it difficult for staff to have time for multidisciplinary meetings across sites, and to have time to update and maintain their qualifications.

Within the Working Time Regulations (1998) the Trust will need to address its responsibilities relating to the Working Time Regulations that became operative October 1998. The NHS Executive has issued general guidance through HSC 1998/204. This will require the Trust to comply, wherever feasible with the Regulations and any variation to be demonstrably linked with the specific, functional requirements of the Trust in delivering an emergency service.

Recommendation:

13. **Consider establishing a formalised ongoing Multidisciplinary Education, Training and Practice Review Programme with staff input to topics selected and regular rostered attendances.**

Issues Raised:

There were high levels of commitment and necessity of staff education/training/Continuing Professional Development (CPD) but concerns regarding difficulties in releasing staff and provision of services.

Some staff were unclear about the policy for attending education and training events and there were perceived difficulties of inequalities of who received payment and time, those who just had time and those who received no support.

There was little evidence of multidisciplinary education and training session particularly in regard to the changing agenda and the need to sustain services alongside the Sperrin Lakeland model. Very little education and training had taken place around clinical risk management, near miss and incident reporting or the use of

clinical indicators with an open and honest culture for sharing of lessons learned, changes in and awareness of best practices.

Discussion:

There is a need for an ongoing structured education and training programme for all grades of staff linked to topic selection and training needs analysis. This could also help with the communication strategy and be used as the vehicle for ongoing review of practice, research and clinical audit. Within the Trust there should be better linkages into the universities and health studies colleges for service level agreements on the educational requirements and understanding of Post Registration Education and Practice (PREP), Continued Medical Education (CME) and Continued Professional Development (CPD). Improved educational, research and clinical audit links with the UK and Eire in both directions would help to provide flexibility for the province's needs in the future, the needs of the Greenfield site in the WHSSB and for succession planning of on-going needs.

In order to ensure that the interim period of service provision meets the appropriate quality standards and is sustainable, the education, training and skills, competency and confidence levels of staff are a crucial element. The Trust should address this by organising multidisciplinary sessions with rostered attendances to ensure staff are kept up to date, feels their education/training needs are being met and feel valued by the organisation. Clinical Governance places a duty of responsibility on all healthcare professionals to ensure that care is satisfactory, consistent and responsive, each individual will be responsible for the quality of their clinical practice as part of professional self-regulation.

SUMMARY OF RECOMMENDATIONS

Organisational/Management Issues

1. **The Trust need to identify the infrastructure, business requirements and resources which are required in order to sustain the local high quality services outlined within the Sperrin Lakeland model.**

2. **The Trust should review the community care provision and the impact of primary care developments alongside the acute services review to ensure better continuity of patient care across all health and social care sectors.**

3. **There is a need for a clear Communication Strategy with standards and audit criteria to monitor and measure effectiveness.**

4. **With the expected decision to extend the concept of Clinical Governance to Northern Ireland with modification to include Social Care, it is recommended that the Trust staff are made aware of their requirements to its implementation and sustainability across the Trust.**

5. **Patient and staff safety should be paramount during the interim period of service provision in considering appropriateness of care delivery, achievement of standards, quality criteria and outcomes.**

Services and Systems Issues

6. **Innovations, development and continuation of high quality services for patients and staff should be encouraged throughout the interim period with clear direction for clinical audit, continuous quality improvements and full utilisation of multidisciplinary standard of care delivery. The Trust should review its arrangements for the conduct and support of clinical audit to clinical teams. It should also tighten up the process of sharing and dissemination of audit. There should be clear direction given to audit topics in the light of implementation of the Sperrin Lakeland Model.**

7. **Consider the use of Trust Wide and Speciality specific regularly updated multidisciplinary pathways and clinical guidelines, policies and procedures with input from other wards and departments as deemed necessary.**

8. **The Trust should ensure it has a clear Patient Transfer Policy which is audited on a regular basis for compliance and appropriateness. This will be an essential policy which will need to link with existing policies across the managed clinical networks.**

9. **Consider a system for regular monitoring and recording of occurrence, complaints, near misses, incident and clinical indicators to staff and patients. It would be also beneficial to have guidelines for recording the severity of incidence, action taken and their potential for complaints, claims and or pending litigation.**

Workforce Issues

10. **The Trust should develop without delay a robust Human Resources Strategy outlining ways of achieving safe organisational practice, through safe up-to-date clinical practices with healthy staff who are fit to practice.**

11. **Consider the development of a process by which the performance, in line with clinical governance of all the medical, midwifery, nursing, therapy and support staff will be measured based upon training, skills, competency and experience through individual job plans. A framework for the Scope of Professional Practice should be developed as a matter of priority.**

12. **The Trust should review the working across sites and the on-call arrangements in terms of meeting patient needs and complying with the Working Time Directive.**

13. **Consider establishing a formalised ongoing Multidisciplinary Education, Training and Practice Review Programme with staff input to topics selected and regular rostered attendances.**

APPENDIX A

LIST OF PERSONNEL INTERVIEWED

Mr Hugh Mills	Chief Executive
[redacted]	Outpatients Services Manager
	Consultant Physician and Nephrologist, Clinical Co-ordinator, Medical Services
	Director of Mental Health and Elderly
	Acting Information Manager
Mr G McLaughlin	Director of Human Resources and Operational Services
[redacted]	Consultant Physician
	Community Nurse Manager
	Assistant Director of Estates
Mrs B Donaghy	Acting Director of Corporate Affairs
[redacted]	Associate Specialist – Accident and Emergency
	Senior Sister – Geriatrics
	Consultant- ENT
	Cardiologist-Chairman of the Medical Staff Committee
	Pharmacy and Sterile Supplies Manager
Mrs M Martin	Infection Control Nurse (Telephone Interview)
Mrs M Murphy	Health Visitor-Nurse Manger
[redacted]	Consultant-ENT
	Director of Planning, Contracting and Information
	Director of Community Care
	Acting Director of Community Care
Mr M MacCrossan	Director of Finance
[redacted]	Projects Nurse
Dr J Kelly	Consultant Geriatrician, Acting Medical Director
[redacted]	Consultant Physician
Mr S Millar	Chief Officer, Western Health and Social Services Council
[redacted]	Director of Business Services, Altnagelvin HSS Trust
Mrs T Brown	Risk Manager, Altnagelvin HSS Trust

[redacted]	Chief MLSO
	Consultant Surgeon
	Senior Sister, Elderly Care
	Senior Sister, Surgery
	Senior Physiotherapist
	Clinical Audit Facilitator
	Community Services Manager /Child Health Care
	Electro Biomedical Engineering
	Resuscitation Officer
	Consultant Surgeon
	Consultant Pathologist
	Consultant Anaesthetist
Ms E Millar	Clinical Service Manager, Women and Children's Services
Mr T Anderson	Consultant Obstetrician, Acting Clinical Co-ordinator, Women and Children's Services
[redacted]	Acting Clinical Service Manager, Medical Services
	Senior Social Worker, Family and Child Care
Dr C Halakoon	Consultant Neonatologist/Paediatrician
[redacted]	Consultant Anaesthetist
	Consultant Surgeon
	Superintendent Radiologist
	Trust Chairman
Mr E Fee	Director of Acute Services
[redacted]	General Services Manager
Mr T Frawley	General Manager, WHSSB
Mr M Bradley	Chief Nurse, WHSSB
[redacted]	Consultant Anaesthetist, Clinical Co-ordinator, Surgical Services
	GP, Erne Health Centre
	Ambulance Service
	Ambulance Service