

(b) Eastern Health and Social Services Board Meeting held on 9 June 2005

Dr Kilbane outlined the following issues which were discussed at the Board meeting:

- Annual review of Standing Orders
As governance is a central issue within Health and Social Services and other public services, an annual review of standing orders is carried out. This year the EHSSB were particularly keen to take on board any lessons that would be likely to be learnt from the Jack Report which focused on Financial Management in Education and Library Boards. The EHSSB had concluded that although the procedures and processes were in place it would be helpful to be more explicit in the standing orders.
- Strategy for adults with a physical disability including sensory impairment
This draft strategy had been circulated for a three month consultation period in November 2004. At the Board Meeting the strategy was approved and there is now a 10 year strategy in place to address the needs of physically disabled people. As this is a large agenda, work will be done to identify the short term objectives which will be focused on initially. This will involve engagement of patients with a variety of disabilities in the planning of services so that patients can facilitate the design of individual care and maximise the use of new technologies.
- Response to the Childrens Services Plan
Some progress has been made in relation to the collaboration of a variety of organisations whose activities can impact on children. There is still a lack of joined up initiatives, with some organisations undertaking individual initiatives without giving full consideration to the impact it may have on other service areas. There are also financial difficulties in relation to the adequacy of funding for services for children.

The EHSSB is meeting with the Commissioner for Children and Young People to discuss how to develop the provision of children's services against the restraint on resources. In the current year there has been no allocated resource to deal with the emerging need of some services, in particular speech and language therapy.
- Paper on victims and survivors of Northern Irelands' 'troubles'
The EHSSB response to consultation on the Trauma of the Troubles and Services for Victims and Survivors was discussed. This outlined the individual and differing needs of people who have been victims of the troubles and about what needs to happen to help them move onto becoming survivors. There was discussion about the range of services provided including therapeutic support. The EHSSB would support a Commissioner for survivors but the role and responsibility of a Commissioner would need to be clarified with legislative support.
- Making the best use of the Pharmacy Workforce
This consultation document from the DHSS&PS was discussed. The document outlines proposals for changing the roles of pharmacists in order that they may use other skills which they have achieved through long hard study.

The EHSSB would support the change in the role of the pharmacist. Although there is a risk associated with the proposed delegation of some functions to pharmacists, this must be measured against the risk of not using the limited number of pharmacists available to their full potential. Other professions are extending their roles and delegating functions. The use of additional pharmacist skills would build into the EHSSB Strategy for the development of Primary Care, where pharmacists will be an important part of medicines management.

Miss McMillan said that having recently called into the new pharmacy in Strangford it is welcoming to see prescribing pharmacists. It is important to recognise that medicines management is not only a patient health matter but also a financial matter, as this will free up resources which could be diverted to other services.

The Chair thanked Dr Kilbane for providing the update to Council.

55/05 MR STEPHEN ADAMS, HEAD OF CORPORATE SERVICES, EASTERN HEALTH AND SOCIAL SERVICES BOARD

Mr Adams was attending the meeting to clarify questions raised by Council on medical and clinical negligence. The concept of clinical negligence and claims has been in the National Health Service (NHS) since 1948 with evidence of claims available prior to this in the days of the voluntary, charitable and religious hospitals. Until around the 1990s most clinicians and nurses contributed to funds from which the NHS would meet its clinical negligence costs, which was similar to an insurance fund. However, by the early 1990s these funds were inadequate and government nationally recognised that this issue required some reserve to be set aside with a process in place to identify a means of meeting claims. Government also recognised that it was not only a matter of meeting the financial requirements of claims but that lessons needed to be learned and shared through review, audit and change of practice.

In practice all health organisations in Northern Ireland are self-insured and carry their own liability. The EHSSB carries the responsibility for the care issues of a clinical negligence nature that arose when the EHSSB managed all the hospitals and community services across the Eastern area. By 1993/1994 when Health and Social Services Trusts were formed, Trusts took on responsibilities for their own clinical negligence claims. In most Trusts, claims would be managed by a senior clinician with the support of an administrator, legal advisor and other advisors as required. The other advisors would be professional experts in a particular field pertaining to the individual case. Often the resolution of a clinical negligence claim is decided on the balance of the opinion of the experts speaking on behalf of the person making the claim and the experts speaking on behalf of the organisation that is seeking to defend its practice.

Mr Adams explained that when he received the outstanding EHSSB cases in 1993/1994 there were around 1000 cases. It is important to recognise that this reflected 1000 individual people who felt they had an unacceptable experience to varying degrees. About 8 years ago the EHSSB started categorising claims as follows:

1. Active—where there is clear evidence on the part of the person making the claim or their representative leading to further action such as a writ, hearing or settlement
2. Held—for further information.

Of the 680 cases the EHSSB had outstanding in 1994, 249 were categorised as active. In relation to ultimate settlement of cases, Mr Adams explained that for every 1 settlement made, 5 cases are closed by mutual agreement with no settlement. This is because the person making the clinical negligence claim may have been advised that their experience was not unusual or evident of negligence.

Mr Adams reported that in the past year the EHSSB closed 41 cases of which 7 required some settlement. In the average year settlements are small and sometimes a decision is made to make an economic settlement to bring closure to a case rather than have costs for both parties rising.

Mr Adams gave examples of some of the reasons for claims:

- Unexpected complications
- Outcome which led to further complications and deterioration resulting in physical or psychological damage
- Failure of equipment
- Communication and consent – with patients or their representatives not having a full understanding of risk of procedures
- Confidence – in new procedures or practice such as new vaccination initiatives

The main areas of care resulting in claims include:

- Obstetrics -very often the claims that are longstanding are linked to the area of births and complications and Mr Adams confirmed that obstetrics presents the largest area of settlements across the EHSSB area. A child has a right to lodge a claim up to the age of 21 years and this can be difficult when trying to look back on records when you consider how obstetric care has changed with closure of GP maternity units and consolidation of a number of maternity units.
- Orthopaedics - another area resulting in a fairly large number of claims which is very often linked to trauma and road traffic accidents.
- Accident and Emergency – sometimes patients feel outcomes are unsatisfactory in pressure areas such as Accident and Emergency where often staff and practitioners are under extreme pressure.

Mr Adams emphasised that if a patient makes a claim this must not affect the care they receive from the organisation. If the patient feels uncomfortable about receiving continuing treatment after making a claim, the organisation has a responsibility to arrange for the patient to receive care elsewhere.

The support mechanisms in place for a person making a claim involves their legal team. How much they can advance a case is strongly influenced by the legislation and the funding available through legal aid. A person may get help at an early stage through legal aid but an expert opinion will determine whether there is a case to proceed through the legal aid process. . There are currently local and national initiatives to try and make sure that court processes don't make it any more difficult or slower for people who have reasonable and legitimate claims against any service.

The EHSSB claims managers get support from a legal team and experts in public health, obstetrics and orthopaedics

Each year the Health and Social Services Boards and Trusts advise the DHSS&PS of an estimate of costs for claims. The DHSS&PS then hold this as a projected reserve for the incoming year. However, it is difficult to assess if the figures are an over or an under estimate. In the first year or two it is difficult to put an estimate of cost onto a case as it can take this time to get a full indication of the gravity and extent of the case. At this stage a percentage estimate of severity of the case is assessed and this is what is notified to the DHSS&PS. The assessed percentage can change as more information about the case becomes available.

The EHSSB make a quarterly return to the DHSS&PS providing details on the number of cases that may close within the next quarter and an annual return is made estimating the reserves required.

In relation to learning from mistakes and complaints there was significant investment in clinical audit in the 1990s and this is now matched with various quality and clinical standards initiatives for patient safety which include risk management, incident reporting and near misses. There is a National Patient Safety Agency to which all Health Authorities in England report and we are currently seeking agreement in Northern Ireland to work with this agency.

The DHSS&PS have been seeking to develop a coordinated central database from all the health and social services organisation to provide central information on numbers of cases, the costs and reserves required and to identify areas which can be learnt from. This resulted from a national and a Northern Ireland audit.

Mr Compston highlighted that the projected figure for settlements over the next five years is £90million which is a substantial amount of money. He asked Mr Adams what proactive measures are in place to prevent negligence and what lessons have been learnt to prevent similar mistakes happening to patients in the future.

Mr Adams explained that some claims are settled economically for an amount of £500 or £1000 in order to let the claimant know that their representation was not in vain. There are proactive initiatives in place both regionally and within individual Trusts aimed at improving quality of care. These include:

- reporting procedures for near misses for in-depth investigation.
- clinical audit
- review of complications and unexpected outcomes
- risk management
- active ongoing professional training
- active screening and immunisation programmes
- consent and communication improvements
- improved documentation
- replication of good practice

The important thing about the whole governance initiative is reviewing, identifying if change is needed, identifying who needs to be informed and learning from situations instead of just dealing with them.

In response to a question from Mr Marshall regarding the legal implications of signing a consent form, Mr Adams said that the consent form does not alter patients' legal rights in any way. The consent form is used to explain to a patient the nature of what they are agreeing to and what the possible risks or complications are. Consent is an essential pre-requisite to a procedure and is usually discussed prior to admission. In emergency situations a guardian or representative may have to consent on a patient's behalf. In the rare emergency cases where someone would require a procedure but no representative is available, sound clinical judgement would be exercised with probably more than one doctor making a clinical decision. Mr Adams confirmed that the governance and risk arrangements for research and for clinical trials has been tightened considerably over the last 3-4 years. Patients receiving treatment as part of research must have this fully explained and patient consent is required. It is recognised that the timing and patients understanding of consent are issues which must be considered by doctors.

In response to a question from Mrs Canning, Mr Adams confirmed that an allocated figure is not put on a case until information is available and the nature of the case can be assessed. Every case is reviewed at least yearly and every contact with the client's solicitor or the EHSSB's professional advisor results in a review of the case to assess if the percentage estimate requires revision. The EHSSB uses legal advisors who are based in the Central Services Agency but the handling of cases and final decisions are managed by the EHSSB. In relation to cases which relate back to hospitals prior to self management in 1993, there is close liaison with the current management of the relevant Health and Social Services Trust. As some of the cases date back some time, the current service often bears no resemblance to the service in place when the case arose.

A central fund exists in Northern Ireland and the DHSS&PS are setting up a central database to monitor this and there are close links with the NHS Central Litigation Authority in England.

Mr Graham asked Mr Adams to clarify that the money held for clinical negligence settlements is a contingency sum and not taken from resources allocated for patient services. Mr Adams confirmed that the money held is non-recurrent money which is there should it be needed, but is not taken from direct patient services.

Mr Compston asked if registers of negligence cases would be available for patients in the future. Mr Adams explained that naming individual doctors who may have one adverse outcome in a long established career could result in some doctors deciding not to undertake high-risk procedures. It must be recognised that some doctors undertake procedures which may be carried out infrequently, making the risk greater, but which can make an enormous difference to a patient's quality of life. The balance of acceptable risk against patient safety is often difficult to determine.

Mr Adams confirmed that all HPSS organisations must have a 'whistle blowing' policy that enables staff to raise concerns they may have about processes or colleagues in relation to quality and safety of patient care. Although quality of care is a high priority the initiatives in place to monitor this are often first to suffer when resources need to be saved.

The Chair thanked Mr Adams for attending the meeting and providing a comprehensive report on this important issue.

56/05 CHAIR'S BUSINESS PAPER 11/05

Miss McMillan highlighted the following from her list of Chair's business:-

- (a) Joint Board/Council Workshop, 24 May 2005
Part of the workshop involved the viewing of a DVD from South and East Belfast Trust that highlights the wide range of activities used to involve young and old people in promoting their Health and Well-being Improvement Plan.
- (b) Northern Ireland Regional Transfusion Committee, 27 May 2005
As lay representative on the Northern Ireland Regional Transfusion Committee, Miss McMillan confirmed that the draft Regional Transfusion Policy is now being finalised. Once implemented, the same procedures will be in place across Northern Ireland, which will be less confusing for doctors as they move through different hospitals.
- (c) Future of Public Administration, 6 June 2005
This conference had focused not only on health, but also on the future of all public authorities.
- (d) Note of thanks
Miss McMillan advised members that she had received a card from Mrs Jane Graham expressing thanks to Council for the best wishes she had received on her retirement.

The Chair, who has now held the position for one year, thanked Council members and staff for their support over the last year.

57/05 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on Thursday 19 May 2005 were agreed by members subject to the following change:-

43/05 under 'Infrastructure'. 'She was though interested in the new dental contracts because she has anecdotal evidence from constituents who fear they will not be able to obtain NHS treatment.' should read 'who are not able to obtain NHS treatment.'

58/05 MATTERS ARISING

- (a) Minute 43/05 Consultant and GP contracts
The Chief Officer confirmed that he is still awaiting a reply from the EHSSB who are collating their reply to Council regarding a query made on the productivity achieved with the increase in resources into GP and consultant contracts and the Agenda for Change initiative.

In response to questions from members, Mr Dixon confirmed that the EHSSB hope to provide figures on the use of Accident and Emergency for GP out of hours service at the end of the summer, as there has been some suggestion that there is over-referral and increased patient attendance at Accident and Emergency because of confusion over the new GP out of hours service.

(b) Minute 44/05 (i) Patients waiting on trolleys

The waiting time figures for patients waiting on trolleys in May 2005 were circulated to members.

Some Council members had met with Mr Clive Gowdy, Permanent Secretary, DHSS&PS on the 17 May 2005 to discuss the unacceptable trolley wait situation. A letter of thanks has been sent to the Permanent Secretary stating:

- that Council welcomed Mr Gowdy's invitation to meet regularly
- that Council would like to receive a copy of the terms of reference for the Regional Steering Group.

(c) Minute 46/05 (a) Paediatric Cardiac Surgery

The Chief Officer reported on a discussion with Dr Miriam McCarthy, Medical Officer, DHSS&PS, who had confirmed that a group has been established under the Chief Medical Officer to look specifically at the provision of paediatric cardiac surgery in Northern Ireland. This group has met once so far and Dr McCarthy has undertaken to keep Council up to date with the progress made by this group.

The purpose of this group is to plan for the future provision of paediatric cardiac surgery and it will begin with a consideration of all possible options, including a stand-alone service and a networked service with other service providers. In taking this action, the DHSS&PS is seeking to be proactive in planning for future service provision in anticipation of the retirement of the one consultant currently in this speciality in Northern Ireland.

Dr McCarthy confirmed that the service is safe and secure and is adequately resourced by skilled professionals. There are very effective network arrangements with specialist services in Dublin, Glasgow, Birmingham and Newcastle-upon Tyne. The Belfast service is excellent at stabilising patients and transfer is undertaken with all appropriate professional support including air ambulance.

The issue around patients too ill to be transferred is a matter of local clinical decision-making. The inability to transfer a patient has not been an issue in ensuring patients have access to the services they require and it is not anticipated that it will arise as a concern in the delivery of this service in future as current arrangements are sufficiently robust.

(d) Minute 46/05 (c) Priorities for Action (Drugs)

- Anti-TNF for Rheumatological Conditions.

The Chief Officer confirmed that at the end of April 2005 there were 132 patients funded on Anti-TNF treatment in Greenpark Healthcare Trust and 16 patients funded in the Ulster Hospital at a total service cost of £1.374 million. The Health and Well-being Improvement Plan proposes further funding of £202, 000 to support the

commencement of treatment for an additional 37 patients. This would bring the service provision level to 185 patients and a total annual service cost of £1.576 million.

At the end of April 2005 there were 235 patients on the waiting list for this drug, the profile of which was:

Waiting Time (Months)	Number of Patients Waiting
0-2	44
3-5	40
6-8	23
9-11	33
12-14	21
15-17	20
18-20	14
21-23	17
24 +	23

Waiting times are monitored via monthly returns from the Trusts. The waiting list is increasing and there is no indication of additional resources in 2005/2006.

Mrs McGarry said that as Anti-TNF treatment costs approximately £10,000 per patient each year, the additional investment of £202,000, although welcomed, will not impact greatly on the waiting list.

It was agreed that Council should continue to monitor this situation.

- **Beta-Interferon for Multiple Sclerosis**

The Chief Officer confirmed that at 31 March 2005, there were 210 patients receiving Beta Interferon at a cost of £1.47 million for drug costs only. There has been further investment also in medicine, nursing and pharmacy. The estimated Northern Ireland wide requirement of this treatment is 550 patients.

The EHSSB currently provides 94% of its share of patients with this treatment. At the end of March 2005, there were 30 patients waiting for this treatment with the following profile:

Months Waiting	Patient Numbers
0-2	10
3-5	14
6-8	6
> 8 months	0

The waiting lists are provided on a monthly basis by Trusts.

(e) Minute 46/05 (h) Cholesterol Test Results

Dr Stanton Adair, Medical Director of Primary Care, EHSSB, had replied to a question raised at the previous Council Meeting by Mr Graham. He had confirmed that the Freedom of Information and Data Protection Acts do not impinge in any way on normal communication between staff and individual patients. Informing patients of

the result of their investigations would be considered part of normal practice/patient communication and should not be influenced by either of the acts.

(f) Minute 49/05 (c) Direct Payments Scheme

In response to a query from Council at the last meeting, Ms Philomena McCrory of the Centre for Independent Living had confirmed that changing the name of Direct Payment has been under discussion for some time, particularly in England. Consideration of the name change has been prompted by the similarity in name to Direct Payment—the scheme to pay state benefit and pensions direct to Bank Accounts.

This is subject to consultation in England at present in a Green Paper entitled “Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England” and some alternative names suggested include “individual service budgets” and “personal budgets”. There is no immediate prospect of a change in name in Northern Ireland.

59/05 REPORT FROM CHIEF OFFICER

(a) Review of Public Administration (RPA), Council draft Response

The Chair and Chief Officer thanked Mr Sean Brown, Senior Manager and Mr Ryan Simpson, Information Officer, for their useful summary of the Review of Public Administration at a Council Workshop held on 2 June 2005. Members had worked hard at the workshop to identify the key themes and issues that need to be included in Council’s response to the consultation. The Chief Officer circulated a paper to members which provided a summary of the issues discussed and the key themes identified. He outlined the proposed timescales for the response process as follows:

1. Draft Response to RPA (EHSSC plus 4 Council Response) – 30 June 2005
2. Draft Response to RPA – Council Proposals (4 Council Response) – 8 July 2005
3. Discussion of Draft and further feedback – July/August 2005
4. Final Draft response to RPA and Council Proposals – Early Summer 2005
5. Formal acceptance by Councils – 30 September 2005

Mr Dixon asked members to review the paper which outlines the issues identified from the RPA document on a whole and those issues specific to the proposals for a Regional Council.

Cllr Curran suggested that someone from the Review of Public Administration be invited to a Council Meeting to present and discuss proposals detailed in the consultation document. The Chair explained that previous briefing and consultation on this matter, including the workshop had given the Council a thorough understanding of issues under Review of Public Administration and that Council’s focus in coming months would be on drafting its response.

Members were asked to forward any comments or suggestions on Councils’ response to the Chief Officer as soon as possible. Mr Dixon hopes to draft a response by the end of June and this will be circulated to members for comment.

(b) EHSSC Workplan 2005/2006

The Chief Officer circulated a paper on the EHSSC Workplan 2005/2006, showing work proposals for Council for the coming year. The paper includes:

- Priority Areas across the EHSSB area
- Relationship to Workplan Objectives
- Manageability and Outcomes
- Suggested Actions Proforma
- Other Council Priorities
- Specific Tasks Suggested Under Priority Areas

Mr Dixon asked that members review the paper and advise him of any changes or suggestions for priority areas.

(c) Response to Consultation on Standards in Clinical and Social Care

This consultation issued by the DHSS&PS closes on the 4 July 2005. It is proposed that a set of basic standards in clinical and social care will be put in place for the Health and Social Services Regulation and Improvement Authority to use to appraise and assess services. Mr Dixon informed members that he proposes to broadly welcome the standards in his response on behalf of the 4 Councils. He will ask for clarification on whether these standards are all essential as defined, or whether these are standards that are aspired to as this could be confusing for patients.

60/05 CORRESPONDENCE PAPER EC 12/05

Paper EC12/05 was taken as read and no additional items were highlighted.

61/05 INPUT FROM COUNCIL MEMBERS

For the benefit of new members the Chair explained that Council members representing the EHSSC on various committees should complete a Members Report form which is circulated with monthly Council papers.

(a) Down Lisburn Trust Board Meeting

Cllr Mrs Campbell had attended the Down Lisburn Trust Board Meeting on the 15 June 2005. She said of note the following issues had been discussed:

- Presentation on new Downe Hospital. Stage 1 of the new hospital has been approved and the Trust is now progressing to Stage 2 which is the detailed design stage.
- Midwifery Led Care Unit at Downpatrick. Working Groups are being set up and a user group will be set up soon with representation from the Council and the Local Health and Social Care Group. Public meetings and a publicity campaign are planned in the Downpatrick area.

(b) Reports of Meetings

Mrs McGrotty submitted reports on the following conferences she had attended:

- Infection Control Workshop on 24 May 2005
- Healthy Ageing Conference: Interaction towards an action plan on 20 May 2005
- Review of Public Administration Workshop on 2 June 2005

- (c) Belfast City Hospital Trust Patients' Complaints Committee
Mr Graham had recently attended his first meeting of this committee where the complaints received over the first three months of the year were reviewed. Mr Graham said he was impressed with the commitment of the staff that are managing and administering these complaints. The next meeting is scheduled for September 2005.

62/05 INPUT FROM MEMBERS OF THE PUBLIC

Some District Councillors who are joining the EHSSC had attended the Council Meeting. The Chair apologised that she had to take their questions as part of the input from the public as the EHSSC has not yet received official notification of their appointment.

- (a) Beta Interferon Treatment for patients with Multiple Sclerosis
In response to a question from Cllr Calvert the Chief Officer confirmed that he would obtain a breakdown of patients on Beta Interferon in each Trust area.
- (b) EHSSC Workplan 2005/2006
Cllr Kelly has a particular interest in Mental Health and welcomed Council's proposal to include the rates of suicide as one of its priority areas for review in 2005/2006.
- (c) EHSSB queries
Cllr Leslie asked if the Chief Officer could find out the following information:
- whether the other Health and Social Services Boards are dealing with the same number of clinical negligence claims as the EHSSB
 - what staff sickness levels are in the EHSSB area and what is being done to reduce these levels.

Cllr Leslie took the opportunity to congratulate the ambulance service and the Ulster Hospital on the care recently given to a family member in an emergency situation and said that although there are many problems with the health service, it is important to recognise that a great deal of good work is done.

63/05 ANY OTHER BUSINESS

- (a) Microphone system
Members agreed that the microphone system is not required for meetings held in Grosvenor House and the need for the system in other venues should be assessed individually.
- (b) Banking details form
If members wish to have expenses paid directly into their bank account they should complete the banking details form previously circulated and return this to the Council.
- (c) Press Release
Members agreed that the Chief Officer should issue a press release following the Council Meeting.

64/05 DATE, TIME AND VENUE OF NEXT MEETING

The next meeting will be held on Thursday 18 August 2005 at 1.30 pm in the Bann Room, Farset International, Springfield Road, Belfast

Signed _____ Date _____
Chair

Signed _____ Date _____
Chief Officer