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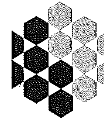

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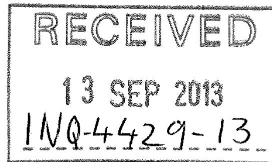

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Mrs Bernie Conlan
Secretary to the Inquiry
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Your Ref: BMcL-0138-13
Our Ref: LIT 0477/2008/CR

Date: 13th September 2013

Dear Bernie

HYPONATRAEMIA INQUIRY - DEPARTMENTAL AN ADDITIONAL GOVERNMENT SEGMENT

I refer to the above and your e-mail of 6 September 2013 attaching our request for information from the Assistant Solicitor to the inquiry. Please find enclosed a copy of HPSS Management Plans for 1996/97/98/99, 1997/98 - 1999/2000 and 1998/99 - 2000/2001.

Yours sincerely

C. Rodgers

CATHERINE RODGERS
for The Solicitor
Direct Dial: [redacted]

Encs

DF1/13/589886 CR/EC

HPSS MANAGEMENT PLAN 1996/97 - 1998/99

HPSS MANAGEMENT EXECUTIVE

The primary purpose of the Management Executive is to secure improvements in the health and social well-being of people in Northern Ireland by leading the implementation of government policy and by ensuring the provision of high-quality services which are both efficient and cost-effective.

MAIN FUNCTIONS OF THE MANAGEMENT EXECUTIVE

1. To provide, leadership, direction and support to the health and personal social services (HPSS) in Northern Ireland;
2. To set and ensure the achievement of precise objectives and targets for the health and personal social services in accordance with national and regional policies and priorities;
3. To monitor the performance of the health and personal social services in assessing need and improving the health and social well-being of the population;
4. To allocate resources and to ensure that they are used effectively, efficiently and economically, in accordance with the required standards of public accountability;
5. To promote the managerial environment necessary to achieve these objectives;
6. To provide, as required, advice, information and support to Ministers relating to the management and performance of the HPSS.

FOREWORD

Communications

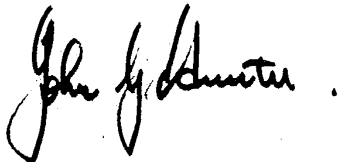
Effective communications are critically important, not least at a time of major change. Changes in clinical practice are affecting the nature and pattern of services. Changes in professional practice are affecting the organisation of services. Changes in public expectations are affecting the responsiveness of services to patients and clients. Changes in structure are affecting the roles and responsibilities of various HPSS agencies.

All these changes create uncertainty for both the public and staff. Their impact is often exacerbated by our use of jargon. We frequently fail to communicate plans and policies simply and succinctly. We owe it to our public and staff to communicate effectively.

This process also requires us to listen: communication should be a two way process. The promotion of locality sensitive purchasing requires Boards to purchase services for their resident populations which are sensitive to their needs. The informed views of the public must be sought if Boards are to contract for services which are needs led and patient or client centred.

Trusts and Units also need to communicate. The many examples of innovative practice, which I see on my visits, need to be publicised. We must build public confidence in our services.

This Management Plan sets out the Management Executive's policies and plans, with associated objectives and targets, for the period 1996/97 to 1998/99. The achievement of its challenging goals will require the co-operation and collaboration of the whole family of HPSS organisations and their staff.



J G HUNTER
Chief Executive

1. INTRODUCTION

1.1 CONTENT OF THE MANAGEMENT PLAN

1.1.1 This Management Plan, which is the fifth in the series, sets out a corporate agenda for the HPSS in Northern Ireland for the period 1996/97 - 1998/99. Whilst the format of the Plan is broadly similar to that developed last year, some refinements have been made specifically with the aim of giving the Plan a sharper focus. In particular, the Plan concentrates on areas of service delivery where the Management Executive expects Health and Social Services Boards to secure quantifiable, year-on-year improvements during the period covered by the Plan.

1.1.2 Other areas of service delivery - for example, some aspects of health promotion - for which improvements may take longer clearly to emerge, or which are not easily measurable on an annual basis, do not appear in the current Plan. However, these areas will continue to be included in the Regional Strategy, and Boards will be expected, as before, to work toward their achievement.

1.1.3 The Plan focuses primarily on 1996/97 and outlines the strategic priorities for the period 1996/97 - 1998/99. It is intended to provide direction to Boards, Trusts and others involved in the commissioning, purchasing, and delivery of health and personal social care on the key objectives, priorities and management tasks for that period. Health and Social Services Boards will be expected to reflect these priorities in their 1996/97 Purchasing Prospectuses and in their subsequent contracts with providers, and in their 1996/97 Action Plans which will be subject to endorsement by the Minister in the course of the annual Accountability Reviews in 1996. Health and Social Services Trusts and GP Fundholders will also be expected to reflect relevant targets in their business plans.

1.2 KEY OBJECTIVES

1.2.1 The next HPSS Regional Strategy, which will be published early in 1996, will cover the period 1997 - 2002. This will enable Boards to reflect the new Strategy's priorities and objectives in their purchasing prospectuses for 1997/98, and GP fundholders to reflect them in their business plans. Normally, the Management Plan contains specific targets for each of the three years covered in each Plan which reflect, where appropriate, the corresponding targets in the Regional Strategy. However, for a number of areas of service delivery it is not possible now - because the next Regional Strategy has not yet been finalised - to set targets for the two years following the focal year of 1996/97. Targets for 1997/98 and 1998/99 will, therefore, be published in the next Management Plan, following completion of the roll-forward of the Regional Strategy.

1.2.2 In the meantime, a series of Key Area Action Plans has been published and distributed widely throughout the HPSS, which identify a range of practical measures which should facilitate implementation of the current Regional Strategy.

1.3 CORPORATE CONTRACTS

1.3.1 The Management Executive has recently agreed individual corporate contracts with Health and Social Services Boards for 1995/96. Each contract represents an agreed list of items which each Board and the Management Executive will take forward in 1995/96, in addition to the items in the Management Plan for 1995 - 1998.

1.3.2 The Management Executive intends to take forward the corporate contract cycle by drawing up corporate contracts for 1996/97. Bilateral discussions with each Board will take place during the period November 1995 - January 1996, with the aim of completing the contracts by the end of March 1996.

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2.1 KEY OBJECTIVES

2.1.1 The key strategic objectives for the period 1996/97 - 1998/99 will be focused on:

- improving the health and social well-being of the population, which will be the main focus of the forthcoming Regional Strategy for 1997 - 2002;
- raising standards, improving quality and making services more responsive to the needs of individuals through the development of the Charter for Patients and Clients;
- targeting resources on those with greatest need;
- improving efficiency and ensuring value for money in the use of resources;
- developing the role of Health and Social Services Boards as commissioners of care; and,
- developing contracting with an emphasis on evidence-based decision making throughout the HPSS which will secure the greatest health gain from the resources available.

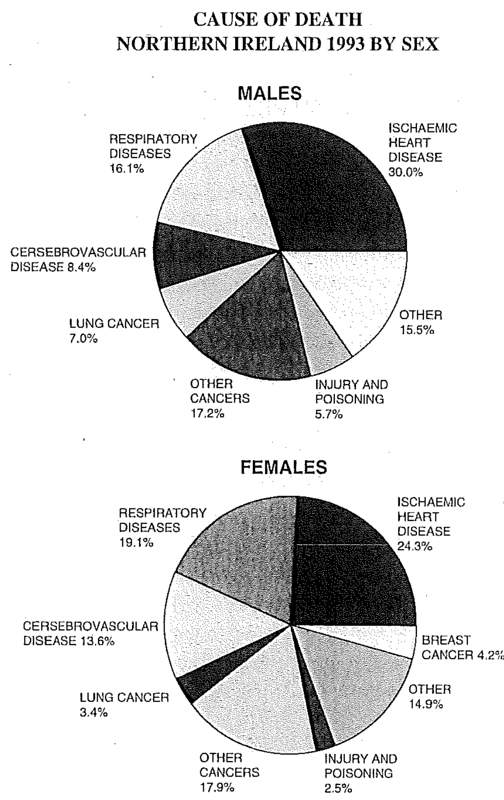
2.2 IMPROVING HEALTH AND SOCIAL WELL-BEING

2.2.1 The number of deaths from ischaemic heart disease has fallen by over 30% during the past ten years. In particular, significant progress is being made in reducing the number of premature deaths from the disease. It remains, however, the main cause of death in both men and women in Northern Ireland (Figure 1). Increased public awareness of the risk factors which give rise to ischaemic heart disease - such as cigarette smoking, unhealthy diet, excessive alcohol consumption and lack of physical activity - together with people's desire to adopt healthier lifestyles have been major contributory factors in this sharp decline. However, results from the most recent Continuous Household Survey indicate that around 30% of people in Northern Ireland still smoke cigarettes - well in excess of the Regional Strategy target of 25% by 1997.

2.2.2 Cancers are the second most common cause of premature death in Northern Ireland, with cancers of the lung and breast accounting for the largest proportion of all cancer deaths (Figure 2).

FIGURE 1

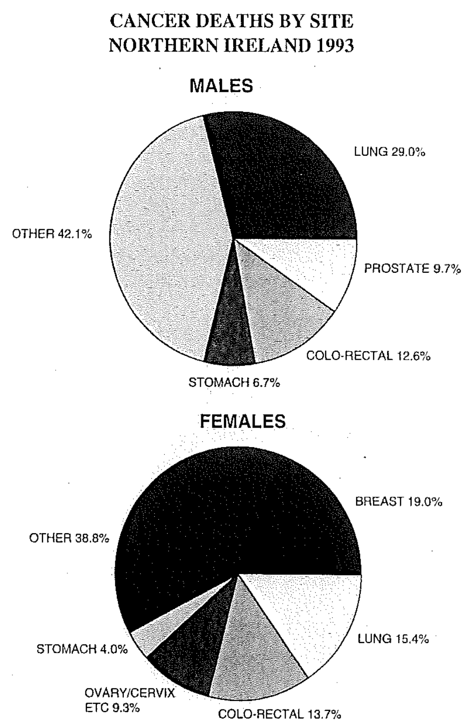
CAUSE OF DEATH
NORTHERN IRELAND 1993 BY SEX



Source: General Register Office

FIGURE 2

CANCER DEATHS BY SITE
NORTHERN IRELAND 1993



Source: General Register Office

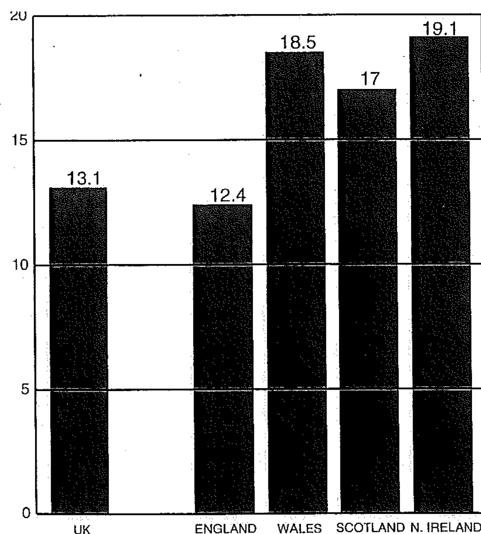
Deaths from these causes remain stubbornly high despite medical advances and a greater awareness of the risk factors which give rise to them. Mortality figures for these cancer types indicate that there has been no discernible decrease in the number of deaths from these causes in the age groups covered by the Regional Strategy targets. Indeed, data indicate that female deaths from lung cancer are increasing.

2.2.3 Significant progress is being made in the area of maternal and child health. All primary immunisations, with the exception of whooping cough and MMR, have exceeded the 95% target for uptake; the continuing encouraging downward trend in the number of births to teenage mothers means that the Regional Strategy target for 1997 is achievable; the appointment of an additional consultant to the Regional Genetic Service will enable clinics to be provided locally, as well as at the Belfast City Hospital.

2.2.4 While the patterns of mortality in Northern Ireland are similar to those in the rest of the UK, people in Northern Ireland have relatively poor health compared with others in Great Britain. One of the possible reasons for this is the higher levels of material deprivation which exist within Northern Ireland. Long-term unemployment is very considerably higher than in the UK as a whole. In addition, a larger proportion of average household income is derived from social security benefits (Figure 3). Other indicators of social deprivation give a similar message.

FIGURE 3

% AVERAGE GROSS WEEKLY HOUSEHOLD INCOME DERIVED FROM SOCIAL SECURITY BENEFITS, 1992



Source: Family Expenditure Survey

2.3 RAISING STANDARDS

2.3.1 The Charter for Patients and Clients sets out the minimum standards of care and treatment that all patients and clients can expect when they are ill or in need of care and support. Boards will be expected to maintain and improve and extend these standards as local circumstances permit, and, in doing so, to seek the views of Health and Social Services Councils. Improvements should be incorporated in contracts and service agreements with providers, and Boards should publish an annual report on their achievements. Boards should encourage the publication or upgrading of patients and clients through consumer surveys and regular consultation with the GP practice leaflets to include the Charter standards for the services they provide.

2.3.2 A new Community Services Charter, published in July 1995, builds on the Charter for Patients and Clients, and sets standards for health and social services which support people in their own homes or in the community. The standards set cover: family practitioner services; nursing; midwifery and health visiting; personal social services; and the professions allied to medicine.

2.3.3 In June 1993 the Secretary of State for Health set up an independent review of NHS complaints procedures under the chairmanship of Professor Alan Wilson, Vice-Chancellor of Leeds University. This followed increasing concern about the procedures from within the NHS, the professions, patient representative organisations, and by the Health Service Commissioner. The health services in Northern Ireland were included within the remit of the review. The complaints procedures for community care and child care, which are the responsibility of local authorities in Great Britain, were outside the scope of the review. The review committee's report - 'Being Heard' - was issued for consultation in May 1994.

2.3.4 The Management Executive published its response - 'Acting on Complaints' - in March 1995. This announced the Minister's decision to have a new two-stage complaints procedure in the HPSS which will incorporate community care. Child care will be dealt with separately under the Children (NI) Order 1995. The Management Executive will take forward

implementation following consultation with relevant interests. The target date for introduction of the new procedures across the UK is 1 April 1996.

2.4 TARGETING NEED

2.4.1 Targeting health and social need (THSN) is a major theme of the Regional Strategy. Its ultimate objective is to minimise the inequalities in health and social well-being which exist in Northern Ireland by targeting resources where needs are greatest. Greater need for health and social care may be found in particular groups within the population linked by such factors as socioeconomic status, social grouping, location, age, sex and community background.

2.4.2 During the period of this Plan, Boards and GP fundholders will be expected to give priority to:

- implementing arrangements for the assessment of health and social care needs, at population as well as individual level, including the design and installation of appropriate information systems;
- identifying areas and groups with particular needs and ensuring that services are targeted and resources redeployed accordingly;
- identifying and, where possible, removing organisational or social barriers for disadvantaged groups;
- establishing, at local level, good inter-agency working arrangements with key agencies whose work impacts on health and social need; and,
- facilitating the participation of lay people in the decision-making process.

2.4.3 At regional level, a working group consisting of representatives from the Department, Management Executive, Boards and the Health Promotion Agency will consider how THSN might best be taken forward in the areas of:

- identification of need;
- effectiveness of interventions to reduce variations in health and social well-being;
- targeting of resources;
- assessment of any differential impact of policies and services;
- establishment of monitoring systems;
- strategic alliances with other organisations to address variations in health and social well-being;
- participation of users and potential users of services in the identification of need and targeting of resources; and,
- research and development.

The group's work will feed into the new Regional Strategy and future Management Plans.

2.5 VALUE FOR MONEY

2.5.1 Value For Money (VFM) remains a major priority. Bids for additional resources are strengthened if it can be demonstrated that improvements in efficiency are being rigorously sought. VFM improvements can also release valuable resources for redeployment. Despite the frequent focus on savings, VFM initiatives are also about quality and effectiveness.

2.5.2 The key factors in the delivery of improved VFM are sound information and effective implementation. Information on VFM recommendations and data on performance must be timely, accurate and relevant. Implementation of change as a result of VFM recommendations must be planned and achievable, but, most of all, it must be carried through to completion. The support of key staff is vital if improvements are to be real and sustainable. Many of the targets in this Plan involve improvements in service efficiency which can only be achieved with the commitment of the professionals involved.

2.5.3 Throughout the period of this Plan, purchasers and providers will again be required to:

- achieve further annual efficiency improvements amounting to at least 3%[1];
- continue the expansion of market testing into new areas;
- identify and disseminate any examples of good practice in achieving VFM;

[1] This target applies to GP fundholders in relation to the purchase of hospital services.

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- eliminate, as far as possible, inefficient and ineffective procedures; and,

- ensure the involvement of staff in the identification and delivery of improvements.

2.6 DEVELOPMENT OF COMMISSIONING

2.6.1 1994/95 saw the further development of the commissioning process and the internal market in Northern Ireland. In particular there was a continued expansion in the numbers of HSS Trusts and GP Fundholding practices.

2.6.2 A review of the purchasing function and structures in the Northern Ireland HPSS was completed. The review confirmed that the role of purchasing is to secure the provision of effective services which meet the needs of patients and clients, their carers and wider families, and hence improve the health and social well-being of the whole population. The review concluded that the key to the development of effective purchasing is to make it locally sensitive. This means that Boards must consult local communities, GPs and service providers about the provision and development of services. A key outcome of the review is that targets have been set for Health and Social Services Boards' commissioning costs as percentages of their revenue allocations for hospital, community health, and personal social services. The 1995/96 targets for each Board are as follows:

Eastern Board	1.5%
Northern Board	1.8%
Southern Board	1.9%
Western Board	1.9%

2.6.3 In common with developments in the NHS, Ministers in Northern Ireland wish to encourage the evolution of a primary care-led service, with more decisions about patient and client care being taken by primary care professionals. The extension of fundholding to more GPs is an integral part of that strategy, and the Management Executive will be looking to Boards to encourage eligible GP practices to enter the Fundholding Scheme and to help prepare others who are not yet ready for it.

2.6.4 The development of a primary care-led service will not, however, depend on fundholding alone; some GPs may not wish to join the Scheme, which remains wholly voluntary; and Boards will continue to be responsible for those services which are outside the scope of the fund. The Management Executive will expect Boards to work in partnership with all GPs, be they fundholders or not.

2.6.5 1994/95 was the first year of operation of the Purchasing Development Steering Group which is charged with:

- charting progress made by purchasers;

- identifying areas for further development;

- sharing examples of good practice; and,

- influencing the development of the purchasing environment in Northern Ireland.

The Group initially focused its attention on: involving the public in the commissioning process; contracting for quality including the use of outcome measures; developing contract types and currencies as incentives for delivering change; and involving GPs in the commissioning and purchasing of care.

2.7 CONTRACTING

2.7.1 In 1994/95 further progress was made in developing contract types. There has also been a growing use of cost-and-volume and cost-per-case contracts. The majority of contracts are increasingly sophisticated in their format and content. They now detail such areas as: agreed strategic direction; quality standards including audit areas; activity volumes; incentives, penalties and renegotiation triggers; as well as service investment or disinvestment plans.

2.7.2 The Management Executive issued guidelines and a revised timetable for the 1995/96 contracting process. This covered a number of areas including: adjustments to 1994/95 prices; handling capital charges; cost improvement targets; and extra contractual referrals. It highlighted the need for purchasers to engage their providers in developing contracts of longer than one year's duration. The importance of taking into account available information on clinical effectiveness and outcome measurement was stressed. The guidance also encouraged the development of condition - or disease - specific contracts and programme of care contracts in the interests of ensuring the provision of

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comprehensive care to patients and clients. These aspects continue to be relevant in 1996/97 and beyond.

2.7.3 The Management Executive in conjunction with Boards, Trusts and GP Fundholders has undertaken a review of the current contracting timetable. The new timetable is detailed in Appendix 2.

2.7.4 The Management Executive has also issued guidance on Professional Advice to Purchasers and the Development of Multi-Professional Audit. Implementation of this guidance will promote the further development of 'evidence-based' purchasing of health and personal social services. Increasingly, therefore, the emphasis must be on effectiveness and outcome measurement including the use of appropriate quality standards developed by professional organisations and other expert bodies.

2.7.5 From 1996/97 onwards the Management Executive expects that there will be no simple block contracts. All contracts, at a minimum, must have indicative volumes and thresholds in the form of floors and ceilings and agreed arrangements for managing over or under performance.

Contracts for acute hospital services should also have a breakdown in case-mix by in-patient, out-patient, day care and diagnostic service. Where possible there should be a clear identification of cost and volumes for each of these elements. The development of contract formats will require continued improvement in the coverage, depth and quality of clinical coding as well as the development of more sophisticated costing methodologies. The providers of community services must make significant progress in developing appropriate contract currencies and costing methodologies so that purchasing can be developed in this area. In addition, purchasers and providers should be able to demonstrate that they have made measurable progress, in appropriate areas of the service, in developing contracts of longer than one year's duration.

2.7.6 The Management Executive expects that all HPSS providers should have in place effective arrangements to ensure that the content and requirements of all contracts are understood by the staff required to deliver them. It is important that professional staff are fully involved in discussions about contract specifications, in-year monitoring, and management of contracts.

2.7.7 To assist in the management of emergency work, purchasers and providers should work closely with provider clinicians and GPs in developing appropriate referral guidelines to minimise inappropriate admissions, and to ensure that clear and adequate discharge arrangements are in place.

2.7.8 Boards must put in place arrangements to ensure all GPs can contribute at the key stages of the 1996/97 purchasing and contracting process.

2.7.9 Purchasers must ensure that they have arrangements in place to inform local people about the content of contracts, including changes from previous contracts and the benefits patients or clients can expect from them.

2.7.10 Finally, in previous guidance the Management Executive emphasised the importance of the development of mature working relationships between purchaser and provider. Boards and all providers also need to develop effective working relationships with GP fundholders, non-fundholding GPs, clinicians and other care professionals. Provider managers should ensure arrangements for allowing provider professional staff direct and open access to purchasers where these are not already in place. If the current developments in working towards longer term contracts, building mature relations and involving professional staff and GPs are to be enhanced, it is vital that purchasers and providers share at an early stage their respective strategic directions. In particular, purchasers - including GP fundholders - will need to develop a clear picture of preferred service configurations to guide providers in making significant capital investments.

3.1 BACKGROUND

3.1.1 This section reviews the progress that has been made in achieving the objectives and targets set for 1994/95 in the Management Plan for 1993/94 - 1995/96, and sets out the key service priorities for 1996/97 - 1998/99, based on: the strategic objectives and targets in the Regional Strategy 1992 - 1997; the strategic themes to be included in the forthcoming Regional Strategy for 1997 - 2002; and the commitments made in the Charter for Patients and Clients; and the Community Services Charter. These objectives and targets are not comprehensive and Boards will be expected to supplement them as necessary to reflect local needs and priorities.

3.2 FAMILY PRACTITIONER SERVICES

GP Prescribing - review of 1994/95 objectives

3.2.1 Fundholding has continued to be the single most effective method of containing the cost of GP prescribing. In 1994/95 the total overspend by all GPs in Northern Ireland on their indicative prescribing amount was 1.27%. Within this total overspend the 43 fundholding units had underspent their amalgamated indicative prescribing amounts by 3.76%.

3.2.2 To encourage non-fundholding GPs to achieve savings in prescribing, it had been intended to introduce in 1994/95 an incentive scheme specifically designed for Northern Ireland. This would have operated in conjunction with the indicative prescribing scheme, but legal difficulties were encountered and, as a result, it was not possible to proceed with the proposed scheme. Developments in the meantime elsewhere in the United Kingdom designed to promote more cost effective prescribing have led the Management Executive to decide, in conjunction with Board GP prescribing advisers, to look to the introduction of the Community GP Fundholding Scheme in Northern Ireland as a means of making further impact on prescribing. Boards will be expected to promote this Scheme actively with non-fundholding GPs, and the Management Executive will be monitoring uptake before reviewing the need to design another prescribing incentive scheme for those GPs who decide not to participate in any form of fundholding.

GP Prescribing - priorities for 1996/97 - 1998/99

3.2.3 Government policy is that patients should receive the drugs they need but that wasteful and unnecessary prescribing should be eliminated. To this end Boards should continue their regular and systematic visiting of practices to analyse GPs prescribing habits and discuss with them how to achieve greater cost-effectiveness without loss of quality in care and treatment. GPs should be actively encouraged to prescribe generically, to use a practice formulary and to agree repeat prescribing protocols within their practices.

GP Fundholding - review of 1994/95 objectives

3.2.4 Although the number of GPs coming into fundholding in 1994/95 was lower than expected, the Scheme continues to grow in popularity. By 1 April 1995, a total of 53 fundholding units, comprising 261 GPs, had been established. By that date 31% of Northern Ireland's population was registered with fundholding GPs. More practices are now preparing to become fundholders in April 1996.

3.2.5 Important changes to the scope and management of the Scheme took place during 1994/95, with community nursing services being added to the fund from 1 April 1995 and many of the day-to-day management responsibilities being delegated to the Boards.

GP Fundholding - priorities for 1996/97 - 1998/99

3.2.6 In line with the delegation of management responsibilities for fundholding to Boards, the Management Executive will later this year be issuing for consultation a draft framework of accountability, which will clarify the roles and relationships both of fundholders and Boards. It is intended that a final agreed framework will be identified by 1 April 1996.

Development of Fundholding

3.2.7 The Minister has announced that he will be considering the introduction of a Community Fundholding Scheme, along the lines of the English model, from April 1997 and, from the same date, lowering the list size criterion for the Standard Scheme from 5,000 to 4,000. The Management Executive will be issuing guidance on this subject during 1995/96, and Boards will be expected to promote both Schemes, if available, among eligible practices for preparatory work to begin on 1 April 1996.

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Oral Health

3.2.8 The Oral Health Strategy to be published in 1995 is Northern Ireland's first oral health strategy. It will review the present state of oral health in Northern Ireland, highlight the problem areas and suggest how these might be tackled. It is a long term strategy, as measures to secure improvements in oral health will take some time to have an impact.

3.2.9 It is recognised that achievement of the targets set for improving oral health will require the commitment not only of dental health professionals, but also of others in the wider Health and Personal Social Services, of those in the education service, of parents and of individuals themselves. Nevertheless, there are specific objectives which the Management Executive will expect Boards to address, including:

- ensuring that securing improvements in oral health is an integral part of health promotion and educational programmes designed to improve diet and nutrition;
- ensuring that health promotion programmes highlight the risk factors associated with oral cancer;
- promoting the use of fluoride supplements in those areas where the water supply has not been fluoridated ; and,
- promoting good oral health and effectively managing the treatment of caries by: encouraging parents to register children with a general dental practitioner from shortly after birth; increasing the percentage of children registered with a general dental practitioner under the capitation scheme; increasing the percentage of adults registered with a general dental practitioner for continuing care; and ensuring that the community dental service screens all children on at least three occasions during their school career, and more frequently where particular need arises.

Care in the Community Review of 1994/95 objectives

3.2.10 In 1994/95 an additional £41.2million, specifically earmarked for the development of community care services, was allocated to Boards. In the 2 years from the start of the new community care arrangements in April 1993 until 31 March 1995, about 18,000 people were referred for community care assessments, resulting in over 15,000 care packages being put into effect over the period. Of the care packages in place at the end of March 1995, some 52% were providing support for people in their own homes, 30% in nursing home care and 18% in residential care homes. Overall around 96% of all assessments now commence within 3 weeks of referral, and over 92% of care packages are being secured and delivered within 3 weeks of assessment. Some 74% of those being referred for assessment are elderly people.

3.2.11 Boards remain on course to achieve the overall target reductions in the numbers of long stay patients in institutions for people with a mental illness or a learning disability. During the period from April 1992 to February 1995 the number of people in psychiatric hospitals fell by 23%. The number of people in learning disability hospitals was reduced by 23% over the same period. Further action will be required in 1995/96 to resettle all of those patients with learning disability in hospitals who have been identified as suitable for living in community settings. It will also be a priority for the Eastern and Northern Boards, in conjunction with the North and West Belfast Trust, to develop an implementation plan for the future delivery of specialist hospital services for people with a learning disability within their areas.

3.2.12 The Department's Charter for Community Services contains new differential standards for occupational therapy assessments. Boards should take steps now to ensure that these new targets are achieved in 1996/97.

Priorities for 1996/97 - 1998/99

3.2.13 By 1995/96, the third and final year of the social security transfer, the cumulative amount which Boards will have under 'People First' to spend on community care, including partnership arrangements with the Independent Living 1993 Fund, will be in excess of £109 million. Priorities will continue to be:

- the further development of flexible and innovative packages of care tailored to the needs of individuals and their carers;
- the expansion of the range of community care services available in the statutory, voluntary and private sectors;
- improving co-ordination and co-operation between Boards, Trusts, GPs, service

providers and other agencies to secure efficient use of resources;

- the concentration of services on those in greatest need;
- improvement in communication with vulnerable people, their carers, and other agencies; and,
- implementation of guidance about HPSS responsibilities for meeting continuing health care needs which will be published in Autumn 1995.

Child Care Review of 1994/95 objectives

3.2.14 There is a welcome emphasis on multi-disciplinary working and family focused approaches. The four Boards are currently engaged in a range of evaluative exercises aimed at informing policy and professional practice in the area.

3.2.15 To facilitate further evaluation of Northern Ireland services, the Department intends to disseminate information about existing treatments, projects, and approaches, and the results of a national evaluation of treatment programmes which has been commissioned by the Department of Health (England).

3.2.16 All Boards met the target for increasing the proportion of children in care who are placed with a family to 73%.

Priorities for 1996/97 - 1998/99

3.2.17 Boards should re-examine the availability of evaluated treatment and services for sexually abused children and their families, and increase the level of provision where necessary.

3.2.18 Boards should aim to increase further the proportion of children in care who are placed with a family to 75%.

3.2.19 Boards should continue to prepare for the implementation of the Children (Northern Ireland) Order 1995, which is expected to come into operation in October 1996.

Acute Hospital Services Review of 1994/95 objectives

3.2.20 The March 1995 Corporate Monitoring return shows that throughput rates and day case percentages in all specialties have already been met or are approaching the 1994/95 targets as specified in the 1993/94 - 1995/96 Management Plan. Those specialties in which the throughput targets have already been surpassed include: general medicine; dermatology; general surgery; trauma and orthopaedics; ENT; ophthalmology; and plastic surgery. In day cases, the 1994/95 targets were shown as exceeded in all but neurosurgery. However, in the light of the concerns about the quality of the recording of day cases, an audit of day cases was conducted by the Strategy and Intelligence Group in the latter part of 1994.

3.2.21 On the basis of the day case audit - on which work is continuing - it is now recognised that there has been an erroneous recording of out-patient activity as day cases, and that, by definition, only elective admissions can be day cases. Nevertheless, day case activity has an important contribution to make to increasing efficiency in the health service. To monitor this, new targets have been developed for day cases as a proportion of elective procedures. The targets - which are procedure-based rather than specialty-based and are included in Appendix 1. In developing these targets, consideration was given to: the day case procedures which were identified in the 1990 National Audit Office Report entitled 'A Short Cut to a Better Service': the procedures included in the Northern Ireland Performance Tables: medical advice as to the suitability of inclusion of procedures: and the comparison between Northern Ireland and GB of activity in the chosen procedures.

3.2.22 The total number of patients treated in acute specialties continued to show an increase in 1994/95. Ordinary admissions remained fairly steady at around 230,000 whereas day case activity is shown as having increased by approximately 15,000 on the 1993/94 activity to almost 90,000 cases. The number of patients waiting more than 18 months for ordinary admissions fell from 2,060 at December 1993 to 432 at March 1995. In cardiac surgery, the numbers fell from 171 to 3 in the same period.

3.2.23 Every effort was made to ensure that the majority of patients who were waiting in excess of the Charter guarantee received treatment or had an offer of treatment by 31 March 1995. It was not possible to treat all excess waiters in all specialties by 31 March 1995, but purchasers and providers are fully aware of need to take appropriate action to ensure early compliance with Charter standards and to reach the

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Management Plan targets. The specialties with the greatest problems were: plastic surgery; trauma and orthopaedics; and, for day cases, paediatric surgery.

3.2.24 Progress continues to be made towards achieving the Charter standard, effective from 1 April 1993, on the maximum waiting time for first out-patient appointment (ie not exceeding 3 months). Of the total numbers waiting who had their first out-patient appointment in the quarter ending March 1995, 85% had waited less than three months. Since the CREST report on the Management of Outpatient Waiting Lists, much attention has been focused on outpatient waits and attendances and this continues to be the case. The introduction of agreed referral protocols and outpatient slots in the orthopaedic specialty has resulted in considerable reductions in waiting times for those with a genuine need to see a consultant. The Department intends to launch in the next few months a publicity campaign aimed at reducing non-attendances, which are currently running at about 14%.

Priorities for 1996/97 - 1998/99

3.2.25 Aside from changes taking place at local level, there are three major issues which have an impact on all purchasers and which have been taken into account in the roll forward of the Regional Strategy due to be published in early 1996.

3.2.26 The Acute Services Re-Organisation Project led by a steering group under the chairmanship of Dr McKenna continues to make progress. Sub-groups of this Steering Group have been reviewing all specialties provided in the Royal and Belfast City hospitals with a view to recommending the changes which should take place. Consultation on the first tranche of specialties began in June and continued to 29 September. It is expected that a second range of services will be consulted on in the autumn. Any significant changes will require Ministerial approval. The work of this group is expected to continue during 1996.

3.2.27 The second issue arises out of the Calman Report on the development of cancer services. This Report has important implications for the organisation of hospital services throughout Northern Ireland. The Department has established an expert group, under the Chairmanship of the Chief Medical Officer, to develop clinical standards for Northern Ireland, taking account of the Calman Report and of subsequent quality standards in cancer services which are produced nationally.

3.2.28 In November 1994, the Department endorsed the conclusions and the recommendations of the Maternity Unit Study Group (MUSG) which it had established to consider the establishment of maternity units led by midwives or general practitioners. A draft policy circular, taking account of the MUSG Report, the 'Changing Childbirth' report, and other developments in maternity services was issued in June for consultation which will continue until October 1995. The Management Executive will expect purchasers to secure the purchase of women-centred maternity services in line with the guidance in the new policy circular through their contracts with providers. Purchasers will also be expected to secure the achievement of the specific targets set out in Appendix 1 (paragraph 18) of this Plan.

3.2.29 The Management Executive endorses the pursuit of further efficiencies in the acute hospital sector through the use of comparative data. Purchasers will be expected to promote the use of comparative data with providers as an aid to achieving greater efficiency gains. The targets for throughputs of ordinary admissions and day case percentages will, for the time being, remain part of the Management Plan.

3.2.30 The priorities for acute hospital services remain:

- to continue to develop the quality and range of acute services to patients by concentrating acute hospitals on a smaller number of acute hospital sites;
- to develop services for patients locally to complement those provided by acute hospitals; and,
- to improve efficiency in the use of beds and encourage greater use of day and outpatient treatment, and to reduce the overall requirement for acute beds.

These priorities will be reflected in the Regional Strategy for 1997-2002.

3.2.31 In the light of the Clothier Report (the Allitt Inquiry), the Management Executive expects purchasers to include, as quality standards for contracts for paediatric hospital services, those recommendations on numbers and qualification of nursing staff contained in the report 'Welfare of Children and Young People in Hospital.'

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Personal Social Services Training

3.2.32 A revised Personal Social Services (PSS) Training Strategy will be published in 1996. Under the Strategy, Health and Social Services Boards will be responsible for commissioning training to achieve national, regional, and local service objectives to predetermined quality standards which are directly related to desired service outcomes. Health and Social Services Trusts will be responsible for the delivery of agreed training programmes - including practice placements - and will manage training resources including staff and capital assets such as premises and equipment.

3.2.33 Health and Social Services Boards will be required to prepare training needs assessments for social services staff, which will form the basis for training contracts for 1996/97 to be agreed between the Department and each Board. More detailed guidance on the revised arrangements is contained in a circular issued by the Social Services Inspectorate on 27 July 1995.

3.3 PROVIDER STRATEGIC PRIORITIES Review of 1994/95 Objectives

Trust Development

3.3.1 The HSS Trusts programme remains on target to have all Directly Managed Units (DMUs), established as Trusts by 1 April 1996. Applications have been received from the five remaining DMUs and these have been issued for public consultation.

3.3.2 During the year under review applications were processed from 3 prospective Trusts, Armagh/Dungannon, Causeway and one from the amalgamated Northern Ireland Ambulance Trust which was established following a detailed review of the ambulance service here. Following public consultation all were approved. Two Trusts were approved with an operation date of 1 April 1995 and the third, (Armagh/Dungannon) was deferred pending the appointment of a suitable Chairman.

3.3.3 An accountability framework was established which allows the Management Executive to monitor the performance of HSS trusts and to ensure that they meet their statutory responsibilities. Trusts are offered advice and guidance on their business plans at draft stage and progress is monitored against the targets set in their plans and against Management Plan targets.

3.3.4 The Northern Ireland Medical Physics Agency and the Northern Ireland Blood Transfusion Service Agency were established as Special Agencies during 1994/95.

Capital/Estate Management

3.3.5 Providers have made considerable progress towards meeting their 1994/95 targets in respect of statutory standards and energy savings. Monitoring through the Business Planning process will ensure that further progress is made.

3.3.6 Funding was provided via the Capital Development Programme for a total of 12 major schemes which were under construction or in planning in 1994/95.

3.3.7 A funding programme for major schemes within the HPSS was established for emerging Trusts with provision as appropriate via their External Financing Limit and with funds continuing to Boards as appropriate. Detailed advice on Allocation and Monitoring of capital for 1994/95 and beyond was issued to Boards, Trusts etc in March 1995 under cover of HSS (PDD) 3/94.

3.3.8 The new NHS Capital Investment Manual introducing business case techniques for capital investment has been adapted for the HPSS and distributed to Boards, Trusts and HPSS Agencies. The Manual sets out the detailed requirements for preparation of business cases, focusing on purchaser support and affordability. A staged approval process has been introduced, and there is now a requirement to test all capital proposals for private finance under the Government's Private Finance Initiative. Guidance on the implementation of capital schemes is incorporated.

Human Resources

3.3.9 On the Management Development front, the 'regional' Top Management and Senior Management programmes have been maintained and a Chief Executive programme has been designed.

3.3.10 The Council for Postgraduate Medical and Dental Education, which was reconstituted on 1 April 1994, took on additional responsibilities in respect of Junior Doctors' hours. Further work has been done on this initiative but, in February 1995, the Regional Task Force reported that 5.8% of posts still failed to meet the December 1994 target of 72 hours for hard pressed posts and 56 hours for full shifts.

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3.3.11 Following consultation with employers and staff interests, the Management Executive commissioned consultants to develop an existing job evaluation scheme for use in the HPSS. A Management Board and Steering Committee were established and a Project Manager was appointed. Significant progress has been made on benchmarking and equity proofing. Roadshows have been held as part of the Communications Strategy on the development and roll-out of the scheme.

3.3.12 The review of the 'regional' collective bargaining machinery has been completed, resulting in the abolition of Joint Councils with effect from 1 April 1995. This outcome and the need to negotiate the Local Pay elements of the National Agreements have placed on employers an urgent need to develop their capability in this area. To support them in this, there have been a number of development initiatives including the Human Resources Conference held in December 1994.

Priorities for 1996/97 - 1998/99

3.3.13 With the programme for the introduction of HSS Trusts almost complete, providers will be able to concentrate their efforts on the development and implementation of policies which will maximise their ability to respond effectively to the changing demands of the internal market. Over the period of this Management Plan the Management Executive will monitor performance in the following areas.

Efficiency/Value for Money

3.3.14 Providers will be expected to develop policies and practices which will ensure, as a minimum:

- the achievement of cost improvement targets agreed through contracts with purchasers;
- full participation in the achievement of value for money targets described in paragraph 2.5.3, for example, to continue to explore the value of market testing in different areas of business and to implement where appropriate; and,
- that statutory financial obligations are met.

Organisational Development

3.3.15 Providers must continue to review their policies and training requirements to ensure that their organisations are well placed to cope with the complex and changing demands of the market environment. Particular attention should be paid to:

- securing the active participation of professional staff in the contracting process and in the planning of service delivery;
- reviewing organisational structures and processes to ensure that they are able to respond flexibly to changing needs and that they represent best value for money;
- providing for the ongoing training and development of trust board members; and,
- ensuring, in collaboration with other trusts, private and voluntary organisations, that fully integrated services are delivered in response to purchasers' requirements.

Management Costs

3.3.16 It is important that management costs are identified and constantly reviewed to ensure that the level and quality of staff are at that which is necessary to ensure cost-effective services.

3.3.17 To facilitate this, each provider received guidance in July 1995 on identifying management costs. The Management Executive will publish annually a management costs league table from October 1995. Trusts will be expected to take action to maintain downward pressure on the level of costs identified.

Human Resources

3.3.18 Throughout the period of this Plan, each HPSS employer should continue to review and develop its Human Resource Strategy which should be integrated with its overall strategic directions and business plan. Particular attention should be given to: fair employment/equal opportunity; workforce planning (including staff reprofiling and skill mix); education and training; reward systems; employment policies; and staff welfare.

3.3.19 In particular, arrangements must be in place to ensure the effective delivery of non-medical education and training to meet the established needs of the HPSS. The Postgraduate Council should manage the new approach on higher specialist training and should have appropriate contracts with Trusts for the provision of postgraduate medical and dental education. The specialist registrar grade must be established and employers must strive to achieve the final target on Junior Doctors' hours, namely that by

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December 1996, no Junior Doctor/Dentist should work more than 56 hours per week.

3.3.20 By April 1996, all employers should have in place effective mechanisms to deal with negotiations on local pay, both for staff on 'National' terms and for staff on Trust terms. There should be significant progress by Trusts in the development of their own reward packages and conditions of service during the period covered by this Plan.

Local Responsiveness and Communications

3.3.21 Providers must continue to develop their communication policies which ensure that the needs and wishes of local communities are properly reflected in their delivery of services. They should have mechanisms in place for publicising their achievements to their communities at large, and they should be able to demonstrate how consultation has influenced the delivery of services, with particular regard to:

- the establishment of relationships with local groups and representatives and the maintenance of regular and meaningful dialogue with their local Health and Social Services Council and GPs;
- the maximisation of individual choice including the development of partnership arrangements with the independent sector;
- the requirements of the Charter for Patients and Clients;
- comprehensive consultation with purchasers, public representatives and other interests prior to the change of use or closure of facilities; and,
- implementing revised complaints procedures in line with the requirements of the Management Executive publication: 'Acting on Complaints'.

Accountability

3.3.22 Providers must ensure that proper standards are maintained in the conduct of public business. Frameworks must be in place which provide effective systems of control and accountability, and which promote a responsible attitude by all who handle public money. In particular the framework should include measures to ensure:

- strict financial control and monitoring;
- compliance with the rules regarding the stewardship of public funds and assets entrusted to providers, for example the Codes of Conduct and Accountability;
- value for money in all transactions; and,
- proper system of individual accountability and control.

3.3.23 In future all capital investment must be supported by a business case which conforms to the requirements of the Capital Investment Manual. Management Executive approval must be obtained in accordance with the delegated limits and at the appropriate stages set out in the guidance. The requirement of the new procedures including exploration of private finance are onerous and resource intensive. It is important therefore that scarce recources are not expended on development of speculative proposals. It is the responsibility of providers therefore to ensure purchaser support from the earliest stages, in specific terms, for inclusion with submissions for approval to capital investment, and obtain the necessary approval before proceeding to the next stage. In addition providers should increasingly focus on ensuring that proposed capital investment is sufficient, but no more, to meet service requirements and purchaser specifications.

Capital and Estate Management

3.3.24 Trusts should continue to rationalise their estate to ensure that they retain only those elements which are necessary for the effective discharge of their business. They should also ensure, within their prioritised needs, that they invest resources effectively in respect of fire safety and statutory standards and fully comply with health and safety and environmental protection standards in the HPSS estate. Each Trust should have an environmental policy statement in place.

Better Practice

3.3.25 Providers should continue to seek improvements in the standard of service they provide and should ensure that they achieve the best possible outcomes for patients and clients within the available resources, through a strategy aimed at sustaining a process of continuing quality improvement. Specifically, providers should have clear policies on:

- role of clinical audit as part of a programme to improve all aspects of service quality, not

just clinical outcomes;

- support for, and evaluation of, quality improvement programmes; and,
- multi-disciplinary approaches to the development of best practice in service delivery.

3.4 INFORMATION/INFORMATION SERVICES

3.4.1 HPSS organisations will be expected to collaborate through the Regional Information Steering Committee (RISC) to secure the outcomes of the review of the Strategic Framework for Planning for the Development and Use of Information and Information Systems in the HPSS. In particular it is essential that purchasers and providers:

- co-operate in the development of a common approach to contract currencies;
- meet the Department's central requirements for data in a timely manner, including the Management Executive's need to monitor properly the provision of health and personal social services in Northern Ireland. The Department is undertaking a review of its information requirements and will consult the HPSS on these during 1995;
- ensure the quality of the information by co-operating with the development and implementation of a data audit strategy; and,
- collaborate where possible to secure value for money in the design, procurement and implementation of information systems.

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4.1 FINANCE

4.1.1 Allocations for the health and personal social services are negotiated annually with the Department of Finance and Personnel and depend on the total levels of public expenditure for the Province. The 1995 Public Expenditure Survey settlement, which will be announced towards the end of the year, will determine the level of revenue and capital resources available to the HPSS for 1996/97.

4.1.2 Despite the difficult 1994 Public Expenditure Survey settlement, the Management Executive was able to ensure that, for the second year in succession, the available revenue resources were allocated in line with the Boards' respective capitation shares.

4.1.3 The Management Executive will seek to maintain this position in 1996/97. In so doing it will take account of the findings of the multi-disciplinary group of Board officers, chaired by the Management Executive's Director of Financial Management, which has been reviewing existing capitation formula arrangements. When the group produces its report the Management Executive will consider the impact, if any, of implementing the recommendations and agree a timescale for implementation.

4.1.4 The HPSS will operate for the foreseeable future against a background of tight controls on public expenditure. As the 1995 Public Expenditure Survey is not yet complete, no definitive resource figures can be provided at this stage for the period of the Plan. For planning purposes, Boards should proceed on the assumption that annual revenue resources available for health and personal social services will not be more than their present level in real terms allowing for the Government's forecast inflation. Purchasers and providers should also assume that they will be expected to achieve continuing improvements in efficiency across the period of the Plan. (see 2.5.3).

4.1.5 In view of the anticipated continuing limitations on public funds, and in line with the Government's Private Finance Initiative, Boards and Trusts should increase their efforts to investigate opportunities to secure private sector funding as an additional means of resourcing works and equipment projects.

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SERVICE DELIVERY - TASKS FOR 1996/99

APPENDIX 1

TOPIC		OBJECTIVE	TARGET 1996/97	TARGET 1997/98	TARGET 1998/99
Health promotion and Disease Prevention	1.	Continue fluoridation programme so that some 60% of the population will have their water supply fluoridated.	*		
	2.	Achieve a minimum acceptable response rate of the target population for breast cancer screening of:	70%	RS[1]	RS[1]
Family Practitioner Services	3.	Approve applications for and monitor performance under the new Pharmacy Professional Allowance.	*	*	*
	4.	Encourage GPs to increase the level of their generic prescribing to:	40%	45%	50%
	5.	Work with GPs to increase the percentage of practices actively using a practice prescribing formulary to:	60%	75%	80%
	6.	Work with GPs to increase the percentage of practices using a protocol for repeat prescribing to:	60%	80%	90%
	7.	Increase the number of practices in the Standard GP Fundholding Scheme by:	25	20	20
	8.	Bring numbers of practices into the Community GP Fundholding Scheme:	30	20	20
Services for Elderly People	9.	Develop community services for the elderly to support an increase in the proportion of people aged 75 or over who are cared for in their own homes:	[illegible]	RS[1]	RS[1]
Services for Mentally Ill People	10.[2]	Continue to increase and target community services to:			
		a. effect a reduction in the number of patients with dementia in long-stay hospitals of:	[illegible]	RS[1]	[illegible]

[1] Targets for these areas will be included in the next Management Plan, following publication of the Regional Strategy for 1997 - 2002.

[2] These targets are cumulative and follow on from the targets in the previous Management Plan.

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TOPIC		OBJECTIVE	TARGET 1996/97	1997/98	1998/99
		b. effect a reduction in the number of patients with chronic mental illness in long-stay hospitals of:	30%	RS[1]	RS[1]
Services for People with a learning disability	11.	Increase and target community services to support a reduction in the number of people in learning disability hospitals of:	25%	RS[1]	RS[1]
Physical and Sensory Disability	12.	Ensure that the Charter standards for occupational therapy assessments for equipment and adaptations to the homes of disabled people are achieved.	*		
Child Care	13.	Prepare for implementation of the Children (Northern Ireland) Order 1995.	*		
	14.	Ensure that the proportion of children in care, placed with a family (excluding those home on trial) is at least:	75%	RS[1]	RS[1]
Maternal and Child Health	15.	Ensure an uptake rate for immunisations in line with the Regional Strategy for:			
		a. Diphtheria	95%	RS[1]	RS[1]
		b. Polio	95%	RS[1]	RS[1]
		c Tetanus	95%	RS[1]	RS[1]
		d Pertussis	95%	RS[1]	RS[1]
		e. Measles, Mumps & Rubella	95%	RS[1]	RS[1]
		f. HIB	95%	RS[1]	RS[1]
Acute Hospital Services	16.	Achieve a minimum throughput (average annual number of patients treated per bed) for the following specialties:			
		a. General Medical Group (including gastroenterology and endocrinology):		52	

SERVICE DELIVERY - TASKS FOR 1996/99

APPENDIX 1

TOPIC	OBJECTIVE	1996/97	TARGET 1997/98	1998/99
	b. Dermatology	26	28	30
	c. General Surgery/Urology	57	59	61
	d. T & O Surgery	39	41	43
	e. Cardiothoracic Surgery	44	45	46
	f. Gynaecology	72	74	76
	g. ENT	92	94	96
	h. Ophthalmology	102	104	105
	i. Plastic Surgery	57	59	61
	j. Neurosurgery	37	38	39
	17. Increase the level of day case activity as a percentage of elective admissions in the following procedures:			
	a. Inguinal Hernia	25%	30%	35%
	b. Varicose Veins	22%	27%	35%
	c. Cystoscopy	75%	80%	85%
	d. Circumcision	75%	80%	85%
	e. Arthroscopy of Knee & other joints	82%	85%	87%
	f. Cataract Extraction	27%	30%	35%
	g. Correction of squint	15%	25%	35%
	h Laparoscopic Steralisation	55%	65%	75%
	i. Endoscopy of Gastric Intestinal Tract	90%	90%	90%
	j. Bronchoscopy	[illegible]	73%	[illegible]

TOPIC	OBJECTIVE	TARGET 1996/97	TARGET 1997/98	TARGET 1998/99
	18. Ensure that action is taken to meet the objectives in the Department's latest policy guidelines on maternity services, and, in particular:			
	a. take steps to involve women in planning the development of women-centred maternity services;	*	*	*
	b. introduce new models of care which will extend the choice of care available to women;	*	*	*
	c. produce local guidelines on the operation of and criteria for delivery in a midwife/GP led maternity unit;	*	*	*
	d. provide information to women on the range of maternity services available in their locality.	*	*	*

TIMETABLE FOR 1996/97 CONTRACTING PROCESS

April-June 1995	• Boards' informal consultation with key interest groups.
	• Management Plan to be produced by Management Executive.
30 June 1995	• Boards to produce their purchasing intentions.
July-mid Sept 1995	• Boards formally consult on their purchasing intentions.
30 September 1995	• GP fundholders to produce their purchasing intentions.
15 October 1995	• Trusts to respond to Boards (1st cut prices).
31 October 1995	• Trusts to produce draft Strategic Directions and draft Business Plans.
15 November 1995	• Trusts to supply final prices to GP fundholders.
December 1995	• Provisional allocation letters from Management Executive to purchasers.
31 December 1995	• Boards finalise purchasing intentions.
January 1996	• Formal allocation letters from Management Executive to Boards.
31 January 1996	• Prospective GP fundholder budgets finalised and Business Plans submitted. • Providers produce final prices for Boards. • Existing GP fundholder budgets finalised and Business Plans submitted.
31 March 1996	• Contracts signed.
April 1996	• Trusts produce final Strategic Directions and Business Plans.

HPSS Management Plan

1997/98 - 1999/00

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2. HPSS Key Objectives and Priorities
3. Review of Performance
4. Service Development Priorities

Appendix

Appendix 1 Service Delivery

HSS Executive Mission Statement

The primary purpose of the HSS Executive is to secure improvements in the health and social well-being of people in Northern Ireland.

Main Functions of the HSS Executive

1. To provide leadership, direction and support to the Health and Personal Social Services (HPSS) in Northern Ireland.

2. To set and ensure the achievement of specific objectives and targets for the HPSS in accordance with national and regional policies and priorities.

3. To monitor the performance of the HPSS in assessing need and improving the health and social well-being of the population.

4. To allocate resources and to ensure that they are used effectively, efficiently and economically, in accordance with the required standards of public accountability.

5. To promote the managerial environment necessary to achieve these objectives.

6. To provide, as required, advice, information and support to Ministers relating to the management and performance of the HPSS.

Foreword

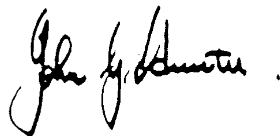
This Management Plan seeks to build on the foundations laid by the Department's Regional Strategy 1997 - 2002. Like its predecessor, the new strategy focuses on opportunities for improving the health and social well-being of the population. They have been incorporated in the Management Plan, which sets out specific objectives and targets to be achieved over the next three years and constitutes a framework for Boards' purchasing prospectuses and plans.

Since the production of the last Management Plan there has been a reorganisation of the Department. It resulted in the transfer of certain operational responsibilities to the Executive which has been renamed the Health and Social Services Executive - a title which is more consistent with those of Health and Social Services Boards, Trusts and Agencies.

The Plan assumes that the services will continue to achieve a 3% savings target from a combination of cash releasing and non-cash releasing measures. While the resources for the HPSS in 1997/98 will not be known until the completion of the Public Expenditure Survey in December 1996, it is clear that financial pressures will remain as demands on services continue to grow. The drive for greater efficiency and effectiveness is ever more important both strategically, in terms of the pattern of care, and operationally, in terms of service delivery. Only by making more cost-effective use of existing resources will we be able to enhance present service levels and develop those new services which advances in medical science make possible and the changing needs of the population demand.

In addressing this challenge, the HPSS must continue to reflect the crucial public service values set out in the Codes of Conduct and Accountability issued last year by the Executive. These emphasise accountability, probity and openness. They are reinforced by the requirements of Government policy in respect of fair employment, equal opportunity and policy appraisal and fair treatment.

Finally, I am very conscious of the many examples of high quality care and innovation throughout the HPSS. They reflect great credit on all staff, whose dedication and commitment is particularly apparent to those they serve. It is their efforts which will ultimately secure our overriding objective of improving the health and social well-being of the population.



JG Hunter
Chief Executive

1.1 Background

1.1.1 Since its inception in 1990, the HSS Executive has published an annual Management Plan which provides guidance on the priorities and objectives to be pursued by the HPSS for the following three years. This Plan, while focusing primarily on 1997/98, outlines the strategic priorities for the period 1997 - 2000. It takes account of the priorities and objectives set in the Regional Strategy for 1997 - 2002, which was published in July 1996.

1.1.2 The Plan is a framework within which all members of the HPSS family of businesses must operate. It gives the direction to Boards for the development of their strategic commissioning role and to Boards, GP Fundholders and other primary care professionals alike to work in partnership to agree local strategies and the content of purchasing prospectuses which will govern the contracts agreed with providers.

1.1.3 The Plan concentrates on areas of service delivery where the HSS Executive expects Boards to secure quantifiable year-on-year improvements during the period covered by the Plan. Other areas of service delivery - for example, some aspects of health promotion - for which improvements may take longer clearly to emerge, or which are not easily measurable on an annual basis, do not appear in the current Plan. However, these areas are included in the Regional Strategy for 1997 - 2002, and Boards will be expected to reflect the new Strategy's priorities and objectives in their purchasing prospectuses for 1997/98, and GP Fundholders to reflect them in their business plans.

1.1.4 Boards will be expected to take account of the priorities set out in Section 4 and the targets in Appendix 1 of the Management Plan when drawing up their individual Action Plans for 1997/98. These will be subject to endorsement by the Minister in the course of the annual Accountability Reviews. The HSS Executive will also wish to see evidence of the action planned by Boards to achieve the Regional Strategy targets in their Action Plans.

2.1 Key Objectives

2.1.1 The key strategic objectives for the period 1997 - 2000 flow from the Regional Strategy and will be focused on:

- promoting the development of a primary care-led service;
- continuing to improve and reshape hospital services;
- continuing to develop care in the community;
- targeting resources and services where they are most needed;
- improving efficiency and ensuring value for money in the use of resources; and
- increasing the emphasis on effectiveness and outcome measurement throughout the HPSS to ensure the greatest health and social gain from the resources available.

2.2 Developing Primary Care-led Services

2.2.1 The enhancement of the role of primary care is one of the underlying principles of the Regional Strategy for 1997 - 2002 and the strategy recognises the benefits of empowering those working in primary care to influence the process of service commissioning on behalf of their patients and clients. This is not a new concept for the HPSS, which has previously sponsored or worked with GP forums and community groups, but this method of working is now to be developed as the central approach to the commissioning of care.

2.2.2 Previous Management Plans have dealt with purchasing rather than commissioning. **Purchasing** in the HPSS context actually means the process by which Boards and GP Fundholders obtain care services from providers. **Commissioning**, on the other hand, embraces assessment of need, planning, specification and contracting and service monitoring activities for individuals and populations.

2.2.3 Boards should increasingly be able to demonstrate that their commissioning actions are based on methods which are responsive to and influenced by their local populations. The intention is to develop a needs-led, evidence-based and user-centred service, where resource decisions are taken as close to users as practicable. To achieve this aim Boards will need to work closely with primary care teams. Such work will include supporting team development and relating the overall commissioning process to a structure which reflects the primary care team population and territorial boundaries.

2.2.4 Community development also has an important contribution to make within the health and social services in reaching and involving people in need in encouraging active participation of service users and potential users in the decision making process.

2.2.5 In achieving this aim there will be a constant tension arising from the annual decision-making timetable, the need to balance income and expenditure and the pressures from various interested groups (providers, locality-centred groups, voluntary and community sector agencies etc). Each Board must develop a framework to work closely on a partnership basis with primary care teams and other interest groups but care will be needed to ensure that improved commissioning structures do not become so complex as to be unworkable. This will be a challenging task for each Board.

2.3 Improving and Reshaping Acute Hospital Services

2.3.1 In recent years there have been significant changes in the way hospital services are delivered and in the range of treatments available to patients. Developments in clinical practice and the introduction of new technologies, a trend towards specialisation and other changes in working practices have had a major impact on the delivery of services. These changes are reflected in the increasing number of procedures now carried out on a day case basis without the need for an overnight stay in hospital.

2.3.2 Further improvements in quality as a result of specialisation and the introduction of new techniques will inevitably lead to more changes in the way services are provided including the settings in which they will be available. In future, acute hospital services will tend to be concentrated on fewer hospital sites.

2.3.3 Developments such as tele-medicine and hospital-at-home schemes also mean that it will be possible in future for some treatment and diagnosis to be provided outside hospital. This will require enhanced co-operation between hospital and primary and community care teams.

2.3.4 Evidence based purchasing of services, particularly hospital services, should in future become the norm. All purchasers of services will want to ensure that they contract only for those procedures and treatments which are proven to be effective. In fulfilling their commissioning role Boards will need to ensure that all general medical practitioners (not just those who manage their own funds) and other professionals are kept apprised of evidence about those procedures and treatments which do not benefit patients, so that all referrals are adequately informed.

2.3.5 The new Regional Strategy (Chapter 6) sets out these drivers for change in some detail. A clear conclusion is reached that Northern Ireland cannot sustain the current pattern of 19 acute hospitals providing inpatient acute care. Boards, working closely with GPs, will therefore be expected to review their current pattern of acute hospital care, and to consider the range of services which should be provided in local hospitals and other community settings.

2.4 Developing Care in the Community

2.4.1 The development of assessment and care management arrangements has contributed significantly to the successful development of community services to support people with disabilities or mental illness and frail elderly people to live at home or in their own community as far as possible.

2.4.2 The 1995 Report of "A Multi-Disciplinary Inspection of Assessment and Care Management Arrangements" sets out a valuable framework for the future development and improvement of these arrangements. Corporate monitoring has also given a useful insight into the trends and pressures which have emerged during the first three years of operation. It is clear that there is now a need for a renewec emphasis on the provision of domiciliary and day care services, particularly in developing contracts with the independent sector. In addition, in line with the Carers (Recognition and Services) Act 1995 in Great Britain, from April 1996, carers should be offered a separate assessment of their own needs by Boards.

2.4.3 For those with greatest needs care management must become central to the way that services are delivered and the interface between primary care and the care management arrangements needs to be further developed. Boards will need to ensure that there is effective contact between GP Practices and care managers within the practice area. This may be achieved in a number of ways but

Boards should encourage Trusts to continue developing procedures for closer working relationships between primary care teams and others working in the community to ensure that there are regular meetings between care managers, GPs and other primary care professionals and that primary care team members are involved fully in the formulation and review of care plans.

2.5 Targeting Resources

2.5.1 In order to minimise the inequalities in health and social well-being which exist in Northern Ireland, the concept of targeting health and social need was introduced in the Regional Strategy for 1992 - 1997 and has been retained as a major theme in the new Regional Strategy. It is fundamental to targeting health and social need that resources should be targeted where needs are greatest. Likewise, the effectiveness of the targeted resources, programmes and services must be assessed to ensure that they are succeeding in reducing, and not inadvertently perpetuating or increasing, variations in health and social well-being or in the availability of, or access to, health and social care.

2.5.2 The Department has work in hand to produce a resource allocation formula for use in the distribution of resources to Board level, which is based upon the relative need for health and social care in each Board area. Boards and other purchasers should continue to develop formal links between their population needs assessments and the consequent allocation and use of resources so that they are able to demonstrate shifts in resources to improve equity and efficiency of resource distribution relative to health and social care needs.

2.6 Value for Money

2.6.1 There have been substantial improvements in efficiency within the HPSS in recent years. It is also clear that the scope for, and scale of, further efficiency gains are likely to be increasingly difficult to obtain. Although the easier options may now be gone, there are undoubtedly areas of activity which would merit further examination and efficiency gains must be pursued wherever they are found.

2.6.2 At the strategic level, Boards will be expected to deliver value for money, for example, through stimulating changes in the patterns of care, seeking greater effectiveness in treatment and care, and promoting clinical and multi-professional audit.

2.6.3 The primary responsibility for delivering improved efficiency at local level falls to service providers, who are best placed to review and assess performance of services under their control, whether by reference to good practice guidelines, benchmarking with equivalent services elsewhere, workforce planning and skill mix or other means. Value for money should feature on the agenda of every management forum. Trusts, in particular, should ensure that the Trust Board and senior managers have available to them the data necessary to assess their services in terms of relative performance.

2.6.4 Purchasers and providers will be required to:

- achieve further cash releasing and non-cash releasing efficiency improvements amounting to at least 3% annually;
- further extend the range of services subjected to market testing;
- identify and disseminate good practice in obtaining value for money;
- continue to develop procedures to assess relative performance and recognise those areas where improvements can be delivered; and

- ensure that managers at all levels promote the process of continuous improvement.

2.7 Effectiveness and Outcome Measurement

2.7.1 Effectiveness concerns everyone in the HPSS. The Department is in the process of establishing a mechanism to promote effectiveness and evidence-based decision making in Northern Ireland and to encourage investment in interventions shown to be more effective. The intention is to identify a few key areas each year and to provide guidelines to purchasers on the delivery of effective treatment and care in these areas.

2.7.2 At present targets and comparisons of HPSS activity are mostly based on inputs or outputs rather than outcomes. Whilst potentially more difficult to measure it is essential to focus more on the benefits of the care and treatment provided to patients and clients. To this end the HSS Executive will be seeking to encourage outcome measures which reflect the effectiveness of services.

2.7.3 During the period of this Management Plan the Department aims to bring about improvements in health and social-wellbeing through high quality research and improvement in professional and management practice through the uptake of evaluated research findings. A strategy for the dissemination and uptake of evaluated research findings has been commissioned to support a movement towards evidence-based practice throughout the HPSS. A Research and Development Office, established as a Special HSS Agency, will be responsible for the commissioning, management and strategic co-ordination of research and development activity for the entire HPSS.

3.1 Background

3.1.1 This section reviews the progress that has been made in achieving the main objectives and targets set for 1995/96 in the Management Plan for 1995/96 - 1997/98.

3.2 Purchasing Development

3.2.1 Following the "Review of the Purchasing Function and Structures in the HPSS", Boards have further developed and strengthened their locally sensitive commissioning arrangements. These arrangements ensure that the views of Health and Social Services Councils, GPs, voluntary bodies, the wider public and their representatives are actively sought and acted upon during the commissioning process.

3.2.2 On contract development, Boards and providers have continued to make progress in such areas as: agreed strategic direction; quality standards including audit areas; incentives, penalties, and renegotiation triggers; and the development of contracts for specific programmes of care. There are now very few contracts of the 'simple block' type, with most having at least an indicative activity volume based on the previous year's outturn. However, there has been little progress on the use of a wider range of contract types - such as cost and volume or cost per case contracts, the development of contracts of longer than one year's duration, and disease or condition-specific contracts.

3.2.3 Three contracts were referred to the HSS Executive for resolution in 1995 under the contract arbitration arrangements. Corporate contracts between each of the four Boards and the HSS Executive were agreed for 1995/96. For 1996/97 these will no longer be separate documents but will be included in Boards' Accountability Review action plans.

3.2.4 Boards have continued to develop arrangements for securing professional advice during the commissioning process, based on the key principles contained in HSS Executive guidance circular HSS (PPRD5) 6/94 namely: broad-based involvement of GPs; direct relationships with provider professionals; shared advisory arrangements between primary and secondary care professionals; and access to external advice.

3.3 Family Practitioner Services

GP Prescribing

3.3.1 Progress in achieving the objectives in the last Management Plan has been poor, particularly in relation to generic prescribing, where the level in Northern Ireland, at December 1995, was 28.9%. This compares unfavourably with England where the equivalent figure was 44.6%.

3.3.2 It has been decided to roll the targets back by one year to enable Boards to make a more concerted effort to ensure that they are met. The achievement of the revised targets is an essential component in our efforts to apply downward pressure to the drugs bill.

GP Fundholding

3.3.3 Interest amongst GP practices in joining the fourth fundholding wave was considerable, with the result that 48 practices entered the standard GP Fundholding Scheme on 1 April 1996, 36 as part of the Eastern Multifund. These new additions to the Scheme increased the number of GP practices in fundholding to 117 - a total of 415 GPs, whose combined list sizes comprise 43% of the population. Eight more practices are now preparing to join the standard Fundholding Scheme from April 1997. The Community Fundholding Scheme was launched during 1995/96 and 24 practices are currently preparing to join its first wave, which will begin on 1 April 1997.

3.3.4 The scope of the standard Scheme was expanded further during 1995/96, with

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the majority of surgical procedures, orthotics and orthoptic services being included from 1 April 1996. In addition, the list size requirement of the standard Scheme was lowered from 5,000 to 4,000.

3.3.5 An Accountability Framework for GP Fundholding, clarifying the roles and responsibilities of Boards and fundholders, was published in July 1996.

3.4 Care in the Community

3.4.1 A further £35.9 million was allocated in 1995/96 for the implementation of the community care arrangements. This third and final tranche of the Social Security transfer completes the funding for the initial phase of the "People First" reforms and brings the total additional funding for community care since 1993/94 to almost £110 million. In the three years from the start of the new arrangements in April 1993 until March 1996, about 26,000 people have been referred for care management, resulting in over 23,000 care packages being put into effect over the period. Of the 12,180 care packages in place at the end of March 1996, some 50% were providing support for people in their own homes, 30% in nursing homes and 20% in residential care homes. Overall around 98% of all assessments now commence within three weeks of referral, and 71% of care packages are being secured and delivered within three weeks of assessment. Some 81% of those recently referred for assessment were elderly people.

3.4.2 Boards have continued to increase and target community services to effect a reduction in the numbers of long stay patients in psychiatric hospitals and specialist hospitals for people with a learning disability. During the period from February 1992 to February 1996 the number of long stay patients in psychiatric hospitals was reduced by 41%, while the number in specialist hospitals for people with a learning disability fell by 22%.

3.4.3 Boards have identified the numbers and needs of physically disabled children and of sensorily impaired adults in their areas. The service needs of these vulnerable groups we identified as a priority in Boards' 1995/96 purchasing prospectuses. Boards have continued to work towards reducing the time taken to carry out occupational therapy assessments for aids and adaptation New targets, effective from 1 April 1996, for completion of assessments are set out in the Charter for Community Services.

3.5 Child Care

3.5.1 Good progress has been made on the provision of evaluated treatment and services for sexually abused children and their families. All Boards are providing treatment and services on the basis of assessed need which is kept under review. Most treatment and services have been or will be evaluated, although the sophisticatio of the evaluation tends to vary from Board to Board.

3.5.2 All Boards have established multi-agency implementation groups to oversee and co-ordinate the implementation of the Children (Northern Ireland) Order 1995. Foundation level training has been completed and all Boards are well advanced in plans to implement comprehensive and specialist levels c training for a broad range of staff.

3.5.3 All Boards have made substantial progress in placing children in care i family settings. At December 1995, 83% of children in care, excluding those home on trial, were placed wit a family.

3.6 Acute Hospital Services

3.6.1 The number of people, in all specialties, waiting for treatment in hospital in excess of Charter standards decreased slightly during the year. The total number of people waiting for ordinary admission to hospital fell from 21,132 at the end of March 1995 to 20,365 in March 1996.

3.6.2 Recent Management Plans have set targets for increasing the level of day cases as a percentage of all admissions. These targets have been achieved for 1995/96 in virtually all specialties as have the throughput targets.

3.6.3 The past year has seen further progress in the work of the Acute Hospitals Reorganisation Project in the Belfast area. Since the publication of the original document "In Shape for the Future" in 1994, two further consultative papers have been issued. Proposals in the first of these, "A Singular Service" were the subject of consultation during 1995 and recommendations from the Project Steering Group about the location of some twelve services at the Royal and City Hospitals were endorsed by the Minister early in 1996. Consultation on the most recent paper "Seeking Balance" was completed at the beginning of April 1996 and recommendations concerning the third and final tranche of services will be put to the Minister by the Steering Group during 1996.

3.6.4 In July 1995, following the publication of the Calman report "A Policy Framework for Commissioning Cancer Services", the Minister approved the establishment of the Cancer Working Group in Northern Ireland to consider its implications for Northern Ireland. The Group completed its work and presented its final report to the Minister on 1 April 1996. The report's main recommendation is that Northern Ireland should have a regional cancer centre based in Belfast City Hospital (BCH) and four other cancer units, one for each Board area. The BCH would also serve as a cancer unit for its local catchment population. The report is currently out for consultation.

3.6.5 The report on maternity services by the House of Commons Health Committee in February 1992 emphasised "the right of women to be full partners in their care, to have high quality care and to receive clear and honest information enabling them to exercise choice". Much has been done since then to work towards this goal. The Department set up the Maternity Unit Study Group which produced a report "Delivering Choice". The report which recommended the development of midwifery/GP led maternity units was endorsed by the Department in November 1994 and new policy guidelines for the commissioning and provision of maternity services were issued in June 1996. Meanwhile, the Department has set up a Regional Steering Group to promote the development of midwifery-led care and has set aside funding of £130,000 for 1996/97 and £100,000 for 1997/98, to create a midwifery development project fund.

3.7 Provider Objectives

Efficiency/Value for money

3.7.1 While providers have been relatively successful in expanding market testing into different areas of business, some delays have occurred due to the need to integrate the Policy Appraisal and Fair Treatment Guidelines into the market testing process.

3.7.2 Some providers had difficulty in achieving the required level of cash-releasing efficiency measures. Taken overall, however, HPSS providers met the cost improvement targets required by purchasers.

Management Costs

3.7.3 An exercise was conducted to identify management costs in HSS Trusts for the 1994/95 year. The results were published in March 1996 and on the

basis of the information obtained. Trusts have been asked to secure a 5% reduction in their management costs from 1995/96 to 1996/97. Trusts are required to publish the management costs of senior managers together with the costs of management consultancy contracts in their 1995/96 annual reports. From 1996/97 that requirement will be extended to include the salary costs of all other staff who work in corporate management functions.

Achieving Trust Status

3.7.4 All the former directly managed units have now made the transition to Trust status. With effect from 1 April 1996, there are a total of 20 operational HSS Trusts.

Human Resources

3.7.5 HPSS employers have continued to review and develop their Human Resource Strategies. Significant progress has been made in the following areas:

- the four Management Development Training Units joined with the HSS Executive to form the Regional Development Consortium in 1995. The Top Management Development Programme has been maintained and arrangements are in hand to deliver Chief Executive and Executive Director Programmes;
- the need to negotiate the local pay elements of the 1995/96 pay awards placed on employers an urgent need to develop their capability in this area. To support them in this, there have been a number of development initiatives. A series of team workshops were held during 1995 and arising from these, a residential Pay and Reward workshop was held in early 1996;
- the Project Plan for the HPSS Job Evaluation Scheme was revised during 1995 and the roll-out of the system is due at the end of October 1996. The factors to be used h[a]
been determined and over 60% the benchmark job holders have been identified. Communication initiatives for staff and management continued through[out] 1995/96;
- the February 1995 survey of Junior Doctors' Hours showed th[at] 5.8% of posts failed to meet the December 1994 target of 72 contracted hours for hard-presse[d] posts and 56 hours for full shifts. Funds have been allocated to establish new medical posts and promote skill-mix initiatives with the aim of ensuring that all posts meet the December 1994 target. The Regional Task Force commissioned a further survey in March 1996 to monitor progress towards the final target set for December 1996; and
- the Specialist Registrar Grade was introduced in two "vanguard" specialties, General Surgery and Diagnostic Radiography, on 1 December 1995 and was formally launched on 1 April 1996.

Capital and Estate Management

3.7.6 The Capital Investment Manual has been introduced in the HPSS and now governs the preparation of cases for capital investment, their phased approval process and requirement to test for Private Finance in line with Government policy. Capital resources have continued to be directed towards the twin priorities of concentrating and reshaping the acute sector and enabling providers to address local needs. The latter has increasingly focused on health and safety investment, including Fire Code and the funding available through general capital has enabled providers to significantly increase investment in these areas to ensure compliance with statutory standards.

3.7.7 The majority of Trusts have signed up to "Greencode", an environmental auditing tool which is in the process of

development. The HPSS achieved the Government target of 15% energy savings by the target date of March 1996, since the base year 1990/91.

Information and Information Systems

3.7.8 The timeliness, accuracy and quality standards of the information supplied has improved but more work needs to be done by some providers in this area. They have co-operated with the development of a data audit strategy which will be completed and distributed during 1996.

Better Clinical Practice

3.7.9 Providers have continued to focus on improvement in standards of practice. Significant developments have taken place - a formal Regional Multi-Professional Audit Committee has been established, a Regional Facilitator has been appointed for two years, applications for regional funding of pilot projects are being received and a regional database is operational and being piloted.

4.1 Background

4.1.1 This section sets out the key service priorities for 1997/98 - 1999/00, based on the strategic objectives and targets in the Regional Strategy for 1997 - 2002, and the commitments made in the Charter for Patients and Clients, and the Community Services Charter. These objectives and targets are not comprehensive and Boards will be expected to supplement them as necessary to reflect local needs and priorities.

4.2 Development of Commissioning

4.2.1 The empowerment of primary care teams is an essential element of commissioning development. In England this has been associated with a major change in commissioning structures. This has had some major benefits for the new Health Authorities, who are able in many ways to begin afresh and re-focused. Boards in Northern Ireland are not facing this sort of difficult change but may need to consider how best to inject a similar freshness and focus into their approach and maintain momentum in the development of their commissioning role. The development of the national vision of a primary care-led service in Northern Ireland must embrace and build on the strengths of our integrated structure for the delivery of health and social services.

4.2.2 Boards will be required in 1997/98 to consider how best to improve their linkages to, and partnerships with, primary care teams as a source of commissioning information and advice, and also as a means of sharing essential information on epidemiology, planning and resource constraints, overall population needs, and programme of care aspirations with primary care representatives. The combining of knowledge and experience, and the interaction of the wider Board perspective, with the more detailed needs assessment expertise of primary care teams must be an ongoing process. This should inform commissioning from the outset of planning; inputs to Boards' purchasing prospectuses and plans; form the basis of decision-making; and impact on the design and negotiation of contracts. Creation of such a primary care-led service is undoubtedly a major challenge especially for Boards who have a pivotal role to play in successful implementation of this policy in their areas.

4.2.3 Boards have developed different models of locality-sensitive purchasing arrangements to inform their decisions. This work now needs to be consolidated and linked to the primary care team empowerment process so that both inputs (from localities and teams) can be handled effectively by the commissioning arrangements. There may be scope for rationalisation and for fine tuning of the arrangements required to give the population a voice, recognising the role of HSS Councils.

4.2.4 The HSS Executive will issue guidance setting directions and seeking to translate the vision of a primary care-led service into a reality. It will be for Boards to examine the stage of primary care development reached in their areas and decide how to progress such development and address the practical steps needed to draw primary care into the commissioning process. Before the end of 1997/98 Boards will be expected to produce, for consultation with the HSS Executive, development plans setting out their commissioning role and how they intend to implement it over the 1998/99 year in order to give effect to full primary care empowerment.

4.3 Market Regulation

4.3.1 The HSS Executive commissioned a major review of contracting within the HPSS internal market earlier this year. The review which is now underway will focus on the contracting process rather than on the overall policy, that is, on the arrangements for

contracting and their operation by purchasers and providers. The review covers internal contracts between HPSS bodies only. An examination of contracting with voluntary sector providers will be the subject of a separate exercise.

4.3.2 The object of the review is to identify the current strengths and weaknesses of the contracting process, and its ability to contribute to the objectives of the internal market. Recommendations for improvements in the contracting process for the 1997/98 contracting round and thereafter will form the basis for further guidance on contracting which purchasers will be expected to adhere to.

4.3.3 The HSS Executive wishes to see consolidation of the progress made by Boards in developing arrangements for securing professional advice during the commissioning process. Further broad-based guidance will issue in 1996 suggesting types of structures which Boards may wish to adopt to ensure access to multi-disciplinary and uni-disciplinary professional advice.

4.4 GP Fundholding

4.4.1 Following the Minister's announcement that fundholding GPs would be invited to run pilot schemes in maternity and mental health services, as well as in total purchasing, preparatory work is being undertaken for these schemes, which are likely to run from April 1997. Once established, pilots will be monitored and evaluated by independent assessors on the basis of their viability, effect on services, organisational impact and value for money.

4.4.2 Work is planned for later in 1996/97, involving Boards and fundholding practices, which will lead to the introduction of a more sophisticated approach to the setting of fundholders' budgets from April 1997, more accurately reflecting individual practice needs.

4.4.3 It is intended that training initiated during 1996/97 by the HSS Executive on the new accountability framework for fundholding will be taken forward by Boards from 1997/98 onwards, in order to underpin the framework and ensure its successful implementation.

4.5 GP Prescribing

4.5.1 Government policy remains that patients should receive the drugs they need but that wasteful and unnecessary prescribing should be eliminated. To this end, Boards should pursue a systematic programme of practice visits to discuss prescribing with GPs and identify areas where greater cost-effectiveness can be achieved without compromising quality of care. GPs should, in particular, be actively encouraged to agree repeat prescribing protocols within their practices. Evidence of much higher levels of prescribing and costs in Northern Ireland, compared to Great Britain, reinforces the need to apply pressure to contain the rise in the drugs bill.

4.6 Pharmaceutical Care

4.6.1 The cost of prescribed drugs is in excess of £170 million per annum and rising. At the same time there is a continuing process of deregulation of medicines from Prescription Only to Pharmacy Only status and there is a need, therefore, for pharmaceutical care and medicines management, operating in a multi-disciplinary environment, to maximise effectiveness and minimise risk and cost.

4.6.2 Pharmaceutical care is the responsible provision of drug therapy to achieve definite outcomes that improve a patient's quality of life. Boards, in conjunction with the pharmaceutical profession, should pursue opportunities to fully utilise community pharmacists' skills, particularly in the areas of ongoing medication review, improving compliance, developing care programmes and services for 'at risk'

patient groups, protocols for patient counselling and self-medication, health promotion and multi-disciplinary research, audit and drug utilisation review.

4.6.3 Boards are also expected to continue to approve applications for, and monitor, performance under the new Pharmacy Professional Allowance, to monitor performance under the Pharmacist Patient Medication Record Scheme, and the provision of community pharmacy services to residential care homes.

4.7 Oral Health

4.7.1 Northern Ireland's first oral health strategy was published in 1995. Achievement of the targets set in that strategy for improving oral health will require the commitment not only of dental health professionals, but also of others in the wider HPSS, of those in the education service, of parents and of individuals themselves. Nevertheless, there are specific objectives which the HSS Executive will expect Boards to address. These include:

- ensuring that securing improvements in oral health is an integral part of health promotion and educational programmes designed to improve diet and nutrition;
- ensuring that health promotion programmes highlight the risk factors associated with oral cancer;
- promoting the use of fluoride supplements in those areas where the water supply has not been fluoridated; and
- promoting good oral health and effectively managing the treatment of caries by: encouraging parents to register children with a general dental practitioner from shortly after birth; increasing the percentage of children registered with a general dental practitioner under the capitation scheme; increasing the percentage of adults registered with a general dental practitioner for continuing care; and ensuring that the community dental service screens all children on at least three occasions during their school career, and more frequently where particular need arises.

4.8 Community Care

4.8.1 The allocation of £14.8m new money for community care in 1996/97 underlines the priority attached to this programme. Priorities for service development are:

- the continued development of basic social care services giving practical assistance with daily living to enable people to retain their independence;
- the refinement of the assessment and care management processes in line with the recommendations of the 1995 Report, "A Multi-Disciplinary Inspection of Assessment and Care Management Arrangements" and the Regional Strategy target to offer a separate assessment to carers by 1997;
- the separation of the care management function from day-to-day operational management of service provision;
- promoting the purchase of non-residential community care services from independent sector providers;
- the implementation of routine audits which determine need for and outcomes of care management and inform the optimum targeting of resources;
- the maintenance of the strategy target that at least 88% of people aged 75 and over will be supported in their own homes; and
- more effective links with GP practices, and with a wide variety

of independent sector interests and other bodies to ensure firm inter-agency working arrangements.

4.8.2 Priorities for services for mentally ill people and people with a learning disability will continue to be to increase and target community services to facilitate a reduction in hospital admissions and in the number of people in psychiatric hospitals and specialist hospitals for people with a learning disability. By 1998, Boards should have determined their future requirements for specialist hospital services for mentally ill people and people with a learning disability and have developed implementation plans for the future delivery of these services.

4.8.3 Priorities for people with a physical disability will be to develop a comprehensive range of services to ensure quality of life and equality of opportunity with particular focus on people aged 16 to 25, disabled parents with dependant children, individuals with traumatic brain injury and the newly disabled.

4.9 Child Care

4.9.1 The Children (Northern Ireland) Order 1995 requires Boards to assess the extent to which there are children in need in their areas and to commission services for them. Boards should seek to develop needs assessment procedures to meet the requirements of the Order and to facilitate the development of Children's Services Plans.

4.9.2 The Children Order calls for a strong emphasis on family support services. Boards should ensure that children in need under school age have access to good quality early years services and that all children in need have access to appropriate family support services. Wherever possible these services should be provided in partnership with parents.

4.9.3 Under the Children Order Boards should ensure that the development of services is carried out in partnership with other agencies including Education and Library Boards, the Northern Ireland Housing Executive and District Councils.

4.9.4 The Children Order also requires that Boards should facilitate, wherever possible, the provision of services by others, in particular voluntary organisations.

4.9.5 Boards, working with Area Child Protection Committees, should develop a child protection system which records and monitors the abuse and re-abuse of children.

4.10 Acute Hospital Services

4.10.1 The Regional Strategy for 1997 - 2002 set out the Department's overall aim for acute care for the next 5 years and listed 7 priorities for action to move towards achievement of the aim. Purchasers in co-operation with providers of services will be expected to begin now to take action on the advice and suggestions outlined in the strategy document. In the course of 1997/98 action should be concentrated on the following areas:

- **number of acute hospital sites** - the Strategy makes it very clear that Northern Ireland has too many acute hospitals. The present pattern of 19 cannot be sustained into the new millennium and the HSS Executive expects Boards to develop, with GPs and providers, plans during 1997/98 to bring about a reduction in the number of hospitals providing acute care.

- **locally accessible services** - purchasers will have to ensure that alternative locations are made available for a range of services that can be provided outside the acute setting. In drawing up their plans for acute hospital services, purchasers will have to demonstrate how this shift in care is to be achieved.

- **evidence-based purchasing** - the Department will be issuing guidelines to purchasers to assist the movement to more evidence-based purchasing. Purchasers should use the guidelines to include standards for the delivery of effective treatment and care in their contract specifications with providers. Purchasers will also want to link with the work undertaken by the new Research and Development Office. The HSS Executive will be asking Boards to demonstrate their commitment to evidence-based purchasing in the 1998 Accountability Reviews.

4.10.2 At specialty level in 1997/98, the HSS Executive will expect to see steps taken to implement:

- the recommendations of the **Cancer Services Report - "Investing in the Future"**;

- the recommendations of the **Renal Services Review Group** particularly in so far as it affects the haemodialysis patients currently receiving dialysis only twice weekly;

- the guidance in the new **Maternity Services Policy Circular** as quickly as possible. The establishment of a "women-centred" service should be seen as a high priority. The objectives set out in last year's Management Plan are restated in Appendix 1 to this Plan.

- the standards set in the **Charter for Maternity Services,** which will be issued by the HSS Executive in August 1996. The Charter will give mothers more choice and control over their maternity services. Purchasers will be expected to reflect the standards in the Charter in their contracts with providers for 1997/98; and

- a review of progress on **The Way Forward for Hospital Pharmaceutical Services** and its further development, including extension into the primary care sector.

4.11 Voluntary and Community Sector Development

4.11.1 A central theme of the Government's UK-wide Make a Difference Initiative is the promotion and involvement of volunteers in a wider variety of activities which benefit both themselves and their communities.

4.11.2 The Department will produce, during 1996, a circular on relationships with the voluntary sector covering both policy and operational issues, incorporating guidance on the implications of contracting arrangements for the voluntary sector and the maintenance of effective volunteering and volunteer resourcing

4.11.3 During the period of this Plan, all purchasers and providers should seek to maximise the involvement of volunteers and will be required to produce and publish policies for involving volunteers. Policies should be in place by March 1997 with measurable targets for extending the involvement of volunteers in a wide range of activities. Contracts and service agreements with voluntary organisations for 1997/98 should take account of the costs of involving volunteers. Purchasers should also make explicit their policies in relation to carers and develop further the support for carers provided through the voluntary sector.

4.12 Provider Priorities

Efficiency/Value for Money

4.12.1 Providers will be expected to develop policies and practices which will ensure, as a minimum:

- the achievement of cost improvement targets agreed through contracts with purchasers;

- full participation in the achievement of value for money targets as set out in paragraph 2.6.4; and

- that statutory financial obligations are met.

Management Costs

4.12.2 All Trusts will be expected to keep their organisational structures and working arrangements under review to make sure that the maximum levels of contract income find their way directly into services for patients and clients.

Corporate Governance

4.12.3 All Trusts will be required to develop their own arrangements and participate in a service-wide programme for the development of board members in the area of Corporate Governance.

Provider Project Board

4.12.4 The Provider Project Board, whose membership was representative of all HSS Board areas, was set up following the report of the Purchasing Functions and Structures Review, to examine the potential for the reorganisation of provider support functions. The Provider Boards research indicated scope for alternative approaches to the provision of trust support services and within that, the potential to achieve both savings and improved delivery of services.

4.12.5 The Provider Board's report identified functions which are of core significance to the business and corporate identity of a Trust and which, it concluded, represent the minimum range which a Trust must manage in-house. The other non-core services could, when feasible, be provided by an outside source. As a result of this review, all Trusts are required to take measures to ensure in-house provision of all core functions and to carry out an examination of their arrangements for the other support services with a view to identifying savings and improved patterns of service delivery.

Human Resources

4.12.6 Each HPSS employer is required to review and develop its Human Resource Strategy to ensure that it continues to be fully integrated with, and support, its annual Business Plans. In doing so, due attention should be given to issues such as fair employment, equal opportunities, reward systems, staff welfare and general employment policies and effective workforce planning, linked to education and training needs and commitments.

4.12.7 With the financial pressures on the HPSS comes the need to radically review the way in which the Service is delivered. Full use should be made of current thinking as regards business re-engineering processes, to effectively address issues such as skills mix, with the aim of producing a workforce which is equipped to meet the demands of the 21st Century. In particular, arrangements must be in place to ensure the effective identification and delivery of non-medical education and training to meet the requirements, both current and future, of the HPSS.

4.12.8 The revised PSS Training Strategy for the period 1997 - 2002 will be implemented from April 1997. Targets have been set for improvements in the competence of the PSS workforce at vocational, professional and post professional levels. Commissioners will link the targets to service areas through audits of competence requirements, associated with assessment of need and service commissioning plans. By 2000, 60% of the targets set should have been achieved.

Opportunity 2000

4.12.9 Providers will be expected to take forward practical initiatives to address imbalances between men and women in the workforce.

Capital and Estate Management

4.12.10 Providers will be expected to continue to prioritise and propose investment consistent with the Regional Strategy and Boards' purchasing strategies and in line with the Capital Investment Manual. Increasingly they will be expected to look to the Private Finance Initiative as a mechanism to ensure that investments reflect greater creativity and innovation than in the past and to ensure that the scope for capital investment in the HPSS is maximised although public resources remain limited.

4.12.11 Trusts will also be expected to look critically at their estates with a view to rationalising these and identifying further assets for disposal.

Better Practice

4.12.12 Providers must continue to seek improvements in the standard of service they provide and should ensure that they deliver to contract the outcomes for patients and clients required by purchasers. Providers should also have a strategy aimed at sustaining a process of continuing quality improvement. Specifically, providers should:

- have clear policies on the role of clinical audit as part of a programme to improve all aspects of service quality; and

- take account of any advice on the effectiveness of treatment and care which is produced by the Department.

4.13 Information/Information Systems

4.13.1 HPSS organisations will be expected t continue to co-operate, including through the Regional Information Steering Committee, in a programme of work to ensure that data required for operational and management purposes within the HPSS and the Department are generated efficiently, and to appropriate quality standards. This programme will include:

- developing information strategies which meet current and projected HPSS needs;

- responding to the outcome of the Department's review of information requirements;

- developing and delivery of IM&T training for HPSS staff;

- developing and implementing data audit within the HPSS; and

- acquiring new services to support data and voice communications between HPSS organisations.

Topic	Objective		Target 1997/98	Target 1998/99	Target 1999/00
Health Promotion and Disease Prevention	1.	Continue fluoridation programme so that some 60% of the population will have their water supply fluoridated:	*		
	2.	Achieve a minimum acceptable response rate of the target population for breast cancer screening of:	75%	75%	75%
Family Practitioner Services	3.	Persuade GPs to increase the level of their generic prescribing to:	40%	45%	50%
	4.	Work with GPs to increase the percentage of practices actively using a practice prescribing formulary to:	60%	75%	80%
	5.	Work with GPs to increase the percentage of practices using a protocol for repeat prescribing to:	60%	80%	90%
	6.	Promote the Standard and Community Fundholding Schemes amongst eligible GP practices:	*	*	*
Services for Elderly People	7.	Develop community services for the elderly to maintain the proportion of people aged 75 or over who are cared for in their own homes:	88%	88%	88%
Services for Mentally Ill People	8.	Put in place an agreed approach to outcomes measurement and monitor all services in the statutory and independent sectors against common quality standards:	*		

Topic	Objective	Target 1997/98	Target 1998/99	Target 1999/00
	9. Boards should assess the needs of their population and determine the future requirements for specialist hospital services and establish the implications for each psychiatric hospital:	*		
Services for People with a Learning Disability	10. Commission a range of community based services for people with a learning disability to:			
	a. promote inclusion:	*		
	b. effect a reduction in the number of longstay patients in specialist hospitals of:	20%[1]	40%[1]	60%[1]
	c. effect a reduction in the number of adults admitted to specialist hospitals of:	10%[1]	20%[1]	30%[1]
	d. effect a reduction in the number of children admitted to specialist hospitals of:	20%[1]	40%[1]	60%[1]
Physical and Sensory Disability	11. Boards should commission the range of services needed to maximise opportunities for newly disabled people to continue their usual and planned lifestyle/activities:	*		
	12. Boards should commission a range of services to meet the identified needs of disabled parents with dependent children, including young carers:	*		

[1] Target reductions are from the 31 March 1997 baseline.

Topic	Objective	Target 1997/98	Target 1998/99	Target 1999/00
	13. Boards should develop strategies for the commissioning of well integrated, accessible and complementary hospital and community services for individuals with traumatic brain injury and their families:	•		
	14. Boards should commission the range of services needed to maximise opportunities for disabled young people aged 16-25:	•		
Care in the Community	15. Develop a strategy within each Board to identify the numbers and needs of vulnerable people within the community in their area:	•		
Services for People with Dementia	16. Boards and Trusts should conduct a detailed audit of the needs of people with dementia and the services available to meet those needs:	•		
Child Care	17. Boards should develop a child protection information system which monitors abuse and re-abuse of children. They should establish a baseline in 1997/98 and ensure that the number of children who are abused or re-abused is reduced by 20% by 1999/00:	•		•
Acute Hospital Services	18. Increase the level of day case activity as a percentage of elective admissions in the following procedures:			
	a. Inguinal Hernia:	30%	35%	
	b. Varicose Veins:	27%	35%	
	c. Cystoscopy:	80%	85%	

Topic	Objective	Target 1997/98	Target 1998/99	Target 1999/00
	d. Circumcision:	80%	85%	
	e. Arthoscopy of Knee & other joints:	85%	87%	
	f. Cataract Extraction:	30%	35%	
	g. Correction of squint:	25%	35%	
	h. Laparoscopic Sterilisation:	65%	75%	
	i. Endoscopy of Gastric Intestinal Tract:	90%	90%	
	j. Bronchoscopy:	73%	75%	
	19. Ensure that action is taken to meet the objectives in the Department's latest policy guidelines on maternity services, and, in particular:	*	*	
	a. take steps to involve women in planning the development of women-centred maternity services:	*	*	
	b. introduce new models of care which will extend the choice of care available to women:	*	*	
	c. produce local guidelines on the operation of and criteria for delivery in a midwife/GP led maternity unit:	*	*	
	d. provide information to women on the range of maternity services available in their locality:	*	*	
	20. Reduce the total number of hospital bed days occupied per annum by children aged 0 - 15 years by:	5%[1]	10%[1]	15%[1]

[1] Target reductions are from the 31 March 1997 baseline.

Topic	Objective	Target 1997/98	Target 1998/99	Target 1999/00
Voluntary and Community Sector Development	21. Ensure that contracts and service agreements with voluntary organisations take account of the costs of involving volunteers:	•		

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HPSS MANAGEMENT PLAN 1998/99–2000/01

HSS
EXECUTIVE

HPSS MANAGEMENT PLAN
1998/99 - 2000/01

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HSS Executive Mission Statement

The primary purpose of the HSS Executive is to secure improvements in the health and social well-being of people in Northern Ireland.

Main Functions of the HSS Executive:

- to provide leadership, direction and support to the health and personal social services (HPSS);
- to set and ensure the achievement of specific objectives and targets for the HPSS in accordance with national and regional policies and priorities;
- to monitor the performance of the HPSS in assessing need and improving the health and social well-being of the population;
- to allocate resources and ensure that they are used effectively, efficiently and economically, in accordance with the required standards of public accountability;
- to promote the right environment for managers to achieve these objectives; and
- to provide advice, information and support to Ministers on the management and performance of the HPSS.

1. Introduction

1.1 Background

1.1.1 The purpose of the annual Management Plan is to provide the overall context for the planning and delivery of health and social care for the coming year, and to focus the HPSS on the most important priorities to be pursued over the next three years. This Plan, while focusing primarily on 1998/99, outlines the strategic priorities for the period 1998-2001. It takes account of the priorities and objectives in the Regional Strategy for 1997-2002 *Health and Well-being: Into the Next Millennium* which was published in July 1996.

1.1.2 The characteristics and health and social needs of local populations vary in different parts of the Province. Plans drawn up by Boards in consultation with other agencies should reflect local needs and priorities. The purpose of this Plan is to give a broad direction to Boards for the development of their strategic role. Specific quantified objectives and targets will be agreed in individual Action Plans between each Board and the HSS Executive, and in service agreements between purchasers and providers.

1.1.3 In developing local purchasing strategies and plans, Boards will be expected to work in partnership with primary care professionals, and in particular all their GPs. In turn, primary care professionals will be expected to engage with Boards in the full commissioning process and to have ownership of, and act upon, local strategies. Agreed strategies are expected to be given effect by all purchasers and supported by all primary care professionals in their day to day practice.

1.1.4 Boards will be expected to take account of the priorities set out in Section 4 and the targets in the Appendix of the Management Plan when drawing up their individual Action Plans for 1998/99. The HSS Executive will also wish to see evidence of the action planned by Boards to achieve the Regional Strategy targets in their Action Plans. The Plans will be subject to endorsement by the Minister in the course of the annual Accountability Reviews.

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2. HPSS Key Objectives and Priorities for 1998 - 2000

2.1 Key Objectives

2.1.1 The key strategic objectives for the Management Plan flow from the Regional Strategy. They focus on:

- targeting health and social need;
- promoting the development of a primary care-centred service;
- improving and reshaping acute hospital services;
- developing care in the community;
- improving efficiency and ensuring value for money in the use of resources; and
- increasing effectiveness and outcome measurement throughout the HPSS to ensure the greatest health and social gain from the resources available.

2.2 Targeting Health and Social Need

2.2.1 In order to address the inequalities that exist in health and social well-being in Northern Ireland, the HPSS must work towards improving (both absolutely and relative to the population as a whole) the health and social well-being of all disadvantaged groups.

2.2.2 Boards should take forward initiatives to ensure that the priorities for action outlined in the Regional Strategy for *Targeting Health and Social Need* (THSN) are met. A Department-led Steering Group has been established to advise on the implementation of the THSN initiative. This includes advising on how the Department, Boards and Trusts can further promote and employ community development.

2.2.3 Community development seeks to encourage local communities to tackle the problems which they face and to empower them to change things through developing their skills and working in partnership with other groups and with the statutory agencies. Participation by communities has a particularly important part to play in making services more responsive to users' needs, and in generating a sense of local ownership and control over the matters which affect their lives.

2.2.4 As part of the process of targeting need, an HSS Executive Review Group which aims to provide a more accurate resource allocation formula for distributing financial resources to Boards, will publish its report in

September 1997. This has made recommendations for a revised population-based (capitation) funding formula that will indicate the relative need for health and personal social services in each Board area. The HSS Executive is committed to begin implementation of the revised formula in 1998/99.

2.3 Primary Care Services

2.3.1 Enhancing the role of primary care is one of the underlying principles of the Regional Strategy. The Strategy recognises the benefits of empowering those working in primary care to influence service commissioning on behalf of their patients and clients. This approach is central to the commissioning of care by Boards. Commissioning, the overall process through which services are, where necessary, brought into being and secured through purchasing actions, remains a central focus for Boards.

2.3.2 A needs-led, evidence-based, and patient or client-centred service, with resource commitment decisions taken as close to patients or clients as possible, remains a clear goal for commissioners. Boards and primary care teams should increasingly work together to develop services which are demonstrably responsive to and influenced by local populations. Commissioners also have a corporate responsibility to the entire population to ensure that high quality, population-wide services are available. They must balance this responsibility with other more local concerns.

2.3.3 The Health Services (Primary Care) (Northern Ireland) Order 1997 provides (subject to the making of Commencement Orders) for local flexibility in the delivery of pharmaceutical services and for the piloting of different approaches to the delivery of general medical and general dental services in order to address problems of accessibility or to improve, in specified ways, the provision of those services. Other provisions could also allow the testing of new models of combining the provision of general medical services with either the provision or purchase of secondary and community care services using a unified budget.

2.3.4 Boards should play a major part in shaping a primary care-centred service. They should do this through the relationships they form with primary care teams in commissioning services, particularly in the assessment of need, in the planning and specification of services, and in the monitoring of care delivery.

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2.4 Acute Hospital Services

2.4.1 Acute hospital services have changed significantly in recent years. New techniques and changes in clinical practice enable many patients to be treated as day cases, as outpatients, or by their GP without having to go to hospital. Minor surgery, specialist consultant outpatient clinics, and chronic disease management can all be provided in the GP's surgery. The development of telemedicine will, in the future, also enable more advanced diagnoses to be undertaken in local centres. This means providing locally accessible services for more routine procedures through enhanced co-operation between primary, community and hospital care teams.

2.4.2 On the other hand, greater specialisation by hospital consultants, the trend towards working in larger clinical teams, and advances in medical technology with the use of more expensive specialist equipment, all point to greater centralisation of acute hospital services.

2.4.3 The ever increasing demand for health care, especially the needs of an aging population and the realisation that duplicating services wastes scarce resources, are economic imperatives which require immediate action if the quality of acute care is to be maintained. Any unnecessary duplication of services therefore must be eliminated as far as possible. It is essential that the reviews of hospital services, including the future organisation of cancer services, are finalised as quickly as possible.

2.4.4 The ability of hospitals to cope with fluctuations in the demand for emergency admissions is fundamentally influenced by management arrangements within hospitals and between hospitals and other care providers. There is a need to put in place plans to meet sudden rises in demand to ensure that the needs of emergency patients receive the appropriate priority without, as far as possible, interfering with planned admissions.

2.4.5 Similarly, it will be important for Trusts to ensure that timely and effective discharge arrangements are in place in order to reduce the number of patients who have been assessed for care management but have not been discharged due to the lack of community funding to meet their agreed care package.

2.5 Care in the Community

2.5.1 Most health and social care is delivered in the community - in peoples' homes, in health centres, in surgeries, in residential and nursing homes, and in a variety of day care settings. These can be provided by the

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statutory, voluntary or private sectors. Continuing to improve care in the community is one of the main themes of the Regional Strategy, which recognises the need to support people in their own homes and in the community unless their needs can be better met in hospital. Improving care includes responding flexibly and sensitively to the needs of individuals and the relatives and friends who care for them. The role of carers is a high priority and they should be made aware of their right to a separate assessment of their needs.

2.5.2 Assessment and care management arrangements have contributed significantly to the realisation of the *People First* agenda for older people and people with disabilities or mental illness since the introduction of the community care changes in April 1993. The Report by the Department's Social Services Inspectorate *A Multi-Disciplinary Inspection of Trusts' Arrangements for the Discharge of Older People from Hospital to their Own Homes, Residential or Nursing Home Care,* to be completed in late 1997, will provide a useful benchmark for the future development and improvement of referral arrangements for care management and the timely delivery of appropriate community care services.

2.5.3 Following completion of the initial three year social security transfer phase of the *People First* programme in the 1995/96 financial year, and the allocation of additional funding for 1996/97, care management budgets continue to be under pressure from increased demand for residential and domiciliary care services. Funding for care in the community has now been subsumed within overall HPSS spending and should benefit from strategic adjustments in purchasing policies. These reflect the priority attached to community-based health and personal social services and, in particular, the move away from long-stay hospital provision.

2.5.4 The emphasis on ensuring effective contacts between primary care teams and care management must also be maintained. It is important that GPs and other primary care team members are enabled to participate fully in the assessment of need, and the formulation and review of care plans. The introduction of the Direct Payments scheme in 1997/98, for clients who are disabled and under 65 years, will provide further opportunities for innovation in designing care packages. It will also empower individuals and afford greater choice in selecting and managing personal care services.

2.6 Value for Money

2.6.1 Since the introduction of cost improvement targets in 1983/84, the HPSS has made significant progress in pursuing efficiency gains and greater value for money. The majority of indicators demonstrate that resources are now used more effectively, whether in terms of staffing, bed throughput, length of stay, energy consumption or other key areas.

2.6.2 The increasing demand for services, leading to pressure on finite resources, provides a continuing challenge for managers to continue the search for efficiency gains. Each management Board must recognise its role in terms of leadership, in reviewing and assessing the performance of the services under its control. Economy, efficiency and effectiveness should be on the agenda at every level of management activity.

2.6.3 Throughout the period of this Plan, purchasers and providers will be required to:

- achieve further annual efficiency improvements within set targets;
- identify and disseminate good practice in obtaining value for money;
- continue to develop procedures to assess relative performance and recognise those areas where improvements can be delivered; and
- establish structures that involve managers at all levels in the process of continuous improvement.

2.6.4 Improvements to professional and management practices need to be backed by the best possible research. A Research and Development Agency will be established in 1997/98 to help this process. This will help provide the evidence base for effective health and social care in Northern Ireland through:

- the commissioning of new research;
- the dissemination of research findings; and
- the formulation of strategies for implementation of research findings so that research gets into practice.

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2.7 Effectiveness and Outcome Measurement

2.7.1 One of the goals of the Management Plan is to secure greater effectiveness as well as efficiency in service delivery. Ideally, all health and social care should be effective and evidence based. One of the ways to ensure this is through a regular programme of clinical and multi-professional audit. This is the systematic analysis of the quality and outcome of health and social care. The care provided will be measured against agreed standards, which should be evidence based and supported by research. Such standards and guidelines may be internationally, nationally or locally produced. This is relevant irrespective of whether care is provided in an acute, community, or primary care setting. It is equally relevant to policy makers, commissioners, purchasers and providers of services.

2.7.2 The Department, commissioners, purchasers and providers of services are all responsible for providing effective and evidence based care. It is therefore important that there are effective links between the new Research and Development Agency, the Clinical Effectiveness Initiative and CREST that provide and disseminate research evidence, and guidelines and standards on effective care.

3. Review of Performance in 1996/97

3.1 Background

3.1.1 This section reviews the progress that has been made in achieving the main objectives and targets set for 1996/97 in the Management Plan for 1996/97-1998/99.

3.2 Commissioning Development

3.2.1 In January 1996, the Purchasing Development Steering Group embarked upon a review of the Group's title, function and membership. To reflect change in the roles of both Boards and GPs, the Group has assumed the title of Commissioning Development Steering Group. In November 1996, the Group oversaw the publication of a two-part report and self-audit tool which identifies the key variables for commissioning organisations and an immediate workplan. A later workshop led to the production of a draft of a Commissioning Framework for Northern Ireland which has still to be finalised.

3.2.2 The development of a primary care-centred service, based on primary care teams, was advanced during 1996 in parallel with the emerging national programme first documented in *Primary Care: the Future*. A major Northern Ireland conference in June 1996 affirmed the basic principles of the policy for a primary care-centred service, with the emphasis on empowering multi-disciplinary primary care teams. A policy paper on primary care is likely to be issued in late 1997.

3.3 Contracting

3.3.1 Progress towards meeting the targets for further development of the contracting process has been mixed.

3.3.2 The majority of 1996/97 contracts between Boards and Trusts/Agencies were of the 'sophisticated block' type (63%), with indicative volumes, activity and costs identified to at least specialty levels. The majority of GP fundholder contracts are of the cost per case or cost and volume type.

3.3.3 Very few Board contracts for acute hospital services show a breakdown by case mix, or a clear breakdown of costs and volumes for the inpatient, outpatient, day case and diagnostic services elements of the contracts.

3.3.4 Boards have had limited success in developing contracts with longer than one year's duration. While some 46% of contracts are described as

being of three year duration, the majority of these are subject to annual review and re-negotiation of price and volume. The vast majority of GP fundholder contracts are for one year.

3.4 Primary Care Services

GP Prescribing

3.4.1 Some progress has been made towards achieving the target set for generic prescribing. The level of generic prescribing in Northern Ireland at March 1997 was 30.4%, compared with 28.5% in March 1996. When compared with the equivalent English position, where 46.2% of prescriptions dispensed during 1996 were generic, the overall rate is still disappointing.

3.4.2 There is evidence of better performance by practices in the use of prescribing formularies and protocols for repeat prescribing, which are highly important components in the effort to contain the drugs bill. About 43% of practices in Northern Ireland have prescribing formularies and around 53% of practices have protocols for repeat prescribing. These percentages are still well short of the targets set.

Oral Health

3.4.3 Following the launch of Northern Ireland's first Oral Health Strategy in 1995, all Boards have been actively involved in working towards achieving the targets and meeting the recommendations contained in the Strategy. Oral health promotion campaigns have covered a range of incentives, from the promotion of sugar free medicines, and the 'Gob-Smacked' roadshow to the use of a video and information pack on the benefits of wearing a mouthguard during sporting activity. A survey of the oral health knowledge, attitudes and behaviour of 14-15 year olds was also carried out. This aimed to develop appropriate oral health promotion activities for that age group.

3.4.4 Other initiatives involved nutritional guidelines to health professionals, multi-professional training courses on current dental and nutritional messages, screening and oral hygiene programmes and a survey of non - attenders at the dentist to help formulate plans for increasing registration.

3.4.5 The Community Dental Service has continued to screen all children on at least three occasions during their school career.

Pharmaceutical Care

3.4.6 Boards have continued to approve applications for, and monitor pharmacists' performance under the qualifying criteria for the Pharmacy Professional Allowance.

GP Fundholding

3.4.7 A further 11 practices joined the standard GP Fundholding Scheme on 1 April 1997, while 28 practices joined the first wave of the new Community Fundholding Scheme from the same date. These additions to the Scheme have increased the number of GP practices in fundholding (for both options) to 155 - a total of 524 GPs. Their combined patient lists comprise 54% of the population.

3.4.8 A Working Group of Board, GP fundholder and HSS Executive representatives was set up in September 1996 to examine arrangements for establishing GP fundholder budgets, with a view to advising on regional guidelines for fundholder budget-setting in the future. The Group is awaiting the outcome of work by the Health and Health Care Research Unit of the Queen's University, Belfast to devise a formula for the equitable allocation of acute services funding at GP practice level. In view of the timescale for the results of this work, and the detailed calculations which will subsequently have to be done in each Board, the HSS Executive decided that the implementation of new budget-setting arrangements would be postponed until the 1998/99 financial year.

3.4.9 The HSS Executive arranged regional workshops during 1996/97 to assist Boards and fundholders in the local application of the Accountability Framework for GP fundholding. This was published in July 1996.

3.4.10 Six purchasing pilot schemes, involving a total of 15 GP fundholding practices, were established on 1 April 1997 after a period of project design. Three of the schemes are in total purchasing, two in mental health and one in maternity services. The schemes will test the effects of involving GP fundholding practices directly in the commissioning and purchase of services which are the responsibility of Boards.

3.5 Acute Hospital Services

3.5.1 Boards and Trusts have taken steps to meet the Regional Strategy priorities for changing the pattern of acute hospital services. These include:

- ongoing reviews of acute services in the Northern, Southern and Western Board areas;
- increased emphasis on day case and outpatient investigation and treatment;
- cessation of acute services at Banbridge Hospital, and efforts to secure

a range of outpatient, diagnostic and other services on the hospital site;

- consultation about the transfer of acute services (including obstetrics) from Ards Hospital to the Ulster Hospital;
- continuing action to implement the decisions arising from the Acute Hospitals Reorganisation Project, which examined services at the RGH and BCH Trusts; and
- plans to pilot Community Hospitals in Bangor and Newtownards.

Activity

3.5.2 Progress in meeting the targets set for acute services activity was mixed during 1996/97. The 1.5% budget cut targeted particularly on elective surgery, coupled with pressure from emergency admissions, contributed to an increase in waiting lists. Between March 1996 and March 1997, the total number of people waiting for inpatient treatment increased by 26%. In the same period those waiting in excess of the Charter standard for inpatient treatment rose from 837 to 3,084. By March 1997, there were 63,227 patients waiting for a first outpatient appointment, an increase of 7% over the previous year. The percentage of people waiting in excess of the Charter standard of 3 months for a first outpatient appointment rose from 22% in March 1996 to 27% in March 1997.

Acute Hospitals Reorganisation Project

3.5.3 On 19 March, the Department announced its decision to centralise maternity and associated services in a new unit in the BCH, with the closure of the Royal Maternity and Jubilee Hospitals. At the same time a decision was announced to transfer the A&E department at the BCH to the Royal Hospital.

3.5.4 The proposed transfer of maternity services is currently under review by the Minister, who has commissioned an independent medical review panel to advise him on the clinical aspects of the decision. The outcome of the review is expected to be announced before the end of the year.

Maternity Services

3.5.5 Work in relation to the further development of midwifery-led maternity care started in 1996. The Regional Steering Group considered 37 applications for the funding of pilot projects in midwifery-led care in 1996/97. Nine awards totalling £100,000 were agreed and work has begun on the projects. A further 16 applications were considered in March 1997 and agreement was reached to fund five projects in 1997/98. Additional funding to develop midwifery-led units is available this year and applications have been invited by the Steering Group.

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Cancer Services

3.5.6 The Department endorsed the Cancer Working Group's report to set up a regional cancer centre, led by the Belfast City Hospital, and four cancer units, one for each Board area, at Altnagelvin, Antrim, Craigavon and Ulster Hospitals. While it was agreed that a strong clinical case had been made for the relocation of services from Belvoir Park Hospital to the proposed cancer centre at the BCH, no final decision will be made until the costs and benefits of the proposed move have been assessed. The Eastern Board, on behalf of all purchasers, has been commissioned by the HSS Executive to lead an option appraisal to examine this issue in more detail. This will be informed by the reviews of local cancer services which are currently underway in each Board area.

Renal Services

3.5.7 The report of the Renal Services Review Group on the level and quality of renal services needed over the next five years was endorsed by the Department and issued to commissioners and providers in June 1996. The HSS Executive has since identified renal services as a priority area for development and has set targets for renal replacement therapy and haemodialysis.

3.6 Care in the Community

3.6.1 A further £14 million was allocated in 1996/97 to develop community care services, including £2 million to compensate for changes in the capital levels disregarded when charging for residential and nursing home care. This brings the total extra funding for community care since it was introduced in April 1993 to £124 million. By April 1997, 13,491 care packages were in place providing support for 6,581 people in their own homes (49%), 4,308 nursing home placements (32%) and 2,602 places in residential care homes (19%). Overall, 95% of all assessments now commence within three weeks of referral, and 60% of care packages are delivered within three weeks of assessment. Over 84% of those recently referred for care management were older people.

3.6.2 Boards have continued to increase and target community services to effect a reduction in the number of long-stay patients in psychiatric hospitals and specialist hospitals for people with a learning disability. Between December 1992 and February 1997, the number of long-stay patients in psychiatric hospitals reduced by 47%. The number in specialist hospitals for people with a learning disability fell by 26% during the same period. The figures indicate that the targets set for 1996/97 in the Regional Strategy have been met.

3.6.3 Boards have also worked towards reducing the time taken to carry out

occupational therapy assessments for equipment and housing adaptations and meeting the standards set out in the Charter for Community Services. Special initiatives have been funded in areas of particular difficulty. The HSS Executive has also collaborated with the Northern Ireland Housing Executive on a model service agreement for Boards, Trusts and local NIHE offices. This sets out responsibilities and response times of those involved in the adaptations process. While recognising the work done to date by Boards to meet the Charter standards, the HSS Executive is concerned that many people are still waiting too long for both priority and non-priority assessments.

Child Care

3.6.4 Implementation of the Children Order on 4 November 1996 was preceded by the issue of guidance and Regulations to the HPSS. By March 1997, the major part of the regional multi-disciplinary start-up training strategy had been completed. Boards and voluntary organisations were funded to secure training for 20,000 staff at foundation level, over 2,700 at comprehensive level and approximately 1,600 at specialist level, this being two-thirds of the specialist training needed. Boards co-operated with voluntary sector agencies and others, including Education and Library Boards and the Northern Ireland Courts Service, to ensure the quality of the training. This was the largest multi-disciplinary and inter-agency training exercise ever undertaken in Northern Ireland. Boards have continued to give emphasis to placing children in family settings. Boards were to ensure that 75% of children in care, excluding those home on trial, were placed with a family by the end of 1996/97. By September 1996 (the latest figures available), 82% of those children had been placed with a family.

Domestic Violence

3.6.5 In 1996 the Northern Ireland Regional Forum on Domestic Violence recommended that Community Trusts should set up local inter-agency networks to co-ordinate action against domestic violence. Boards and Trusts responded positively to this recommendation and the Department asked them to implement it by September 1997. The NI Women's Aid Federation has appointed two Regional Development Workers to support the local networks.

3.7 Clinical Effectiveness

3.7.1 Each Board has established a clinical effectiveness initiative to try to ensure that all services purchased and provided are effective and based where possible on sound evidence. Boards have access to the latest research evidence through information sources and international databases like Medline and the Cochrane Database. In addition, the

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Department has recently established a Regional Effectiveness Committee to promote effectiveness in health and social care and to disseminate and promote the implementation of best practice in agreed priority areas.

Multi-Professional Audit

3.7.2 The Department has also established a Regional Multi-Professional Audit Group to co-ordinate multi-professional audit and to advise on regional topics for audit. A regional database has also been established to hold summary information on audit projects carried out throughout the HPSS.

CREST

3.7.3 The Clinical Resource Efficiency Support Team (CREST) has been an important vehicle for producing and disseminating guidelines on clinical practice in Northern Ireland. CREST was established in 1988 to help promote good clinical practice. Each year it produces and publishes reports and guidelines in three key practice or service areas. In 1996 reports were produced on Diabetes, Control of Blood Pressure, and the use of Magnetic Resonance Imaging.

3.8 Efficiency/Value for Money

3.8.1 Progress in market testing during 1996/97 was patchy, despite the pressure on many HSS Trusts to produce challenging cash-releasing measures. Nevertheless, services to the value of £9.59m per annum were tested and others have begun, or are planned for 1997/98.

3.8.2 A number of providers continue to experience difficulty in achieving the target level for cash releasing and non-cash releasing efficiency improvements required by purchasers. The projected shortfall on the overall efficiency target is reflected in a number of Trusts failing to balance their income and expenditure.

Management Costs

3.8.3 HSS Trusts are required to publish the management costs of senior managers, and the costs of staff who work in corporate management together with the cost of management consultancy contracts for 1996/97. The HSS Executive continues to monitor Trust management costs to ensure that the targets set are achieved.

3.9 Human Resources

Medical Staff

3.9.1 The specialist registrar grade was formally launched on 1 April 1996. It has been successfully commissioned in all grades and the new curricula

for the various specialties have been introduced.

3.9.2 Steady progress continues to be made towards achieving the December 1996 targets for the hours and working conditions of junior doctors and dentists. Since December 1996, no junior doctor or dentist should be contracted for more than 72 hours, nor work for more than 56 hours per week. The March 1997 survey of junior doctors' hours showed that of the 1,072 junior doctors and dentists in post, 24% still exceed the 1996 target. The HSS Executive continues to monitor progress whilst the Regional Task Force is co-operating with Trusts to devise measures for dealing with the remaining intransigent posts.

Equal Opportunities

3.9.3 Representatives of purchasers and providers, helped by the HSS Executive, organised a major Opportunity 2000 conference in 1996 aimed at senior representatives of HPSS employers. It provided the forum to kick start initiatives aimed at addressing the imbalances between men and women in the workforce.

Local Pay

3.9.4 Employers throughout the HPSS established local recognition and negotiation arrangements to take forward the local pay element of the 1996/97 'national' pay awards and to develop Trusts' own reward packages. As a result, more meaningful negotiations took place, producing pay settlements tailored to meet the available resources and needs of individual employers.

PSS Training

3.9.5 The timescale for issuing a revised Personal Social Services Training Strategy is currently under review. Commissioning by Boards has proceeded with targets established for improvements in the competence of the workforce. These include targets at vocational and post-professional levels as well as those for securing the supply of qualified social workers. All Boards showed satisfactory progress towards achieving targets by the end of 1996. All Boards have begun to establish mechanisms for auditing the competence requirements.

3.10 Information Management and Technology

3.10.1 Considerable progress was made on the development of strategic frameworks for the HPSS, for the Community sector, for the Acute sector and for General Practitioners. The review of Departmental information requirements has led to the immediate cancellation of various returns collected by the Department and the simplification of others. Some new returns, such as those required under the Children Order, have been added.

4. Service Development Priorities 1998–2001

4.1 Background

4.1.1 This section sets out the key service priorities for 1998/99 to 2000/01, based on the objectives and targets set out in the Regional Strategy and the commitments in the Charter for Patients and Clients. These priorities are not comprehensive and Boards will be expected to supplement them to reflect local needs and priorities.

4.2 Targeting Health and Social Need

4.2.1 In taking forward THSN during 1998/99 Boards should be able to demonstrate:

- that they have established a systematic approach to identifying local needs and preferences;
- how they have promoted and employed community development approaches in targeting health and social need;
- that staff who would benefit most from education and training in community development approaches have had access to it;
- that their population needs assessments and the consequent allocation and use of resources conforms with paragraphs 4.17 and 4.22 of the Regional Strategy;
- that they have identified, implemented and provided for the formal evaluation of interventions that might succeed locally in reducing the inequalities identified in the Regional Strategy, and have begun to extend this work throughout the key areas in the Strategy;
- that the programmes and services are routinely evaluated to ensure the targeted resources are succeeding in reducing inequalities;
- shifts in resources due to better population needs assessments and evaluation of the effectiveness of targeted resources; and
- that locally agreed strategies and associated implementation plans for achieving THSN objectives are in place.

4.3 Replacement of the Internal Market

4.3.1 The HSS Executive is currently considering how to take forward proposals for new and more cost effective arrangements for the

planning, commissioning and delivery of health and social services. This will include discussion with HSS organisations and other interests. The new arrangements will, in time, replace the existing internal market.

4.3.2 The new arrangements will retain the separation between the planning and delivery of services, and will be based on locality commissioning groups involving general practitioners and other primary care professionals. However, as the proposals are at a very early stage of development, it is not yet possible to give details of the new arrangements or the timescale for their introduction.

4.3.3 The new arrangements will take account of the outcome of the recent review of the contracting process for health and personal social services. Whilst the focus of the review was on improving the efficiency and effectiveness of the existing internal market arrangements, it highlighted a number of matters which will be relevant to any new arrangements. These include the need for a clear understanding of the roles and responsibilities of health and social services organisations, and the further development of stable and mature partnership relationships between them.

4.4 Primary Care Services

4.4.1 Boards have been asked to audit the structure, assets and resources of general medical practices in their areas, with a view to improving their database of those services, and in particular, to identify any deficits or need for future change. In 1998/99 Boards, together with their primary care colleagues, will be expected to produce initial plans for the medium term development of primary care. The establishment of a comprehensive database and the related medium term plans will be important to the identification of the desired future configuration of primary care and will support the case for better funding of primary care.

GP Fundholding

4.4.2 The six GP fundholding pilot schemes that came into operation on 1 April 1997 will be evaluated by an independent body under four broad headings:

- their effect on services;
- organisational impact;
- viability; and
- value for money.

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4.4.3 The Budget Setting Working Group, established to advise the HSS Executive on the regional guidelines which should be adopted for establishing GP fundholding budgets will report during 1997/98 and its recommendations will be implemented from April 1998. The HSS Executive will review the operation of the Accountability Framework for GP fundholding during 1997/98.

GP Prescribing

4.4.4 Further action is needed to contain expenditure on prescribing without infringing the general principle that patients should receive the drugs and medicines they need. Accordingly, the HSS Executive has devised a Prescribing Action Plan which targets nine specific areas where downward pressure can be exerted on prescribing costs. Boards will be expected to work closely with the Executive in implementing this Plan.

4.4.5 Boards should also review critically the work that they have been doing to achieve a higher level of generic prescribing. There is a need to look urgently at whether more effective measures can be identified and implemented.

4.4.6 Regular and systematic practice visits should be maintained to discuss prescribing performance with GPs and to encourage them in the use of practice formularies and the adoption of repeat prescribing protocols.

Pharmaceutical Care

4.4.7 The role of the pharmacist as an integral member of the primary care team continues to develop. Key areas where the pharmacist can contribute are:

- prescribing for minor illness and advised self-care;
- health promotion, advice on prescribing, patient education and protection;
- use of medicines in specific patient groups; and
- continuity of care between secondary and primary sectors.

4.4.8 These come under the umbrella of pharmaceutical care and medicines management. They will be supported by education, research and audit, and used within a multi-disciplinary environment.

4.4.9 Pharmaceutical care is the responsible provision of drug therapy to achieve a definite outcome that improves a patient's quality of life. Boards, in conjunction with the pharmaceutical profession, should continue to pursue opportunities to make full use of community pharmacists' skills, particularly in the areas of:

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- ongoing medication review;
- improving compliance;
- developing care programmes and services for '*at risk*' patient groups;
- protocols for patient counselling and self-medication;
- health promotion; and
- multi-disciplinary research, audit and drug utilisation review.

4.4.10 The pharmaceutical care needs of older people are a particular priority.

4.4.11 Boards will be expected to continue to approve applications from, and monitor the performance of, pharmacists who qualify for the Pharmacy Professional Allowance. To obtain the Pharmacy Professional Allowance pharmacists will be required to provide certain professional services, namely to produce a practice leaflet, to display health promotion material and to keep patient medication records. Boards will also be expected to manage the out-of-hours arrangements for community pharmacists, the provision of advice by community pharmacists to residential care and nursing homes, and the arrangements for the delivery of the domiciliary oxygen therapy service.

Oral Health

4.4.12 The HSS Executive expects Boards to implement the Northern Ireland Oral Health Strategy. This includes assessing the oral health needs of people and taking remedial action where appropriate. This will include setting specific targets at local level to address special needs and to reduce variations in oral health. Boards will also be expected to continue to address the following specific objectives:

- ensure that oral health is an integral part of health promotion and educational programmes designed to improve diet and nutrition;
- ensure that health promotion programmes highlight the risk factors associated with oral cancer;
- promote the use of fluoride supplements; and
- promote good oral health and manage the treatment of caries.

4.4.13 Action should include:

- encouraging parents to register children with a general dental practitioner from shortly after birth;

- increasing the percentage of children and adults registered with a general dental practitioner; and

- ensuring that the community dental service screens all children on at least three occasions during their school career, and more frequently where a particular need arises.

4.5 Health Promotion

4.5.1 A number of objectives to promote health and social well-being have been set in the Regional Strategy. These cover the major areas which lead to premature death or long-term illness such as coronary heart disease, cancers and smoking, through to accidents to children. Boards will be expected to make a substantial contribution to achieving these targets. In addition to the targets set in the Strategy, Boards will be expected to meet the uptake rates for breast screening and cervical screening set out in the Appendix.

4.6 Acute Hospital Services

4.6.1 Last year's Management Plan asked Boards to concentrate action on a few particular areas - a reduction in the number of acute hospital sites, the provision of locally accessible services and the further development of evidence based purchasing. Action on these will continue into 1998/99 and Boards, in collaboration with Trusts, should be able to show evidence of steps taken to bring about the changes required in the pattern of acute hospital services.

4.6.2 Boards are currently undertaking, or due to begin, reviews of acute hospital services. These should all be completed during the course of 1998/99. Decisions will then be made based on the findings and recommendations. In addition, Boards in 1998/99 should pay particular attention to three other areas:

- emergency admissions;

- inpatient waiting lists; and

- discharge arrangements.

Emergency Admissions

4.6.3 As indicated in paragraph 2.4.4 it is essential that commissioners and providers work together to put in place effective plans to manage seasonal variations in emergency admissions. Emergency cases must have immediate access to treatment. With a proper strategy this should

be possible with the minimum disruption to planned admissions to hospitals.

Inpatient Waiting Lists

4.6.4 Prior to 1996/97 there was considerable progress in reducing the number of people waiting longer than the Charter standard for inpatient treatment. The 1.5% budget cut in 1996/97, with its direct application to elective admissions, undid much of the good work of the earlier years.

4.6.5 The HSS Executive is currently examining the impact in Northern Ireland of the Government's manifesto commitment to treat an extra 100,000 patients across the United Kingdom. Meanwhile, Boards should ensure that, as far as possible, the Charter standards are met.

4.6.6 Boards, for example, might review the need for emergency care and, where necessary, secure a network of services such as continuing care, nursing home care and residential care, to meet these needs. Any review would need to take into account the need for a balance between the emergency and the elective workload. Securing a network of services would involve agreeing with hospital providers the arrangements for dealing with sudden increases in demand. Service contracts would have to be structured and resourced accordingly. The contribution which community hospitals and nursing homes could make in providing non-specialist care, especially in time of peak demand, should also be taken into account.

4.6.7 While appreciating the difficulties arising from the budget reduction in 1996/97, every effort should be made to ensure that Charter standards are met. Boards and GP fundholders must therefore target those patients who are waiting in excess of the standards, while taking account of emergency and urgent cases.

Ambulance Services

4.6.8 Work will be undertaken with the Northern Ireland Ambulance Service Trust on a cost evaluation study to determine the staged introduction of a new response time system which is currently being piloted in Great Britain. Under the proposed new system, the service will be expected to meet 75% of category A calls (immediately life threatening) within 8 minutes by the year 2000/01.

4.7 Care in the Community

4.7.1 The Regional Strategy sets priorities and targets for community care. These seek to build on the initial achievements of *People First*, and to ensure continuous improvement in the way peoples' needs are assessed

and met. In particular, attention should be paid to the interests of carers and to the value of advocacy, where the views of users and carers differ, or where individuals need help in expressing their views about the assessment of their need and their care plan. The main service priorities to be addressed are:

- the promotion of practical help for carers, including a separate assessment of their needs;
- the establishment and publicising of independent advocacy services designed to help users participate in planning and arranging their care;
- the maintenance of the Regional Strategy target that at least 88% of people aged 75 and over will be supported in their own homes; and
- the continued development of direct payment schemes to ensure that anyone eligible and capable of managing direct payments has the opportunity to participate.

People with Mental Health Problems and/or a Learning Disability

4.7.2 Priorities for services for people with a mental illness and for people with a learning disability will be to continue increasing and targeting community services to facilitate a reduction in hospital admissions, and in the number of these people in long-stay hospitals.

4.7.3 The strategic goal for people with a mental illness is that long-term institutional care should no longer be provided in traditional psychiatric hospital environments. The overall objective for people with a learning disability is that by 2002:

- long-term institutional care should no longer be provided in traditional specialist hospital environments for people with a learning disability;
- adult admissions to specialist hospitals should be reduced by 50%; and
- admissions of children to specialist hospitals, other than in exceptional cases, should be reduced to zero.

People with a Physical Disability

4.7.4 The priority for services for people with a physical disability will be to continue to develop a comprehensive range of services to ensure quality of life and equality of opportunity. There should be a particular focus on:

- people aged 16 to 25;
- people newly disabled;
- parents with a disability who have dependent children; and
- individuals with traumatic brain injuries.

Child Care

4.7.5 Following implementation of the Children Order, Boards should develop child service plans in collaboration with Education and Library Boards, the Probation Service, voluntary organisations and other key agencies. The plans should be drawn up in accordance with Departmental guidance which will be issued during 1997.

Domestic Violence

4.7.6 Following the recommendations of the Northern Ireland Regional Forum on Domestic Violence, each Community Trust should set up inter-agency networks to co-ordinate action against domestic violence. Action may include multi-disciplinary training programmes, reviews of policy and practice across local agencies, reviews of agencies' recording and response systems and undertaking or commissioning research.

Partnerships with Voluntary and Community Organisations

4.7.7 The Department will issue guidance in 1998 on partnership relationships and funding arrangements between statutory and voluntary agencies in the health and social services field. Boards and Trusts should establish mechanisms to ensure that the principles and practice outlined in the guidance will govern their future relationships with the voluntary sector.

Volunteering

4.7.8 The HSS Executive is committed to the promotion of volunteering and the involvement of volunteers in the HPSS in as wide a variety of activities as possible. In the previous Management Plan, Boards and Trusts were required to produce and publish policies for involving volunteers. During the period of this Plan, Boards and Trusts should therefore continue to seek to maximise the involvement of volunteers in line with their published policies. Measurable targets should be put in place for extending the involvement of volunteers in a wide range of activities. Contracts and service agreements with voluntary organisations should take account of the costs of involving volunteers.

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4.8 Provider Priorities

Management Costs

4.8.1 The guidance on identifying management costs, issued in July 1995, was expanded for 1995/96 and subsequent years to include an even wider range of information on management costs. This includes information on costs of senior managers and costs of staff who work in corporate management together with the cost of management consultancy.

4.8.2 Challenging efficiency targets are set annually to ensure that taxpayers money is being used prudently and that as much as possible goes directly into patient and client care. The achievement of targets will be monitored closely by the HSS Executive throughout the year.

Human Resources

4.8.3 Each HPSS employer should review and develop its Human Resource strategy and ensure that it continues to be fully integrated with its annual Business Plan. In doing so, due attention should be given to issues such as fair employment, equal opportunities, PAFT principles, reward systems, staff welfare, general employment practices and effective workforce planning. These should be linked to education and training needs and commitments. Employers will also be expected to show continued progress in taking forward practical initiatives under Opportunity 2000 to address any imbalances between men and women in the workforce.

4.8.4 Targets for continuing improvements in workforce competence will be agreed with each Board to reflect its own assessment of need. Over the next three years attention will focus on improving workforce information and planning and supporting improved timescales for award achievement.

4.8.5 Employers should fully implement the targets for reducing the hours and intensity of work for junior doctors as set out in the terms and conditions of service for hospital medical and dental staff. HSS Trusts should ensure that the hours and intensity of work are regularly monitored and that an accurate and timely report on compliance with the targets is provided to the HSS Executive on request.

Corporate Governance

4.8.6 All HSS Trusts will be required to develop their own arrangements for the development of Board members and their organisations as a whole in the area of corporate governance. They will also be expected to participate in service wide events to address both particular and general issues within this area.

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Better Practice

4.8.7 Providers must continue to seek improvements in the standard of services they provide and should ensure that they deliver to contract the outcomes required by purchasers. Providers should also have a strategy aimed at sustaining a process of continuing quality improvement. In particular, providers should:

- have clear policies on the role of multi–professional audit as part of a programme to improve all aspects of service quality;
- take account of any advice on the effectiveness of treatment and care which is produced by the Department;
- be willing to share information where it can be demonstrated that best practice has achieved improved performance;
- undertake to implement best practice as indicated in research findings published by relevant professional bodies; and
- address the recommendations made in Inspection Reports by the Social Services Inspectorate.

4.8.8 The arrangements for the provision of non-core services, to identify opportunities for savings and improved provision of service, should be reviewed as part of the annual business planning cycle. HSS Trusts will be expected to demonstrate that arrangements for securing these services represent best value for money.

4.9 Research and Development

4.9.1 Research and development (R&D) activity within the HPSS is currently supported by a range of mechanisms including a Departmental R&D budget, R&D expenditure by Boards and Special Agencies, and a notional 25% of STAR funding. It is also likely that R&D in some HSS Trusts is subsidised from contract income for patient/client care.

4.9.2 Over the next two years the introduction of the new approach to funding R&D will strengthen the arrangements for identifying, prioritising, costing, supporting, commissioning and accounting for R&D activity. This will ensure that all of the HPSS, including primary and community care, have increased access to R&D funding. It will mean that those who carry out or support R&D must justify their claim for funding in competition with others, and will be held accountable for their work. This new approach is in response to the recommendations of the Task Force chaired by Professor Anthony Culyer and similar to the approach taken in Great Britain.

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4.9.3 Boards, HSS Trusts and Special Agencies have been asked to identify their current support for R&D. From 1998/99, the new Research and Development Agency will commission and manage R&D activity on behalf of the HPSS. There will be a transitional period of steady-state arrangements for Trusts in the first year, but subsequent commissioning will be on a competitive basis.

4.9.4 The HSS Executive has issued guidance on how to identify and cost the current support for R&D, and the future commissioning framework.

4.10 Information Management and Technology

4.10.1 HPSS organisations will be expected to continue to co-operate to ensure operational and management information is acquired and distributed efficiently, and to appropriate standards of quality, confidentiality and security. This will include:

- collaborative work to implement information strategies;
- the implementation and exploitation of new services supporting data and voice communications between HPSS organisations;
- taking forward agreed actions in relation to a Unique Patient and Client Identifier (UPCI) for the HPSS;
- the development and delivery of information management and technology training for HPSS staff;
- the implementation of a data audit strategy (to be derived from a scoping study report and HPSS reaction to it).

5. APPENDIX

Management Plan Targets - 1998/99 to 2000/01

Topic	Objective		TARGET*	
		1998/99	1999/00	2000/01
Health Promotion and Disease Prevention	1 Achieve an uptake rate for all primary immunisations at 12 months of:	95%	96%	97%
	2 Achieve an uptake rate for MMR immunisations at 2 years of:	95%	95%	95%
	3 Achieve an uptake rate for breast screening of:	75%	75%	75%
	4 Achieve an uptake rate for cervical screening of eligible women aged 20 - 64 of:	80%	80%	80%
	5 Appoint a co-ordinator for the Cervical Screening Programme, establish an Area Co-ordinating Committee comprising representatives of key interests and audit the position against national quality standards:	*		
Family Practitioner Services	6 Persuade GPs to increase the level of generic prescribing to:	45%	50%	52.5%
	7 Work with GPs to increase the percentage of practices actively using a prescribing formulary to:	75%	80%	85%
	8 Work with GPs to increase the percentage of practices using a protocol for repeat prescribing to:	80%	90%	95%
Services for People who are Elderly	9 Develop community services for elderly people to maintain the proportion of people aged 75 or over who are cared for in their own homes:	88%	88%	88%
Services for People with Mental Illness	10 Put in place an agreed approach to outcomes measurement and monitor all services in the statutory and independent sectors against common quality standards:	*		
	11 Assess the needs of Board population to determine future requirements for specialist hospital services, and establish the implications for each psychiatric hospital:	*		
Services for People with a Learning Disability	12 Commission a range of community based services for people with a learning disability to -			
	• promote inclusion:	*	*	*
	• effect a reduction in the number of long-stay patients in specialist hospitals of:	40%	60%	80%
	• effect a reduction in the number of adults admitted to specialist hospitals of:	20%	30%	40%
	• effect a reduction in the number of children admitted to specialist hospitals of:	40%	60%	80%

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Topic	Objective	1998/99	TARGET* 1999/00	2000/01
Services for People with Physical and Sensory Disability	13 Commission a range of services to:			
	• maximise opportunities for disabled young people aged 16-25:	*		
	• maximise opportunities for newly disabled people to continue their usual and planned lifestyles/activities:	*		
	• meet identified needs of disabled parents with dependent children, including young carers:	*		
	14 Develop strategies for commissioning well integrated, accessible, and complementary hospital and community services for people with traumatic brain injury and their families:	*		
Care in the Community	15 Develop strategies to:			
	• identify the numbers and needs of vulnerable people within the community:	*		
	• to provide opportunities for carers to be made aware of their right to a separate assessment of their needs:	*		
Services for People with Dementia	16 Take account of the 1997/98 audit of the needs of, and services for, people with dementia. The Department will establish quantifiable service delivery targets for 1998/2001 - to be notified to Boards/Trusts separately:	*		
Child Care	17 Develop services plans for children in liaison with other statutory and voluntary organisations in Board area:	*		
Volunteering	18 Set targets for extending the involvement of volunteers in a wide range of activities:	*	*	*
	Ensure that contracts and service agreements with voluntary organisations take account of the costs of involving volunteers:	*	*	*
Acute Hospital Services	19 Work towards a reduction, by the year 2002, of at least 25% in the total number of acute hospital bed days occupied per annum by children aged 0-15 years old:	*	*	*
	20 Work towards a reduction, by the year 2002, of 10% in the number of stillbirths and deaths in children under one year old:	*	*	*

Topic	Objective	1998/99	TARGET* 1999/00	2000/01
	21 Increase level of day case activity as a percentage of elective admissions in the following procedures:			
	• Inguinal Hernia:	35%	40%	45%
	• Varicose Veins:	35%	40%	45%
	• Cystoscopy:	85%	90%	90%
	• Circumcision:	85%	90%	90%
	• Arthroscopy of the knee:	87%	90%	90%
	• Cataract Extraction:	65%	70%	75%
	• Correction of Squint:	35%	40%	45%
	• Laparascopic Sterilisation:	75%	80%	85%
	• Endoscopy of Gastric Intestinal Tract:	90%	90%	90%
	• Bronchoscopy:	75%	80%	85%
	• Carpal Tunnel[1]:	75%	80%	85%
	• Ganglion Excision[1]:	85%	90%	90%
	• Operations on Nasal Septum/turbinate[1]:	25%	30%	35%
	[1] *new procedures and targets*			
	22 Develop renal services to:			
	• meet a projected increase in the number of patients on renal replacement therapy by the year 2000 of:	*	*	50%
	• increase the number of patients receiving haemodialysis thrice weekly from 45% to 90% by 2002:	*	*	*

Note:* Financial Year 1 April to 31 March