E-mail Message

From:	Rodgers, Catherine [EX:/O=NIGOV/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=[redacted]
To:	Dillon, Anne [EX:/O=NIGOV/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=Ihrdadillon]
Cc:	Conlon, Bernie (IHRD) [EX:/O=NIGOV/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=[redacted]
Sent:	24/02/2012 at 13:35
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Subject:	FW: Paper on commissioning for the Inquiry into hyponatraemia-related deaths
Attachments:	Overview of HPSS, pre 2009.DOCX

Anne

Further to your e-mail of 15 February, the Department have prepared the attached summary, which I hope will provide a helpful overview of the position from 1991 to 2009. Please let me know if anything further is required.

Regards

Catherine

Catherine Rodgers
Departmental Solicitors Office
2nd Floor, Centre House,
79 Chichester Street,
Belfast BT1 4JE

Tel: [redacted]
Fax:

Commissioning Arrangements for Health & Personal Social Services in Northern Ireland from 1991 to 2009

Background

1. The Health & Personal Social Services (NI) Order 1972 was the underpinning piece of legislation for the provision of health and personal social services in Northern Ireland throughout this period. It placed a duty on the Department to provide or secure the provision of health services to promote the physical and mental health of the people of Northern Ireland and to provide or secure the provision of social services designed to promote their social welfare.

2. Until the separation of purchaser and provider roles outlined below, the Health and Social Services Boards fulfilled the role of both planning and providing (directly or through contracts with independent and voluntary providers) the range of health and social services to meet the needs of residents in their areas. Prior to 1991, Boards were funded on the basis of the services they provided.

Reconstitution of HSS Boards, 1991

3. There were four Health and Social Services (HSS) Boards – Northern, Southern, Eastern and Western. The Boards were reconstituted with effect from 1 April 1991 in line with proposals in the Government's White Paper "Working for Patients" and, following that, received their funding from the Department on the basis of "weighted capitation". This system allocated funds in proportion to the resident population of the area covered, whilst making adjustments to account for a number of factors likely to influence the level of care required, for example: demography; morbidity; and social deprivation.

4. Post 1991, membership of Boards consisted of a non-executive Chairman; six executive; and six non-executive directors. The Chairman and non-executive members were appointed by the Minister (with the approval of the Secretary of State in the case of the Chairman).

5. By statute, two of the executive members were the Chief Executive/General Manager and the Director of Finance. The Chief Executive/General Manager became personally accountable to the Chief Executive of the HSSE for the efficient and effective use of resources available for patient and client care.

Health and Social Services Executive

6. The Health and Social Services Executive was created within the Department to manage the HPSS. Its main functions were:

    - To provide leadership, direction and support to the HPSS in Northern Ireland;
    - To set and ensure the achievement of specific objectives and targets for the HPSS in accordance with national and regional priorities and policies;
    - To monitor the performance of the HPSS in assessing need and improving the health and social wellbeing of the population;
    - To allocate resources and to ensure they were used effectively, efficiently and economically in accordance with the required standards of public accountability;
    - To promote the managerial environment necessary to achieve these objectives; and
    - To provide, as required, advice, information and support to Ministers relating to the management and performance of the HPSS.

Purchaser/Provider Split

7. "Working for Patients" also signalled the Government's intention to create an "internal market" in health and social care whereby the purchasing of services was split from the management of hospitals and other provider services. In Northern Ireland, these changes were enacted through the Health and Personal Social Services (Northern Ireland) Order 1991, which gave HSS

Boards a specific role as purchasers of health and social services for their residents. This role involved:

- Assessing the health and social wellbeing of their populations;
- Consulting widely with their resident population;
- Determining their health and social care needs;
- Planning and procuring of services to meet those needs;
- Contract monitoring; and
- Assessing the outcomes and gains in health and social wellbeing.

Health and Social Care Councils

8. The 1991 Order provided for the establishment of a Health and Social Services Council for the area of each Board. Their function was to represent the population of the area and their primary focus was the purchasing policies of each Board. Appointments were made with Ministerial approval and anyone could nominate or be nominated for membership – although 40% of the membership of each Council was reserved for nominees of District Councils.

9. The HSS Councils monitored the operation of health and personal social services in their areas, provided advice to members of the public about the services, made recommendations on how services might be improved and offered advice to Boards with the aim of ensuring that the needs of the whole community were identified and met within available resources. Councils had a statutory right to visit (by arrangement) facilities operated by Trusts and may have represented patients and clients in the event of complaints.

Establishment of HSS Trusts

10. A major feature of the reforms was the establishment of HSS Trusts. They were set up as providers of health and social services and were formed to assume responsibility for the management of staff and services from hospitals

or other establishments previously managed or provided directly by Boards. Trusts had responsibility for their own budgets and whilst managerially independent of Boards, were accountable to the HSSE.

11. The first hospital Trusts were established in April 1993. The Northern Ireland HPSS (1994) Order enabled Boards to delegate a range of statutory functions to HSS Trusts and paved the way for the establishment of the first community Trusts in 1994.

General Practice

12. The internal market was further developed by the introduction of GP Fund holding in 1993. The scheme was voluntary, and allowed selected GP practices to hold a budget from which to purchase a defined range of non-emergency services for their patients. These services included most surgical procedures, outpatient appointments, paramedical services and community nursing services. Fundholders also used their budgets to pay for the drugs they prescribed and meet the costs of practice staff.

13. Boards remained responsible for purchasing services for patients of non-fundholding GPs and for purchasing for fundholders' patients those services not covered by the fundholding scheme.

Local Health and Social Care Groups

14. In April 2002, 15 Local Health and Social Care Groups (LHSCGs) became responsible for planning and delivering primary and social care services in their areas. Replacing GP fundholders, they operated as 'committees' of the local health and social services board, and were based on groups of GP practices, serving populations ranging from 60,000 to 200,000. LHSCGs were responsible for planning and delivering both health and social care services outside the hospital setting, including those provided by GPs, dentists, community pharmacists and optometrists. They were intended to facilitate

partnership working between health and social services organisations, and enable community involvement in the planning and delivery of services.

Regional Services

15. Specialist regional services such as those for acquired brain injury or genetics testing were commissioned by the Regional Medical Services Consortium. This was made up of the four HSS Boards. Until 1995, separate ambulance services had been provided by each HSS Board. The establishment of the Northern Ireland Ambulance Service Trust introduced a regional service.

Special Agencies

16. Additionally, there were five independent special agencies of the HPSS that were accountable to the Minister:
    - The Northern Ireland Blood Transfusion Service – responsible for supplying all hospitals and clinical units with safe and effective blood and blood products;
    - The Guardian Ad Litem Agency – provides guardians on appointment by the Court for children who are subjects of proceedings such as adoption orders or care order applications;
    - The Health Promotion Agency – co-ordinated health promotion activities, undertook education campaigns, provided training and carried out research into public health; and
    - The Regional Medical Physics Agency – provided a range of scientific, technical and clinical services, primarily in support of trusts in the areas of diagnostic and information and treatment. It also undertook research and training.
    - The Northern Ireland Medical and Dental Training Agency is responsible for funding, managing and supporting postgraduate medical and dental education within Northern Ireland. It provides a range of services for those engaged in the delivery of postgraduate medical and dental education and training.

Creation of the Regulation and Quality Improvement Authority (RQIA)

17. The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, created a statutory duty of quality for HSS Boards and Trusts. In April 2005, the Regulation and Quality Improvement Authority was established as a non-departmental public body. Since April 2009, RQIA has also undertaken the functions previously carried out by of the Mental Health Commission.

18. RQIA monitors and inspects the quality of health and social care services in Northern Ireland, and encourages improvements in the quality of those services. RQIA's role is to ensure that health and social care services are accessible, well managed and meet the required standards. RQIA also works to ensure that there is openness, clarity and accountability in the management and delivery of these services.

19. RQIA's main functions include:

    - regulation (registration and inspection) of a wide range of health and social care services delivered by health and social care bodies and by the independent sector. The regulation of services is based on minimum care standards to ensure that service users know what quality of services they can expect to receive and service providers have a benchmark against which to measure their quality;
    - inspection of the quality and availability of health and social care services in Northern Ireland through reviews of clinical and social care governance arrangements within these bodies by means of thematic and special reviews; and
    - keeping the Department informed of the quality and availability of health and social care services in Northern Ireland.

20. In 2005, a further review of Health and Social Care services was announced as part of the Review of Public Administration. As a result of this review, HSC structures were reconfigured to those described in the HSC (Reform) Act (NI) 2009.