Witness Statement Ref. No. 066/1

INQUIRY INTO HYPONATRAEMIA-RELATED DEATHS

Name: David Galloway

Title: Mr

Present position and department/employer:
Deputy Director
Performance Management Unit,
Department of Health, Social Services and Public Safety
Length of time in post: 3 years

Previous position and department/employer in 1995:
Equal Opportunities Officer,
Police Authority for Northern Ireland

Previous position and department/employer in 2000:
Deputy Principal,
Equality Unit
Office of the First Minister and Deputy First Minister

Previous position and department/employer in 2001:
Deputy Principal,
Equality Unit
Office of the First Minister and Deputy First Minister

Membership of Professionals Bodies:

Particular areas of interest
[Please attach additional sheets if more space is required]

(i) Describe in detail the system in place for the monitoring of Health Boards and Trusts to include details of the system in place in 1995, 2000, 2001 and 2005.

I joined the Department in May 2002 having never previously worked in health and social services and so I have only a limited understanding of the monitoring processes that were in place in earlier years. That understanding arises solely from reviewing previous papers in order to provide information in response to this request.

The arrangements for monitoring Boards and Trusts in 2005 are as follows:

Government's main policies and priorities are published on a rolling 3-year basis and for 2005-06 to 2007-08 have been integrated with Budget proposals in the document "***Priorities and Budget 2005-08***". This includes a separate **Public Service Agreement** ("PSA") for each Department setting out the main departmental objectives, budgets, planned citizen outcomes, key service channels and targets. For DHSSPS, this identifies 17 high level targets (supported by technical notes which set out how each target will be measured) under 7 strategic outcomes as follows:-

- increase in life expectancy, improvement in health and well-being and reduction in health inequalities;
- equitable access to life saving interventions;
- improvements in quality, efficiency, effectiveness, value for money and accountability of Health & Social Care provided;
- more effective hospital services;
- equitable access to high quality modernised acute primary and community care services on a regional and local basis;
- better life changes for children and support for families
- fast, responsive and effective fire-fighting and rescue services. [The arrangements supporting this last outcome are not addressed in this note.]

The **DHSSPS Business Plan 2005-06** details the actions which will be undertaken in-year by the Department to contribute to the delivery of PSA targets.

"***Priorities for Action***" sets out the Department's expectations of the HPSS in regard to the delivery of PSA targets and more detailed requirements in regard to service improvements, efficiency management/effectiveness and reform. Short and medium term targets are set on the basis of the Department's analysis of the capacity and capability of the HPSS to deliver effective, quality services and to make improvements in the quality of service, the methods of delivery and the level of service provided.

Boards and Trusts are required to submit for Ministerial approval, **Health and Wellbeing Investment Plans** (HWIPs) and **Trust Delivery Plans** (TDPs) respectively, detailing how they intend to deploy the totality of their resources to meet identified priorities and targets. Detailed guidance is issued to ensure that these provide sufficient information on expenditure plans and how Boards and Trusts will respond to the challenges for increased efficiency, improved effectiveness, greater productivity and enhanced quality.

Departmental Officials conduct a series of progress review meetings with the Chief Executives and senior managers of Boards and Trusts during the year, at which quarterly reports, detailing progress against the targets set out in "***Priorities for Action***" are reviewed.

In addition to dealing with "***Priorities for Action***" targets, discussions with Trust Chief Executives will also address their Trust's utilisation of resources, their plans for reform, modernisation and greater efficiency in the delivery of services, their progress in giving effect to the Department's guidance on risk management and good governance and measures taken to engage more effectively with service users. Progress meetings with Boards also provide Departmental Officials with an opportunity to discuss issues of the moment with the Boards' Chief Executives and their senior management teams.

Progress against the Department's established priorities is reported to the Departmental Board and progress against specific PSA targets is reported to the Department of Finance and Personnel and the Office of the First Minister and Deputy First Minister.

The Minister has annual accountability meetings with the Chairperson and Chief Executive of each of the Boards to review achievements against plans and to discuss prospects for delivery of the Department's priorities in the year ahead. In addition to this formal monitoring structure, ad hoc groups are established to monitor performance of service providers in specific areas, eg waiting lists.

All HPSS organisations are required to break even in terms of income and expenditure in-year and recurrently. This and other detailed financial requirements are monitored throughout the year and discussed at regular meetings of Finance Officers.

The arrangements for 2005 were set out for Boards and Trusts in circular HSS (PPM) 03/2005.

1995 Arrangements

The HPSS Management Executive came into being in 1990 as that part of the then Department of Health and Social Services which had responsibility for policy direction to the HPSS. Each year, the Executive published a Management Plan setting out a corporate agenda for the HPSS. The Management Plan for 1995/96 provided direction to Boards and Trusts and others involved in the commissioning and delivery of health and personal

social care on the key objectives, priorities and management tasks for the period 1995/98. A photocopy of the plan together with a circular dating from 1993 that describes the accountability relationships between the HPSS Management Executive, Boards and Trusts (METL2/93) are provided by way of background.

In response to the Management Plan, Health and Social Services Boards were required to provide Action Plans which were subject to Ministerial endorsement in the course of an annual Accountability Review process. Health and Social Services Trusts, directly managed units and GP Fundholders were also expected to reflect relevant targets in their Business Plans. I understand from past papers that there was a standard format for the agenda for accountability reviews between the Management Executive and the Boards. These meetings dealt with the extent to which Boards succeeded in meeting their targets in the preceding year, a review of their financial position and considered their plans for the incoming year. A copy of an internal memo outlining the agenda for 1999 is provided.

2000 and 2001 Arrangements

The arrangements explained above in relation to 1995 remained in place until 2000/2001. This was a year of transition between moving from the Management Plan process to the Priorities for Action process described at the beginning of this response. The decision that a new Management Plan would not issue to the HPSS for the year 2000/01 was communicated to the HPSS by way of circular PRSC (PR) 2/99. A copy is provided together with a copy of the Management Plan for the period 1999/00 to 2001/02. ✓

The "***Priorities for Action***" document was first issued in 2001 in relation to the financial year 2001/2002. A copy of this document is provided. Thereafter, the arrangements described for 2005 have applied with the exception that due to staff pressures, formal review meetings with Trust Chief Executives did not commence until the autumn of 2002 following my appointment and that of a colleague, Margaret Rose McNaughton. The arrangements applied in 2001/2002 were set out in circular HSS (PPM) 5/2001, which is also provided.

(ii) What was the system in place in Northern Ireland at the time of Adam Strain's death in 1995 for reporting untoward deaths to the DHSSPS and disseminating information on the outcomes of Coroners' Inquests within the health service?

I have no knowledge of the system in place, nor indeed does this matter fall within the range of work undertaken by my Unit.

Particular areas of interest (Cont'd)

(iii) What was the role of the DHSSPS in reporting, analysing and disseminating the information referred to at (ii) above and in ensuring that lessons learned would be fed into teaching/training and the care of patients?

I have no knowledge of this matter.

(iv) What procedures existed in 1995 to ensure the fulfilling of roles relating to the reporting, analysing, disseminating of information from a Coroner's Inquest or untoward death and to ensure that lessons would be learned?

I have no knowledge of this matter.

(v) With reference to issues (ii) to (iv) above, what was the situation in 2000 and 2001 respectively?

I have no knowledge of this matter.

Particular areas of interest (Cont'd)

(vi) With reference to issues (ii) to (iv) above, what is the situation now?

This area of work does not fall to my Unit, I have no knowledge of this matter.

(vii) Give details of how and when you first became aware of the deaths of Adam, Lucy and Raychel.

I believe I read about the inquest into the death of Adam Strain in the local press some years ago. I was not aware of the deaths of Lucy Crawford or Raychel Ferguson until the UTV Insight programme was broadcast last year.

(viii) Explain in detail the actions taken by the Performance Management Division to inquire into the deaths of Adam, Lucy and Raychel and to monitor the performance of the relevant Trust and Board staff who were involved with her care.

I am not aware of any action taken by Planning and Performance Management Directorate to inquire into these deaths or the performance of the staff involved in her care. Monitoring the performance of individual members of Trust and Board staff does not fall within the remit of my Unit or this Directorate of the Department, it is a matter for local management.

Other points you wish to make including additions to any previous Statements, Depositions and or Reports
[Please attach additional sheets if more space is required]

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: [signature] **Dated:** 30 June 2006.

For Action -

Chief Executives, HSS Boards
Chief Executives, HSS Trusts
General Medical Practitioners
Chief Executive, Central Services Agency
Chief Executives, Special Agencies

For Information –
Chief Executive, HPSSRIA
Chief Executive, NICPGMDE
Chief Executive, NIPEC
Chief Executive, NISCC
Chief Officers, HSS Councils

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Room D4.17
Castle Buildings
Stormont
BELFAST
BT4 3SJ

Tel: [redacted]
Fax:
Email:

Your Ref:
Our Ref: **HSS (PPM) 03 / 2005**

6 April 2005

Dear Colleague

PRIORITIES FOR ACTION 2005/08

1. The publication of Priorities for Action 2005-08 has been postponed because of the announcement of a general election on 5 May 2005. Copies have however been issued to HPSS organisations to ensure that they are able to proceed with the development of HWIPs and TDPs. This circular identifies the implications and responsibilities for HPSS bodies and also provides guidance on the development and submission of Health and Wellbeing Investment Plans and Trust Delivery Plans. Although directed primarily at Boards and Trusts, it should be noted that *Priorities for Action* also covers targets relevant to other organisations and to GPs.

2. *Priorities for Action 2005/08* has been framed in the context of the Secretary of State's *Priorities and Budget 2005/08* and the resources available to the HPSS in the planning period. The 2004 Budget set firm control totals for the new financial year and indicative totals for the second and third years. While the 2007-08 total will be reviewed in a new Spending Review, there are no grounds for expecting significant change to the 2006-07 figure. Given the terms of the 2004 Spending

Review and the overall Northern Ireland financial context, it is very probable that Departments will be required to live within the 2005-06 and 2006-07 figures published in *Priorities and Budget*. It is also probable that the availability of additional resources from in-year monitoring will be minimal.

Planned Outcomes

3. The document sets out a range of priorities and targets for 2005/08 that will support the delivery of the planned outcomes detailed in *Priorities and Budget 2005/08*, namely:

- a reduction in preventable deaths and diseases and improvement in wellbeing;
- improvements in the quality of health and social care provided;
- more responsive hospital services;
- an accessible and effective primary care service;
- better support for those who need care in the community; and
- better life chances for children and the protection of their rights and interests.

Planning Arrangements

4. Encouraging HPSS bodies to work together to meet the challenges posed by the Secretary of State's *Priorities and Budget 2005/2008* will be at the heart of planning arrangements for 2005/08.

5. In response to *Priorities for Action*, Boards are required to submit **Health and Wellbeing Investment Plans** (HWIPs), in line with the guidance set out in Appendix A, **by 16 May 2005**. Boards must copy the HWIPs to those Trusts involved in their development by the same date. **HWIPs must be submitted strictly in accordance with the template set out in Appendix A**.

6. Investment and delivery plans are required to identify planned expenditure in 2005/06 and 2006/07 and to set out clear plans for reform, modernisation and efficiency for the three years to 31 March 2008 which deliver the three-year efficiency targets. These must ensure that 2005/06 and 2006/07 expenditure commitments are capable of being managed recurrently within the resources available in 2006/07.

7. In reaching their **Service and Budget Agreements** (SBAs), Boards and Trusts should ensure close collaboration in meeting the needs of service users and the community.

8. All HPSS organisations will be required to adhere to the principles set out in the Circular HSS (F) 29/2000 "Promoting Financial Stability within HPSS Organisations". The following parameters should continue to be applied:

- Boards, Trusts and Agencies are required to break even in terms of income and expenditure in-year and recurrently;

- existing services should be placed on a sound financial footing before expansion is envisaged - although this should not be through the recurrent use of service development funding;
- recurring over-commitment of resources into 2006/07 should be avoided unless explicitly agreed with the Department; and
- commissioners and other funding agencies, including the Department, should agree annual recurring budgets for each provider where appropriate. In circumstances where resources are allocated on a non-recurrent basis, for example, where given resources are made available to the Department by DFP non-recurrently, or where there is an unproven recurrent requirement, this should be clearly highlighted in the HWIP.

9. HWIPs should demonstrate how the totality of revenue resources has been committed to individual organisations. This includes the allocation of all new amounts available for maintaining existing services and service developments. Resources allocated include the recurring costs of all service developments planned for 2004/05.

10. Boards and Trusts must conclude their negotiations on SBAs by 30 April 2005, in time for HWIPs to be submitted to the Department by 16 May 2005. **Boards and Trusts must therefore confirm in writing to the Department by 16 May 2005 that SBAs have been formally agreed and signed**.

11. Flowing from the HWIPs and SBAs, Trusts will be required to submit **Trust Delivery Plans** (TDPs), in line with the guidance set out in Appendix B, to the Department and relevant Boards **by 31 May 2005**.

Reform Modernisation and Efficiency

12. A key aspect of plans for the forthcoming years will be to establish how the HPSS will respond to the challenges for increased efficiency, improved effectiveness, greater productivity and enhanced quality posed by the Department's reform, modernisation and efficiency targets. HWIPs should contain the following responses to this challenging agenda:

- Boards' proposals for the allocation of Reform and Modernisation Funds. £11.5m is available regionally and the Department anticipates that this sum will be allocated largely on the capitation formula basis. Boards in receipt of capitation redistribution resources are also expected to give priority to reform and modernisarion in the use of these resources.

- Details of proposals for Boards' application of the additional money available for inescapable developments. £6.5m is available which will be allocated on a capitation formula basis. These allocations are made on the understanding that they are ringfenced to the specified services. Should a Board wish to be granted some flexibility in the use of the funding, its HWIP must present a quantified argument for limited redeployment. No such redeployment can take place in advance of the Department's decision. It is essential that any alternative proposal is developmental.

- Board's proposals, developed through Local Health and Care Economy Groups, for the achievement of the Department's resource releasing and non-resource releasing efficiency targets for the planning period 2005/06 to 2007/08. Details of how these proposals should be reflected to the Department are set out in Appendices A and B.

Accountability

13. Subject to Ministerial approval, the Department is aiming to complete its scrutiny of HWIPs by 30 June 2005. Along with the end-year position on *Priorities for Action 2004/05*, they will then form the basis of the Minister's annual Accountability Review meetings with Boards. The Department aims to have resolved all outstanding issues relating to TDPs within one month of endorsing the HWIPs.

Monitoring

14. Throughout the year, the Department will monitor progress on the delivery of the agreed HWIPs and, in particular, the achievement of *Priorities for Action* and progress towards achievement of the Department's efficiency targets. To this end, Boards and Trusts will be expected to submit regular progress reports. These will provide the focus for the Department's formal Progress Review meetings with Boards. This process will permit the Department to meet the requirement to make progress reports to the Office of the First Minister and Deputy First Minister on the delivery of the Public Service Agreement commitments.

15. The Department will also monitor the progress Trusts are making generally in the delivery of their Plans.

Action Summary

16. Boards and, where appropriate, Local Health and Social Care Groups, should engage in dialogue with Trusts on the direction provided in *Priorities for Action* as a matter of urgency, with a view to concluding Service and Budget Agreements as soon as possible. Linked to this, the timetable for the production of Plans is:

    - **Health and Wellbeing Investment Plans** – to be submitted to the Department in the agreed format by 16 May 2005;
    - **Service and Budget Agreements** – written confirmation that SBAs have been agreed and signed must be sent to the Department by all Boards and Trusts by 16 May 2005;
    - **Trust Delivery Plans** – to be submitted to the Department by 31 May 2005; and
    - **Progress Reports** – to be submitted to the Department in accordance with the requirements and timetables set out in Appendices A and B.

17. All plans and the written confirmation of SBAs should be submitted to David Galloway, Performance Management Unit, Room D2.2, Castle Buildings, with electronic copies of the Plans, in Word format, e-mailed to: performancemgt[redacted]

Enquiries

18. Any enquiries about this circular should be directed, in the first instance, to David Galloway, tel: [redacted] e-mail: david.galloway[redacted]

Yours sincerely

Signed Noel McCann

NOEL McCANN

APPENDIX A

HEALTH AND WELLBEING INVESTMENT PLANS

Investing for Health introduced the concept of Health and Wellbeing Investment Plans (HWIPs) as the vehicle for Boards to take forward their overarching responsibilities to secure effective health and social services for their local populations, improve health and social wellbeing and reduce inequalities.

Scope of HWIPs

HWIPs will provide the key vehicle for planning and accountability within the HPSS. Local Health and Social Care Groups (LHSCGs) should be fully involved in their development. The HWIP will consist of three elements.

- Boards' plans for commissioning services in their local areas, including those services for which LHSCGs have assumed commissioning responsibility, supported by financial proformas summarising the Boards' planned income and expenditure commitments in 2005/06 and 2006/07;

- Boards' plans for the achievement of the government's targets for reform, modernisation and efficiency for the three years 2005/06 to 2007/08.

- Boards' plans to advance regional health promotion strategies and their activity to improve public health.

HWIPS must be composed around the following key sections:

Section 1 - Commissioning of Services

Board plans for commissioning services in their local areas will focus heavily on Ministerial priorities for the relevant year. This will therefore constitute the Boards' response to the challenges set by the Secretary of State's *Priorities and Budget* and will be the Department's main focus for accountability and progress review arrangements in the HPSS.

This section must include the following subsections as numbered:

1.1. Local context for *Priorities for Action*, including the major challenges faced by the Board in the planning period (no more than two pages of narrative);

1.2. The Board's deployment of resources in terms of total planned activity for the years 2005/06 and 2006/07. The detailed financial proformas are attached in addition to a supporting annex which details any key changes from last year and contact points within the Department (see Annex to this Appendix). The completed proformas should be submitted as part of the HWIP by 16 May 2005;

1.3. A line-by-line schedule of the Board's plans to deliver on the targets set out in *Priorities for Action*. The schedule should include the action the Board is proposing to take, the resources to be committed and an indication of the Board's ability to deliver on each of the required actions. The schedule, a template for which is included at Appendix C, will form the basis for subsequent Progress Reviews. Baseline data, including, where appropriate, an individual Board's share of regional targets should be included.

1.4 It should be noted that the progress indicators used for PfA are being brought into line with those used for the Department's monitoring of PSA commitments. Boards should now use the following codes when reporting progress against PfA targets.

Code	Definition	Circumstance for Use
A1	Achieved	When action has been completed in line with PfA commitment on or before the published date.
A2	Substantially Achieved	When a significant percentage (at least 75%) of an action has been completed in line with the PfA commitment.
A3	On Track for Achievement	When work has been progressing satisfactorily and action is very likely to be achieved within published PfA timescale.
A4	Likely to be Achieved but with some delay	When action is likely to be achieved in full but after the published timescale (the likely extent of slippage should be reported, together with details of the remedial action being taken).
X	Unlikely to be achieved	When action is unlikely to be achieved within the period covered by the PfA.
NA	Not Applicable	Not applicable to a particular Board or Trust.

Section 2 – Reform Modernisation and Efficiency

2.1. The second section of the HWIP should focus on Boards' local plans to deliver on the Department's efficiency targets for the period 2005/6 to 2007/08 and to drive forward reform and modernisation. At Board level, Local Health and Care Economy Groups will produce proposals that will, at a minimum, be consistent with a proportionate share of the Department's targets for the planning period.

2.2. Pro forma returns are provided for the submission of proposals to use the resources available within the Reform and Modernisation Fund. For administrative purposes the returns are numbered FP7 and FP8 however the returns will form the core of this section of the HWIP. Proposals should demonstrate that they will support change and contribute to the Department's efficiency targets. It is expected that proposals will have a recurrent effect, but other short term proposals will be considered within the total recurrent resources available.

2.3. The FP7 has been designed to allow a summary narrative description of each proposal to be entered. The following information is also required:

- each scheme should be linked to at least one of the two key reform strands [improving health and social well being and developing resources to avoid unnecessary reliance on the acute hospital sector and/or improving patient flows and throughput within the hospital system] although Local Health and Care Economy Groups can discuss other proposals with the Department
- the Trusts charged with delivering the scheme must be identified – where investment is to be made in the primary care sector this should also be reflected here, as per the example provided.
- the return must quantify the resulting resource releasing or non-resource releasing efficiency
- the monies sought from the Reform and Moderisation Fund to support the scheme must be identified, if any.

2.4 Boards may have schemes they would wish to advance, for example in primary care, that would not be caught within Trust returns. If any such schemes can be taken forward without investment from the Reform and Modernisation Fund, they should be entered on pro forma return FP8.

2.5 The Department will consider all cash releasing efficiency proposals to ensure that they result from efficiency measures, rather than arising from service reductions which are not part of the reform and modernisation agenda. We recognise that, after consideration by Local Health and Care Economy Groups, Boards and Trusts will wish to begin to achieve their cash releasing efficiency savings as soon as possible, even though proposals will not be approved until the end of June for HWIPs and July for TDPs. The Department is happy to discuss any specific proposals informally, if that is needed.

2.6 Boards and Trusts should include, in their responses to PfA, details of the specific actions to be taken during the next two years to modernise elective services. In developing their responses, Boards and Trusts should make specific reference to the continuing body of work, begun in 2004-05. They should also provide their responses to the compulsory actions included in both the Regional Waiting List and Emergency Pressures Programmes using the pro-formas included at Appendices E and F.

Section 3 – Health Improvement

3.1 The Health Improvement section of the HWIP should focus on key actions for the planning period for the Investing for Health Partnerships for which each Board has lead responsibility. This should include a summary of activity to improve and protect public health and should incorporate how regional health promotion strategies are being taken forward.

3.2 Investing for Health Partnerships will review their detailed long term Health Improvement Plans and, in line with PfA targets, detailed HIP updates for 2005/06 should be submitted by 30 June 2005 and should include the deployment of resources. More detailed guidance on this will issue separately from DHSSPS Investing for Health Team.

Involvement of Others

In developing and producing their HWIPs, Boards should build upon their existing work with Investing for Health Partnerships (IFHPs), other partner organisations and a wide range of local interests, including users and carers.

Accountability & Monitoring

HWIPs will continue to be the main focus of accountability for the Health and Personal Social Services. This means that they must fully reflect HPSS responsibilities under the Secretary of State's *Priorities and Budget*, as interpreted in *Priorities for Action*.

Throughout the year, the Department will monitor progress on the delivery of HWIPs and, in particular, the achievement of *Priorities for Action* and progress towards achievement of the Department's efficiency targets. Boards will therefore be required to submit regular progress reports reflecting the position at:

- 30 September, by 7 October 2005;
- 31 December by 6 January 2006; and
- 31 March, by 30 April 2006.

The reports will be the focus for the Department's formal Progress Review meetings with Boards. The end-year reports and the HWIPs for the incoming year will provide the focus for the Minister's annual Accountability Review meetings with Boards.

Boards should submit composite PfA Progress Reports in the required tabular format. The template provided for reporting on the specific PfA actions has been designed so that it can be revisited and updated on a regular basis, providing consistency in reporting and, at a glance, identifying changes in the status of each target throughout the year.

Each Progress Report should therefore include an updated version of this template, including an assessment of the status of each target for that report in strict accordance with the key provided on the template and should take account of any issues raised during the scrutiny and endorsement of the HWIP.

Information given must also include the latest figures available on progress against the Board's share of the target (including percentages).

Boards should anticipate Progress Review meetings in October 2005 and Ministerial Accountability Reviews in June 2006. Meetings in 2006/07 are also anticipated to fall in October and June. Specific details of the meetings will be arranged with each Board separately.

Consultation

The link to the Budget timetable inevitably means that there will be little or no time for consultation on the finished HWIP. Although the Secretary of State's *Priorities and Budget* will have been subject to public consultation, Boards will need to have appropriate arrangements in place to ensure that the views of interested parties are continuously fed into the process.

Boards will be able to consult on those component elements of the HWIP that are not wholly dependent upon the annual review of priorities and plans. This will, of course, be particularly important where there is a statutory obligation to do so, for example, in the case of Equality.

ANNEX TO APPENDIX A

HEALTH AND WELLBEING INVESTMENT PLANS: PRO FORMA FINANCIAL RETURNS

CONTENT

The HWIP pro forma returns differ significantly from those for 2004/05, reflecting the 2-year planning horizon, the change in focus from the deployment of additional funds in previous years to the emphasis of the Secretary of State's *Priorities and Budget 2005/08* and the development of the Reform and Modernisation initiative. A number of returns have been deleted and replaced with others that better reflect the focus of this year's Priorities for Action.

The main changes and details required are as follows:

- **FP1: Planned income and expenditure commitments 2005 - 2007**

  This return has been amended to record planned commitments (on a full-year basis only) for 2006/07 as well as 2005/06. Within the analysis of expenditure, line 6, 'management and administration', has been simplified and an additional category is added at line 11, 'pay award provision', to record pay provision relating to Agenda for Change.

- **FP2: Recurring expenditure commitments by trust and other agency**

  As for FP1, this return has been amended to record planned commitments (on a full-year basis only) for 2006/07 as well as 2005/06.

- **FP3: Resource-releasing efficiency savings**

  This is a new return, intended to capture each Board's share of the planned resource-releasing efficiency savings required to meet PfA targets. Boards should indicate how these savings are to be realised across Trusts and also indicate the individual measures contributing to the achievement of the 0.5% efficiencies required in 2005/06(1.0% in 2006/07 and 2007/08).

  The previous returns FP3 and FP3(A) to (C) are deleted

- **FP4: Allocation of MES, local cost pressure and EPF/RRI funding**

  This is a new return designed to capture Boards' allocation of the additional resources provided for these priority areas in their 2005/06 allocations. Refer to lines 23, 24 & 25 in the Department's final allocation letter. Boards should indicate the individual projects / schemes receiving funding. These are expected to include children with complex needs, increased decontamination costs, blood products including haemophilia and other priorities as identified by each Board. Boards should complete a separate return for each category, as follows:

FP4(a): Local cost pressures

FP4(b): Capitation

FP4(c): EPF / RRI revenue consequences. In this case, Boards should indicate the individual projects/schemes receiving funding, for both 2005/06 and 2006/07.

The previous return FP4 has been deleted.

- **FP5: Planned inescapable service developments**

  This new return should record the Boards' allocations of the additional resources that have been provided for a range of additional service developments. Boards should indicate planned allocations on both an in-year (FP5(a)) and full-year (FP5(b)) basis.

- **FP6: Increases / decreases in provisions**

  This is the previous return FP5 re-numbered.

- **FP7: Reform and Modernisation Fund Proposals**

  This is a new return to record both the proposed investment of funds in reform and modernising actions but also to indicate how that investment is to be allocated to Trusts and provide an estimate of the savings that investment will generate across the planning period. Estimated savings over the planning period should be identified by Trust where applicable. This form should be used to record both resource releasing and non-resource releasing schemes.

  In the case of resource releasing schemes, the information in FP7 will be a subset of the information behind the completion of FP3 i.e. FP7 will only feature those resource releasing schemes which are dependent upon an up front investment.

- **FP8: BOARD REFORM AND MODERNISATION SCHEMES (NOT SUBJECT TO REFORM AND MODERNISATION FUND INVESTMENT)**

  This is a new return, designed to capture any schemes being taken forward by **Boards** in areas for which they have specific responsibility such as primary care. Schemes entered on FP8 will not require investment from the Reform and Modernisation Fund. In order to avoid double counting, schemes agreed by Local Health Economy Groups that require action by Trusts should **not** appear on the FP8.

  Trusts are required to provide a separate return detailing schemes to be undertaken without a Reform and Modernisation Fund investment on pro forma return FP10(T).

SUBMISSION OF RETURNS TO THE DEPARTMENT

Returns should be submitted as part of the HWIP to Planning and Performance Management Directorate on the due date.

RECONCILIATION TO TRUST DELIVERY PLANS

As indicated under the Planning Arrangements section of this circular, Boards must copy their HWIP to those trusts involved in their development by the due date. The Trust Delivery Plan pro forma returns require each trust to show that the income included in the TDP agrees with the level of income included in the Board HWIP for that trust. Where there is a difference, trusts are required to provide a reconciliation. Trusts should confirm all reconciling items with Boards prior to submission of their TDPs.

QUERIES

If you have any queries regarding the returns please contact John McGinnity on [redacted] or John McCracken on [redacted] or via e-mail to: John.McGinnity[redacted] or John.McCracken[redacted]

APPENDIX B

TRUST DELIVERY PLANS

HWIPs will provide the key focus for accountability arrangements in relation to service issues. HSS Trusts, however, are held directly accountable by the Department for the effective deployment of all the resources at their disposal. This includes income, capital, workforce and estate. Trusts will also be held to account for the effectiveness of their arrangements for engaging with users, carers and the wider community.

Trusts will be held directly accountable for delivery of service improvements, efficiencies and other reforming and modernising actions specified in Priorities for Action 2005/08. The Trust Delivery Plan (TDP) monitoring process will focus on this aspect of the Chief Executive's responsibilities.

Flowing from HWIPs, therefore, each Trust is required to produce a TDP reflecting the summation of Service and Budget Agreements reached with commissioners, capital investment plans and management objectives in line with the Minister's expectations. TDPs must demonstrate that they are compatible with the total income available and that Trusts are planning to remain, in-year and on a recurrent basis, within the income levels agreed with Boards and other funding sources. Trusts should therefore ensure that the income included in the TDP narrative and pro forma returns is agreed to the relevant amounts detailed in the Boards' HWIPs. The development of new services or the expansion of existing services must be undertaken only with the expressed support of commissioners.

The purpose of the TDP will be to demonstrate, under the following headings, that the totality of a Trust's resources is being deployed in the most effective way in pursuit of the planned outcomes for the citizen, as set out in Priorities for Action (PfA). It will be particularly important for Trusts to demonstrate that, in seeking to contribute to the reform, modernisation and efficiency agenda set by the Department, they are engaged in an ongoing programme of benchmarking leading to the development of locally generated initiatives to improve the delivery, level and quality of services.

TDPs must be composed around the following key sections:

Section 1 - Local Context (no more than 2 pages of narrative)

1.1 A summary of the key challenges and major issues facing the Trust over the planning period.

Section 2 - Priorities for Action

2.1 A line-by-line response to those actions in PfA for which the Trust is specifically responsible, or to which it is making a contribution. A template for this purpose has been provided at Appendix C. It is important that this part of the TDP is submitted in accordance with the template provided in order to maintain consistency within the system of reporting against the actions in PfA. In line with the promotion of a whole

system approach, Trusts must respond to all actions where they can make a positive contribution to achievement, irrespective of Programme of Care.

2.2 It should be noted that the progress indicators used for PfA are being brought into line with those used for the Department's monitoring of PSA commitments. Trusts should now use the following codes when reporting progress against PfA targets.

Code	Definition	Circumstance for Use
A1	Achieved	When action has been completed in line with PfA commitment on or before the published date.
A2	Substantially Achieved	When a significant percentage (at least 75%) of an action has been completed in line with the PfA commitment.
A3	On Track for Achievement	When work has been progressing satisfactorily and action is very likely to be achieved within published PfA timescale.
A4	Likely to be Achieved but with some delay	When action is likely to be achieved in full but after the published timescale (the likely extent of slippage should be reported, together with details of the remedial action being taken).
X	Unlikely to be achieved	When action is unlikely to be achieved within the period covered by the PfA.
NA	Not Applicable	Not applicable to a particular Board or Trust.

Section 3 - Resource Utilisation

3.1. A high-level summary of income and expenditure. The detailed financial pro forma returns are attached in addition to a supporting annex which details any key changes from last year and contact points within the Department (see Annex to this Appendix). The completed returns should be submitted as part of the TDP by 31 May 2005.

3.2. Workforce strategy, including recruitment, retention, absenteeism, training, staff development, workforce planning, agency staffing.

3.3. A capital investment plan, including estate control and programme for disposals, for approval by the Department.

3.4. Measures to break down barriers and promote collaborative working arrangements with HPSS bodies and other partners to reduce the administrative burden and maximise resources for the delivery of health and social care.

Section 4 - Reform, Modernisation and Efficiency

4.1 Trusts will work within Local Health and Social Care Economy Groups to establish proposals for the delivery of the Department's efficiency targets and their response to the reform and modernisation agenda. The processes of bidding for the resources available from the Reform and Moderisation Fund and monitoring action being taken to deliver against the reform and modernisation agenda will be managed through the Local Heath and Social Care Economy Groups in the respective Board areas.

4.2 Trusts will have a number of reforms and modernisation schemes that are to be taken forward without investment from the Reform and Modernisation Fund. All such schemes should be entered into the pro forma return provided (FP10(T)).

4.3 Trust responses to PfA must however contain settled proposals for working practice changes which will bring benefits to service users as outlined at Section 3, paragraph 35 of PfA 2005/08.

4.4 Trust responses must also include details of the specific actions to be taken during the next two years to modernise elective services. In developing their responses, Trusts should make specific reference to the continuing body of work, begun in 2004-05. They should also provide their responses to the compulsory actions included in both the Regional Waiting List and Emergency Pressures Programmes using the pro-formas included at Appendices E and F.

4.5 Trusts must provide details of all ongoing and planned benchmarking exercises for 2005/06 and include exercises flowing from both reference costs and other sources. A benchmarking register for this purpose is provided at Appendix D. In completing the register, Trusts are asked to identify all their benchmarking activities, recording in each case whether the exercise has originated from the investigation of reference cost variations or from other sources, and to describe how these have led to the achievement of, or demonstrate:

- Better outcomes for patients and service users; and/or
- Greater productivity; and/or
- Improved efficiency; or
- Existing efficiency.

4.6 Where completed benchmarking exercises have confirmed that there is scope in the planning period for improvement, the Department would anticipate that Trusts

will bring these issues forward so that they might contribute to the achievement of the Department's efficiency targets. It remains important that, where possible, the quantified gains associated with each benchmarking exercise are separately and explicitly recorded.

4.7 Where possible, benefits should be described in quantitative terms with a reference to the position prior to the planned exercise. But Trusts should also include those exercises where the benefits are largely qualitative since these, too, will count towards achievement of the non-resource releasing efficiency target.

4.8 Benchmarking activities recorded in previous years' TDPs (or follow-up responses) but not completed and reported at the close of 2004/05, should be rolled forward to the current year's benchmarking register or an explanation provided if the Trust no longer intends to pursue that activity.

4.9 Reference Costs – a letter will issue to each Trust pointing to significant reference cost variations revealed by the 2003/04 dataset, in the expectation that any necessary remedial action will be taken and that the material will be used to inform the Trust's benchmarking plans for 2005/06 (as monitored through the register at Appendix D). In the meantime, Trusts should endeavour to complete prior year projects and report the results.

4.10 The Management Improvement Targets issued by the Department in March 2003 should now be addressed within the context of the over-arching reform, modernisation and efficiency agenda and incorporated fully into the internal performance management arrangements of each organisation.

Section 5 – Governance (no more than 2 pages of narrative)

5.1. Strategy for an organisation-wide system of risk management which reflects embedding of arrangements and encouragement of culture change across all aspects of governance, including financial, organisational and clinical and social care.

Section 6 - User Experience (no more than 2 pages of narrative)

6.1. Actions planned to contribute to the delivery of the *Investing for Health* Strategy. This should include the role the Trust is playing within the Board-wide Investing for Health Partnerships; what steps are being taken to ensure the Trust is a health-promoting organisation for the benefit of staff, patients and the wider community; how the workforce is promoting and protecting health with a greater emphasis on preventative measures.

6.2. Measures to engage users, carers and communities in the planning, delivery and evaluation of health and personal social services.

6.3. Measures to assess user experience in terms of the level, quality and method of delivery of services.

Accountability & Monitoring

Throughout the year the Department will monitor progress on the delivery of HWIPs and, in particular, the actions in PfA. To this end, HSS Boards will be expected to submit regular progress reports. Trusts will be expected to contribute to this process.

In addition, Trusts will be expected to report separately on the progress they are making against delivery of their own Plans. The reports will be the focus for review by Departmental officials during the financial year, with issues being raised as necessary.

Trusts should therefore submit Progress Reports on the position in relation to the delivery of Priorities for Action at:

- 30 September, by 7 October 2005,
- 31 December by 6 January 2006; and
- 31 March, by 30 April 2006.

The report should include updates on each of the 6 main headings within the TDP as detailed above. The template at Appendix C, developed for reporting on the specific PfA actions, has been designed so that it can be revisited and updated on a quarterly basis, providing consistency in reporting and at a glance identifying changes in the status of each target throughout the year. Each progress report should therefore include an updated version of this template, including an assessment of the status of each target for that report in strict accordance with the key provided on the template, and should take account of any issues raised during the scrutiny and endorsement of the TDP. Information given must also include the latest figures available on progress against the Trust's share of the target (including percentages).

Trusts should anticipate formal progress review meetings with the Department in November 2005 and March/April 2006.

ANNEX TO APPENDIX B

TRUST DELIVERY PLANS: PRO FORMA FINANCIAL RETURNS

CONTENT

The attached pro forma returns differ significantly from those for 2004/05, reflecting the 2-year planning horizon, the change in focus from the deployment of additional funds in previous years to the emphasis of the Secretary of State's *Priorities and Budget 2005/08* and the development of the Reform and Modernisation initiative. A number of returns have been deleted and replaced with others better reflecting the focus of this year's Priorities for Action. Others have been amended as appropriate.

The main changes and details required are as follows:

- **FP1(T): Income and Expenditure account 2005 - 2007**

  This return has been amended to include forecast income and expenditure for 2006/07 (Full-year basis only) as well as 2005/06. This reflects the fact that Boards' Health and Wellbeing Investment Plans must now show planned commitments for both years.

- **FP2A(T): Analysis of Income** – Unchanged in format

- **FP2B(T): Reconciliation of Trust TDP Income to Income included in Boards' HWIPs**

  As with FP1(T), this return has also been amended to include income for 2006/07.

- **FP3(T): Resource-releasing efficiency savings**

  This is a new return, intended to capture each trust's share of the planned resource-releasing efficiency savings required to meet PfA targets. Trusts should also indicate the individual measures contributing to the achievement of the 0.5% efficiencies required in 2005/06 (1.0% in 2006/07 and 2007/08).

- **FP4(T): Allocation of EPF/RRI revenue consequences funding**

  This is a new return to record how each trust intends to deploy the additional funding provided for EPF/RRI revenue consequences. Trusts should specify the individual items that the additional funds will support, for both 2005/06 and 2006/07.

  The previous FP3 and FP4 returns are deleted.

- **FP5(T): Balance Sheet information, FP6(T): Cash flow analysis, FP7(T): Movement in provisions, FP8(T): Analysis of capital expenditure.**

These returns remain unchanged in format

- **FP9(T) : Planned Trust Outcome of Reform And Modernisation Fund Investments.**

  This is a new return, developed to capture the individual Trust contribution to the reform and modernisation activity arising from Board Investment in agreed schemes. For each scheme, identified in Board HWIP's (FP7) as entailing investment in your Trust, the investment and estimated savings over the planning period should be specified. This form should be used to record both resource releasing and non-resource releasing schemes.

- **FP10(T): Reform and Modernisation Schemes (Not subject to Reform and Modernisation Fund investment)**

  This is a new return, developed to capture the reform and modernisation activity planned by Trusts in response to the Department's efficiency targets which can be advanced without support from the Reform and Modernisation Fund. The return allows both resource releasing (RR) and non-resource releasing (NRR) schemes to be entered. The relevant Programme of Care and the related reform strand should be recorded. A detailed description of the scheme should be provided including timescales for change, inputs, outcomes for service users. Within the description, Trusts should record the preferred approach to measurement even if it is not yet clear how the improvement is to be quantified. Trusts should indicate whether the scheme will provide improved quality of service, an improved method of delivery or an improved level of service. Estimated savings for the planning period should be entered.

SUBMISSION OF RETURNS TO THE DEPARTMENT

Returns should be submitted as part of the TDP to Planning and Performance Management Directorate by the due date.

QUERIES

If you have any queries regarding the returns please contact John McGinnity on [redacted] or John McCracken on [redacted] or by e-mail to: John.McGinnity[redacted] or John.McCracken[redacted]

HPSS MANAGEMENT PLAN
1995/96 - 1997/98

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MANAGEMENT EXECUTIVE MISSION STATEMENT AND MAIN OBJECTIVES

FOREWORD by the Chief Executive

1. INTRODUCTION
2. MANAGEMENT EXECUTIVE KEY ORGANISATIONAL TASKS
3. HPSS KEY OBJECTIVES AND PRIORITIES
4. PERFORMANCE REVIEW AND SERVICE DEVELOPMENT PRIORITIES
5. FINANCE

APPENDICES

Appendix 1 Service Delivery

HPSS MANAGEMENT EXECUTIVE

MISSION STATEMENT

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

MAIN OBJECTIVES

1. To provide leadership, direction and support to the health and personal social services (HPSS).
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 create and promote the managerial environment necessary to achieve these objectives.
6. To ensure the availability of the requisite support services to the HPSS.
7. To encourage the development and best use of staff.

FOREWORD

The fundamental goal of the health and social services is to improve the health and social well-being of the population of Northern Ireland. To that end, it is the responsibility of Boards and GP fundholders, as the champions of their patients and clients, to purchase high quality services, which meet their needs.

Significant improvements in health and social well-being have been made in recent years. Perinatal mortality rates have fallen from 13.1 per thousand births in 1983 to 8.3 per thousand births in 1992, while the number of deaths from coronary heart disease has been reduced by around 30% over the period 1984 to 1994. However there remains substantial scope for further improvements. The Department's Regional Strategy for 1992 - 1997 contains no fewer than 60 objectives and targets designed to raise the standards of health and social well-being of our population. Purchasing must increasingly be directed at achieving these potential gains.

As in previous years this Plan focuses on five key strategic objectives which link improvements in health and social well-being with better quality of care, more effective targeting of resources, better value for money and changes in structure and organisation. It covers the period 1995/96 - 1997/98 and has been produced in sufficient time to influence Boards' purchasing prospectuses for 1995/96 and beyond.

Although the Plan concentrates on the role of Health and Social Services Boards as purchasers in securing various objectives, priorities and targets through their purchasing prospectuses, GP fundholders as purchasers of certain health services are also required to contribute to the achievement of appropriate objectives, priorities and targets. The Plan is, of course, also relevant to HSS Trusts, directly managed units and all family practitioners who, in their own areas of HPSS business, need to be aware of the content of the Plan and to contribute to its implementation. It is through a "partnership of care" between purchasers and providers that services can best be developed which meet the needs of the population and secure continuing improvements in quality. Our joint aim must be to provide services which are people-centred, needs-led, and which improve the health and social well-being of the population.

John G Hunter

J G HUNTER
Chief Executive

1.1 REVISED FORMAT OF THE MANAGEMENT PLAN

1.1.1 Since its inception in 1990, the Management Executive has published a Management Plan each year, setting out a corporate agenda for the HPSS in Northern Ireland. Successive Plans have been refined and developed and the Management Plan is now the key element in the annual HPSS planning cycle. This year further changes have been made to the Plan's timetable and content to take account of comments by Health and Social Services Boards. The changes are aimed at:

- reducing the number of targets and concentrating on service delivery;
- specifying priorities more clearly; and
- publishing the Plan well in advance of the focal year so that it may be taken into account more readily in the preparation of Boards' Purchasing Prospectuses.

1.2 TIMETABLE

1.2.1 Last year's Plan was rolled forward by means of the Chief Executive's letter of 8 October 1993 which identified a number of key priorities for 1994/95. This provided the opportunity to revise the planning cycle, and the current Plan therefore focuses on 1995/96 and outlines the strategic priorities for the period 1995 - 1998.

1.2.2 The Plan provides direction to Boards, Trusts and others involved in the commissioning and delivery of health and personal social care on the key objectives, priorities and management tasks for the period 1995 - 1998. Health and Social Services Boards will be expected to reflect these in their 1995/96 Action Plans which will be subject to endorsement by the Minister in the course of the annual Accountability Reviews in 1995. Health and Social Services Trusts, directly managed units and GP Fundholders will also be expected to reflect relevant targets in their Business Plans.

1.3 CONTENT

1.3.1 In view of the need to focus on the key area of service delivery, the Management Plan will no longer include specific sections covering those areas of business which fall under the broad heading of 'customer support' to Boards and Trusts, such as: Human Resource Development; Information Services; Financial Management; Estate Management; and Capital Development. However, certain key targets in these areas, which impinge directly on Boards' ability to meet service delivery targets, will continue to be included.

1.3.2 The Management Executive will wish to continue to maintain a programme for action in respect of these areas. To that end, separate service agreements will be drawn up between individual Management Executive Directorates and Boards/Trusts covering each relevant area of business. These service agreements will set out agreed services and targets for the period 1995/96 to 1997/98.

1.3.3 The current Management Plan also includes sections on the Management Executive's key internal objectives for 1995/96 to 1997/98, and the strategic objectives for purchasers and providers across the period.

1.4 CORPORATE CONTRACTS

1.4.1 This year, in addition to the main Management Plan, the Management Executive intends to draw up individual corporate contracts with each Health and Social Services Board. The role of corporate contracts will be to complement the Management Plan, which is common to all Boards, by addressing certain areas of service provision or aspects of performance specific to each Board where the Management Executive wishes to secure improvement.

1.4.2 The introduction of corporate contracts will not involve setting different strategic objectives for individual Boards. However, the corporate contracting process will involve a recognition of the need to tailor action to accommodate the particular circumstances of individual Boards, for example, to take account of past or current variations in performance between Boards, or historical differences in baseline levels of provision. The overall objectives will remain common to all Boards but their inclusion in corporate contracts will enable individual action plans and intermediate targets to be developed.

1.4.3 Frameworks for the corporate contracts, outlining in broad terms the areas to be included, will be forwarded to Boards later in the year. The issues will be firmed up, and programmes of action agreed, through bilateral discussions between the Management Executive and

Boards and the corporate contracts finalised by 31 March 1995. The corporate contracts should in turn be reflected in Boards' purchasing Prospectuses.

1.5 REGIONAL STRATEGY

1.5.1 It had been envisaged that the current Regional Strategy would be rolled forward from April 1995, in line with the original concept of a five year plan rolled forward every three years. However, it has been decided to defer the roll-forward for one year until April 1996. The next Regional Strategy will therefore cover the period April 1996 to March 2001.

1.5.2 A series of booklets containing Action Plans for each "key area of concern" in the Regional Strategy, except Accidents and Trauma which is being taken forward by the Inter-Departmental Group on Health, is in the final stages of preparation. The Action Plans identify a range of practical measures which should facilitate implementation of the Strategy. The booklets will be issued to the HPSS and other interested organisations as they become available.

2 MANAGEMENT EXECUTIVE KEY ORGANISATIONAL TASKS

2.1 The Management Executive's key organisational tasks for the period 1995/96 - 1996/97 are:

- To implement any recommendations arising from the review of the health and personal social services purchasing function.
- To secure the complete separation of purchaser and provider organisations by 1 April 1996 through the establishment of successful "fifth" and "sixth" wave applicants for Trust status.
- To establish successful "fourth wave" candidates for GP fundholding status (target date: April 1995) and to invite further expressions of interest in GP fundholding status for 1996/97 (target date: November 1995).
- To prepare for implementation of an extension of the scope of the GP fundholding scheme (target date: April 1996).
- To prepare and introduce further targets on prescribing to exert downward pressure on the drugs bill (target date: April 1996).
- To establish successful "fifth wave" candidates for GP fundholding status (target date: April 1996) and to invite further expressions of interest in GP fundholding status for 1997/98 (target date: November 1996).

3.1 KEY OBJECTIVES

The key strategic objectives for the period 1995/96 -1997/98 will continue to be focused on:

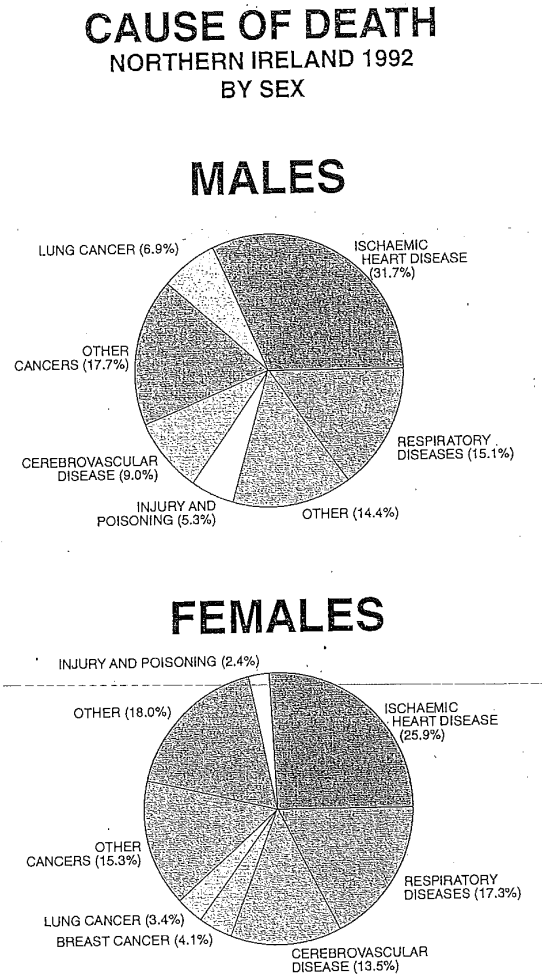
- improving the health and social well-being of the population in line with the Regional Strategy 1992 -1997;
- raising standards, improving quality and making services more responsive to the needs of individuals through the development of the Charter for Patients and Clients and greater emphasis on the identification of effective clinical outcome measures and their use in informing the contracting process;
- targeting resources on those with greatest need;
- improving efficiency and ensuring value for money in the use of resources; and,
- securing the managerial and organisational changes stemming from 'Working for Patients' and 'People First'.

3.2 IMPROVING HEALTH AND SOCIAL WELL-BEING

3.2.1 The number of deaths from ischaemic heart disease has fallen by around 30% over the past ten years. This exceeds the Change of Heart target, which the Department and Boards adopted in 1986, for a 15% reduction in premature deaths by 1997. Despite this encouraging trend, ischaemic heart disease remains the largest single cause of premature deaths among males and females, accounting for over 4000 deaths in 1992 (Figure 1). There is, therefore, no room for complacency. It is for this reason that a new and more ambitious target has been set which aims to reduce premature deaths from this disease by 40% between 1988 and 2002.

3.2.2 Cancers are the second most common cause of premature death in Northern Ireland, with cancers of the lung and breast accounting for a large proportion of all cancer deaths (Figure 2). New targets which aim to reduce the death rate from lung cancer by at least 30% in men under 75 and 15% in women under 75 by 2010, and to reduce the death rate from breast cancer in the population invited for screening by at least 25% by the turn of the century, have been announced.

FIGURE 1



There are also indications that the incidences of testicular cancer and malignant melanoma are increasing, whilst the incidence of cervical cancer has shown only a small decrease in the last couple of decades.

3.2.3 Cigarette smoking is the largest preventable cause of death in Northern Ireland, as well as being a major cause of serious ill-health. Active health education programmes are vital if the problem is to be overcome, and many studies have highlighted the importance of intervention with young people before the habit becomes established. A new target, which has recently been announced, requires Boards to take steps to establish programmes aimed at achieving an increase in the percentage of 15-year-olds who do not smoke to 80% (from 75%) by 1997.

3.2.4 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 their counterparts in Great Britain. One of the possible reasons for this is the higher levels of material deprivation within Northern Ireland. Long-term unemployment is almost five times higher than in the UK as a whole (Figure 3). In addition, a larger proportion of average household income is derived from social security benefits (Figure 4). Other indicators of social deprivation give a similar message.

FIGURE 2

CANCER DEATHS BY SITE
NORTHERN IRELAND 1991

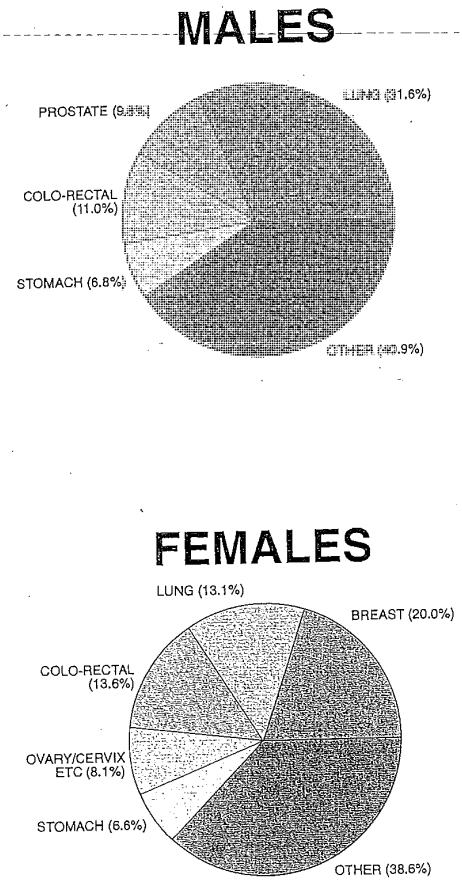
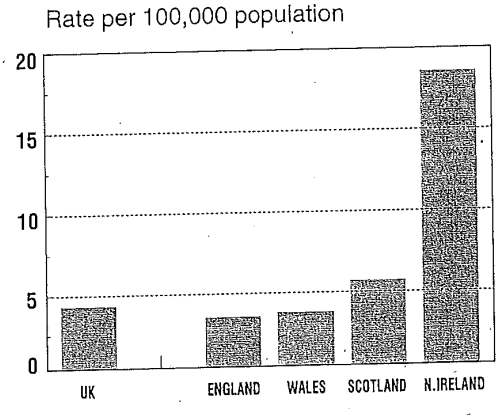


FIGURE 3

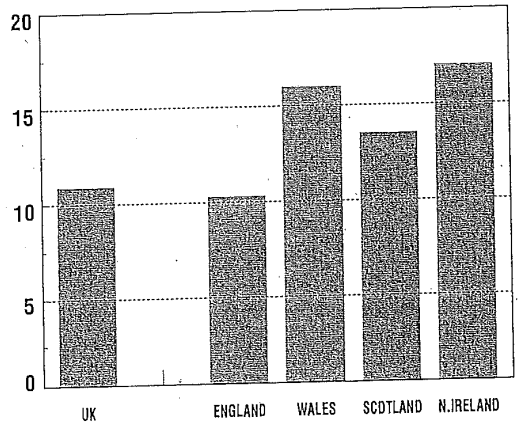
LONG TERM UNEMPLOYMENT (5+ Years)
Rate per 1,000 population of working age
United Kingdom, January 1993



Source: Employment Department

FIGURE 4

% AVERAGE GROSS WEEKLY HOUSEHOLD INCOME DERIVED FROM SOCIAL SECURITY BENEFITS, 1990-1991



Source: Family Expenditure Survey

3.3 RAISING STANDARDS

3.3.1 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 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. Further Charter standards covering other areas of health and personal social services will be introduced during the period of the Plan.

3.3.2 In evaluating and seeking to improve the standard of services in their areas, Boards should concentrate not only on quality of care but also on the sensitivity of service provision to local need.

3.3.3 A survey of patients is one way of monitoring services and of gauging public perception both of the quality of services received and of their accessibility and suitability. This is a particularly useful tool in relation to general medical, ophthalmic and dental services and also community pharmaceutical services. Boards should therefore regularly conduct patient surveys, whether by written questionnaire or by personal interview, in relation to the family practitioner services.

3.3.4 As purchasers of certain hospital and community services, GP fundholders too are expected to ensure that standards set out in the Charter are incorporated in contracts agreed with providers. Through the contracting process they should aim to ensure that minimum Charter standards are achieved and, where possible, exceeded.

3.3.5 The Department has decided to establish a Clinical Standards Group to evaluate and disseminate information about clinical effectiveness. This will help purchasers to contract for clinically effective treatments and care.

3.4 TARGETING HEALTH AND SOCIAL NEED

3.4.1 The Regional Strategy identifies, as a priority, the need to address the inequalities in health and social well-being which exist in Northern Ireland. Greater need for health and social care may be found in particular groups within the population, linked by such factors as location, community affiliation or material deprivation.

3.4.2 During the period of this Plan, Boards 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.

3.4.3 At regional level the Department and the Management Executive are addressing this priority through:

- the establishment of a working group involving the Department, Management Executive, Boards and the Health Promotion Agency, to consider how health and social care inequalities might be identified and reduced or eliminated;
- the commissioning of research into inequalities in health and social well-being and equity in the provision of health and social services in Northern Ireland; and
- the review of capitation based funding arrangements.

3.5 VALUE FOR MONEY

3.5.1 The continous pursuit of value for money (VFM) assumes a particular importance in the current public expenditure climate, not only because of the need to demonstrate real VFM improvements in support of bids for additional resources, but also as a means of releasing resources for the development of new or enhanced services and transferring resources to the community.

3.5.2 The Management Executive will ask purchasers and providers to focus on the issues which demand priority in their particular circumstances. While the achievement of savings is the normal expected consequence of VFM initiatives this will not always be the case

in that the quality of service can often be improved without necessarily releasing cash. It will be essential to improve information to support the pursuit of VFM, not only in the traditional areas of good practice recommendations and efficiency indicators, for example; energy usage, provision of support services, or nursing skill mix, but also on a wider front involving, among other measures, customer satisfaction surveys and measurement of potential benefits. Account also needs to be taken of the efficiency increases to be gained from changes in delivery methods, and many of the targets in this Management Plan address that issue, for example, those on day surgery and bed throughput.

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

- achieve further annual efficiency improvements amounting to at least 3%;
- extend the range of services subjected to market testing;
- identify and disseminate good practice;
- develop procedures to measure relative efficiency and identify the causes and solutions in respect of inefficient procedures;
- promote the involvement of all staff in decision making to identify efficiency improvements at all levels of the organisation; and
- actively investigate, as part of the option appraisal of development plans, opportunities to secure private sector funding under the Private Finance Initiative.

3.6 SECURING MANAGERIAL AND ORGANISATIONAL CHANGE

3.6.1 Throughout the period of the Plan the Management Executive will seek to continue the process of managerial and organisational change which stemmed from the HPSS reforms. In particular the Management Executive will:

- promote the GP fundholding scheme with the aim of increasing the number of fundholding practices;
- expect all Boards to be free of direct management responsibilities for providers by 1 April 1996;
- expect all remaining directly managed services to be delivered through trust status from 1 April 1996;
- continue to work with Boards and Trusts to further develop and refine the purchasing function.

4.1 BACKGROUND

4.1.1 This section reviews the progress that has been made in achieving the objectives and targets set for 1993/94 in the last Management Plan and sets out the key service priorities for 1995/96 to 1997/98 based on the strategic objectives and targets in the 'Regional Strategy 1992 - 1997' and the commitments made in the Charter for Patients and Clients. It also develops the objectives and priorities to be pursued in connection with the major reforms stemming from 'Promoting Better Health', 'Working for Patients' and 'People First'.

4.1.2 These objectives and targets are not comprehensive and Boards will be expected to supplement them as necessary to reflect local needs and priorities. Purchasers and providers will be expected to balance income and expenditure.

4.2 REVIEW OF 1993/94 OBJECTIVES

Family Practitioner Services

4.2.1 GP fundholding was not introduced in Northern Ireland until 1 April 1993, when 20 fundholding units, comprising 100 GPs, were established. A further 23 fundholding units, representing 126 GPs, joined the scheme on 1 April 1994, by which date some 26% of the population of Northern Ireland belonged to fundholding practices. Further practices are preparing for fundholding status from 1 April 1995.

4.2.2 Fundholding has proved to be the single most effective lever in containing the cost of GP prescribing. In 1993/94 the total overspend by all GPs in Northern Ireland on their indicative prescribing amount was 2.02 per cent. Within this total overspend the 20 GP fundholding units had underspent their amalgamated indicative prescribing amounts by 7.45 per cent.

Care in the Community

4.2.3 In 1993/94 Boards were allocated an additional £29.4m specifically earmarked for the implementation of the new community care arrangements. This money has been used to develop innovative packages of care which have assisted the increase in the proportion of people aged 75 or over who are cared for in their own homes. During the 9 months from April to December 1993 Boards received about 6,000 referrals for community care assessments. Almost 75% of referrals were from elderly people and in total some 5,900 assessments were carried out. Over 90% of assessments were commenced within 7 days from referral, 82% were completed in under a week and only 2% were outstanding at 5 weeks. Some 50% of the care packages commenced were domiciliary based, 30% required nursing home care and 20% were in residential care homes.

4.2.4 Following recent increases in the number of admissions to acute psychiatric care the Department has commissioned further research into the possible causes of the increases and the effectiveness of the different models for the treatment of acute mental illness. The Management Executive expects that the number of such admissions should continue to be kept to a minimum. 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 mental handicap. During the period from April 1992 to February 1994 the number of people in psychiatric hospitals fell by 20%. The number of people in mental handicap hospitals was reduced by 16% over the same period.

Child Care

4.2.5 Health and Social Services Boards are continuing to make progress on the target of ensuring that there is an abuse prevention programme such as "Kidscape" for every child of primary school age. All Boards expect to meet the target during 1994/95.

4.2.6 All Health and Social Services Boards have implemented revised procedures for the management of child abuse in accordance with the Departmental guidance document "Co-operating to Protect Children". Boards have continued to make good progress in developing and implementing inter-agency arrangements, for example, the Joint Board/RUC protocol for the investigation of child abuse, the working party on the video recording of children's evidence for court proceedings, and the working party on the proposal to establish a regional child protection helpline.

4.2.7 All Boards met the target for increasing the proportion of children in care who are placed with a family to 71%.

Acute Hospital Services

4.2.8 The latest available Corporate Monitoring return (for December 1993) shows that throughput 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 in-patient specialties in which the targets have already been surpassed include general medicine, dermatology, general surgery, trauma and orthopaedics, ENT, ophthalmology and plastic surgery. In day cases, the targets have been exceeded in all but general medicine, trauma and orthopaedics and neurosurgery. The continuing improvements in efficiency and the increased use of day and outpatient treatments should ensure that greater numbers of patients will be able to be treated. At the same time, continued progress towards the reduction in the number of acute beds over the period of this Plan should be possible without adverse effect on patient treatment.

4.2.9 As a result of the injection of additional resources to tackle waiting list problems, some of which were specifically earmarked for cardiac surgery in 1993/94, considerable improvements have been achieved. The number of patients waiting more than 18 months for inpatient treatment (excluding cardiac surgery for which the Charter guarantee from April 1993 was 24 months) fell from 2563 at December 1992 to just over 1100 at March 1994. However, day case numbers waiting more than 18 months increased from 418 to 502 in the same period. In cardiac surgery, the numbers waiting decreased from 227 to 38 over the same period.

4.2.10 In most of these cases, contracts have been made and the majority of patients were expected to have received treatment or to have had an offer of treatment made by 31 March 1994. In a small number of cardiac surgery cases and in other specialties such as paediatric surgery, ophthalmology and plastic surgery, the Charter guarantees will not have been met by 31 March 1994 but appropriate action has been taken to ensure early compliance with the Charter standards.

4.2.11 Progress has been 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 who had their first out-patient appointment in the quarter ending December 1993 (ie 64,538), 85% had waited less than 3 months.

Purchasing Development

4.2.12 1993/94 saw the further development of the internal market in Northern Ireland with the planned move away from "steady state" contracting and the successful introduction of HSS Trusts and GP Fundholding. Health and Social Services Board contracts remain predominantly of the block type though in some limited areas cost and volume and cost per case contracts were developed. Boards, as purchasers, have also developed arrangements to take on board the views of GPs, (including fundholding GPs), users, carers, voluntary organisations and elected representatives in the commissioning of health and social services.

4.2.13 The Management Executive and the 4 Boards have jointly established a Purchasing Development Steering Group with the tasks of: 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. In addition, the Management Executive, in the light of issues raised in the 1993/94 contracting round, issued revised guidelines for the 1994/95 contracting process.

4.2.14 Since the publication of the previous Management Plan seven new HSS Trusts have been established. In addition, a further two potential Trusts have been invited to apply for Trust status.

4.3 PURCHASER SERVICE DEVELOPMENT PRIORITIES FOR 1995/96 - 1997/98

Family Practitioner Services

4.3.1 Prescribing is one area where there is considerable scope for obtaining better value for money without any reduction in quality of care or treatment. Where money is spent on drugs unnecessarily and without clear policy parameters, the rest of the health and personal social services suffer from reduced funding provision.

4.3.2 Over the period covered by this Plan, Boards should therefore take steps to ensure that general medical practices continue to be visited on a regular and systematic basis and prescribing habits analysed and fully discussed with all the GPs. Boards may find it useful to enhance the pharmaceutical advisory input to this visiting

and analytical work, which should lead to more efficacious, safer and more cost-effective prescribing.

4.3.3 Since the cost of drugs to the health and personal social services continued to escalate during 1993/94, with the greatest downward pressure being exerted by fundholding GPs, a joint Management Executive/Boards working group was set up to design a prescribing incentive scheme for non-fundholding GPs which would be specific to Northern Ireland and operate in conjunction with the indicative prescribing scheme. This new incentive scheme will become operational during 1994/95, and Boards should actively promote it.

4.3.4 Future targets for GP fundholding status are that at least 25 practices should join the scheme on 1 April 1996 and at least a further 20 on 1 April 1997. Boards will be expected to support the Management Executive in promoting the scheme to GPs in order to achieve these incremental increases in uptake.

Care in the Community

4.3.5 A further £41.2m was allocated in 1994/95 for the implementation of the community care arrangements and an additional £35.9m will be made available in 1995/96. Although progress has been encouraging it will be necessary to further develop, in co-operation with the private and voluntary sectors, the range of domiciliary and other non-residential services to ensure that the community care targets are met.

4.3.6 Although some progress has been made, further action will be required by Boards in 1994/95 to ensure that, by 1995/96, systems are in place to identify the numbers and the needs of physically disabled children and of sensorily impaired adults. Boards will be expected to ensure that their purchasing prospectuses address the service needs of these vulnerable groups. Similarly, continued action will be expected from Boards to overcome the difficulties in reducing the time taken for occupational therapy assessments for aids and adaptations.

Child Care

4.3.7 The forthcoming Children (Northern Ireland) Order will have major implications for the planning and delivery of child care services. Boards and Trusts wil be expected, during 1995/96, to begin preparation for its implementation.

Acute Hospital Services

4.3.8 The provision of high quality acute hospital services is dependent on a partnership approach between all those involved in the purchase and delivery of these services. Many changes are occurring which will affect the pattern of these services. For example, as a result of the New Deal which has been secured in relation to junior doctors' hours, and the impact which the implementation of the Calman Report will have, fundamental changes will be required in the way in which all hospital doctors work. These changes will include: better cross-cover arrangements; more effective team working; greater use of shift systems; and a review of skills mix. The co-operation of medical and other professional staff will be essential to implement the working patterns which best match the intensity and volume of the clinical workload. The shift towards an increase in day case procedures and greater throughput of in-patient cases will also impact on the pattern of service delivery.

4.3.9 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;
- develop services for patients locally to complement those provided by acute hospitals;
- improve efficiency in the use of beds and encourage greater use of day and out-patient treatment, and so reduce the overall requirement for acute beds;
- continue to develop specialised regional services;
- improve the quality of obstetric care by seeking to ensure optimum safety standards for mothers and babies, having regard to accessibility of services;
- improve the quality of care to patients and reduce waiting times.

4.3.10 Continued concentration on reduction in waiting lists numbers and waiting times will be supported in 1995/96 by the additional funding secured in the 1992 Public Expenditure Survey and provided under the Waiting List Initiative.

4.3.11 The targets for throughput and day cases in this Plan have been increased to take account of progress already made in these areas and to reflect up to date information on performance in Great Britain. The Management Executive is currently considering appropriate comparators for setting future targets.

Purchasing Development

4.3.12 All purchasers will be expected to be able to demonstrate clearly the tangible benefits for patients and clients they have achieved. The Management Executive recognises that variability in purchaser achievement is a performance management issue and intends to make more systematic comparisons of performance between purchasers. Challenging targets will be agreed by means of corporate contracts with individual purchasers to improve performance and progress towards meeting these will be closely monitored.

4.3.13 The Management Executive expects Boards to make their purchasing more sensitive to GPs and local communities by developing locality sensitive arrangements. Whatever arrangements are put in place, Boards will be expected to be able to demonstrate the resulting benefits to patients and clients.

4.3.14 Purchasers are expected to make appropriate use of a wider range of contract types. Contracts should include suitable incentives and penalties which encourage service providers to deliver on agreed targets. Purchasers need access to a wide range of professional advice and expertise throughout the commissioning process. The Management Executive therefore expects Boards to:

- further develop arrangements for securing sound health and personal social services advice; and
- ensure that local professionals know what mechanisms exist to give advice and that they have a defined process for contributing to the commissioning process.

4.3.15 It is widely recognised that knowledge of people's perceptions, preferences and experience of health and social services is essential in assessing needs and how to meet them. Consultation is a very important part of a purchaser's role and needs to be addressed in an open-minded and receptive manner. The Management Executive expects purchasers to consider such views in drawing up their purchasing intentions, and to be able to indicate where these have been taken on board and where and why others have not.

4.3.16 The Management Executive is presently carrying out a review of purchasing functions and structures in Northern Ireland. The review group established by the Management Executive will report with recommendations to the Minister shortly.

4.4 PROVIDER STRATEGIC PRIORITIES FOR 1995/96 - 1997/98

Efficiency/Value For Money

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

- the achievement of the cost improvement targets required by purchasers;
- full participation in the achievement of value for money targets described in paragraph 3.5.3, for example, to explore the value of market testing in different areas of business and to implement where appropriate; and
- that trusts meet their statutory financial obligations.

Organisational Development

4.4.2 Providers must develop and implement policies and plans which maximise their ability to respond effectively to the changing demands of the internal market. Particular attention should be paid to:

- securing the active participation of professional staff in the contracting process and the planning of service delivery;
- the review of organisational structures and processes to ensure that they are able to respond flexibly to changing needs and that they represent best value for money.

Management Costs

4.4.3 It is important that management costs in particular are critically reviewed and that they are contained at, or reduced to, cost effective levels. Higher than average expenditure may be justified in a limited number of cases, but only if the extra numbers or quality of staff result in

overall savings or greater efficiency.

Achieving Trust Status

4.4.4 Remaining directly managed units must take steps to achieve trust status by 1 April 1996, subject to Management Executive agreement on configuration.

Human Resource

4.4.5 Each provider will be expected to develop and implement a human resource strategy which provides staff at all levels with:

- a clear understanding of the main objectives of their organisation; and
- training and development opportunities to improve their contribution to the organisation's objectives and provide continuing scope for personal development.

In developing the strategy special attention should be paid to:

- fair employment and equal opportunity;
- manpower planning;
- staff development and training arrangements;
- pay and reward systems;
- achieving nationally agreed terms and conditions of service requirements for junior hospital doctors and dentists hours of work; and
- the need to begin implementation of the recommendations of the Calman Report.

Local Responsiveness

4.4.6 Providers will be required to develop and implement effective communication policies which ensure the needs and wishes of the local community are properly reflected in their practices, with particular regard to:

- the establishment of relationships with local groups, bodies and representatives, and maintaining regular and meaningful dialogue with the local Health and Social Services Council;
- the maximisation of individual choice including the development of partnership arrangements with the independent sector; and
- the requirements of the Charter for Patients and Clients.

Accountability

4.4.7 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, above all, which promote a responsible attitude by all who handle public money. In particular the frameworks should include measures to ensure:

- strict financial control and monitoring;
- compliance with 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;
- proper systems of individual accountability and control.

Capital and Estate Management

4.4.8 Trusts and directly managed units must take appropriate action within their prioritised needs to invest resources effectively and to have management systems in place to ensure compliance with fire safety and statutory standards applying to health and safety and environmental protection in the HPSS estate.

4.4.9 Trusts and directly managed units should have environmental policy statements in place and are expected to meet the Government's public sector energy campaign target of a 15% saving in energy over the five year period to March 1996.

Information/Information Systems

4.4.10 Providers will be expected to meet the requirements of the outcome of the Regional Strategy for Information and Information Systems in their development plans. It is also essential that they:

- provide on time, all current information requirements and any minimal additional requirements that become necessary to enable

the Management Executive to monitor properly the provision of health and personal social services in Northern Ireland;

- ensure the quality of the information by having appropriate structures and/or processes in place and by co-operating with the development and implementation of a data audit strategy.

Better Practice

4.4.11 Providers need to continue to focus on improvement in standards of practice. The service they provide should also continue to achieve the best possible outcomes for patients and clients within the available resources, which necessitates a strategy aimed at sustaining a process of continuing quality improvement. Specifically, units should ensure that there is a clear policy on:

- clinical audit as part of a programme to improve all aspects of service quality, not just clinical outcomes;
- support and evaluation of quality improvement programmes; and
- multi-disciplinary approaches to the development of best practice in service delivery.

5.1 FINANCIAL RESOURCES

5.1.1 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 1994 Public Expenditure Survey settlement, which will be announced towards the end of the year, will determine the level of revenue and capital resources available in 1995/96.

5.1.2 Having moved Boards effectively onto their capitation target shares of resources in 1994/95 the Management Executive will aim to distribute the available resources for 1995/96 in a way which will best maintain this position.

5.1.3 The Management Executive has established a multi-disciplinary group of Board officers, chaired by the Management Executive's Director of Financial Management, to review and, if necessary, revise the existing capitation formula. When the review group has completed its deliberations the Management Executive will consider the impact, if any, of implementing the recommendations and the timescale for implementation will be agreed accordingly.

5.1.4 The HPSS will operate in the next two to three years against a background of tight controls on public expenditure. As the 1994 Public Expenditure Survey is not yet complete no definitive resource figures can be provided at this stage for the period of the Plan. However, for planning purposes, Boards should proceed on the assumption that annual revenue resources available for health and personal social services will continue at their present level in real terms allowing for the Government's forecast inflation. However, purchasers and providers should assume that they will be expected to achieve continuing improvements in efficiency across the period of the Plan which will secure minimum total cost improvement savings of 3% annually.

5.1.5 In view of these limitations on public funds, Boards and Trusts should actively investigate opportunities to secure private sector funding, as part of the Private Finance Initiative, as an alternative.

SERVICE DELIVERY - TASKS FOR 1995/98

APPENDIX 1

TOPIC	OBJECTIVE	1995/96	TARGET 1996/97	1997/98
Health Promotion and Disease Prevention	1. Develop and implement health promotion programmes relating to cigarette smoking, healthy nutrition, blood pressure, sexual and reproductive health and alcohol consumption so that:			
	a. the proportion of adult non-smokers in the community should have increased to:	73%	74%	
	b. the proportion of children who have not started to smoke should have increased to:	92%	93%	
	c. the average serum cholesterol level in adults should be reduced to 5.2 mmol/1.		*	
	d. the proportion of adults having their blood pressure checked at least once in the last 5 years increases to:	77%	80%	
	e. the proportion of energy derived from saturated fat in the diet should be reduced to less than:	15%	15%	
	and from total fats to less than:	36%	35%	
	f. the number of births to teenage mothers should be reduced by a further:	9%	15%	
	g. the proportion of adult men drinking more than the recommended limit (up to 21 units per week) should be reduced to:[1]	28%	25%	
	h. the proportion of adult women drinking more than the recommended limit (up to 14 units per week) should be reduced to:[1]	9%	7%	

[1]Health promotion programmes may need to be modified to take account of the work of the Government Working Party which has been set up to consider the sensible drinking message.

SERVICE DELIVERY - TASKS FOR 1995/98

APPENDIX 1

TOPIC	OBJECTIVE	1995/96	TARGET 1996/97	1997/98
	2. Increase uptake levels for cervical screening through GP contracts mechanisms so that 50% of GPs are achieving the high target and 80% the low target.			
	3. Continue fluoridation programme so that some 60% of the population will have their water supply fluoridated.		*	
	4. Achieve a minimum acceptable response rate of the target population for breast cancer screening of:		70%	
Accidents and Trauma	5. Develop and implement programmes and improved treatment aimed at reducing the number of deaths from accidents and trauma by:		15%	
Family Practitioner Services	6. Approve applications for and monitor performance under the new Pharmacy Professional Allowance.		*	
	7. Encourage GPs to increase the level of their generic prescribing to a minimum of:		40%	
	8. Work with GPs to increase the percentage of practices actively using a practice prescribing formulary to:		60%	
	9. Work with GPs to increase the percentage of practices using a protocol for repeat prescribing to:		60%	
	10. Actively promote the Prescribing Incentive Scheme to achieve an uptake by non-fundholding GPs of:		60%	
	11. Promote the GP fundholding scheme with the aim of increasing the number of GP fundholding practices by:		25%	

SERVICE DELIVERY - TASKS FOR 1995/98

APPENDIX 1

TOPIC	OBJECTIVE	1995/96	TARGET 1996/97	1997/98
Services for Elderly People	12. 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 of:	87%	88%	88%
Services for Mentally Ill People	13.[1] Continue to increase and target community services to:			
	a. effect a reduction in the number of patients with dementia in long-stay hospitals of:	40%	50%	50%
	b. effect a reduction in the number of patients with chronic mental illness in long-stay hospitals of:	25%	30%	30%
	14. Develop and implement mental health promotion programmes.			
Services for Mentally Handicapped People	15. Increase and target community services to support a reduction in the number of people in mental handicap hospitals of:	20%	25%	25%
Physical and Sensory Disability	16. Identify the number and needs of physically disabled children and ensure that these are reflected in Boards' purchasing prospectuses			
	17. Identify the numbers and needs of sensorily impaired people and ensure that these are reflected in Boards' purchasing prospectuses.			
	18. Where application is made for aids or adaptations to a person's home ensure that an assessment of needs is completed within 3 months by an occupational therapist.			
Child Care	19. Ensure access to evaluated treatment and services designed to promote a co-ordinated response for all children who have been sexually abused, and where appropriate, for their families.			

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

SERVICE DELIVERY - TASKS FOR 1995/98

APPENDIX 1

TOPIC	OBJECTIVE	TARGET 1995/96	TARGET 1996/97	TARGET 1997/98
	20. Prepare for implementation of the proposed Children (Northern Ireland) Order.			
	21. Ensure that the proportion of children in care, placed with a family (excluding those home on trial) is at least:	74%	75%	75%
Maternal and Child Health	22. Ensure an uptake rate for immunisations in line with the Regional Strategy for:			
	a. Diphtheria	95%	95%	95%
	b. Polio	95%	95%	95%
	c. Tetanus	95%	95%	95%
	d. Pertussis	95%	95%	95%
	e. Measles, Mumps & Rubella	95%	95%	95%
	f. HIB	95%	95%	95%
	23. Ensure that all consultant-led maternity units meet the Department guidelines on maternity services as set out in Circular HSS (General Hospital Policy) 1/91			
Acute Hospital Services	24. Achieve a minimum throughput (average annual number of patients treated per bed) for the following specialties:			
	a. General Medical Group (Including gastroenterology and endocrinology)	56	58	60
	b. Dermatology	26	28	30
	c. General Surgery/Urology	53	57	60
	d. T & O Surgery	34	39	45
	e. Cardiothoracic Surgery	40	44	48
	f. Gynaecology	80	82	84
	g. ENT	95	100	105
	h. Ophthalmology	95	100	105
	i. Plastic Surgery	53	57	60
	j. Neurosurgery	36	38	39

SERVICE DELIVERY - TASKS FOR 1995/98

APPENDIX 1

TOPIC	OBJECTIVE	TARGET 1995/96	1996/97	1997/98
	25. Continue to increase the level of day cases as a percentage of all admissions for the following specialties:			
	a. General Medical Group (Including gastro-enterology and endocrinology)	16	17	19
	b. Dermatology	76	85	89
	c. General Surgery/Urology	30	33	36
	d. T & O Surgery	18	21	24
	e. Cardiothoracic Surgery	4	6	8
	f. Gynaecology	38	41	44
	g. ENT	28	31	34
	h. Ophthalmology	40	44	48
	i. Plastic Surgery	40	43	46
	j. Neurosurgery	5	5	5
Charter for Patients and Clients	26. Reduce waiting times to:-			
	a. ensure that, from April, people do not wait for inpatient treatment more than:	12 mths	12 mths	12 mths
	b. ensure that local maximum waiting times for inpatient treatments are set and achieved by each Board.		*	
	c. ensure that from April, people do not wait for cardiac surgery more than:	12 mths	12 mths	12 mths
	d. establish maximum waiting time for first out-patient appointments to not normally exceed:	3 mths	3 mths	3 mths
	27. Implement national standards set for ambulance response times in the following classifications;			
	a. 95% of calls answered within 18 minutes in Rural areas.			
	b. 95% of calls answered within 21 minutes in sparsely populated areas.			

TOPIC	OBJECTIVE	TARGET 1995/96	1996/97	1997/98
	28. Set maximum waiting times in A & E departments after the need for treatment has been assessed.		*	
	29. Set waiting times for HPSS transport home after treatment, where there is a medical need for such transport.		*	
	30. Publish annual report on achievements against Charter standards.		*	
	31. Ensure that a GP is provided for an unregistered person within 2 working days.		*	
	32. Ensure that details of how to change GPs, if necessary, including a list of doctors is provided within 2 working days.		*	
	33. Ensure that medical records are transferred within 2 working days (for urgent cases) and within 6 weeks (for routine cases) when a person changes GPs.		*	
Targeting Social Need	34. Identify areas and groups with particular needs and ensure services are targeted accordingly.		*	
	35. Identify and remove organisational and social barriers for disadvantaged people.		*	
	36. Implement arrangements for assessing health and social need.		*	
	37. Maintain capitation based allocation targets.		*	

Management Executive
Office of the Chief Executive

METL 2\93

Chief Executives of HSS Trusts and Shadow Trusts - for action

Area General Managers)
UGMs) for information
GP Fundholders)

(October 1993

Dear Sir\Madam

ACCOUNTABILITY FRAMEWORK FOR TRUSTS

1. This letter sets out the framework of accountability which will exist between the Management Executive (ME) and HSS trusts in the future. It reflects both the statutory responsibilities of trusts and the role they will be expected to play in the pursuit of the corporate objectives of the HPSS currently summarised annually in the Management Plan.

Relationships

2. In developing and articulating this accountability relationship it has been recognised that some refinements may be required in the future. The need for these will be kept under review. It is also intended to develop a set of statements addressing the major relationships which now exist within the HPSS involving the ME, Boards, trusts and GP Fundholders.

3. The reforms of the HPSS brought forward in the Health and Personal Social Services (NI) Order 1991 are designed to enhance the capacity of the HPSS to secure improvements in the health and social well-being of the population by improving performance, raising standards and enhancing quality. The separation of the purchasing and providing roles will in particular allow the delegation of management responsibility to the local level. HSS trusts established under the 1991 Order are independently - managed provider units which are statutory bodies and remain within the HPSS. They are expected to maintain good relationships with purchasers based on collaboration and partnership.

4. As such HSS trusts are accountable to:

   i. the general public and in particular local communities. As statutory bodies utilising public funds, trusts are expected to demonstrate good stewardship to the taxpayer

Health and Personal Social Services Northern Ireland
Dundonald House, Upper Newtownards Road, Belfast BT4 3SF. Tel: [redacted]

LH 89

and an efficient responsive service to the people they serve. They should encourage the involvement of local communities and build up good relationships with their Health and Social Services Councils. Each trust must hold an annual public meeting and issue an annual report.

ii. to purchasers (Boards and GP fundholders). The primary accountability of trusts for the quantity, quality and efficiency of the service they provide will be to their purchasers. The contracting mechanism will provide the means for these to be specified and monitored. In the main therefore the line of accountability for service delivery issues will be initially to the purchaser(s) and from there to the ME if there are strategic implications or the matter is the subject of a Parliamentary Question or Minister's query.

iii. to the ME for the performance of their functions, including the delivery of objectives and targets set out in the Strategic Direction and annual Business Plans. They will also be required to meet their statutory financial obligations and conform with any other specific requirements placed upon them, including those in the Management Plan.

5. The current proposal to amend the 1991 Order will enable Boards to delegate statutory functions to trusts. The new legislation will require each trust involved to develop a scheme specifying how it will discharge these functions in line with Departmental/Board guidance and current good practice. These schemes must be agreed with the appropriate Board and approved by the Management Executive. This mechanism will create a further relationship between certain trusts and Boards in addition, but complementary, to the contractual relationship. Boards will retain a strategic residual responsibility for the functions involved and will be expected to ensure both that the schemes reflect sound and effective working procedures and that they are adhered to by trusts. In turn the Department will retain ultimate legal responsibility for the functions and will wish to ensure that both Boards and trusts are discharging their responsibilities.

Obligations of Trusts

6. Under the 1991 Order, trusts are expected to meet a range of key financial responsibilities:-

   i. break even on an income and expenditure basis taking one year with the next;

   ii. achieve a target return on assets currently 6%;

   iii. stay within the annual External Financing Limit (EFL) set;

   iv. pursue and demonstrate value for money in the services they provide and in the use of the public assets and resources they control.

7. Trusts are also expected to meet all legal obligations, discharge their statutory financial duties and comply with a range of advice, guidance and standards where it is clear that these apply. The ME will establish arrangements to specify where guidance applies to trusts consistent with the principle of maximising operational freedom.

8. All HSS trusts will be expected to contribute to the achievement of corporate objectives of the HPSS and, as appropriate, Government at large. As such they will be required to be committed to:

   - the achievement of the Regional Strategy and Boards' Area Strategies;
   - delivery of the annual HPSS Management Plan;
   - implementation of the Charter for Patients and Clients ;
   - work within the framework of relevant central guidance and policies, particularly on:-

     i. education and training;
     ii. capital investment;
     iii. estate issues and environmental issues;
     iv. information and IT;
     v. procurement;
     vi. 'Competing for Quality'.

Strategic Direction and Business Plans

9. It is proposed that there should be 2 essential requirements in the strategic planning process for HSS trusts:-

   i. to produce, submit to the ME and make available publicly, each year, an updated 5-year Strategic Direction, the first year of which represents the detailed Business Plan. The business planning cycle for trusts needs to align broadly with that for Boards. It will therefore be important that the final version of the trust's business plan is submitted at the same time as the Boards' Purchasing Plans are submitted to the ME. It will be necessary for trusts to submit a draft version to the ME in advance once Boards' purchasing prospectuses are available and a reasonable assessment of the contracts likely to be secured is possible.

   ii. to provide the justification for planned capital investment to allow agreement of the annual EFL for each trust. Outline proposals should be linked to the purchaser's longer term plans and contained in the rolling 5-Year Strategic Direction, but full business cases can be made at any time. Interim business case guidance which is currently available will be superseded following the revision of existing Capricode procedures later this year.

10. The main vehicle for the delivery of purchaser requirements will be contracting. The ME will use the business planning process to secure accountability to the Chief Executive, and hence to Ministers, for the use of public funds and assets. Day to day responsibility for this will lie with the Provider Development Directorate, in conjunction with Financial Management Directorate.

11. Business planning is an important management activity which will enable trusts to ensure their long term financial viability and for planning the direction which the trust is taking in a way that is consistent with the key strategic health and social care objectives of the purchasers, as well as providing the basis for the ME to safeguard Ministers' ultimate responsibility over the use of public funds. These Plans will also be the basis on which trusts' overall performance will be assessed by the ME.

12. The Annex sets out details of the purpose of the Strategic Direction and Business Plan together with requirements on capital investment. It is the intention that all HSS trusts would prepare plans in line with the revised requirements set out in this circular. Normally final versions of these submissions should be available following the completion of the contracting round.

13. The Strategic Direction and Business Plan should set out the key management tasks for the trust and identify how longer term strategic objectives will be pursued. The Business Planning guidance already issued to trusts sets out what the ME would expect to see covered by trusts in order to achieve their desired outcomes in terms of meeting purchaser intention, health and social gain activity and service investment, and the resources which the trusts will need to achieve these. The underlying intention is that the accountability needs and the monitoring arrangements should not be onerous, should be based on a broad, but limited, range of indicators and that trusts should be given the maximum possible freedom to manage their own affairs without detailed intervention.

Monitoring

14. In monitoring the performance of trusts the Management Executive will focus on:-

- performance against targets and objectives in the Business Plan;
- performance in relation to statutory financial obligations based on detailed financial returns;
- the contribution, via contracting, to achievement of service priorities;
- application of funds directly allocated eg for STAR post-graduate medical and dental education and from 1994/95, for the training of junior doctors/dentists;
- adherence to statutory obligations.

15. In addition to the Strategic Direction, Business Plans and Corporate Monitoring returns, trusts will be expected to participate in and contribute to HPSS information systems such as Korner returns. While the normal accountability lines for service delivery issues will be via purchasers, trusts will still be expected to provide

any information required by the ME in support of Ministers or for Parliamentary purposes.

Openness

16. The Management Executive fully supports the flow of information between purchasers and providers. However, openness is not an accountability tool in itself although it will need to exist at several levels:-

- at the public level, trusts are required to publish their Strategic Direction and summaries of their Business Plan, hold public meetings and present audited accounts and an Annual Report (which should include a report on the extent to which targets in the Strategic Direction and Business Plans have been achieved);

- with purchasers, there should be an equivalence of interests and responsibility in sharing information. Purchasers will be concerned to reassure themselves that contract price and capital bids are reasonable and justified.

17. Confidentiality should be the exception to the rule that information on both sides of the contractual divide should be made available on a mutually beneficial basis. The ME will therefore expect that:-

- providers will comply with relevant ME guidance on contract prices (full costs, no subsidisation etc);

- all contracts and tariffs will be published;

- purchasers will discuss purchasing objectives, resources etc openly with their providers who in turn will discuss proposed developments with purchasers;

- no information relating to other providers/purchasers will be exchangeable other than with their agreement.

Ground Rules for Intervention

18. Intervention by the ME in the affairs of a trust should be exceptional, in line with the principles of maximum delegation. It may be judged necessary in certain circumstances eg:-

- items of concern relating to patient or client care;

- failure to discharge statutory functions;
- breach of statutory obligations and EC Directives;
- unacceptable financial performance;
- action in breach of the Establishment Order;
- significant variation from agreed objectives and performance targets.

Any such interventions will not preclude relevant actions by the appropriate Board whether acting in its role of purchaser or fulfilling its statutory residual responsibility in respect of the statutory functions delegated to the trust.

Queries

19. Any queries on the terms of this letter should be directed to the Provider Development Directorate, which is the principal point of contact in the Management Executive for Trusts.

Yours faithfully

JOHN G HUNTER

Health and Personal Social Services Northern Ireland
Dundonald House, Upper Newtownards Road, Belfast BT4 3SF. Tel: [redacted]

ANNEX

The Strategic Direction

1. The identification and agreement of strategic objectives, and of a plan for their achievement are essential business planning practice. The Strategic Direction should help trusts to review their operation and consider their longer term response to purchaser requirements and desired changes in the health care delivery systems.

2. Each trust should be required to make available to the ME, and subsequently the general public, a Strategic Direction. This should outline its strategic objectives and indicate the key tasks and investments on which the achievement of the objectives will depend. Outline business cases for key investments should be made available also.

3. The document should be predominantly narrative and should be concise, but it should provide sufficient information to allow the ME to understand the proposed pattern of the trust's services in the future. This is because this information, together with that provided by Boards in relation to purchasing intentions and DMU's plans, will be crucial to the ME overall co-ordination and management of the HPSS.

4. The document should cover the following 5 years. Trusts may wish to look further forward if there are proposed changes in the longer term which are essential to understanding its strategy. The document should be rolled forward annually, with its detailed Business Plan forming the analysis for the first year in each case.

5. The draft Strategic Direction should be submitted in the Autumn of the year before the strategy's commencement. The ME will then discuss and agree with the trusts when their document can be finalised and made available publicly. This agreement will indicate that the ME regards the strategy as a realistic and sensible one for the future development of the Trust. It will not imply that the ME supports the detail of the strategic planning exercise nor will it replace the formal approval required for capital investment.

The Business Plan

6. The detailed, yet integrated, Business Plan should set out the key management tasks for the Trust and identify

how the longer term strategic objectives outlined in the Strategic Direction will be pursued by the Trust in the coming year. It should identify clearly the Trust's desired outcomes and the resources which the Trust will need to achieve these.

7. The plan should draw together the implications for the coming year of the Strategic Plan, the External Financing Limit (EFL), and the contracts established with purchasers. The plan should also contain summary financial and activity information for the subsequent 2 years, in order to ensure consistency with the financial pro-formas.

8. Both the Strategic Direction and Business Plan should be concise. Apart from the information required for the year ahead, they should contain any revisions to outline business cases for proposed investments, and any changes in the Trust's longer term strategy. In support of their Business Plans, trusts should submit a full set of financial pro-formas containing:

   i. actual figures for the previous year;

   ii. forecast figures for the current year ie that in which the plan is being prepared;

   iii. budget figures for the year of the plan; and

   iv. planning figures for the following 2 years.

9. Taken together, the Business Plan and the pro-formas should:

   i. demonstrate that the Trust has planned to meet its financial obligations of breaking even, earning a target return on assets and remaining within its EFL;

   ii. demonstrate that the Trust's plans are based on realistic planning assumptions about, for example, purchasers' intentions, inflation and efficiency gains; and

   iii. provide a detailed forecast of the Trust's activities.

10. Trusts should provide the ME with a draft business plan by the Autumn of the year prior to the plan's commencement. This will be used to determine indicative EFLs against the background of the availability of resources and assumptions on the level of commissioners'

funding. The ME will discuss and agree with the trusts when their plans can be finalised and a summary be made available publicly. In any event they will need to be finalised, together with the pro-formas before the start of the year in question.

Capital Investment

11. Trusts need to provide a rationale for any proposed investment or disposal of capital assets for 2 reasons:

    i. to demonstrate that there are good service and/or financial reasons for the proposal; and

    ii. to demonstrate that the proposal represents a good use of public money.

12. As a matter of good management practice, trusts need to examine the business case for all investments, whether capital or revenue based, and including acquisitions and disposals.

From: A GAULT

Date: 20 April 1999

To: Mr Baker
Miss Dixon
Mr Frew
Mr Grzymek
Mr McGrath
Mr Scott
Mr Williams
Dr Smith

1999 ACCOUNTABILITY REVIEW MEETINGS

SUMMARY

Issue:	The provision of items for inclusion on the agenda for the official level Accountability Review meetings to be held in early June 1999
Timescale:	Responses are sought via e-mail by Friday, 7 May
Action:	Directors are asked to identify no more than 2-3 top priority items, for each Board, from within their own business area, that they wish to raise at the Review meetings.

1. I am writing to seek your input to inform the agenda for the Accountability Review meetings with HSS Boards, which will take place in early June 1999.
2. The format of the meetings will remain substantially unchanged from previous years. The meetings will have three main sections – (i) matters arising from the 1998 round and the extent to which Boards have succeeded in meeting heir agreed targets in last year's Action Plans;(ii) Finance and (iii) Actions Plans for 1999/00. This request refers only to section one.

3. Directors are asked to:

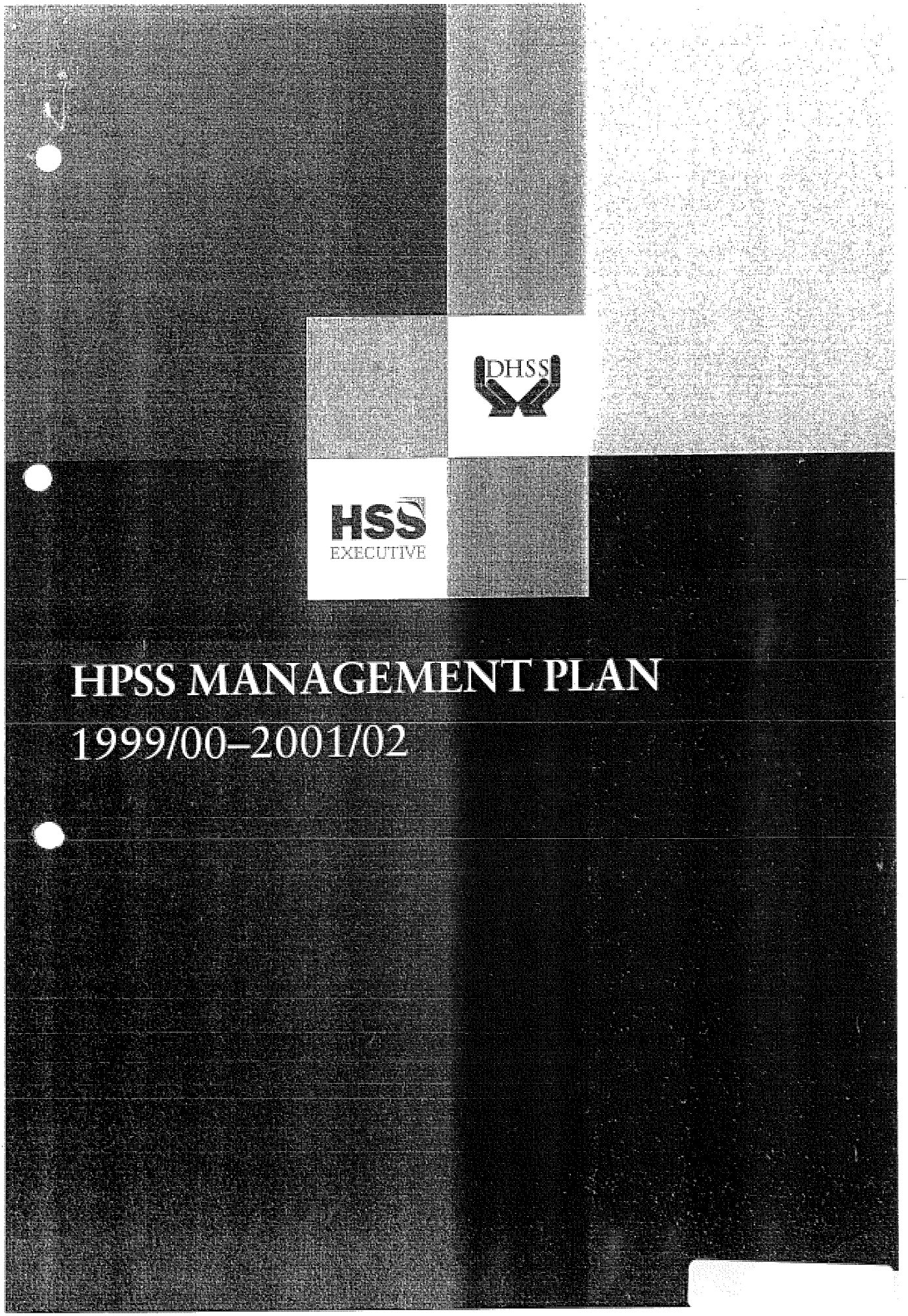
   - examine Boards' 1998/99 agreed Action Plans and minutes of the 1998 Accountability Review meetings (copies attached); and,
   - identify **no more** than 2 or 3 top priority items from within their business area for each Board, the achievement of which they wish to check at the Review meetings.

4. Mr Simpson will select **no more** than 8 key items from the priority items identified by individual Executive Directors. Boards have been advised that they will be advised of the topics on the agenda at least three weeks prior to the meetings.

5. Accordingly, I would be grateful if you would let me have details of the item(s) you wish to raise, together with a short explanatory note why you consider the particular item(s) need to be raised at the review meeting, by close of play on **Friday 7 May.**

A GAULT

cc: Mr Gowdy
Mr Simpson
Mr Hill
HSSEMembers


DHSS
HSS
EXECUTIVE
HPSS MANAGEMENT PLAN
1999/00–2001/02

CONTENTS

HPSS MANAGEMENT PLAN 1999/00 - 2001/02

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HSS EXECUTIVE

HSS Executive Mission Statement

The primary purpose of the HSS Executive is to secure improvements in the health and social wellbeing 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 wellbeing 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.

HSS EXECUTIVE

1. Introduction

1.1 Background

1.1.1 The annual Management Plan provides the setting for the planning and delivery of health and social care by the HPSS for the next three years. This Plan identifies the priorities to be addressed during the period 1999 to 2002, with an emphasis on the objectives and targets to be met in 1999/00.

1.1.2 The Plan takes into account the goals and key messages in *Well into 2000* published in December 1997. The objectives and targets contained in *Health and Wellbeing: Into the Next Millennium,* the Regional Strategy for 1997-2002, should be taken forward in conjunction with the policies outlined in *Well into 2000*.

1.1.3 The health and social needs of local populations vary in different parts of Northern Ireland. Action Plans drawn up by Health and Social Services Boards in consultation with other agencies should reflect these local needs and priorities. Specific quantified objectives and targets will be agreed in individual Action Plans between each Board and the HSS Executive, and in service agreements between commissioners and providers.

1.1.4 In developing local strategies and plans, Boards are expected to work in partnership with primary care professionals, and in particular their GPs. In turn, primary care professionals will be expected to engage with Boards in the full commissioning process and to take ownership of, and act upon, local strategies. Agreed strategies should be put into effect by commissioners and supported by primary care professionals in their day to day practice.

1.1.5 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 1999/00. The HSS Executive will also need to see evidence of the action planned by Boards to achieve the targets in *Well into 2000* and the Regional Strategy in their Action Plans. The Plans will be subject to endorsement by the Minister in the course of the annual Accountability Reviews.

1.1.6 The Department's paper *Accountability and Monitoring* of July 1998 sets out the arrangements for monitoring the implementation of *Well into 2000* and the Regional Strategy by the HPSS and other agencies. It provides a directory of the main parties who are expected to contribute to each objective and target.

1.2 Fit for the Future

1.2.1 The publication of this Management Plan comes at a time when the future of the HPSS is under review. The Government recently published *Fit for the Future*, a consultation paper which set out its vision for reforming and modernising the structure and organisation of the HPSS. The paper identified the Government's view of the key changes needed to achieve that vision.

1.2.2 After consideration of the responses received during the consultation period the Government will issue a policy paper on the way forward.

1.2.3 The purpose of *Fit for the Future* is to pursue the Government's goal of providing and maintaining a structure for the organisation of the health and personal social services which promotes health and social wellbeing, and delivers the best possible services when and where they are needed. It is also intended to publish proposals later this year for a range of measures designed to ensure the quality of social care in Northern Ireland.

2. REVIEW OF PERFORMANCE IN 1997/98

2.1 Background

2.1.1 This section reviews the progress that has been made in achieving the main objectives and targets set for 1997/98 in the Management Plan for 1997/98 - 1999/00.

2.2 Targeting Health and Social Need (THSN)

2.2.1 The publication of *Well into 2000* reaffirmed the priority attached to the THSN initiative. Action taken by Boards during 1997/98 to address the overall objective of THSN covered a range of initiatives.

2.2.2 The Northern Board has developed a Community Development Strategy to steer the development of links with Trusts, the Rural Community Network, and the Community Development and Health Network. Amongst other actions, it will incorporate community development approaches in contracts, and clarify the criteria for the funding of community development initiatives.

2.2.3 The Southern Board undertook an extensive review of expenditure by programmes of care and provider. This identified expenditure and made comparisons with other providers through comparators such as the Regional Capitation Formula. The review of domiciliary care for elderly people examined expenditure patterns, contract investment and usage, and made per capita comparisons of areas such as investment and users. This has lead to an action plan for improving home based services.

2.2.4 The Eastern Board has developed its information database to allow health and social care needs to be correlated with the need for and use of resources by localities and sub-localities. The Board also supports a range of initiatives such as the Health Perceptions Project, a community based examination of the health needs of local communities in both North and East Belfast, and specific local initiatives such as a domestic violence project in the North Down and Ards area.

2.2.5 The Western Board is working with local communities as part of the District Partnerships established under the EU Special Support programme for Peace and Reconciliation. This has been complemented by extensive work on patient and client involvement with the Elderly, Mental Health and Disability programmes of care. The Board is also playing an active part in a number of other inter-agency initiatives in areas such as drug awareness, youth support, and oral health.

Capitation Funding

2.2.6 The Capitation Formula Review Group reported its recommendations in September 1997. Following consultation, the Minister accepted these with one adjustment designed to ensure that all Boards benefited from income received from persons in receipt of personal social services. The revised capitation formula was implemented from 1 April 1998 with baseline protection provided to the Northern and Southern Boards, which are estimated to be above target. Further work is ongoing to identify,

where possible, needs indicators to replace the interim weightings used in the formula for some programmes of care.

2.3 Health Promotion

2.3.1 Considerable advances have been made by all Boards in promoting health and social wellbeing in a range of settings. The uptake target for all primary immunisation at 12 months was met. However, adverse media publicity during the year has affected progress towards the MMR target. The Department is presently working with Boards to develop a strategy to redress the position. The breast screening target remains difficult but efforts have been made to improve uptake rates. All Boards have now established a cervical screening coordinating committee and appointed a coordinator for the cervical screening programme. Boards have also played a key role in taking forward multi-agency initiatives such as the Drug Co-ordination Teams.

2.4 Primary Care Services

GP Fundholding

2.4.1 During 1997/98 interest in the GP Fundholding Scheme continued, with 13 new standard funds and 27 community funds being established on 1 April 1998. From that date the number of GP practices in fundholding rose to 199, making up 172 funds (118 standard and 54 community). A total of 630 GPs are involved and their combined list size comprise 65% of the population.

2.4.2 The Budget Setting Working Group which was set up in October 1996 to develop new arrangements for the setting of GP fundholding budgets reported in 1998, and new capitation-based formulae developed by the Group have been used to set the inpatient, day case and outpatient elements of the GP fundholder budgets for 1998/99.

2.4.3 Six purchasing pilot schemes were established on 1 April 1997 to test the effects of involving GP Fundholders directly in the commissioning and purchasing of services outside the scope of the Fundholding Scheme. The first evaluation report in December 1997 was circulated to all GP practices, Boards and Trusts involved in the pilot schemes.

GP Prescribing

2.4.4 Some progress has been made towards achieving the target set for generic prescribing (40%). The level of prescriptions dispensed generically in Northern Ireland for the period January to December 1997 was 30%, compared to 28% for the same period in 1996. When compared to the position over the same period in England, where 49% of prescriptions were dispensed generically, the level achieved in Northern Ireland was very disappointing and makes the targets for future years particularly challenging.

2.4.5 There was some improvement in performance by GP practices in the use of prescribing formularies and protocols for repeat prescribing. Some 62% of practices have prescribing formularies, although their active use by every GP in the practice would

need to be tested more rigorously than by means of postal surveys of GPs. It is estimated that around 57% of practices have written protocols for repeat prescribing, although again, this needs to be more rigorously monitored. Even this latter estimated percentage falls short of the target for 1997/98 (60%) for practices using a protocol for repeat prescribing.

Nurse Prescribing

2.4.6 Nurse prescribing has been introduced into five test sites to evaluate the efficiency of the administration systems and the effectiveness of the preparation of all primary care staff involved.

Pharmaceutical Care

2.4.7 All Boards have taken steps to develop pharmaceutical care and medicines management. These include:

- pilot projects to identify housebound patients who could benefit from a visit by a community pharmacist;
- the development of prescribing protocols;
- the appointment of practice based pharmacists to assist general practitioners in prescribing;
- the development by the Western Board of a strategy for developing the role of the community pharmacist, alongside a strategy for Prescribing and Patient Care;
- a multi-professional conference *Teamwork in Prescribing and Patient Care;*
- a multi-disciplinary audit of medicines management in the nursing and residential care sector;
- a repeat dispensing pilot involving a collaborative effort between all Boards and the School of Pharmacy (QUB);
- Board-wide reviews on *The Way Forward for Pharmaceutical Services;* and
- a wound management initiative by the Eastern Board.

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

Oral Health

2.4.9 All Boards have been actively involved in working towards achieving the targets and objectives in the Oral Health Strategy. Initiatives undertaken include:

- development of local Oral Health Strategies, and formation of local Oral Health Planning Teams;
- production of a policy document *Nutrition and Dental Health: Guidelines for Professionals;*
- issue of professional guidelines on Nutrition and Dental Health, and workshops to raise awareness of healthy eating among relevant child minders/playgroup organisers;
- provision of workshops within Trusts to raise awareness and promote a multi-disciplinary approach to the provision of dietary advice to the public;

- screening at least every two years of all clients in registered nursing and residential care homes, and all those attending day and occupational centres;
- the offer of a promotional package to general dental practitioners to raise awareness of the risks of smoking among their patients on national *No Smoking Day;* and
- reviewing the strategy for promoting the use of fluoride supplements in the light of the adverse publicity generated during the public consultations on fluoridation of the water supplies.

2.4.10 The Community Dental Service continues to screen all children on at least three occasions during their school career.

2.5 Care in the Community

2.5.1 By 1996/97 the additional recurring allocation to Boards for the community care reforms amounted to £124 million. It was not possible to improve on this allocation during 1997/98 and the effects of this were clearly evident in all areas throughout the year. While it was possible to make a non-recurring allocation of £5 million late in the year to specifically address the delays in delivering care in the community, the underlying problems remain.

2.5.2 At 1 April 1997, there were 13,491 clients receiving care managed services. By April 1998, 13,942 care packages were in place providing support for:

- 6,026 people in their own homes (43%);
- 4,872 nursing home placements (35%); and
- 3,044 places in residential care homes (22%).

2.5.3 Overall, 93% of all assessments now commence within three weeks of referral, and 72% of the care packages delivered are in place within three weeks. However, it is acknowledged that delays are still occurring in some areas. Just over 82% of those referred recently for care management were older people.

2.5.4 The funding problems have contributed to the reduction in the number of people in receipt of home help service over the past year. For example, the number of clients in the elderly programme of care receiving home help stood at 22,382 at the end of March 1998. This represents a 2% reduction from the corresponding quarter last year. Other domiciliary support and day care appear to be largely unaffected.

2.5.5 Boards continue 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 learning disability. In the year to February 1998, the number of long-stay patients in psychiatric hospitals reduced by 57 (8%) to 664. The number of long stay patients in specialist hospitals for people with a learning disability fell by 30 (5%) to 572 during the same period, while the number of children with a learning disability in a specialist hospital fell by 5 (12%) to 37.

2.5.6 Boards have been considering the development of quality standards and outcomes measurement for mental health services. They are also carrying out reviews of their future requirements for specialist hospital services for mentally ill people.

2.5.7 Boards have been considering the numbers and needs of people with a disability and those with traumatic brain injury and are developing commissioning strategies to meet the objectives of the Regional Strategy.

Child Care

2.5.8 As part of the continuing implementation of the Children Order, guidance on the development of Children's Services Plans was issued jointly by the DHSS, DENI and the NIO in July 1998. The development of these Plans reflects the priority given by the three Departments to ensuring the provision of services to children who are assessed to be in need are fully coordinated at the planning and service delivery levels.

2.5.9 In January 1998 the Department issued the consultation document *Children Matter: A Regional Review of Residential Care in Northern Ireland*, with a view to developing a strategy which will ensure a sufficient supply and variety of residential care facilities for children.

2.5.10 Last year's Management Plan asked Boards to develop a child protection information system which monitors abuse and reabuse of children. Boards are collaborating to agree a definition as to what constitutes reabuse in an effort to establish a common baseline across Board areas.

Domestic Violence

2.5.11 Inter-agency networks on domestic violence have been established by all Community Trusts. An information seminar was held in October 1997 for representatives of the networks and the report of the seminar was circulated in February 1998.

Involving Patients and Clients who are Physically Disabled

2.5.12 The Department's Social Services Inspectorate published a report in October 1997, focusing on the extent to which patients and clients who are physically disabled, and their carers, are involved in the planning, delivery and evaluation of community care services. The report identified key findings and made recommendations which Boards and Trusts are now addressing.

2.5.13 All Boards and Trusts have signed service agreements with the Northern Ireland Housing Executive setting out roles, responsibilities and response times of those involved in the housing adaptations process.

2.5.14 The HSS Executive undertook a review of wheelchair services. Recommendations in the report of the review, designed to promote good practice and a more efficient and responsive wheelchair service, are being implemented.

HS EXECUTIVE

2.6 Acute Hospital Services

Number of Acute Hospital Sites

2.6.1 Reviews of acute hospital services are being undertaken in the Northern, Southern and Western Boards. The Southern Board has made its recommendations to the Minister and consideration is being given to the way ahead. As with the Southern Board, it is expected that these reviews will recommend a reduction in the number of acute hospital sites in order to secure optimum levels of clinical effectiveness, quality of care and value for money.

Acute Hospitals Reorganisation Project

2.6.2 In light of the recommendations of the McKenna and later the Donaldson Reports, the shape of services available from the Royal Group of Hospitals Trust and the Belfast City Hospital Trust is changing. It is expected that every effort will be made to facilitate these changes and agree a pragmatic approach which will ensure that regional services are organised in such a way as to secure the optimum quality of service to the patient.

Locally Accessible Services

2.6.3 Against the background of the priorities identified in the Regional Strategy the pattern of service delivery is likely to change. For example, a community hospital has already been established in Newtownards where a minor injury unit is led by specially trained nurse practitioners, with medical advice accessible when required. An out-patient clinic, day surgery, radiography, physiotherapy and chiropody facilities are available. A similar model is being developed for Bangor. In Banbridge, the former nurses' home at Banbridge Hospital has been refurbished and has become the focus for locally-centred health services in the area. It is expected that individual Boards' reviews will lead to further 'community-type' hospitals.

Emergency Admissions

2.6.4 Boards have undertaken specific winter emergency arrangements involving increased provision of community care both pre and post admission with the objective of reducing the numbers of additional emergency admissions.

Inpatient Waiting Lists

2.6.5 In the last financial year an additional £5.3 million was made available to Boards to deal directly with waiting lists. An extra 10,000 procedures were purchased across the Boards. Because the additional money was made available late in the year the full effects of the additional funding have yet to be realised. Figures for the end of March 1998 demonstrate a reduction in the numbers waiting for inpatient treatment of almost 3000 since 31 December 1997.

Cancer Services Report *Investing in the Future*

2.6.6 Boards have completed their reviews of cancer services and have produced proposals to develop and reorganise cancer services in line with the recommendations of the report.

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Renal Services Review Group

2.6.7 A Group, under the auspices of the four Boards, is taking forward the plans to expand renal services in line with the recommendations of the Renal Services Review Group: that patients should receive dialysis three times per week instead of the present two. The average take-on rate of new patients has, however, risen considerably higher than the level expected at the time of the review and the Group is considering the implications of this trend for planned developments.

Guidance on the new Maternity Services Policy Circular

2.6.8 The Department has set up a Regional Steering Group to promote the development of midwifery-led maternity units. Funds were made available in 1996/97 and 1997/98 to support projects in this area, and a conference was held in June 1997 to promote wider understanding of the benefits of a midwifery-led service.

Hospital Pharmaceutical Services.

2.6.9 Boards are reviewing Hospital Pharmaceutical Services jointly with local Trusts. The Directors of Pharmaceutical Services are also considering an additional composite report which reflects the situation across Northern Ireland. The initial work concentrated on the nature, extent and impact of clinical pharmacy services in the hospital sector, to be followed by the implications of clinical pharmacy services for primary care.

2.7 Clinical Effectiveness, Multi-Professional Audit, CREST

2.7.1 Work has continued to consolidate the progress made in clinical effectiveness, evidence based practice and multi-professional audit. Clinical effectiveness and audit projects and initiatives from throughout the HPSS continue to be funded. Details of these are included in the Regional Audit Database which is available in each Board and Trust.

2.7.2 CREST has produced draft reports on wound management and intensive care services, and has commenced work on guidelines on the Use of Blood and Blood Products.

2.7.3 Further work on clinical effectiveness, multi-professional audit and CREST will be reviewed in the light of the proposed development of a new quality framework for the HPSS.

2.8 Commissioning Development

2.8.1 The HSS Executive, informed by work undertaken by the Commissioning Development Steering Group, produced a *Commissioning Framework for Northern Ireland* which was issued to Boards, Trusts, Agencies, professional organisations and GPs. Its purpose is to help create a common awareness, shared vocabulary and way of monitoring progress on the development of commissioning across the HPSS.

2.9 Market Regulation

2.9.1 The report of the Review of the Contracting Process within the HPSS internal market was published in September 1997. The principal recommendations in the Report covered:

- the development of mature partnerships in the commissioning process;
- the need to clarify the roles and responsibilities of, and between, the various health and social services organisations;
- the establishment of longer term contracts;
- the development of information systems; and
- improvements in monitoring of quality and performance.

2.9.2 During 1997/98 a number of minor contractual issues, relating to the 1996/97 accounting period, were raised with the HSS Executive. Formal arbitration on contract disputes between the Eastern Board and four of its major providers also took place. In coming to its decisions the HSS Executive recognised that attempts to drive down costs through annual contracting had not been successful and that a more strategic approach to cost containment needed to be adopted.

2.9.3 The HSS Executive issued guidance in January 1998 on the development of longer term service agreements from 1998/99. This called for a more strategic, open and partnership approach to be adopted to securing those agreements, taking account of the priorities and objectives set by the Government to secure improvement in health and social care. It also signaled the replacement in 1998/99 of existing Board purchasing documents by Service and Financial Framework Documents. These are expected to incorporate the commissioning intentions for health and social care services for all residents of a Board, regardless of who has responsibility for the purchase of those services.

2.9.4 In line with the Government's commitment to abolish the internal market and to replace it with arrangements which focus on partnership and cooperation, rather than competition, a consultation paper on the future of the HPSS, *Fit for the Future*, was published in April 1998.

2.10 Provider Issues

Corporate Governance

2.10.1 During 1997/98 the HSS Executive co-sponsored three major events linked to the development of good governance within the HPSS. These included conferences on corporate governance and the role of the Audit Committee and a workshop on the role of the Remuneration Committee. The Executive also sponsored a forum for non-executive directors to consider what other aspects of corporate governance should be targeted for training and development.

Management Costs

2.10.2 In July 1997, the Minister announced his intention to make early progress in reducing the costs of managing the HPSS so that savings could be re-invested in patient and client care. A further 1% reduction was levied on Board administration and Trust management costs. This was in addition to the 1.5% cash releasing targets which had already been set. HPSS bodies have forwarded plans for achieving the required savings. These will be monitored to ensure that planned savings have actually been achieved.

Human Resources

2.10.3 Each HPSS employer is developing a Human Resources strategy which will be fully integrated into their respective business plans. Progress continues on a number of elements which make up their strategies e.g. selection and appointment.

Equal Opportunities

2.10.4 A high profile was given to equal opportunities and fair employment, with employers focusing their attention on putting procedures in place to ensure equality in the workplace. Particular attention was given to the requirements of people with disabilities. Staff were trained on Policy Appraisal and Fair Treatment (PAFT), resulting in a better awareness and understanding of its requirements.

Employment Procedures

2.10.5 Steady progress was made in relation to the development of procedures on a number of employment issues such as grievances, disciplinary action, and harassment. A number of employers examined policies on sickness/absence with a view to setting targets for reducing absenteeism.

Opportunity 2000

2.10.6 An Opportunity 2000 Regional Forum was established to stimulate good practice in gender participation in the workplace, stressing its importance as one element in effectively managing diversity within the workforce. A regional coordinator was appointed in September 1997 for two years to provide practical support and advice to the HPSS, and to assist the Forum in developing regional activities.

Higher Specialist Training

2.10.7 The specialist registrar grade was formally launched on 1 April 1996. It has been commissioned successfully in all medical specialties from 1 April 1997, and the new curricula for the various specialties have been introduced. Commissioning of the new grade in dentistry began on 1 October 1997 and is ongoing.

2.10.8 A key element in implementing the reform of specialist training has been the introduction of the 'training agreement' concept which set out the roles and responsibilities of all parties involved in training (the trainee, his/her employer and the postgraduate dean).

The New Deal on Junior Doctors' Hours

2.10.9 Since the New Deal was introduced six years ago substantial progress has been made

towards meeting the agreed targets for reducing the hours and intensity of work of junior doctors and dentists. The main aim is to ensure that no junior should be contracted for more than 72 hours, nor work more than 56 hours per week. When the initiative was launched over 60% of the 1,100 junior doctors were working in excess of 83 hours per week, with some working in excess of 100 hours per week. A recent survey indicates that some 80% of posts now comply with the targets. This compares favourably with the rest of the United Kingdom.

PSS Training

2.10.10 Further progress was made in 1997 towards the targets set for improvements in the competence at all levels (vocational qualifying and post-qualifying) of the PSS workforce. It remains a concern that the number of awards gained is relatively small in comparison with the number of registrations. For example, at vocational level, of 534 registrations since 1996, only 130 have achieved awards.

2.10.11 Boards and Trusts also continued work on developing systems for auditing the PSS workforce. Progress has been slow due, in part, to the diversity of the workforce.

Nurse Training

2.10.12 Following the integration of the Colleges of Nursing and Midwifery into the higher education sector, three in-service providers were established in September 1997 to deliver short courses and seminars for post registered nurses in keeping with identified training needs in support of Trusts' Business Plans and in response to professional developments. Funding is provided by the HSS Executive and monitoring arrangements are being developed in relation to the nature and quality of training being delivered. It is intended to introduce Service Level Agreements for this training.

2.11 Research and Development

2.11.1 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.

2.11.2 Boards, Trusts and Special Agencies have identified their current support for research and development. In April 1998, the Research and Development Office was established to commission and manage R&D activity on behalf of the HPSS. After an initial year of steady state arrangements for Trusts, when a budget for the R&D Office will be agreed, commissioning will be on a competitive basis.

3. Key Objectives and Priorities for 1999 - 2002

3.1 Key Objectives

3.1.1 The key strategic objectives for the Management Plan flow from *Well into 2000* and the Regional Strategy. They focus on:

- tackling inequalities through the targeting health and social need initiative;
- promoting health and social wellbeing;
- developing primary and community care;
- improving acute hospital services; and
- securing the maximum health and social gain for the population from the resources available.

3.2 Targeting Health and Social Need (THSN)

3.2.1 The Government's White Paper *Partnership for Equality*, which was published in March 1998, endorsed the rationale and objectives of the Targeting Social Need (TSN) initiative. The White Paper made it clear that TSN should be applied with renewed vigour and effectiveness. The HPSS equivalent of TSN is Targeting Health and Social Need (THSN).

3.2.2 The Government is committed to tackling inequalities in health and social wellbeing and in access to health and social care, and will seek to involve the many arms of Government in addressing the circumstances which give rise to inequalities, including poverty, poor living and working conditions, and long term unemployment.

3.2.3 During 1998/99 the Department intends to develop and consult on a regional Action Plan to support and coordinate implementation of the THSN initiative. This will include, among other things, measures to target resources and services where health and social needs are greatest; advice on how community development approaches might best be used; and arrangements for monitoring and evaluating progress.

3.2.4 The HPSS has a major role to play in identifying and tackling inequalities. Boards, working with partner organisations, will be expected to demonstrate continued action to achieve the goals and objectives set out in *Well into 2000* and the Regional Strategy.

3.3 Promoting Health and Social Wellbeing

3.3.1 The Department's aims for promoting health and social wellbeing are to:

- reduce preventable causes of disease and disability;
- encourage and support people to take responsibility for their own lives;
- develop public policies which protect health and promote social wellbeing;
- develop partnerships to promote health and social wellbeing; and
- help people to obtain relevant information and skills.

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3.3.2 Boards will be expected to make a substantial contribution to achieving each of these aims over the period of this plan. More specific priorities are set out in section 4.

3.4 Primary and Community Care Services

Primary Care

3.4.1 One of the Government's key aims is for all patients and clients to have ready access to effective care and treatment based on need, with services being delivered as close as possible to people's own homes. Increasingly, patients, clients and their advocates, and local communities should become involved in the decision-making process to enhance service responsiveness to local circumstances.

3.4.2 The Government also wants to ensure that the skills and local knowledge of those working in primary care are deployed to their maximum potential in the commissioning of services, particularly in the processes of needs assessment, specification of services and monitoring of care delivery. The consultative paper *Fit for the Future* acknowledges the need for all primary care professionals to have the opportunity to be involved in local commissioning.

3.4.3 The consultative paper also indicates that the GP Fundholding Scheme in Northern Ireland will end on 1 April 2000 and will be replaced by new primary care-centred commissioning arrangements. It confirms that there will be no new admissions to the Fundholding Scheme after those practices which were admitted on 1 April 1998.

3.4.4 During the period covered by this Plan, significant preparatory work will need to be undertaken to ensure a smooth transition from fundholding to the new arrangements for the commissioning of health and social services. The new arrangements will build on existing commissioning experience at primary care level.

3.4.5 Primary care must also develop as a provider of services, and this development should be founded on a multi-professional approach involving all team members in a collaborative way. This should lead to quality improvement, the equitable and efficient use of resources and the reduction of waste and unnecessary bureaucracy. A Primary Care Development Fund has been established to facilitate the trial of new and innovative practical ways of delivering primary care services. A Primary Care Development Policy Paper is due to be issued to the HPSS later in 1998 identifying the qualities which good primary care should have and outlining the principles on which its development should be based.

Care in the Community

3.4.6 The Government is committed to enabling people to live as normal a life as possible for as long as possible, and to provide the right amount of care and support to allow people to gain maximum independence. It believes that success will depend on continuous improvements in promoting a needs-led service supported by better needs assessment and care management; using resources effectively in the delivery of innovative and flexible day, domiciliary and respite care; and involving users and carers in the planning and commissioning of care services.

3.4.7 This requires a coordinated approach by statutory and independent sector providers to bring new skills to bear on the planning, commissioning, standard setting, care management and monitoring of community care. In particular, it is essential that closer working relationships are established with a range of other agencies, including the Northern Ireland Housing Executive and voluntary organisations.

3.4.8 The number of older people is increasing all the time, and this trend will continue beyond the period of this Plan. For some of these people living longer brings infirmity and places further demands on the health and personal social services. Understandably, older people are also anxious about the personal costs of long term care. The Royal Commission on Long Term Care for the Elderly has been tasked to examine the options for a sustainable system of funding for long term care, both in people's own homes and in other settings.

3.4.9 The Department's 1997 Inspection Report *From Hospital to Home* should also help improve the effectiveness and efficiency of the discharge arrangements of older people from hospital. The report makes a number of recommendations about the organisation of assessment and care management which will necessitate the HSS Executive issuing guidance to the HPSS on effective hospital discharge arrangements.

Child Care

3.4.10 Each Board will take forward the implementation of the first Children's Services Plan for its own area through a multi-agency Area Children and Young People's Committee. Implementation will be carried out in liaison with other statutory and voluntary agencies. The first Children's Services Plans will cover the years 1999-2002 and will be reviewed annually.

3.4.11 Whilst a large part of developing Children's Services Plans will involve the provision of services to help families of children in need to bring up their children at home, it is essential that there is appropriate provision of residential care for children which is integrated with the full range of services provided for children.

3.4.12 The Department is developing a Northern Ireland Childcare Strategy, which will set out broad objectives and principles for the development of pre-school and out of school care for children aged 0-14, in line with the Government's commitment to ensure good quality, affordable and accessible child care in every neighbourhood.

3.5 Acute Hospital Services

3.5.1 Developments in surgical and medical techniques and practices in recent years have raised important questions about the pattern of delivery of acute hospital services in Northern Ireland.

3.5.2 Increasingly, treatment can be provided in the GP's surgery or other local settings, whether it is minor surgery, specialist consultant outpatient clinics, or chronic disease management. The effective management of these changes draws on enhanced cooperation between primary and community care based hospital teams.

Furthermore, the growth of telemedicine should facilitate more advanced diagnoses and treatments taking place in local settings.

3.5.3 At the same time hospital consultants are becoming more specialised. In the past general surgeons would carry out a wide range of procedures. However, today's consultant surgeon is likely to specialise in a particular field of expertise. The resulting trend is for consultants to work in larger clinical teams which can make optimum use of expensive specialist equipment.

3.5.4 Against this background Government has concluded that in order to secure optimum levels of clinical effectiveness, quality of care and value for money, specialised services should be concentrated on fewer sites, with locally accessible services being provided for more routine procedures.

3.5.5 To this end it is essential that all reviews of acute hospital services are completed as quickly as possible with due cognisance taken of the wider regional picture.

3.5.6 Hospitals need to be in a position to cope with emergency admissions. Plans should be in place to meet sudden rises in demand which will ensure that patients requiring emergency treatment receive care and attention without, as far as possible, disrupting the flow of planned admissions.

3.5.7 As a corollary, Trusts should have in place effective discharge arrangements which will reduce the number of patients who have been assessed for care management but who have not been discharged due to the lack of community funding to meet their care package.

3.6 Effectiveness and Outcome Measurement

3.6.1 *Fit for the Future* emphasises that in renewing the HPSS the Government will build on those things which work well and discard those which do not. The services are to be built around seven key principles - equity; the promotion of health and wellbeing; quality; a local focus; partnership; efficiency; and openness and accountability. The paper also places a strong emphasis on the development of new performance measures, focused on quality and outcomes. The effective measurement of performance must underpin policy making, strategic planning, the commissioning and delivery of services and the monitoring of outcomes. To adequately capture and reflect all the key aspects of effective performance, a new approach to defining and measuring quality is necessary.

3.6.2 To carry forward the new quality agenda, the HSS Executive will develop, in consultation with the service and patient/client interests, a new framework for measuring the quality and assessing the performance of health and personal social services. The framework will take account of the developments in England, Scotland and Wales on foot of their respective White Papers on the Government's commitments to improve the health service, and its commitments to ensure quality in social care.

3.7 Value for Money

3.7.1 Sound financial management continues to be a key factor in the achievement of the primary objective of providing health and social care at an appropriate level and quality within the resources available. Since 1983 HPSS bodies have responded well to the requirement to produce cost improvement plans and efficiency gains, and this has contributed to significant improvements in the overall efficiency of the HPSS. There remains a need to pursue further productivity, and improved cost effectiveness, in both the delivery of care and the provision of support services.

3.7.2 In the light of all of the gains achieved over the past decade, a major priority of Boards and Trusts will be the identification of new areas for improvement, together with a review of progress within traditional areas. Such activity requires the procurement of relevant information - usually from benchmarking exercises - to underpin any analysis of current efficiency and the scope for further action.

3.7.3 The Government wishes to see improved standards of performance stimulated by performance comparisons and the sharing of good practice, rather than by financial competition between different parts of the service.

3.7.4 The Government is promoting the development of 'best value regimes' in a number of public sectors and this may be extended to the health and personal social services in Northern Ireland. The process would address the efficient provision of support services, with the focus on a strategic approach to identifying the scope for improvement. It may involve the use of benchmarking and other tools, and utilize a range of solutions including market testing.

3.7.5 It remains to be seen what efficiency initiatives will develop over the forthcoming period, but the consistent theme - irrespective of the methods employed - will be the pursuit of efficiency gains through a methodical analysis of current performance, assessed against the best available measures.

4. SERVICE PRIORITIES 1999 - 2002

4.1 Background

4.1.1 This section sets out the key service priorities for 1999/00 to 2001/02. These priorities are not comprehensive and should be supplemented to reflect local needs and priorities.

4.2 The Year 2000 Date Change Problem

4.2.1 The Year 2000 date change problem poses a potential threat to all parts of the HPSS, totally without precedent in almost every respect. It is not just an IT problem, but also a business/operational problem which has the potential to cause serious disruption to the delivery of services and which must be resolved with the utmost urgency. During 1999 and into 2000, this issue is the highest non-clinical priority for the HPSS.

4.2.2 The Year 2000 issue must be addressed at the highest level within organisations and must take the highest possible priority. Even if **ALL** internal IT systems and embedded devices within an HPSS organisation are addressed satisfactorily, external suppliers (utilities or pharmaceutical suppliers) constitute a possible risk. In addition the 'social' effects of celebrating the Millennium should not be underestimated - for example, there are significant risks of traffic disruption and the possibility of casualties arising from organised or spontaneous celebrations. All professionals in the HPSS have a vital role to play in planning for continuity of care in the event of systems failure or the activation of major incident plans.

4.2.3 Accordingly, the major incident plans of all HPSS organisations must be updated to cope with the year 2000, and in particular, the problems posed by external events such as the breakdown of utility services. Boards are also required to coordinate (or ensure the coordination) of area-wide contingency and emergency planning. This planning must be compatible with Departmental disaster planning guidelines and must include all emergency services, public health, the voluntary sector, district councils and private health care providers as well as representatives from the acute and primary care sectors. Contingency plans must include arrangements for staff deployment over the period of the date change.

4.2.4 Chief Executives of all HPSS organisations are personally responsible for ensuring that their organisation will not be adversely affected by the impact of the Year 2000 and are expected to take whatever actions are needed to comply with this responsibility. This applies equally to all areas of their organisation's business, including Information Management and Technology, non-IT such as medical devices and estates equipment, business continuity planning and emergency planning. They are also expected to establish that other (private or voluntary) providers of HPSS care are aware of, and will not be adversely affected by, the Year 2000 problem. Chief Executives will wish to ensure that their duty of care is not compromised by the placing of contracts with non-compliant providers.

4.2.5 Chief Executives of Boards also have responsibility for the effective coordination of action and advice necessary to ensure a proper response to the Year 2000 problem across the whole of primary care.

4.2.6 By 30 September 1999, all HPSS organisations are expected to:

- be fully prepared and have compliant equipment;
- have effective contingency plans in place; and
- have reviewed their major incident plans with specific reference to the Year 2000.

4.3 Targeting Health and Social Need

4.3.1 Boards should continue to promote and implement actions designed to deliver on the objectives and targets set in the Regional Strategy. In particular, Boards should be able to demonstrate that by 1999/00 they have in place:

- a systematic approach to identifying local needs and preferences;
- well targeted arrangements to increase the knowledge of disadvantaged groups about the availability of services, and improve their access to services;
- partnership and community development approaches to target health and social need;
- access to education and training in community development approaches for appropriate staff;
- population needs assessment processes which lead to reductions in inequalities through more effective targeting, allocation and use of resources;
- formal evaluation processes for interventions which aim to reduce the inequalities identified in the Regional Strategy and which cover all of the key areas in the Strategy;
- routine evaluation of programmes and services to ensure that targeted resources are succeeding in reducing inequalities;
- procedures to ensure shifts in resources due to better population needs assessments and evaluation of programmes and services; and
- locally agreed strategies and associated implementation plans for achieving THSN objectives.

4.4 Promoting Health and Social Wellbeing

4.4.1 A number of objectives to promote health and social wellbeing have been set out in the Regional Strategy. These address the major causes of premature death and long-term illness: heart disease and cancer. Boards will be expected to make a substantial contribution to achieving these targets over the period of this plan.

Smoking

4.4.2 Smoking remains the largest preventable cause of ill health and premature death. The Department's aim is to reduce the prevalence of smoking and priority should be given to:

- preventing people starting smoking;
- developing smoke-free environments;
- helping smokers to give up; and
- promoting non-smoking as the norm in society.

4.4.3 The EU Directive on tobacco advertising has been ratified and the Government will publish a White Paper later this year setting out its plans to reduce smoking.

Alcohol

4.4.4 Alcohol misuse accounts for a range of medical, social and psychological problems, including crimes of violence and disorder. It has been estimated that alcohol is either the primary cause of, or an important contributory factor in, some 900 deaths each year.

4.4.5 A detailed review of the Department's strategy for the prevention of alcohol misuse is being taken forward by the Department's Policy Development and Review Group. In so doing, the Group will consult with a wide range of interests including other Government Departments, health and social care professionals, health promotion personnel, and the voluntary sector. It is intended that guidelines for implementing the revised Strategy will be produced in early 1999.

Mental Health

4.4.6 The promotion of positive mental health is a relatively underdeveloped area, and a Regional Group has been established to develop a strategy and action plan for mental health promotion. This work will be completed during 1999. In the meantime, Boards should ensure mental health promotion is included in their programmes to improve the health and social wellbeing of their resident populations.

Health Action Zones

4.4.7 The Government plans to establish up to four Health Action Zones in Northern Ireland under the auspices of the Ministerial Group on Public Health. The purpose of this initiative is to encourage effective inter-sectoral action to address the causes of ill-health in areas of greatest need. Through Health Action Zones, statutory sector bodies will work in partnership with the private, voluntary and community sectors to develop new ways of tackling persistent problems.

4.4.8 Boards and Community Trusts will be leading partners in Health Action Zones and will be the primary sponsors of projects established under the initiative. Criteria for designation as a Health Action Zone will be developed through the Ministerial Group on Public Health.

Healthy Living Centres

4.4.9 Healthy Living Centres is a new Government initiative due to be established under the National Lottery Bill. The New Opportunities Fund has responsibility for distributing monies to four initiatives in the areas of education, health and the environment, including Healthy Living Centres.

4.4.10 Thirteen million pounds from lottery funds have been allocated to Northern Ireland to set up Healthy Living Centres in the Province. The first projects are expected to be in place by the second half of 1999. Subject to a maximum of five years for any one project, the New Opportunities Fund will have discretion about the length of time for which money will be granted to each suitable project and the pattern of grant over time.

4.4.11 Policy directions issued by the Department of Culture, Media and Sport state that Healthy Living Centres should focus on groups who experience worse health than average and that they should be accessible, flexible, sustainable, foster innovative partnerships and involve their target users in defining their role. Healthy Living Centres will be separate from statutory bodies and it is presumed that users will actively participate in running projects.

4.4.12 Healthy Living Centres will provide a related and complementary role to Health Action Zones. Boards will be expected to provide every possible assistance to the New Opportunities Fund in advising on and supporting Healthy Living Centres in their area.

Health Impact Assessments

4.4.13 Health Impact Assessments are concerned with estimating the effects of action by Government Departments on the health of a defined population. They will be a key tool for assessing the overall impact of Departments' policies on public health. The Ministerial Group on Public Health will identify a number of Health Impact Assessments to be carried out in Northern Ireland.

Communicable Disease Control

4.4.14 Following the serious outbreak of E coli 0157 infection in Central Scotland at the end of 1996, the Chief Medical Officer commissioned a review of the arrangements for communicable disease control in Northern Ireland. The report of the review was published in April 1998 and Boards will be expected to implement the recommendations in the report directed to them. These include:

- comprehensive outbreak control plans for the community;
- an inter-agency, multi-disciplinary approach for the development, testing and updating of plans and protocols; and
- a properly organised programme for the induction, supervision and training of Specialist Registrars in Public Health Medicine.

4.5 Development of Commissioning

4.5.1 In view of the importance that the Government places on the involvement of primary care in the commissioning of health and social services, systems should be put in place for the regular audit of current commissioning arrangements to ensure that all primary care professionals are increasingly involved at local level. Commissioners should be able to demonstrate effective strategic planning of the appropriate balance of services which will provide the care needed by patients and clients in the right place and at the right time.

4.5.2 In this context, and in the light of the Government's aim to see responsibility for the commissioning of health and social services move from Boards to a more local level, it is essential in the short to medium term that the commissioning experience of GPs and other primary care professionals is broadened as much as possible.

4.5.3 The HSS Executive issued guidance in March 1998 on the piloting of a limited number of schemes in which GP practices, working on a group basis and pooling their prescribing budgets, could explore different levels of involvement in the commissioning of services and bring a broader range of professionals at practice level into formal commissioning arrangements. The objective of the pilots, which will run for two years from 1 April 1999, will be to encourage GPs and their primary care colleagues to gain some or wider experience of commissioning.

4.5.4 The work of the pilots will be evaluated on an on-going basis by an independent body and, together with the lessons learnt from the continuing evaluation of the purchasing pilot schemes established in 1997, will make a contribution to decisions about longer-term commissioning arrangements.

4.5.5 Once decisions have been taken following consultation on Fit for the Future, the HSS Executive will engage HPSS organisations, GPs and other primary care professionals in the transition to new commissioning arrangements in line with Government policy and organisational decisions.

4.6 Primary and Community Care

General Medical Services

4.6.1 Service development will be based on testing new approaches to the delivery of general medical services. Boards will therefore be expected to ensure that any proposals for assistance from the Primary Care Development Fund must promote the development of primary care services in a way which is consistent with the objectives of *Well into 2000*, the Regional Strategy and Boards' plans at local level.

4.6.2 The HSS Executive issued guidance in December 1997 on piloting different methods for delivering general medical services. Personal Medical Services Pilots present an opportunity to test different contractual arrangements for delivering the existing general medical services and to enhance those services, focusing on local service problems and ways to bring about improvements.

4.6.3 New General Medical Services Regulations have also been made, enabling Boards to introduce schemes, in consultation with their local medical committees, to pay GPs for providing, in a specific locality, services which are additional to their core general medical services contract.

4.6.4 Payments made under such schemes are determined at local level and come from Boards' overall allocations, not from general medical services funds. There can be no duplication of payments made under GPs' contracts for delivering core general medical services. It is, however, possible for Boards to make payments under such Local

Development Schemes towards that proportion of costs of practice staff, improvement grants etc. which are normally met by GPs themselves.

GP Prescribing

4.6.5 Whilst continuing to observe the general principle that patients will be provided with the drugs and medicines they need, the HSS Executive continues to try to constrain the growth of the drugs bill through its Prescribing Action Plan. The Plan targets specific areas where downward pressure can be exerted on prescribing costs, and the HSS Executive will continue to work closely with Boards and primary care professionals in its implementation as well as in the consideration of how the Plan might be expanded.

4.6.6 Without interfering with GPs' clinical judgment and freedom to prescribe, there is a need to change their prescribing behaviour by further encouraging them to increase their level of generic prescribing and actively to use practice formularies and repeat prescribing protocols, particularly those developed specifically for use in their own practice. Boards are expected to continue with programmes of regular and systematic visits to GPs and to provide support and encouragement to GPs to examine critically their prescribing behaviour and modify it, as appropriate.

Nurse Prescribing

4.6.7 Following the evaluation of the test sites Boards, Trusts, and primary care practitioners should work together to implement the recommendations of the Crown Review 1998 on prescribing, supply and administration of medicines, including group protocol arrangements.

Pharmaceutical Care

4.6.8 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, patient education and protection;
- use of medicines in specific patient groups;
- continuity of care between secondary and primary sectors; and
- prescribing support.

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

4.6.10 Boards will be expected to develop and implement local strategies for pharmaceutical services consistent with the needs of their local population.

4.6.11 Boards, in conjunction with the pharmaceutical profession, should continue to pursue opportunities to make full use of the skills of community pharmacists, particularly in the areas of :

- ongoing medication review;
- improving compliance;
- developing care programmes and services for '*at risk*' patient groups, the elderly being a particular priority;
- protocols for patient counseling and self medication;
- health promotion; and
- multi-disciplinary research, audit and drug utilisation review.

4.6.12 Service development will be dependent on testing new approaches to the delivery of pharmaceutical care. Boards will therefore be expected to:

- support initiatives linking community pharmacists with the wider HPSS IT network;
- ensure that any proposals for assistance from the Primary Care Development Fund are consistent with their strategic plans for pharmaceutical services ;
- report on pharmaceutical care and medicines management pilot initiatives, including those supported from the Primary Care Development Fund; and
- work together with the Research and Development Unit, the academic community and the pharmaceutical profession to initiate research that will provide the evidence base for improving and developing pharmaceutical services.

4.6.13 Boards will be expected to continue to:

- approve applications from, and monitor the performance of, pharmacists who qualify for the Pharmacy Professional Allowance; and
- 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

4.6.14 In response to the Oral Health Strategy published in 1995 Boards have developed their own local oral health strategies. Fluoridation is the main plank of the Strategy in terms of a reduction in dental caries. However, in the light of the decision taken in March 1997 not to proceed with the fluoridation of water supplies the targets set for caries reduction have been revised and alternative methods of reducing caries identified.

4.6.15 Boards will be expected to take account of the new targets and alternative measures for reducing caries, in addition to:

- ensuring that securing improvements in oral health is an integral part of health promotion and educational programmes designed to improve diet and nutrition;
- ensuring health promotion programmes highlight the risk factors associated with oral cancer;
- increasing the promotion of alternative methods of imparting fluoride; and
- promoting good oral health and effectively managing the treatment of caries.

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

4.6.17 Boards must ensure that proposals submitted for funding from the Primary Care Development Fund are consistent with their oral health strategies.

4.6.18 The aim of the Personal Dental Pilots, the first of which will come into operation in April 1999, is to test new ways of contracting for and delivering primary care dentistry. Pilot schemes which have been approved will have to be managed and evaluated through local contracts between Boards (commissioners of services) and providers of those services - broadly, dentists and Trusts.

Care in the Community

4.6.19 Seeking to improve the effectiveness and efficiency of the community care arrangements is the theme of current multi-disciplinary reports, including the 1997 inspection report *From Hospital to Home* and the Scottish Accounts Commission's Study Report *The Commissioning Maze*. It is also the message of *Well into 2000* which seeks to reinstate a needs-led focus in tailoring care packages, in developing a mix of public and independent care, and in promoting the meaningful participation of users and carers in the commissioning of community care services.

4.6.20 Consolidation of these arrangements is therefore a key priority in the current climate of financial constraint. During 1997/98 there was evidence of considerable pressure on the funding for community care services. These pressures gave rise, in particular, to delays in discharging patients from hospital and an increase in the numbers of people in the community who were waiting for services. Domiciliary services were affected by the transfer of resources to support the provision of residential and nursing home care mainly for elderly people. It will be necessary to secure and release additional resources throughout the period of this plan to restore and develop the community care programme.

4.6.21 The main service priorities to be addressed are the:

- review and tightening of the mechanisms for assessment and care management in light of recommendations arising from current inspection and audit study reports;
- extension of user and carer participation in the assessment and planning of community care services;
- development of the Direct Payments scheme, including support for local user groups to encourage take-up; and
- establishment of service delivery targets for dementia services. (The Department will

consider with Boards during 1998/99 the outcomes of the 1997/98 audit of needs and services for people with dementia and agree quantifiable service delivery targets.)

4.6.22 Recent monitoring of care management activity for the programme of care relating to elderly people has identified a shift in the balance of care away from domiciliary support to residential care and nursing home placements. At 31 March 1998, 62% of elderly people receiving care managed services were in residential care or nursing homes, which is a 6% increase on the corresponding quarter last year. While this indicator relates only to those people with complex needs for whom care management is necessary, the key service priority continues to be that at least 88% of people aged 75 and over will be supported in their own homes.

People with Mental Health Problems and/or Learning Disability

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

4.6.24 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.

4.6.25 Boards are currently considering expressions of interest in establishing a regional Medium Secure Unit by 2002.

People with a Physical Disability

4.6.26 The priority 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 with 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 injury.

Child Care

4.6.27 Under the Children (NI) Order 1995, Boards should implement their Children's Services Plans for 1999-2002 in collaboration with Education and Library Boards, the Probation Service, voluntary organisations and other key agencies. Each Board should keep the plan under review and update it on an annual basis.

4.6.28 Boards, in acting as chairs of the Area Early Years Committees, will be expected to play an important role in assessing needs, identifying priorities, and planning and arranging the development of early years services in their areas.

Residential Child Care

4.6.29 Following the regional review of residential care for children in Northern Ireland, *Children Matter*, Boards should increase the provision and differentiation of residential care for children, including specialist provision. Boards should ensure that children's homes have stated objectives with regard to the services which they provide and that they comply with stated admission criteria. The report concludes with an action plan to take forward a needs led approach to the planning, provision, structure and development of children's residential services. Boards and Trusts are asked to address those recommendations directed to them in this report.

Fostering

4.6.30 The Department's Social Services Inspectorate undertook the first large scale examinations of fostering services in 1997. The report of June 1998, *Fostering in Northern Ireland - Children and their Carers*, made a number of recommendations. The key issues for Trusts to address include:

- monitoring care planning practices to ensure written care plans are available on children's case files;
- identifying reasons for delay in progressing a decision to secure a child's future and take immediate steps to limit delays which are within their control;
- identifying the range of duties imposed upon them by the Children Order, establish priorities and set timescales to ensure early compliance with their full legislative requirements; and
- reviewing training and financial support provided to carers.

4.6.31 Boards should energetically pursue the recommendations of this report.

Domestic Violence

4.6.32 Inter-agency networks on domestic violence established by Community Trusts should set goals, develop action plans and establish monitoring systems to take forward work on a multi-disciplinary basis.

Living With the Trauma of the Troubles

4.6.33 The Department's Social Services Inspectorate report *Living with the Trauma of the Troubles* was published in April 1998. The report and its recommendations were fully endorsed by Sir Kenneth Bloomfield KCB, Northern Ireland Victims Commissioner, who suggested in his report *We Will Remember Them* that the recommendations of the SSI report should be 'energetically implemented by those interests to which they are directed'.

4.6.34 The SSI report emphasised the need for:

- support for community developments, especially those in the most troubled areas;

- improved availability of information on services;
- improved coordination and liaison of services; and
- an examination of the current adequacy of clinical psychology services in Northern Ireland.

4.6.35 The HSS Executive is preparing guidance for Boards and Trusts on implementation of the reports' recommendations which are appropriate to them.

4.7 Volunteering

4.7.1 In *Well into 2000* the Government acknowledged the contribution which the voluntary and community sector makes to meeting the needs of society and to promoting social cohesion. The Government also set out clearly its belief that volunteering is valuable, both as an expression of citizenship and community, and as an engine of social progress. Volunteering is at the heart of voluntary activity and the encouragement of volunteering is a key aim of Government policy.

4.7.2 The HSS Executive fully supports this and continues to be committed to:

- promoting volunteering;
- developing good practice; and
- involving volunteers in as wide a range of activities as possible across the whole of the HPSS.

4.7.3 Boards and Trusts should continue to maximise the involvement of volunteers in line with their published policies, and ensure that measurable targets are put in place to extend the involvement of volunteering in organisations with which they work in partnership. Moreover, they should ensure that service agreements take account of the costs of developing effective volunteers.

4.8 Acute Hospital Services

4.8.1 Boards will be expected to make progress in relation to the implementation of the recommendations arising from their reviews of the delivery of acute hospital services and cancer services; and the 1995 Review of Renal Services.

Cancer Services

4.8.2 Boards should implement the required service changes set out in their respective Area Strategies for the development of cancer services. By 1 April 1999 the Department expects Boards and the relevant Trusts to have identified the members of the organ specific multi-disciplinary teams for the range of cancers, to be managed in cancer units and the cancer centre. They should also have appointed a lead clinician at each cancer unit and at the cancer centre, to take forward implementation.

4.8.3 Boards and the relevant Trusts will also be expected to make significant progress towards the delivery of cancer chemotherapy within cancer units. Cancer Units should also develop cancer communication strategies that encompass primary care, other

cancer units and the cancer centre.

Renal Services

4.8.4 Boards have already made good progress towards the achievement of those improvements in renal services identified by the 1995 Regional Review of Renal Services. As predicted in the Review, demand for renal services, and particularly for haemodialysis, continues to rise. Boards are expected to put systems in place to monitor this trend and its implications for planned developments. Boards are also expected to maintain an annual acceptance rate into the End Stage Renal Failure programme of at least 80 persons per million for new patients, and to demonstrate progress towards achieving the target of at least 90% of haemodialysis patients receiving dialysis thrice weekly.

Inpatient Waiting Lists

4.8.5 The March 1998 Budget provided an additional £13 million to bring down waiting lists for elective surgery in Northern Ireland. Boards have been set a target waiting list of 39,000 by 31 March 1999. This is 7,000 below the level in May 1997.

4.8.6 The HSS Executive has set up a working group to support the process of bringing down waiting lists and waiting times. Amongst other factors, it will give attention to validating waiting lists, pre-admission confirmation of suitability, and the availability of the specialty in other locations. In addition, Boards will be required to consider the arrangements for the discharge of patients, liaising with primary care teams as appropriate.

Ambulance Services

4.8.7 The HSS Executive is committed to the introduction of new national performance standards as soon as possible. These have recently been piloted in some parts of GB. The results of the pilot exercises will be used during 1999/00 by the HPSS, led by the Northern Ireland Ambulance Service Trust, to identify the measures and resources needed to enable the ambulance service to meet 75% of category A calls (immediately life threatening) within 8 minutes.

4.8.8 This will form part of a wider review to be undertaken shortly involving the HSS Executive, commissioners and the NIAS Trust. The Review will take account of the pattern of acute services and the implications for the Trust. It will also provide advice and recommendations for the future organisation and management of ambulance services in Northern Ireland.

4.9 Provider Priorities

Management Costs

4.9.1 A revised definition of Trust management costs came into effect from 1 April 1998. The revised definition which has been adopted nationally will produce a more robust measure of management costs. It will improve comparability between Trusts, and provide a fairer basis for target setting.

4.9.2 Trusts and Agencies will be expected to reduce their management costs in line with regional targets. Performance against the targets will be monitored.

Corporate Governance

4.9.3 All Trusts are required to develop their own arrangements, and participate in a service-wide programme for the development of board members in corporate governance.

Human Resources

4.9.4 Each HPSS employer should review its human resources strategy in line with the Regional Human Resources Strategy, which is due for publication later in 1998, and ensure that it is fully integrated in its business plan. This should be done with the involvement of staff, and operate within a policy of openness and partnership at all stages. In doing so employers should have regard to developments on the new NHS pay system, and issues such as Family Friendly Policies and workforce planning.

4.9.5 Employers should create an environment in which staff feel that their health and wellbeing is a priority, and that the workplace is as free as possible from health and safety hazards and violence from patients and clients.

4.9.6 Employers should take identifiable action to manage the welfare of staff. They should promote awareness of, and encourage best practice in, health and safety at work. Employers should also take action to identify risks arising from violence and aggression and introduce suitable arrangements to safeguard staff.

Opportunity 2000

4.9.7 Employers are expected to aspire to achieving the HPSS's goals for addressing the imbalances between men and women under Opportunity 2000.

Higher Specialist Training

4.9.8 Commissioning of the specialist registrar grade in the dental specialties is ongoing and should be completed by July 1999.

4.9.9 Trusts must put into place training agreements for all higher specialist trainees detailing the roles and responsibilities of all parties involved.

The New Deal on Junior Doctors' Hours

4.9.10 Since the launch of the New Deal, the HSS Executive has been responsible for the regional overview of progress towards the New Deal targets. A regional task force was set up to provide central leadership, encouragement, and advice in driving the initiative forward. Trusts have carried the major responsibility for the introduction of the New Deal locally, and must continue to do so in the future. The task force will wind down over the next two years and Trusts must establish local measures to ensure the aims and targets of the New Deal - which are encompassed within the national terms and conditions for junior medical and dental staff - will be pursued.

4.9.11 Trusts should be working with their commissioners, the postgraduate Deans, Queen's University, Belfast and junior doctors to develop locally based solutions within the

terms of the New Deal. This process should complement business plans and strategies, and integrate the New Deal with other human resource initiatives.

Nursing Services

4.9.12 Commissioners and employers will be expected to develop nursing services and roles in line with the Strategy for Nursing, Midwifery and Health Visiting, *Valuing Diversity ..a way forward*, to meet the objectives specified in the Strategy as priorities, for example, the development of specialist practitioner roles with added responsibilities for dealing with a range of clinical issues such as minor injuries, community development projects and nurse prescribing.

Workforce Development - Practice Placements

4.9.13 Employers will be expected to support pre-registration training by providing suitable practice placements for undergraduate students. This will help preserve the validity of local training courses and ensure that there is an adequate supply of staff qualified to meet the needs of the HPSS. The HSS Executive has set up a central fund to provide financial support to Trusts providing approved placements in respect of some of the Professions Allied to Medicine.

PSS Training

4.9.14 Employers should place an emphasis on completing the PSS workforce information systems and using these to improve workforce planning. Priority should also be given to improving the number of registrations which achieve awards.

Value for Money and Efficiency

4.9.15 As part of their continuing pursuit of value for money, Trusts and Special Agencies are encouraged to examine the current arrangements for the provision of their non-clinical support services. They should take as a guide the methodology and criteria presented in the report of the Provider Project Board, with a view to achieving both greater cost-effectiveness and direct control of those areas which are central to the development of their individual culture, policy and strategy. The Executive will monitor the results of any such action.

Clinical Effectiveness

4.9.16 Providers will be expected to have systems in place which inform care and clinical practice. These should include:

- easy access to information; and
- structures which integrate the various elements of quality and identify when practice has changed.

Capital and Estate Management

4.9.17 Significant funds are invested in the HPSS estate, and the pressure for better and more effective use and management of the available assets continues to grow. Priorities for providers during the period of this Plan must include eliminating underused or inappropriately used space. Providers should already have in place soundly based plans for their rationalisation, including plans for disposal of surplus property. They must

keep these plans under review to ensure they remain appropriate. Progress against the plans must be monitored robustly and reported annually in their business plans.

4.9.18 Health and Safety and Fire Safety must be given greater priority and action taken to bring the HPSS estate up to health and safety, and firecode standards. Effective disposal of surplus property will release funds for re-investment and this will assist providers to concentrate on improving their core estate to comply with statutory standards.

4.9.19 In considering plans for capital investment, whether or not these involve disposal or rationalisation of existing property, providers must be alert to the possibility of securing a privately financed solution under the Private Finance Initiative. Business cases must explicitly address this issue before public capital can be considered.

Emergency Planning

4.9.20 The Department's Corporate Strategic Plan 1997/98 - 2001/02 emphasises inter-departmental working and cooperation, and encourages risk taking initiatives and innovation. *Fit for the Future* also emphasises partnership between HPSS organisations, as well as with other organisations which can play a part in improving health and wellbeing. The Innes review of emergency planning in Northern Ireland recommended enhanced arrangements for delivering effective emergency planning in the Province.

4.9.21 The HSS Executive will monitor arrangements within, and between, Trusts to ensure that the ambulance service, hospitals and community services deliver an effective response to any emergency situation. HPSS staff should receive appropriate emergency planning training, and have access to information and appropriate protective equipment in order to carry out their duties in relation to casualty care. Training for the medical response to a disaster should include multi-disciplinary training and the exercise of ambulance and hospital staff, GPs, and public health doctors. Similarly, training for the community response to a disaster should include protocols and multi-disciplinary courses for social services, voluntary organisations, district councils, emergency services and other agencies.

4.10 Research and Development

4.10.1 Over the next two years the new approach to funding research and development (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 also means that those who carry out 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 is similar to the approach taken in Great Britain.

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Information and Economic Appraisal Developments

4.10.2 HPSS organisations will be expected to:

- continue to cooperate with the development of new central information requirements and contribute to assessing the impact of change. Any changes as a result of *Fit for the Future* will lead to a comprehensive review of information requirements, including information required to support the clinical effectiveness and outcome measurement agendas;
- cooperate with any implementation of data quality audit strategies;
- implement the relevant principles in the Caldicott Report on the review of patient identifiable information; and
- adhere to the new guidelines arising from revisions to the Capital Investment Manual, to be issued in the near future.

4.11 Information Management and Technology

4.11.1 HPSS organisations will be expected to continue to cooperate to ensure operational and management information is acquired and distributed efficiently, and to appropriate standards of quality, confidentiality and security.

4.11.2 HPSS organisations will be expected to cooperate in securing the implementation of targets set out in *Fit for the Future* over a three year timescale. These cover:

- implementing the unique patient and client identifier;
- electronic linkage of GP surgeries and provision of associated electronic services;
- facilitating greater use of telemedicine;
- piloting the concept of the electronic patient record; and
- increasing integration of information in order to facilitate person-centred care delivered by multi-disciplinary professional teams.

4.11.3 These issues, and IM&T implications of other aspects of *Fit for the Future*, including the new framework for measuring quality and assessing performance of health and personal services, will be addressed by the Regional Information Steering Committee and its sub-groups.

HSC EXECUTIVE

5. APPENDIX
Management Plan Targets - 1999/00 to 2001/02

Topic	Objective	TARGET[1] 1999/00	2000/01	2001/02
Information Management and Technology and Embedded Systems	1. 'Year 2000' compliance during 1999.	*		
Health Promotion and Disease Prevention	2. Reduce the annual number of deaths from accidents from 26.3 per 100,000 (1994) to:			22.4
	3. (i) Increase the proportion of the adult population age 16+ who do not smoke cigarettes from 72% (1994/95) to:			74% (2002/ 2003)
	(ii) Increase the proportion of the population aged 11-15 years who do not smoke cigarettes from 83% (1994) to:			85% (2002/ 2003)
	4. (i) Increase the proportion of women breastfeeding during the first 2 or 3 days after birth from 30% (1994) to:			50%
	(ii) Increase the proportion of women breastfeeding at 6 weeks from 17% (1990) to:			35%
	5. (i) Reduce the proportion of men and women aged 16+ who are classified as sedentary from 20% (1992) to:			15%
	(ii) Increase the proportion of men and women aged 16+ who achieve recommended age-related activity levels from 30% of men and 20% of women (1992) to:			35% (men) 25% (women)
	6. Reduce the overall number of births to teenage mothers from 17 per 1000 (1992-94) to:			15.3
	7. Each Board should increase the uptake rate for all primary immunisations from between 93%-95% (1993) to:			97
	8. (i) Reduce the death rate from coronary heart diseases among 35-64 year olds by 40% from 202.7 per 100,000 (1988) to:			121.6

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Topic	Objective	1999/00	TARGET[1] 2000/01	2001/02
	(ii) Reduce the death rate from coronary heart disease among 65-74 year olds by 30% from 933.2 per 100,000 (1994) to:		653.2	
	9. Reduce the death rate from stroke in those aged 15-74 year olds by 40% from 46.3 per 100,000 (1990) to:		27.8	
	10. Reduce the death rate from lung cancer in men and women under 75 from 49.8 and 22.4 per 100,000 respectively (1990) to:			34.9 (men) (2010) 19.0 (women) (2010)
	11. Reduce the death rate from breast cancer in women aged 50-69 from 90 per 100,000 (1990) to:			67.5
	12. Reduce the incidence of invasive cervical cancer in women aged 20 and over from 12.8 per 100,000 (1989) to:			10.2
	13. Improve the uptake rate for breast screening from 71% (1996/97) to:	75%	75%	75%
	14. Achieve an uptake rate for cervical screening of eligible women aged 20 - 64 of:	80%	80%	80%
Family Practitioner Services	15. Work with GPs to increase their level of generic prescribing to:	50%	52.5%	52.5%
	16. Work with GPs to increase the percentage of practices actively using a prescribing formula to:	80%	85%	85%
	17. Work with GPs to increase the percentage of practices using a written protocol for repeat prescribing to:	90%	95%	95%
Services for People who are Elderly	18. Develop community services for elderly people to maintain the proportion of people aged 75 or over who are cared for in their own homes to at least:	88%	88%	88%
Services for People with Mental Illness	19. Put in place an agreed approach to outcomes measurement and monitor all services in the statutory and independent sectors against common quality standards:	*		

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Topic	Objective	TARGET[1] 1999/00	2000/01	2001/02
	20. 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	21. Commission a range of community based services for people with a learning disability to -			
	• promote inclusion:	*	*	*
	• effect a reduction in number of long-stay patients in specialist hospitals of:	60%	80%	100%
	• effect a reduction in number of adults admitted to specialist hospitals of:	30%	40%	50%
	• effect a reduction in the number of children admitted for long term care to specialist hospitals of:	60%	80%	100%
Services for People with Physical and Sensory Disability	22. Commission 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:	*		
	23. 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	24. Develop strategies to:			
	• extend user/carer participation in assessing and planning services:	*		
	• develop the Direct Payments scheme for adults under 65 years of age:	*		
Services for People with Dementia	25. Implement service delivery targets set during 1998/99:	*	*	*
Child Care	26. Implement Children's Services Plans for 1999-2002 and review plans on an annual basis, in liaison with other statutory and voluntary organisations in each Board area:	*	*	*

APPENDIX

EXECUTIVE

Topic	Objective		TARGET[1]	
		1999/00	2000/01	2001/02
Acute Hospital Services	27. Increase level of day case activity as a percentage of elective admissions in the following procedures:			
NI Average 1996/97:				
20%	• Inguinal Hernia:	25%	28%	30%
17%	• Varicose Veins:	28%	30%	32%
79%	• Cystoscopy:	85%	87%	90%
76%	• Circumcision:	80%	82%	84%
75%	• Arthroscopy of the knee:	85%	88%	90%
63%	• Cataract Extraction:	77%	80%	80%
37%	• Correction of Squint:	45%	48%	50%
64%	• Laparascopic Sterilisation:	75%	78%	80%
89%	• Endoscopy of Gastric Intestinal Tract:	93%	95%	95%
70%	• Bronchoscopy:	80%	83%	85%
40%	• Carpal Tunnel:	65%	70%	75%
73%	• Ganglion Excision:	85%	87%	88%
17%	• Operations on Nasal Septum/turbinate:	25%	27%	29%
	28. 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.	*	*	*
Volunteering	29. Boards and Trusts should:			
	• maximise the involvement of volunteers:	*	*	*
	• ensure measurable targets are put in place:	*	*	*
	• support the promotion of volunteering in partnership organisations:	*	*	*
	• ensure service agreements take account of costs of developing volunteers:	*	*	*

Note:[1] Financial Year - 1 April to 31 March

General Manager/Chief Executives
of each Health and Social Services Board
Chief Executives of HSS Trusts
Chief Executives of Special Agencies
Family Practitioners
Central Services Agency
Chief Officers of HSS Councils

Circular: PRSC (PR) 2/99

9 August 1999

Dear Colleague

HPSS MANAGEMENT PLAN 1999/00 – 2001/02:
FURTHER GUIDANCE FOR YEAR 2000/01

1. Since its inception in 1990, the Health and Social Services Executive has produced an annual Management Plan, which provides guidance on the priorities and objectives to be pursued by the Health and Personal Social Services for the following three years. The current Management Plan, which covers the period 1999/00 – 2001/02, was issued in September 1998.

2. Under the Belfast Agreement, which heralded new devolved arrangements for government in Northern Ireland, the proposed new Department of Health, Social Services and Public Safety will review the strategic planning processes. The HPSS will be kept informed as the review develops.

3. The HSS Executive Board has decided that in light of the proposed review of the planning processes the current Management Plan should be rolled forward for a further year, thereby maintaining the momentum in the planning and delivery of services over the coming year. A new Management Plan will not therefore be issued this year. Health and Social Services Boards, Trusts and others involved in the commissioning and delivery of services should take account of the objectives and targets in the current Plan, plus the supplementary guidance in the attached annex, when preparing plans for managing and delivering health and social services in 2000/01. Value for Money, in

particular, continues to be a high priority and should feature in every management agenda.

4. Boards' Action Plans will be subject to endorsement by the Minister in the course of the annual Accountability Reviews.
5. The strategic objectives set out in the current Management Plan remain. They are:
   - tackling inequalities through the targeting health and social need initiative;
   - promoting health and social well-being;
   - developing primary and community care
   - improving acute hospital services; and
   - securing the maximum health and social gain for the population from the resources available.

Further Information

6. Enquiries about this circular should be addressed to:

Allan Gault
Strategy and Performance Review Unit
Phone: [redacted]
Fax:
E-mail: allan.gault[redacted]

Further Copies

7. This circular and the HPSS Management Plan 1999/00-2001/02 are available on the DHSS Internet website at: **http://www.dhssni.gov.uk**. You can also obtain a copy by contacting:

Ms Bronagh McGarvey
Strategy and Performance Review Unit
Phone: [redacted]
Fax:
E-mail: bronagh.mcgarvey[redacted]

Yours faithfully

B Grzymek
Director

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Department of Health and Children, Dublin
Houses of Parliament Libraries
New Northern Ireland Assembly Library
Queen's University, Belfast Library
University of Ulster Library

Annex

HPSS MANAGEMENT PLAN 1999/00 – 2001/02: FURTHER GUIDANCE FOR YEAR 2000/01

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1 TARGETING HEALTH AND SOCIAL NEED

New Targeting Social Need Initiative

1.1 Under the Government's New Targeting Social Need initiative, all of the main HPSS programmes were recently audited. The Department will take account of the recommendations arising from the audit in its New TSN Action Plan, which is due to be issued for consultation by September 1999. The objective is to publish, in 2001, locally agreed strategies and associated action plans under the New TSN initiative, including monitoring and evaluation systems and local targets for ensuring fair access to services.

1.2 In England, the Acheson Report[1] on health inequalities has flagged up areas where solid scientific evidence shows that action to tackle health inequalities might best be concentrated. Health Action Zones offer an important new opportunity to address such inequalities, linking the contribution of health and social services to work on regeneration, housing and employment.

1.3 Health and Social Services Boards should ensure that their strategies for reducing inequalities take these developments into account, and that they are implemented effectively, in line with the Regional Strategy and the New TSN Action Plan.

[1] *Independent Inquiry into Inequalities in Health Report*, Sir Donald Acheson , Stationery Office, November 1998

Health Improvement Programmes (HImPs)

1.4 Health Improvement Programmes are the local plans for improving health and social well-being, tackling inequalities, and developing high quality, responsive services. The Department will issue guidance on HImPs during 2000/01, and will consider whether these should incorporate the Action Plans required under the New TSN initiative.

1.5 Boards will be responsible for leading the development of HImPs. Boards, Trusts, primary care practitioners, local communities and others, including government departments, the Northern Ireland Housing Executive and district councils, will all need to work together in an open and collaborative manner to produce HImPs for the people of each Board area. These HImPs should be informed by as wide a range of local perspectives as possible. Each Board will be responsible for ensuring that the people it serves are fully engaged in planning changes and new developments, and understand how they will contribute to health and social gain for the greater good of the local population.

2 HEALTH AND SOCIAL WELL-BEING

Smoking

2.1 The White Paper '*Smoking Kills*'[2], published in December 1998, set out a comprehensive strategy for tackling smoking across the UK. It particularly targets, children and young people, the poor who smoke and pregnant women. The White Paper identifies tackling smoking as a priority for the HPSS at all levels. Specific action required by the HPSS includes:

- funding and delivery of specialist advice and support to those who wish to stop smoking, starting with smokers who are poor;
- making nicotine replacement therapy available to smokers wanting to stop, starting with smokers who are poor;

[2] *Smoking Kills - A White Paper on tobacco*, DoH, Cm4177, Stationery Office, December 1998

- ensuring that all health professionals routinely offer advice to help people give up smoking; and
- reviewing smoking policies in all HPSS buildings.

2.2 A Northern Ireland strategy to tackle smoking is due to be issued by March 2000.

Teenage Parenthood

2.3 The Department established a working group in May 1999 to tackle the problems associated with teenage parenthood. The group will be developing a co-ordinated strategy under which the relevant agencies will work together to address:

- the issue of unplanned teenage pregnancies, including the difficulties which young parents face during pregnancy and after birth to prevent them or their children from being socially excluded.

2.4 The Department intends to publish the strategy by February 2000.

2.5 The Regional Strategy target for sexual health and the Management Plan target to reduce the overall number of births to teenage mothers have been revised in the light of further information on births. The number of live births in the 15-19 age group in 1993 was 1595; this represents 27.5 per 1000 of the total female population in that age range (58,000).

2.6 The revised target number of live births in the 15-19 age group in 2001/02 is 1560, representing 24.75 per 1000 of the total female population in that age range (63,000).

2.7 Boards should continue to work with Trusts, primary care professionals and other agencies to address the issue of unplanned teenage pregnancies with a view to reducing the number of births in this age group.

Drug Misuse

2.8 Drug misuse is of growing concern in Northern Ireland, with some areas experiencing particular problems. Although the scale of the problem has not yet reached the levels to be found in Great Britain, there is clearly a need to ensure

that a range of services is in place to tackle the problem. These include health promotion and education programmes, treatment, care and rehabilitation services.

2.9 The Ministerial Co-ordinating Group for Action Against Drugs intends to publish a new strategy on drug misuse during the summer. In addition to their continuing role in taking forward multi-agency initiatives, including Drug Co-ordination Teams, Boards will be expected to take additional measures, as outlined in the new strategy, to tackle the problem.

Communicable Disease Control

2.10 The HPSS should ensure that it meets its responsibilities for the effective control of the public's health with particular regard to the prevention and control of communicable disease, including the control of antibiotic resistance and hospital infection.

3 PRIMARY AND COMMUNITY CARE

Primary Care

3.1 Primary care must continue to develop as a provider of services, and those who work in primary care must be able to take on wider roles and responsibilities. The most effective way of doing this is through primary care teams, which make the most of Northern Ireland's integrated health and personal social services. Equally important is the need for primary care professionals to play a positive part in disease prevention and the promotion of better health and social well-being.

3.2 A Primary Care Development Fund was therefore established in 1998, to facilitate the trial of new and innovative practical ways to deliver primary care services. At present, 30 projects costing a total of £0.925m are being tested throughout Northern Ireland, and further funding remains available.

Primary Care Centred Commissioning

3.3 The key policy aim of developing primary care centred commissioning of health and social services remains in focus, as exemplified in *'Fit for the Future'*[3]. This offered proposals on organizational arrangements for the HPSS for supporting a primary care centred service. Until final decisions are made by the Northern Ireland Assembly about the future shape of the HPSS, Boards will be expected to:

- ensure continuing support for the Purchasing and Commissioning Pilots in order to help primary care professionals gain experience of what is involved in commissioning, and to provide lessons for the new commissioning arrangements of the future; and
- facilitate the establishment of further Commissioning Pilots, subject to the availability of resources, in order to increase the number and broaden the range of primary care professionals involved in commissioning.

Pharmaceutical Care

3.4 Boards will be expected to:

- monitor the performance of pharmacists and dispensing doctors in seeking evidence from patients of entitlement to exemption from payment of prescription charges; and
- make arrangements to implement, monitor and evaluate the outcomes of new community pharmacy services under the Medicines Management allocation introduced in 1999/2000, and to report annually on the outcome of initiatives developed as a result.

Oral Health

3.5 In implementing the Oral Health Strategy (Revised) Boards will be expected to:

- contribute to the formal review of the Oral Health Strategy to be undertaken in the year 2000.

3.6 The aim of the Personal Dental Service Pilots, the first of which came into operation on 1 April 1999, is to test new ways of contracting for and delivering

[3] *Fit for the Future- A New Approach, The Government's Proposals for the Future of the HPSS in Northern Ireland,* DHSS, March 1999

primary care dentistry. For those pilot schemes that have been approved, Boards will be expected to:

- produce and publicise a brief annual report describing the monitoring process and the findings from the local monitoring of the pilots.

GP Prescribing

3.7 The HSS Executive continues to work with Boards to encourage GPs to change their prescribing behaviour as appropriate to reduce the drugs bill. It is crucial, however, to balance this objective with ensuring that patients continue to have access to high quality treatment at all times. Boards should therefore set goals for improving the prescribing behaviour of GPs. In doing so, they should take account of prescribing targets in the Management Plan, as well as best practice in the prevention and management of clinical conditions in terms of:

- the appropriate use of Aspirin in the prevention of cardiovascular disease;
- the effective use of ulcer-healing drugs in the management of gastrointestinal conditions;
- the need to optimise antimicrobial prescribing, in line with 'The Path of Least Resistance' (Standing Medical Advisory Committee Sub-Group on Antimicrobial Resistance); and
- pharmaceutical interventions in the management of hypertension.

3.8 Boards, in conjunction with Trusts, general practitioners, pharmacists, and the Central Services Agency should continue the roll out of nurse prescribing. In doing so, they should take into account the guidance published by the Department and make use of the educational programmes developed by the University of Ulster. The Department's aim is that there should be at least one nurse-prescribing site in every Trust.

Family Practitioner Service Fraud Action Plan

3.9 Boards and the Central Services Agency should continue to contribute to the FPS Fraud Action Plan through the various fraud working groups, and to implement agreed recommendations.

Community Care

3.10 Key elements in the provision of quality community care continue to be to:

- improve the effectiveness and efficiency of community care arrangements;
- promote a needs-led focus in tailoring care packages; and
- encourage meaningful participation of users and carers in commissioning services.

3.11 Funding made available by the Comprehensive Spending Review will, in time, help to reduce delays in the discharge of patients from hospital and decrease the numbers of people in the community awaiting services. It should also increase the provision of respite care and improve support services for carers.

3.12 The main service areas to be addressed are:

- **For people with a mental illness** - the key priority is to make significant progress towards the development of a regional medium secure unit and a comprehensive regional forensic mental health service. A Project Board has been established to take this forward and Boards and Trusts will be expected to facilitate and contribute to the work of the Project Board, as necessary.
- **For people with a physical disability** - the key priorities are the development of the community occupational therapy service to enable it to reduce waiting times and backlogs for housing adaptation and equipment assessments and the promotion of direct payments through the establishment of user led groups.
- **For people with a learning disability** – the key priority continues to be the development of community services to facilitate the rehabilitation of long stay hospital patients.

People with Traumatic Brain Injury

3.13 In 1998 Boards participated in a Regional Medical Services Consortium led project to develop a specification for traumatic brain injury services. Priority must be given to the development of a regional rehabilitation unit, and community rehabilitation services.

People Living with the Trauma of the Troubles

3.14 During 1998/99 implementation of the recommendations in the Bloomfield and SSI reports on the victims of the Troubles was unsatisfactory. The Government attaches a high importance to their implementation, and priority must be given to taking them forward.

Social Services

3.15 The Department will shortly publish proposals[4] to improve social services and protect vulnerable adults through better regulation of a range of care services. The proposals will also detail plans to regulate the social care workforce and social care training, and set practice and ethical standards.

Child Care

3.16 Consultation on the document *'Children First'*[5] closed on 30 April 1999. It set out proposals for the development of a coherent inter-agency childcare strategy for Northern Ireland. It aims to raise the quality of childcare, make childcare more affordable, improve accessibility to and information on childcare and strengthen existing co-ordinating structures.

3.17 The strategy proposes the creation of a Childcare Partnership in each HSS Board area to bring together the range of agencies that have a contribution to make to planning and providing childcare. Boards will be expected to play an important role in the work of the Partnerships in assessing needs, identifying priorities, and planning childcare services in their areas. They will be responsible for producing and co-ordinating the implementation of the Childcare Plans.

3.18 The development of children's residential care in line with *'Children Matter'*[6] remains a top priority for Boards.

[4] *Raising the Standard: Improving Social Services in Northern Ireland*, DHSS SSI, due for publication mid-late 1999
[5] *Children First: Strengthening Childcare in Northern Ireland*, DHSS, DENI, TEA, 1999
[6] *Children Matter: a Review of Residential Child Care Services in Northern Ireland*, DHSS SSI, 1998

4 ACUTE SERVICES

Inpatient Waiting Lists

4.1 The reduction of waiting lists for hospital inpatient treatment remains a high priority for the Government. In 1998/99, additional funding of £13m was allocated to Boards and GP fundholders to reduce in-patient waiting lists. During the year the HSS Executive established the Waiting List Reference Group to assist the HPSS to reduce waiting lists. The total number of people waiting at 31 March 1999 was 43,444 – a reduction of 4,000 over the previous year. The reduction achieved, while significant, fell some way short of the target of 39,000.

4.2 Commissioners and Trusts are expected to keep the waiting list issue high on their agenda, and to work together to bring about opportunities for further reductions, wherever possible. The major objective in this area for the year 2000/2001 will be to maintain downward pressure on waiting lists and to ensure that the gains made are not lost.

4.3 At the beginning of the year new target reductions in waiting list numbers will be set, and by the end of the year no patient will be expected to wait longer for in-patient or day-case treatment than the times set out in the Charter for Patients and Clients.

Winter Pressures

4.4 Over recent years, significant pressures on hospital providers have arisen over winter months as a result of increased emergency medical admissions. Boards and Trusts should work together to put in place plans that ensure emergency treatment is available for those patients who require it without, at the same time, causing major disruption to planned admissions. In particular, acute hospital providers at Community Trusts should ensure that effective plans are developed at an early date for the early discharge of patients into the community.

Acute Hospital Services

4.5 An early priority for the new Northern Ireland Assembly will be to develop the future pattern of acute hospital services. A future hospital strategy for Northern

Ireland will draw on the reviews of acute hospital services carried out by the Northern, Southern and Western Boards[7] and the publication of '*Putting it Right*'[8], which offers a vision for the future of hospital services in Northern Ireland. The intention is to begin implementation of an agreed hospital strategy during 2000/01.

Ambulance Services

4.6 Modernization of the Northern Ireland Ambulance Service is a major priority. The recommendations flowing from the Comprehensive Review, launched by the Minister in October 1998, will provide the basis for change. Immediate priorities are expected to include a significant upgrade of the communications and control systems to support improved performance, including more responsive and clinically effective responses to emergency calls. Changes in patterns of acute care will require increased ambulance provision with personnel trained and proficient in a wider range of skills. In addition, the implications for the ambulance service of a greater emphasis on clinical outcomes and effectiveness will be fully reflected in the Review's modernisation programme. The NIAS Trust, in collaboration with commissioners, will be expected to take the programme forward, quickly and efficiently.

5 INFORMATION MANAGEMENT AND TECHNOLOGY

5.1 Access to good quality, timely information is essential to the planning, commissioning and delivery of high quality health and social services. If individuals are to be fully involved in decisions about their care and treatment, they need clear, comprehensive and personalised information about the risks and benefits of the treatment or care options available. Those delivering services need to be able to record, retrieve and share information about individuals and the services provided. This will enable more efficient and effective provision and management of services.

[7] Report of Review of Western HSS Board to be published in autumn 1999.
[8] *Putting It Right, The Case for Change in Northern Ireland's Hospital Service*, DHSS HSSE, March 1999

5.2 *'Fit for the Future'* made a number of specific commitments in this respect, including establishing a unique patient/client identifier, further electronic links to GPs, piloting electronic patient records (including patient held records for chronic care), and increasing integration of information to facilitate person centred care, delivered by multi-disciplinary teams. Work is progressing in these areas.

5.3 All HPSS organizations should take these targets, and those to be set out in the HPSS IM&T Strategy[9] into account in their local plans for IM&T development.

Data Protection and Confidentiality

5.4 Following the publication of the Caldicott Report[10] on patient identifiable information in 1997 and the enactment of the Data Protection Act in 1998, the HSS Executive has produced revised guidance[11] on the protection and use of patient and client information. During the year 2000, HSS Boards, Trusts and other HPSS bodies should:

- appoint a data guardian to take responsibility for developing and implementing organizational policies;
- establish confidentiality policies to carry forward the major themes of the guidance;
- appoint appropriately placed and qualified data scrutinisers to implement organizational policies; and
- ensure that all staff handling personal data are aware of their responsibilities, and that data scrutinisers are properly trained to carry out their roles.

[9] *HPSS Information Management & Technology Strategy*, DHSS HSSE, due to be published late 1999
[10] *The Caldicott Report: on the Review of Patient Identifiable Information*, DoH, December 1997
[11] *The Protection and Use of Patient and Client Information*, DHSS HSSE, June 1999

6 HEALTH AND SOCIAL GAIN

Quality

6.1 *'Promoting Quality: a Framework for the HPSS'*[12], which is due to be issued in the autumn of 1999, will provide a framework for improving the quality of health and social services. The framework will emphasise that ensuring high quality services is everyone's business. It will build on existing good practice, and set out the action to be taken throughout the HPSS to help fulfil the Government's objective that everyone has fair access to effective, prompt, high quality health and social services. The framework will focus on three areas:

- setting standards for services and for the professions;
- supporting the delivery of quality service at local level; and
- strengthening performance assessment arrangements.

Effectiveness and Outcome Measurement

6.2 Consultation will take place in the autumn on proposals for assessing performance in the HPSS. Final guidance on the framework will be available in early 2000.

Priorities for Capital Investment

6.3 Providers should continue to give appropriate priority to investment in essential replacement of outdated equipment items. The current estimate of the replacement value of radiology and laboratory equipment over 10 years old is of the order of £30m. Because of pressures on resources it will be necessary to deal with the backlog over time. This is one of the main issues to be considered for the medium term in the Capital Investment Strategy now under development. In the meantime the most urgent pressures will need to be addressed.

6.4 It remains a fundamental principle of Government policy that all capital proposals must address the Private Finance Initiative option. Where a PFI solution is clearly available, the PFI process should be pursued to a conclusion to establish

[12] *Promoting Quality: A Framework for the HPSS,* DHSS HSSE, due to be published in autumn 1999

whether the publicly funded or the privately funded option represents the best value for money.

6.5 A record of successful partnerships under PFI for the supply and maintenance of equipment is now well established. In the majority of cases therefore providers should not have to rely on general capital to fund high-cost items and consideration should be given to ways of advancing replacement programmes for major equipment items through PFI procurement.

Human Resources

6.6 Each HPSS employer should review its human resources strategy in line with the Regional Human Resources Strategy, which is due for publication by the end of 1999, and ensure that it is fully integrated in its business plan. This should be done with the involvement of staff, and operate within a policy of openness at all stages. Partnership forums at regional and local level will be developed in 1999/00. Examples of good practice will be shared throughout the HPSS. Employers will be expected to work in a spirit of partnership at all times.

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poib.

GP Received by HSS (PPM) 7/2001

Room D4.17
Castle Buildings
Stormont
BELFAST
BT4 3SJ

Tel No: [redacted]
Fax No:

HSS(PPM) 2/2001

Chief Executives, Health and Social Services Boards
Chief Executives, HSS Trusts
GP Fundholders
General Practitioners
Chief Executive, Central Services Agency
Chief Executives, Special Agencies
Chief Executive, NICPGMDE
Chief Executive, NBNI

8th March 2001

PRIORITIES FOR ACTION 2001/2002

1. This circular issues Priorities for Action 2001/2002 to the Health and Personal Social Services and summarises the implications and responsibilities for HPSS bodies.

2. Priorities for Action 2001/2002 has been framed in the context in the Programme for Government and the resources available to the HPSS in the next financial year. It sets out a clear, challenging but deliverable agenda that will demonstrate how those resources are being deployed to the benefit of the local community. It will also provide the basis for strengthened monitoring and accountability to the Department, to the Minister and to the Assembly.

Priorities

3. The document sets out a detailed range of objectives and targets that will deliver the Minister's planning priorities for the next financial year, namely:-

- Developing, after full public consultation, a cross-cutting public health strategy that maximises, across all sectors, efforts to improve health and wellbeing and reduce health inequalities;

- Consolidating existing services and promoting financial stability. This includes the finalisation and implementation of recovery plans but also, critically, a more rigorous approach to the prioritisation and funding of developments by HPSS organisations;

- Increasing capacity and improving flexibility and responsiveness to meet continuing demand and winter pressures;

- Improving access to services for those needing care and treatment, particularly reducing waiting lists;

- Tackling shortages of skilled staff, particularly in hard-pressed specialised areas. This includes not only increases in the supply of qualified staff but also measures to improve recruitment and retention of staff within the HPSS;

- Developing greater partnership in the planning and delivery of services within the HPSS by removing any last elements of the internal market;

- Developing partnerships with other statutory and voluntary agencies in the development and delivery of services;

- Giving local communities a greater say in shaping and planning services; and

- Developing greater North/South collaboration in accident and emergency, planning for major emergencies, high technology equipment, cancer research and health promotion.

The targets succeed all previous targets set out in the Regional Strategy and elsewhere and represent the main focus for HPSS planning in 2001/2002.

New Planning Arrangements

4. To ensure a co-ordinated pursuit of the priorities and a collective approach to the achievement of the objectives and targets, the Minister wants to see radical changes to the current arrangements for service and financial planning. These involve:

- the replacement of Service Agreements with Service and Budget Agreements (SBAs) between commissioners, including GP fundholders, and providers linking expected service volumes to a fixed budget for the next financial year;

- the requirement for Boards and Trusts to submit Service Investment Plans and Service Delivery Plans respectively. These will be expected to highlight in particular the plans to implement Priorities for Action.

5. These new arrangements, which will remove the last vestiges of competitive, rather than collaborative, behaviour will facilitate:

- greater clarity and transparency from the outset of the financial year about the deployment of resources and the services to be delivered as a result; and

- more effective monitoring of both Boards and Trusts with regular progress reports and end of year accountability for performance. In the case of Boards, this will be built around the existing quarterly bilateral reviews and the annual Accountability Review.

In the case of Trusts, it will be carried forward through new formal accountability mechanisms. Further guidance on these will follow.

Action

6. Boards, Trusts and GP fundholders should engage in dialogue on the direction provided in Priorities for Action as matter of urgency with a view to concluding Service and Budget Agreements as soon as possible. Linked to this, the timetable for the production of Plans is:

- Service Investment Plans – to be submitted to the Department by 31 March 2001;
- Service Delivery Plans – to be submitted to the Department by 30 April 2001. (Trusts are no longer required to submit their Business Plans to the Department.)

7. Service Investment and Service Delivery Plans should be submitted to:-

- **William Dukelow** - Room 514, Dundonald House, (Eastern Board and related Trusts)
- **Allan Gault** - Room 516, Dundonald House (Northern, Southern and Western Boards and related Trusts).

8. As indicated in para 4 the revised arrangements for service and financial planning will apply to GP fundholders. Indeed, for the remainder of this financial year the Department will expect fundholders and Trusts to work together in accordance with the principles contained in Priorities for Action. Further detailed guidance on the implications of the new arrangement for GP fundholders will issue from Primary Care Directorate.

9. Any queries on this circular should be directed, in the first instance, to Ray Martin [redacted] or Jonathan Bill [redacted] Planning and Priorities Unit, Planning and Performance Management Directorate.

JOHN McGRATH
Director
Planning and Performance Management

PRIORITIES FOR ACTION

2001/2002

Planning guidelines, objectives and targets for the Health and Personal Social Services

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Serbhísí Sóisialta agus Sábhailteachta Poiblí
March 2001

1. INTRODUCTION

1.1. This document sets out the Minister's expectations for the Health and Personal Social Services in the context of the Programme for Government and Budget agreed by the Assembly. It sets out the planning priorities for 2001/2002 and the objectives and targets that will ensure their achievement. It introduces radical changes to the arrangements for service and financial planning, which will promote stability and partnership in the HPSS and hence produce gain for the local community.

Programme for Government

1.2. The Programme for Government identified "Working for a Healthier People" as one of its five priorities. Within this priority the Programme focuses on:

- Reducing preventable diseases, ill health and health inequalities;
- Ensuring that the environment supports healthy living and that recreational facilities are improved;
- Modernising and improving hospital and primary care services to ensure more timely and effective care and treatment for patients;
- Enabling those suffering from disability or chronic, mental or terminal illness to live normal lives and contribute to society; and
- Promoting the health and social development of children.

1.3. The HPSS has a lead role to play in tackling these areas. It is clear however that the HPSS will also have a contribution to make in the other four priority areas;

- Growing as a Community;
- Investing in Education and Skills;
- Securing a Competitive Economy;
- Developing North/South, East/West and International Relations.

1.4. The Programme for Government also identifies a number of key themes that should be incorporated at all stages in the development, improvement and evaluation of policies and procedures for the provision of services.

Equality

1.5. The new statutory duty arising from Section 75 of the Northern Ireland Act 1998 makes equality central to the whole range of public policy decision-making. The equality perspective must be incorporated in all policies at all levels and at all stages. The key change for the HPSS is that instead of reacting to identified problems in the area of equality it must have due regard to the need to promote equality of opportunity and develop mechanisms for ensuring that policy makers consider equality implications as an integral part of policy development. All public authorities are also required to have regard to the desirability of promoting good relations between persons of different religious beliefs, political opinions or racial groups.

1.6. HPSS organisations must ensure that there is commitment to the equality agenda from the highest level; that the necessary resources and training are made available for implementation; that there are clear lines of responsibility; and that there is an effective system for monitoring and reviewing progress. The statutory duties will assist the HPSS to address issues of equality, target disadvantage and social need and promote social inclusion.

Human Rights

1.7. The Human Rights Act, which came fully into effect on 2 October 2000, brings in new rights and responsibilities. The Act gives further effect in law to the rights and freedoms guaranteed under the European Convention on Human Rights. It requires that legislation, whenever enacted, should be interpreted as far as possible in a way that is compatible with the Convention rights. It also makes it unlawful for a public authority to act incompatibly with the Convention rights. The Act is likely to have a significant impact on the work of the Department and its associated bodies. The HPSS will need to ensure that, in taking forward the Minister's priorities, policies and procedures are in line with Convention rights.

New Targeting Social Need

1.8. The New Targeting Social Need initiative is designed to address the connection between poverty and unemployment and poor health and social wellbeing by skewing Government and Departmental resources towards those in greatest need. New TSN also aims to promote social inclusion. This will involve the Department and the HPSS working with partners outside Government to tackle issues such as deprivation and disadvantage, which can contribute to the exclusion of groups or individuals within our society. The Minister expects action on taking forward New TSN to give real help and generate fresh hope for groups and individuals in the most disadvantaged areas.

2. PLANNING PRIORITIES

2.1. The Minister wishes to take forward the Programme for Government by focusing on the following planning priorities for the HPSS in the next financial year:

- Developing, after full public consultation, a cross-cutting public health strategy that maximises, across all sectors, efforts to improve health and wellbeing and reduce health inequalities;
- Consolidating existing services and promoting financial stability. This includes the finalisation and implementation of recovery plans but also, critically, a more rigorous approach to the prioritisation and funding of developments by HPSS organisations;
- Increasing capacity and improving flexibility and responsiveness to meet continuing demand and winter pressures;
- Improving access to services for those needing care and treatment, particularly reducing waiting lists;
- Tackling shortages of skilled staff, particularly in hard-pressed specialised areas. This includes not only increases in the supply of qualified staff but also measures to improve recruitment and retention of staff within the HPSS;
- Developing greater partnership in the planning and delivery of services within the HPSS by removing any last elements of the internal market;
- Developing partnerships with other statutory and voluntary agencies in the development and delivery of services;
- Giving local communities a greater say in shaping and planning services; and
- Developing greater North/South collaboration in accident and emergency, planning for major emergencies, high technology equipment, cancer research and health promotion.

2.2. The objectives and targets for priority areas and Programmes of Care are set out later in this document. They have been determined in the context of the overall resources available to the HPSS in 2001/2002.

3. SERVICE INVESTMENT AND SERVICE DELIVERY PLANS

3.1. To deliver these priorities and create the foundation for future development, it is important that there are significant changes in the service and financial planning arrangements between Boards and Trusts. In particular, the last vestiges of competitive behaviour remaining from the internal market should be removed.

3.2. From 2002/2003 onward, Boards will be required to produce Health and Wellbeing Investment Plans, and, in turn, Trusts will be required to draw up plans to implement these. Detailed guidance on these new arrangements will be produced later this year, when the implications of Minister's decisions on Primary Care and Investing for Health are clear, particularly in terms of ending GP Fundholding and the competitive approach towards concluding service agreements characterised by the internal market. This is key to the promotion of a 'whole system' approach to the challenge posed by the Programme for Government. In particular, it is clear that consolidation of services and securing financial stability, including delivery of agreed recovery plans, will require new constructive and realistic working relationships across the HPSS family, not only between commissioners and providers.

3.3. For 2001/2002, Boards are required to produce **Service Investment Plans** setting out, by Programme of Care, the range of services they intend to secure to meet the needs of their local populations and deliver on the targets/objectives set out in this document. To complement this the Department will wish to work with Boards over the next few months in order to quantify the resource consequences of Service Investment Plans by programme of care. The Service Investment Plans, to be submitted to the Department, will be the basis for performance management by the Department over the next financial year and will be the focus of the consequent Accountability Review when each Board's achievement against the Minister's targets/objectives is reviewed. The core elements of Service Investment Plans are set out in Appendix A.

3.4. Flowing from these Service Investment Plans, each Trust will be required to produce a **Service Delivery Plan** for 2001/2002 reflecting the

summation of **Service and Budget Agreements** agreed with commissioners, capital investment plans and management objectives in line with the Minister's expectations. These again will be submitted to the Department and will be a focus for strengthened performance management arrangements for Trusts from 2001/2002 onwards. The core elements of Service Delivery Plans are set out in Appendix B.

3.5. In concluding Service and Budget Agreements, Boards and Trusts will be expected to adopt a more rigorous but collaborative approach based on the expectation of long-term partnership in meeting the needs of service users and the community. All HPSS organisations will be expected to adhere to the principles set out in the Circular HSS (F) 29/2000 "Promoting Financial Stability within HPSS Organisations". In addition however the following parameters should be adopted:

- Existing services should be placed on a sound financial footing before expansion is envisaged;
- Recurring over-commitment of resources into 2002/2003 should be avoided unless explicitly agreed with the Department;
- Annual recurring budgets should be agreed for each provider by commissioners and other funding agencies, including the Department where appropriate; and
- Service Investment Plans should demonstrate that the totality of revenue resources is being committed.

3.6. For 2001/2002 GP Fundholders will be expected to follow the same discipline as Boards in agreeing with Trusts, from the outset, the services they wish to secure over the financial year and the resources involved.

3.7. Through the Service and Budget Agreements commissioners will agree with providers service volumes linked to a fixed budget which will be funded over 12 months to an agreed profile. The only exception to this will be the scope for commissioners to time the release of growth funds to the actual initiation of service developments and the incurring of the associated costs. Commencement dates by quarter for such developments should be identified in both Service Investment and Service Delivery Plans. As a result of these changes, Trusts, in common with most public sector bodies, will have virtually

full details of their annual income available before the beginning of the financial year. This will allow them to develop and plan the deployment of a fixed budget, designed to deliver the Minister's priorities, from early in 2001/2002. In the past, the flow of resources has been used as a lever to attempt to drive up productivity. This practice has proved to be both ineffectual and destabilising, creating uncertainty about levels of income available to Trusts.

3.8. In concluding an initial round of Service and Budget Agreements for 2001/2002, Boards and Trusts will be expected to ensure that core costs, particularly in relation to infrastructure are covered as a step to achieving service and financial stability. Trusts will be expected to remain within the income levels agreed with Boards and other funding sources. Boards and Trusts will have to agree how any additional unavoidable pressures will be dealt with in year. In taking forward strategic change in the profile of services, full cognisance of residual costs and the timing required to release fixed costs must be factored into agreements. Trusts will be expected to release avoidable fixed costs within reasonable time frames.

3.9. From 2002/2003, Health and Wellbeing Investment Plans will represent the framework for service delivery and development in each health and social care economy, embracing the appropriate Board and other contributing Trusts. They will be expected, subject to reasonably firm forward figures becoming available, to have a 3-year horizon and should provide the platform of certitude about income and expenditure to ensure better and more rigorous financial planning by Trusts. Final decisions for each year will remain dependent on Budget decisions by the Assembly but increasingly those decisions will need to be informed and facilitated by strengthened performance management and financial stability within the HPSS.

3.10. A key issue here will be improved planning for the consequences of capital developments. From 2001/2002, Service Delivery Plans submitted by Trusts should detail the proposal for capital investment. Ideally these should be shared with commissioners to enable a collective agreement on the capital priorities in local health and social care economies. In addition, for future business cases, a strategic context should not be initiated without the express agreement of relevant commissioners. The Department will ensure that this is

not interpreted as an obstacle to capital planning at local level but rather as a mechanism to ensure close alignment between service planning, capital planning and resource availability. Where there is agreement on the need to progress a business case, the service specification should be agreed in advance. In addition, the Department will expect those business cases with significant resource consequences to be worked up in conjunction with the main commissioner and jointly submitted.

3.11. Service and Budget Agreements should be concluded to enable Service Investment and Service Delivery Plans to be submitted to the Department by 31 March 2001 and 30 April 2001 respectively.

DELIVERING THE PRIORITIES

This section explains how the Department expects the HPSS to deliver the Minister's priorities across the various Programmes of Care and in other key areas.

Winter Pressures and Community Care

As a result of events during the winter of 1999/2000, when hospital services in particular came under severe pressure because of an outbreak of influenza, comprehensive plans for increased demand during the winter months were put in place this year. These included the provision of additional temporary capacity in order to absorb short-term pressures as well as the improved co-ordination of services across the hospital, community and primary care sectors.

There is a need to increase overall capacity and to make best use of it by ensuring that planned work is phased during the year to level out seasonal peaks and troughs in activity, thus ensuring the effective use of available capacity. There is a need to secure increased capacity in specific areas such as critical care, and to strengthen community/hospital/bridging services, building upon the multi-disciplinary and cross-sectoral arrangements already in place. It is also important to protect the health of elderly people and other vulnerable groups in the winter months through flu vaccination.

Another key element in managing winter pressures will be the links between community, primary and acute care services. Boards, Trusts and GPs should co-operate to have in place the full range of community care services, including residential care, nursing home care, intensive domiciliary care, respite care, and other day and domiciliary services including the home help, to ensure that people are not cared for inappropriately in acute settings. The Department will conduct a review of the implementation of community care policy, paying particular attention to hospital admission and discharge arrangements.

Objectives

- To develop comprehensive plans for winter 2001/2002 that build on the measures put in place for last winter. Such plans should be developed and implemented on a partnership basis, fully involving Boards, Trusts, GPs and other health and social care providers.

- To make the most efficient use of current capacity in the acute sector by front-loading elective surgery in the early part of the year before winter pressures begin to impact on bed or theatre availability.

- To further develop bridging services between community, primary and acute care to ensure that acute admissions take place only where appropriate and patients are assured of a timely return to the community once acute treatment has been completed.

- To continue to share and build on good practice in developing innovative schemes such as step-down and intermediate care services.

- To implement the Executive's decisions on the recommendations of the Royal Commission on the Funding of Long-Term Care.

- To reverse the trend of delivering the majority of care-managed packages in institutional settings.

- To improve the level of support for carers in the community.

Targets

- Boards and Trusts should have available a minimum of 300 medical beds above their medical bed baseline to provide the necessary capacity to cope with winter pressures in 2001/2002.

- Boards and Trusts should put in place flexible arrangements for staffing the additional capacity, particularly in those specialist areas where shortages exist.

- Boards and Trusts should ensure that step-down/intermediate care services are put in place by winter 2001/2002.

- Boards and Trusts should increase the number of high dependency beds by 13 by March 2002.

- Boards and Trusts should plan a further flu vaccination programme to cover at least 70% of the 65 plus population and other vulnerable groups. They should also aim to achieve staff vaccination levels of 20%.

- Boards and Trusts should work in partnership with GPs and other health and social care interests to complete, and submit for approval, comprehensive plans for winter 2001/2002 by 30 September 2001.

- Boards and Trusts should provide an additional 230 care packages and analogous services;

- Boards and Trusts should contribute to the review of the implementation of community care policy.

- Boards and Trusts should contribute to the development of a Carers' Strategy by the end of 2001.

Acute Services

The independent review of acute hospital services commissioned by the Minister is due to submit recommendations shortly on the future profile of acute hospital services in Northern Ireland. The Minister has made it clear that, until strategic decisions on the future of acute hospital services have been taken in the light of that review, existing services should be maintained, provided that this does not compromise the safety or effective treatment of patients. Boards and Trusts should continue to plan hospital services on that basis. For the longer term, Boards and Trusts must work together to develop modern and effective hospital services delivering treatment outcomes equivalent to the best in Europe. The Department will also be taking forward the Minister's decisions following the Comprehensive Review of the Ambulance Service.

Objectives

- To complete consultation and finalise action plans for the future provision of Cardiology and Cardiac Surgery in the light of the Reviews led by the CMO.

- To commission major capital developments at the RVH, Mater and Causeway Hospitals.

- To progress the development of Cancer Units and the Cancer Centre in line with the 1996 Campbell Report "Cancer Services: Investing for the Future".

- To continue the development of palliative care standards for services in line with "Partnerships in Caring....Standards for Service".

- To consult on the Independent Review of Acute Hospital Services and reach an agreed way forward.

- To sustain current service profiles at the smaller acute hospitals pending the outcome of the Independent Review of Acute Hospital Services commissioned by the Minister.

- To develop the Ambulance Service in line with the Minister's decisions on the Strategic Review of the Ambulance Service.

- To ensure full HPSS compliance with existing departmental guidance on decontamination and infection control and the new guidance on decontamination of reusable medical devices set out in Circular HSS (MD) 4/01.

Targets

- Boards and Trusts should reduce waiting lists to 48,000 by March 2002, as a first step towards bringing the numbers waiting down to 39,000 by March 2004.

- Boards and Trusts should reduce the number of those waiting longer than 18 months by 50% by March 2002 towards a total elimination of such long waiters by March 2003.

- Boards should agree the service requirements for the new Cancer Centre by September 2001 to facilitate the completion of an acceptable business case to progress the development of the Centre.

- Boards and Trusts should submit proposals to complete the full implementation of the Campbell Report.

- Boards should establish a regional spinal surgery service at the Royal Victoria Hospital by December 2001.

- Boards and Trusts should continue to collaborate to minimise delays in the delivery of safe and effective fracture services and aim to have patients waiting no more than 48 hours for surgery.

- Boards should begin to implement, by November 2001, those agreed recommendations of the Cardiac Surgery Review and Cardiology Review that require immediate action.

- Boards and Trusts should complete arrangements for the transfer of dental general anaesthetic services from general dental practices to acute hospitals.

- Boards, Trusts and the Blood Transfusion Agency should meet the deadline for action on the decontamination of reusable medical devices set out in Circular HSS (MD) 4/01.

- Trusts should report on bacteraemia rates, including MRSA, in acute and other relevant facilities by end 2001.

- Trusts should introduce single-use instruments for tonsillectomy and adenoidectomy as soon as possible during 2001, subject to availability of supplies.

- All acute Trusts should benchmark the cleanliness of their facilities against standards to be specified by the Department and report their findings by June 2001.

- 10 of the A&E vehicles of the Ambulance Service fleet should be replaced by March 2002.

- A Medical Priority Despatch System aimed at targeting ambulance resource to patient needs in the Eastern Board area should be piloted by March 2002.

- The Ambulance Service to provide a 24-hour on-call system to improve services for major incidents by March 2002.

Maternity and Child Health

The arrangements for providing maternity care need to be both flexible and responsive to people's needs and views and ensure the safety of mothers and babies. Boards and Trusts must work together to provide a women-centred service.

Objectives

- To reduce the number of caesarean births, in line with the recommendations of the national review currently underway.
- To maintain current maternity services pending the outcome of the Acute Hospitals Strategic Review.
- To promote good child health by supporting mothers in establishing and maintaining breast-feeding.
- To increase the number of children registered with dentists.
- To continue to develop community paediatric nursing services.
- To develop community-based antenatal services.
- To develop the Regional Children's Palliative Care Service.

Targets

- Boards and Trusts should continue to monitor the safety and effectiveness of maternity services and put in place contingency plans to maintain services where required.
- Boards should establish a neonatal retrieval service by December 2001, to ensure the safe transfer of neonates between local, area and regional maternity services where this is required.

- Boards and Trusts should put in place plans for the implementation of agreed recommendations arising from the national review of caesarean sections.

- Boards and Trusts should take action to increase the proportion of infants breastfed during the first three days of life to 50% by 2003.

- Boards and Trusts should take action to increase the proportion of infants breastfed at six weeks to 35% by March 2003.

- 30% of 0-2 year olds and 68% of 3-5 year olds should be registered with dentists by December 2003.

Family and Child Care

The development of family and child care services is a priority for the Minister and the Assembly's legislative programme includes a number of measures relating to children. A particular priority is increasing the range of adoption, foster and residential places. In relation to the last, the Children Matter Taskforce has identified a strategy to modernise the residential child care sector and provide the additional places needed. Services for children leaving care need to be enhanced and there needs to be support for frontline family support services to maintain and support families at risk and ensure that the number of looked after children is no more than necessary. The extension of the Sure Start programme is also a priority for action.

Objectives

- To implement the strategy for the development of residential child care services set out in the Children Matter Taskforce Report.
- To improve the range of placement options for children looked after by Trusts, through the further development of adoption and fostering services.
- To make preparatory arrangements for the implications of the Children (Leaving Care) Bill becoming law within 2001/2002.
- To make preparatory arrangements for the implications of the Inter-Country Adoption Bill becoming law within 2001/2002.
- To identify the number of children in need of family support services, including the need for respite care services for disabled children.

Targets

- Boards and Trusts should increase the coverage of the Sure Start programme, targeted at children under 4 in areas of social disadvantage, from 11,000 at March 2001 to 16,000 by March 2002.

- Trusts should provide an additional 40 residential care places by March 2002, towards an eventual 52 additional places by March 2003.

- Boards and Trusts should develop a strategy to improve recruitment and retention of staff in residential child care.

- Boards and Trusts should increase the number of looked after children who are adopted by 40 by March 2002.

- Boards and Trusts should increase the number of foster places by 40 by March 2002.

- Boards and Trusts should finalise plans to provide enhanced leaving care services for the 220 young people in this group each year.

Mental Health

The development of mental health services should be based on a comprehensive model, comprising additional primary care services; appropriately skilled community professional staff; additional child and adolescent mental health teams; and additional inpatient beds for children with mental health problems. There is also a need to provide appropriate treatment for high-risk patients, including regional forensic community services. The Department will initiate a review of current mental health legislation by March 2002.

Objectives

- To increase capacity and capability of primary and community care teams to manage mental health problems.

- To increase the number of child and adolescent psychiatric beds in line with the recommendations of the CMO's report "Commissioning Inpatient Psychiatric Services for Children and Young People".

Targets

- Boards and Trusts should increase the number of child and adolescent psychiatric beds from 6 at 1 April 2000 to 16 by December 2001.

- Boards and Trusts should secure an additional 35,000 consultations for the mentally ill in the community.

- Boards and Trusts should finalise plans for the provision of a Medium Secure Unit by December 2001.

Learning Disability

There remain some 500 long-stay patients in specialist disability hospitals who should be resettled in the community if appropriate services are available. There is also a need to modernise facilities for those who will continue to need long-term hospital care.

Objectives

- To secure agreement on a long-term strategy to reduce significantly the number of long-stay patients inappropriately remaining in hospital care.
- To agree a business case for the redevelopment of Muckamore Hospital.
- To finalise plans for the replacement of Stradreagh Hospital.

Targets

- Boards and Trusts should resettle 35 long stay patients from hospital into the community with appropriate support by March 2002.
- Relevant Boards and the Trust concerned should develop the business case for the development of Muckamore Hospital by September 2001.
- Relevant Boards and the Trust concerned should complete the business case for the replacement of Stradreagh Hospital by April 2001.

Physical and Sensory Disability

Waiting lists for occupational therapy in the community continue to be unacceptably high. These waiting times are delaying discharge from hospital and blocking beds. A joint review of housing adaptation conducted by the Department and the Housing Executive has the potential to deliver significant improvements in waiting times for related OT assessments. Wheelchair services remain under pressure and there is a particular need to provide electrically powered indoor/outdoor chairs. There is also a need to establish a Regional Traumatic Brain Injury Unit.

Objectives

- To establish a Regional Traumatic Brain Injury Unit.
- To reduce significantly the number of those waiting for OT assessment.
- To facilitate early discharge from hospital to the community and improve the mobility of patients.

Targets

- Boards and Trusts should finalise a business case for a Regional Traumatic Brain Injury Unit by December 2001.
- Boards and Trusts should provide 100 additional electrically powered indoor/outdoor wheelchairs in 2001/2002.
- Boards and Trusts should increase the number of Occupational Therapists by at least 20 by March 2002.
- Boards and Trusts should reduce the numbers waiting for occupational therapy assessment for housing adaptation at April 2001 by 20% by March 2002.

Health Development

The 'Investing for Health" document is the subject of widespread consultation until April 2001. The Ministerial Group on Public Health will formulate proposals for a Public Health Strategy to be finalised later in the year. It is critical, however, that during this period Boards and Trusts should continue to make progress in tackling key areas for health improvement. It is important also that the statutory sector should prepare for the key role expected of it in implementing the anticipated new Public Health Strategy.

Objectives

- To finalise and begin to implement the new Public Health Strategy.
- To implement the strategy in "Smoking Kills".
- To implement the Drug Strategy and begin to implement the Alcohol Strategy.
- To implement an agreed programme under the mental health promotion strategy "Minding our Health".
- To reduce the percentage of young people under 25 reporting the use of illegal drugs and delay the age of first use of illegal drugs.
- To reduce teenage pregnancies and support teenage mothers as set out in the "Myths and Reality" Strategy.
- To maintain the uptake of MMR vaccine following the renewed adverse publicity and raised public concern.
- To explore other methods of delivering fluoride to the population.
- To ensure a consistent approach to school dental screening and referral for further treatment.

Targets

- Boards and Trusts should support and facilitate the Investing for Health public engagement and consultation project and encourage the participation of the HPSS workforce in the consultation process.

- Boards with Trusts should make preparatory arrangements for the local Investment for Health Partnerships envisaged in the consultative documents.

- Boards, Trusts and the Family Health Services should aim to increase the uptake rates for breast screening from 73% in 1999 to 75% by March 2002.

- Boards, Trusts and the Family Health Services should aim to increase the uptake rate for cervical screening of eligible women (aged 25-64) from 68% in 1999 to 75% by 2003.

- Boards and Trusts should aim to reduce the death rate from Coronary Heart Disease amongst 65-74 year olds from 687 per 100,000 in 1999 to 633 per 100,000 by March 2002.

- Boards and Trusts should aim to reduce the death rate from strokes amongst 15-74 year olds from 46.3 per 100,000 (1990) to 27 per 100,000 by March 2002.

- Boards and Trusts should aim to increase the proportion of the population who do not smoke from 71% in 1999 to 74% by 2003.

- Boards and Trusts should aim to reduce the number of births to mothers under 20 by 10% by March 2002.

- Boards should work in conjunction with Trusts and primary care professionals to maintain a 92% uptake level of MMR at 24 months.

Family Health Services

The current consultation exercise on *Building the Way Forward in Primary Care* has invited comments on proposals for new arrangements that might be put in place in primary care after the GP Fundholding Scheme ends and on the key areas in which policy in primary care should be developed over the next three to five years in order to improve the delivery of services. The outcome of the consultation exercise and decisions on the future of primary care will be made known during the course of 2001/2002 and it is expected that the new arrangements will start to be put in place during this period.

Additional resources are to be made available to Boards in 2001/2002 for the development of primary care. This additional investment will provide Boards greater flexibility to enhance the quality and quantity of services in primary care. Boards will be expected to work closely with Trusts and primary care professionals in the deployment of these additional resources.

Objectives

- To ensure the development of new arrangements in primary care, once these have been decided. It is important that this process is taken forward on the basis of genuine partnership and co-operation so that all concerned can be confident that they have a real stake in the process.

- To use the additional resources provided for primary care, in consultation with primary care professionals, Boards and Trusts to develop primary care services in ways which:

    - encourage a team approach in primary care and promote multi-disciplinary and collaborative working;

    - invest in services that substitute for services currently provided in secondary care;

    - support primary care in its efforts to target health and social need;

- support services which deliver proven outcomes and which have the capacity to be replicated elsewhere as best practice;

- support Local Development Schemes.

- To use the additional resources provided under the General Medical Services Cash-Limited Budget to enhance the quality of services provided in primary care by assisting general practitioners to invest in the staff employed in general practice and in the infrastructure that supports the operation of general practice (premises and information technology).

- To continue to pursue opportunities to make full use of the skills of community pharmacists. In particular, Boards should develop initiatives to optimise prescribing quality, particularly through collaborative partnerships between general practitioners and community pharmacists.

- To continue to implement local strategies, developed in response to the Oral Health Strategy published in 1995, and take into account any revised measures and targets which arise from the mid-term evaluation of the Oral Health Strategy.

- To ensure that arrangements are in place to prevent, detect and investigate fraud.

Targets

- Boards, Trusts and primary care professionals should maintain a 97% uptake rate for all primary immunisations at 12 months.

- Boards and the CSA should take steps to reduce, by the end of 2003/2004, the estimated patient exemption fraud in the Family Health Services to 50% of the 1999-00 level, through the implementation of the Family Practitioner Services Fraud Action Plan.

- To continue to implement initiatives identified in the FPS Fraud Action Plan to ensure appropriate control is exercised over claims for payment from independent contractors.

- Boards should work with GPs to increase the percentage of GP practices using written protocols for repeat prescribing from 70% at 31 March 2000 to 80% by 31 March 2002.

- Boards should work with GPs to increase the percentage of GP practices actively using a recognised prescribing formulary from 70% at 31 March 2000 to 80% by 31 March 2002.

- Boards should co-operate with the Department to extend and upgrade the secure HPSS telecommunications network to include linking of 100% of GP surgeries by December 2002.

- Boards and Trusts should increase the number of nurses authorised to prescribe drugs from 293 in December 2000 to 500 by March 2002.

- Boards and Trusts should work with community pharmacists to ensure that the community pharmacy medicines management initiative is being delivered from at least 20% of community pharmacy practices by 31 March 2002.

- Boards should encourage anti-microbial prescribing in line with the document "The Path of Least Resistance" published by the Standing Medical Advisory Committee Sub-Group on Anti-Microbial Resistance in 1998.

Workforce

The HPSS employs 60,000 people and is dependent on their skills and availability to provide effective and efficient services. In response to staff shortages, particularly in certain specialised areas, the Minister has highlighted the need for improvements in the recruitment and retention of skilled staff. It is important that the HPSS is clear about service needs and the skills and staff required to deliver those services efficiently and effectively.

Objectives

- To review the effectiveness of current workforce planning mechanisms and introduce improvements to enhance the multi-professional dimension to such activity.

- To ensure that recruitment and retention issues are addressed and that future workforce requirements are identified and linked to workforce planning activities.

- To review utilisation of the workforce in terms of maximising performance and effectiveness. Areas such as staff sickness absence levels should be included and action plans drawn up to address outstanding issues.

- To implement the agreement on "Improving Junior Doctors' Lives" and the changes to Consultants' contracts.

- To introduce new arrangements for the commissioning of post-registration education for nurses, midwives and health visitors.

- To progress the full range of measures identified in the PSS Training Strategy 2000-2003.

Targets

- The Department should increase the intake of student nurses to pre-registration education by a further 100 in 2001/2002 and the following 2 years to provide an output of 640 nurses per annum by 2003/2004.

- The Department should increase the number of medical student places by 14 and Pre-registration House Officer posts by 7 to meet workforce requirements.

- The Department should increase the number of Specialist Registrar posts by 15 to meet service developments.

- The Department should address the need to increase numbers of students pre and post registration education in PAMs, Clinical Scientists and other health and social care professions to meet workforce requirements.

- Trusts should review the effectiveness and efficiency of their workforces and draw up action plans for improvement by December 2001. This should include the establishment of targets and action plans for the reduction of absenteeism.

- Trusts should implement the agreements on junior doctors' conditions and the changes to consultants' contracts within the specified timetables.

- Boards and Trusts should increase practice placements for student social workers by 15% by March 2002 to meet required increased intake to social work training.

Capital Investment

In 2001/2002, the Department plans to issue its Capital Investment Strategy to set a framework for the prioritisation of capital investment in the future. The Strategy will encompass the need to rationalise the HPSS estate. The Budget has provided additional capital funds for 2001/2002. This will enable the completion of major projects at the RVH and Causeway, the initiation of further strategic programmes in relation to imaging and residential child care and an enhancement of the level of general capital to tackle the backlog in statutory standards.

Objectives

- To issue and consult on the Capital Investment Strategy.
- To pursue estate rationalisation in the HPSS.
- To continue to manage major projects within agreed timetables and budgets.
- To reduce the backlog in essential health and safety/firecode work.
- To develop an Imaging Modernisation Programme.
- To support the development of residential child care facilities.
- To continue to modernise key acute hospital provision and, in particular, to begin redevelopment of the Ulster Hospital.

Targets

- Boards and Trusts should participate in the consultation on the Capital Investment Strategy.
- Trusts should clearly identify, in Service Delivery Plans, capital investment proposals focused on reducing the backlog in meeting statutory standards.

- Trusts should identify, in Service Delivery Plans, proposals on how they will ensure that their estate and assets match their delivery needs.

- Boards and Trusts should finalise business cases for the continued expansion of residential child care envisaged by the Children Matter Task Force.

Information and Communications Technologies

A project to develop a new ICT strategy for the HPSS began in 2000/2001. This will continue during 2001/2002 with development of a strategic vision for ICT in the HPSS and an associated implementation plan. The strategy development process will involve all of the HPSS in consultation and, in some cases, will require contributors to the working up of implementation options. A small number of projects and initiatives have already been identified as key components of any strategy and work on them has already begun. The Unique Patient and Client Identifier (UPCI) project, which is the most significant of these, will begin implementation during 2001/2002.

Objective

- To secure the participation of all HPSS organisations to the strategy development process and to contribute, as appropriate, to initial projects and initiatives, particularly the improvement of data quality and harmonisation in preparation for the introduction of the UPCI.

Targets

- All HPSS organisations should contribute to a consultation process leading to the development and publication of an agreed HPSS ICT Strategy by September 2001.
- All HPSS organisations should take steps during 2001/2002 to improve and harmonise user data and modify their operational procedures to make most effective use of UPCI.
- All HPSS organisations should take steps to comply with the HPSS Network Security Policy by August 2001.
- All HPSS organisations should establish effective procedures and ICT mechanisms to support a comprehensive and accessible HPSS-wide electronic mail directory by the end of 2001.

- All HPSS organisations should ensure that their Intranet and Internet sites conform to the appropriate style and content guidelines by the end of 2001.

Partnership with the Voluntary and Community Sector

The voluntary and community sector makes a significant contribution to the health and social wellbeing of the people of Northern Ireland. The Department values this contribution and is committed to partnership approaches in the development of health and social care policies and services that respond effectively to need. Under the Compact between Government and the voluntary and community sector, the Department is committed to developing a strategy for the HPSS, setting out how it intends to promote partnership with the voluntary and community sector. This work will be taken forward during 2001 in collaboration with the Voluntary Activity Unit, Department of Social Development.

Objectives

- To ensure that funding for the voluntary and community sector, either by way of grant aid or through contracting for services, enables the sector to achieve sustainable outcomes in line with Boards' and Trusts' policies and objectives.

- To encourage good volunteering practice throughout the HPSS.

Target

- Boards and Trusts should nominate a liaison officer as a first point of contact to assist voluntary and community organisations in obtaining assistance and information on policy and service-related issues by December 2001.

Equality

Following attempts to make the previous non-statutory Policy Appraisal and Fair Treatment initiative more effective, section 75 of the Northern Ireland Act 1998 imposes specific duties on all public authorities. Schedule 9 of the Act sets out a detailed procedure for the enforcement of these duties. In brief, Boards and Trusts must prepare and submit Equality Schemes to the Equality Commission for approval, including screening their policies for equality of opportunity and drawing up an equality impact assessment programme.

Objectives

- To promote equality of opportunity among the nine groups of people specified in the Northern Ireland Act.

- To promote good relations between people of different religious beliefs, political opinion and racial groups.

Targets

- HPSS organisations should contribute to the consultation process and the development of a synchronised programme of equality impact assessments, by June 2001.

- HPSS organisations should carry out equality impact assessments on those policies identified for year 1 of this programme, by March 2002.

- HPSS organisations should train staff on the new equality obligations, by March 2002.

Human Rights

The Human Rights Act came fully into force in October 2000 and provides additional focus and emphasis to the rights and freedoms of individuals guaranteed under the European Convention on the Human Rights. Consideration of the Human Rights Act and its implications for the development and implementation of policies, procedures and services is likely to have significant impact on the future work of the Department and the HPSS.

Objectives

- To ensure that consideration of Human Rights and their implications should become an integral part of the work and culture of the HPSS.

- To ensure that all policies, procedures and services comply with the Human Rights Act.

Targets

- HPSS organisations should conduct an audit of their policies and practices in order to assess whether they comply with the European Convention on Human Rights by 1 October 2001.

- HPSS organisations should develop and implement a programme of Human Rights awareness training for their staff, as well as more specialist training for groups of staff, by 31 December 2001.

New TSN

The objective of the New Targeting Social Need (New TSN) policy is to tackle social need and social exclusion through the skewing of resources towards those individuals, groups and areas in greatest need, with a particular emphasis on addressing the problem of employment and employability. There is no distinct 'New TSN Programme' and hence no earmarked allocation of resources for the initiative. Instead, New TSN is to be regarded as a theme or standard that runs through spending programmes and requires efforts and resources to be redirected within programmes towards those objectively shown to be in greatest need.

Objectives

- To ensure that New TSN becomes an integral part of the culture of HPSS bodies.
- To ensure that New TSN considerations are built into Service Investment Plans and other documents.

Targets

- Boards and Trusts should identify all areas of their responsibility to which New TSN is relevant and draw on this information when establishing or implementing policy.
- HSS Boards, HSS Councils and the Health Promotion Agency should have New TSN Action Plans in place by 1 April 2001.
- HSS Trusts should develop and consult on New TSN Action Plans and have them in place by 1 April 2002.

North/South Co-operation

Ministers have endorsed a programme of work to further develop cross border co-operation and joint working in a number of areas. These include accident and emergency planning, pre-hospital emergency care, hospital and community related planning for major incidents, development of co-operative arrangements on renal transplantation and radiotherapy services, drawing up protocols for the assessment and evaluation of emerging new technology, cancer research and health promotion. Working Groups have been established to progress these initiatives, which will in the course of the year result in actions to be taken forward by the HPSS and the Health Service in the South.

Objective

- To work together on health and social care matters to secure greater benefits for all than could be achieved through working in isolation.

Targets

- Boards and Trusts should develop proposals for further local collaborative projects for accident and emergency services.

- Boards and Trusts should co-operate with the Regional Hospital Services Group in scoping the development of collaborative arrangements for renal transplantation and radiotherapy services.

- Boards and Trusts should ensure that relevant personnel have participated in a joint training programme on the management of major medical incidents by March 2002.

- Boards and Trusts should put in place arrangements that take account of recommendations and common protocols on hospital and community related responses to major incidents by March 2002.

- Boards and Trusts should ensure that relevant personnel have participated in pilot schemes to improve response times to life threatening emergency calls in rural,

border areas by March 2002.

- HPSS organisations should contribute to the establishment of a joint High Technology Assessment Group to draw up protocols for the assessment/evaluation of emerging new technology.

TIMETABLE

Boards and Trusts should submit Service Investment and Service Delivery Plans to the Department of Health, Social Services and Public Safety by 31 March 2001 and 30 April 2001 respectively.

GENERAL INFORMATION

This document is available on the Department of Health, Social Services and Public Safety's website: www.dhsspsni.gov.uk. Alternatively, further copies may be obtained by contacting Melissa Maguire, Room 106 Dundonald House, Upper Newtownards Road, Belfast BT4 3SF. Tel: [redacted] Fax: [redacted] E-mail: melissa.maguire[redacted]

Appendix A

CORE ELEMENTS OF SERVICE INVESTMENT PLANS

Service Investment Plans must set out, by Programme of Care, the range of services Boards intend to secure to meet the needs of their local populations and deliver on the targets/objectives set out in this document. They must demonstrate that services commissioned have been fully resourced. The Plans, which should be submitted to the Department by 31 March 2001, will be the basis for performance management by the Department over the next financial year and will be the focus of the consequent Accountability Review when each Board's achievement against the Minister's targets/objectives is reviewed. Service Investment Plans must include the following core elements:

- Resources allocated
- ~~Local context for "Priorities for Action"~~
- Priorities, budget allocations and volumes by provider and Programme of Care
- Arrangements for incorporating Equality, Human Rights and New TSN perspectives at all stages of the development, improvement and evaluation of services
- Arrangements to widen public involvement in the development, improvement and evaluation of services
- Strategies to maximise the effective use of Human Resources including workforce planning and managing absenteeism
- Information and Communications Technologies plans
- Measures to control administrative costs

Appendix B

CORE ELEMENTS OF SERVICE DELIVERY PLANS

Service Delivery Plans must reflect the totality of Service and Budget Agreements that Trusts have entered into with their commissioners. They must demonstrate how Trusts, within their income, will deliver on the objectives and targets set out in this document. They must also include the steps that Trusts are taking to improve management efficiency and resource utilisation, including workforce and estate. The Plans, which will be a focus for strengthened performance management arrangements for Trusts, should be submitted to the Department by 30 April 2001. Service Delivery Plans must include the following core elements.

- The projected income expected from within and outside the HPSS by commissioner

- Total planned expenditure and volume of activity by Programme of Care, cross-referenced to Priorities for Action

- Arrangements for incorporating Equality, Human Rights and New TSN perspectives at all stages of the development, improvement and evaluation of policies and procedures for the delivery of services

- Arrangements to widen public involvement in the development, improvement and evaluation of policies and procedures for the delivery of services

- Procedures for handling complaints and achieving Charter standards

- Strategies to maximise the effective use of Human Resources including workforce planning and managing absenteeism

- Management efficiency plans, including benchmarking exercises, VFM studies, quality initiatives and measures to control management costs.

- Capital Investment Plans
- Estate rationalisation and development
- Information and Communications Technologies plans

Department of Health, Social Services & Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteacht Phoiblí

cancelled by HSS (PPM) 7/2002

HSS (PPM) 5/2001

Room D4.17
Castle Buildings
Stormont
BELFAST
BT4 3SJ

Tel No: [redacted]
FAX No:
E-Mail: john.mcgrath [redacted]

Chief Executives of HSS Boards
Chief Executives of HSS Trusts (excluding NIAS)

24 August 2001

PRIORITIES FOR ACTION – MONITORING AND ACCOUNTABILITY

1. When the Minister published her Priorities for Action 2001/2002, she announced that they would form the basis of strengthened monitoring and accountability arrangements. The first stage of the process has now been completed in that the Minister has approved, subject to some clarification, Boards' Service Investment Plans for 2001/2002.

2. The Department will now monitor progress towards the achievement of Priorities for Action targets on a quarterly basis. Boards will be expected to submit formal progress reports on the position at 30 September 2001, 31 December 2001 and 31 March 2002. This will also tie into the Executive's timetable for monitoring of progress on Programme for Government implementation, where Departments are being asked to make progress reports to the Office of the First Minister and Deputy First Minister (OFMDFM) on a quarterly basis.

3. The progress report will be the focus for the regular bi-lateral meetings with each Board, in the future formal Progress Reviews. The overall achievement against targets will be the subject of the 2002 Accountability Review with each Board and the formal accountability mechanisms to be put in place for Trusts.

4. In response to a number of requests made during the process to agree Service Investment Plans, the Department has drawn together all of the Priorities for Action targets in a single matrix which is being e-mailed to you with this letter. Targets that are not relevant to the HPSS at this point have been shaded. I should be grateful if you would provide a progress report at 30

INVESTOR IN PEOPLE

September 2001 beside each relevant target. Your reports will contribute to the Department's own return to OFMDFM. To be in a position to respond fully to OFMDFM, I must ask you to report the action you have taken against each target. A simple "on target" will not suffice. Evidence of progress towards achievement of the target is needed. Where slippage is indicated against a target, you must provide an explanation, including steps you have taken to bring progress back on line. The Executive has emphasised that this is an aspect of Programme for Government performance in which it will take a particularly close interest.

5. The Department's Information and Analysis Unit has already been working with colleagues in Boards to agree the definitions and methodology for monitoring targets, where appropriate. The usual contacts in my own Directorate also stand ready to deal with any other queries you may have.

6. A copy of this letter and the matrix goes to Chief Executives of HSS Trusts so that those with individual responsibility for specific targets may also report progress. I should be grateful if you would do everything possible to ensure that returns are made by e-mail before 5 October 2001 to allan.gault[redacted] for Northern, Southern and Western Board areas and damien.kerr[redacted] for Eastern Board area.

7. Any queries about the general process should be addressed to Ray Martin tel. [redacted]

Yours sincerely

JOHN McGRATH
Director of Planning and Performance Management

INQ - DHSSPS

PfA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
1	Winter Pressures and Community Care			
1.1	Boards and Trusts should have available a minimum of 300 medical beds above their medical bed baseline to provide the necessary capacity to cope with winter pressures in 2001/2002.			
1.2	Boards and Trusts should put in place flexible arrangements for staffing the additional capacity, particularly in those specialist areas where shortages exist.			
1.3	Boards and Trusts should ensure that step-down/intermediate care services are put in place by winter 2001/2002.			
1.4	Boards and Trusts should increase the number of high dependency beds by 13 by March 2002.	1.1	To Improve capacity to meet winter pressures, including expansion of frontline staff and an increase in the number of high dependency beds from 36 at March 2001 to 75 by March 2004, with the immediate aim of increasing the number to 49 by March 2002.	
1.5	Boards and Trusts should plan a further flu vaccination programme to cover at least 70% of the 65 plus population and other vulnerable groups. They should also aim to achieve staff vaccination levels of 20%.			
1.6	Boards and Trusts should work in partnership with GPs and other health and social care interests to complete, and submit for approval, comprehensive plans for winter 2001/2002 by 30 September 2001.			
1.7	Boards and Trusts should provide an additional 230 care packages and analogous services.	1.2	To increase the number of community care packages by 230 in the course of 2001-02 in order to maintain the provision of high quality care for those waiting in the community for suitable care.	
1.8	Boards and Trusts should contribute to the review of the implementation of community care policy.	1.3	By September 2001, to review the implementation of the community care policy, with a view to ensuring that adequate levels of service are available and preventing inappropriate hospital admissions and discharge arrangements.	
1.9	Boards and Trusts should contribute to the development of a Carers' Strategy by the end of 2001.			
2	Acute Services			
2.1	Boards and Trusts should reduce waiting lists to 48,000 by March 2002, as a first step towards bringing the numbers waiting down to 39,000 by March 2004.	2.1	By March 2004, to reduce waiting lists by a quarter, ie from 51,000 to 39,000, with the immediate aim of a reduction to 48,000 by March 2002.	
2.2	Boards and Trusts should reduce the number of those waiting longer than 18 months by 50% by March 2002 towards a total elimination of such long waiters by March 2003.	2.2	By March 2003, to eliminate entirely the need to wait for longer than the Charter Standard of 18 months (12 months for cardiac surgery), with a 50% reduction in the numbers of those waiting by March 2002.	
2.3	Boards should agree the service requirements for the new Cancer Centre by September 2001 to facilitate the completion of an acceptable business case to progress the development of the Centre.	2.3	By September 2001, to finalise plans for Belfast City Hospital Cancer Centre.	
2.4	Boards and Trusts should submit proposals to complete the full implementation of the Campbell Report.			

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PfA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
		2.4	By March 2002, provide for some 45 additional specialist medical, nursing and other staff to improve cancer services and to consolidate progress made on the implementation of the Cancer Strategy.	
2.5	Boards should establish a regional spinal surgery service at the Royal Victoria Hospital by December 2001.			
2.6	Boards and Trusts should continue to collaborate to minimise delays in the delivery of safe and effective fracture services and aim to have patients waiting no more than 48 hours for surgery.			
2.7	Boards should begin to implement, by November 2001, those agreed recommendations of the Cardiac Surgery Review and Cardiology Review that require immediate action.	2.5	By autumn 2001, finalise and begin to implement an action plan for the development of cardiology and cardiac surgery services on foot of the recent Reviews.	
2.8	Boards and Trusts should complete arrangements for the transfer of dental general anaesthetic services from general dental practices to acute hospitals.			
2.9	Boards, Trusts and the Blood Transfusion Agency should meet the deadline for action on the decontamination of reusable medical devices set out in Circular HSS (MD) 4/01.			
2.10	Trusts should report on bacteraemia rates, including MRSA, in acute and other relevant facilities by end 2001.			
2.11	Trusts should introduce single-use instruments for tonsillectomy and adenoidectomy as soon as possible during 2001, subject to availability of supplies.			
2.12	All acute Trusts should benchmark the cleanliness of their facilities against standards to be specified by the Department and report their findings by June 2001.			
2.13	10 of the A&E vehicles of the Ambulance Service fleet should be replaced by March 2002.	2.6	By March 2002, to replace 10 A&E vehicles in the Ambulance Service fleet.	
2.14	A Medical Priority Despatch System aimed at targeting ambulance resources to patient needs in the Eastern Board area should be piloted by March 2002.	2.7	By March 2002 to have piloted and evaluated a Medical Priority Despatch System targeting ambulance resources to patient needs in the Eastern Board area, for rollout across the other three Board areas in the following years.	
2.15	The Ambulance Service to provide a 24-hour on-call system to improve services for major incidents by March 2002.	2.8	By March 2002, to provide a 24-hour officer on-call system that will provide improved ambulance services for major incidents.	
		2.9	To introduce improvements to the Ambulance Service communications and control system.	
		2.10	To undertake key developments in regional services such as renal and cardiac services according to the specific needs of Boards' populations.	
		2.11	By December 2001, following consultation on an equality impact assessment of the Acute Hospitals Review, to reach an agreed way forward.	

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PfA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
		2.12	By December 2002, to develop a fully articulated implementation plan for hospital services, including capital development and human resource programmes	
3	Maternity and Child Health			
3.1	Boards and Trusts should continue to monitor the safety and effectiveness of maternity services and put in place contingency plans to maintain services where required.			
3.2	Boards should establish a neonatal retrieval service by December 2001, to ensure the safe transfer of neonates between local, area and regional maternity services where this is required.			
3.3	Boards and Trusts should put in place plans for the implementation of agreed recommendations arising from the national review of caesarean sections.			
3.4	Boards and Trusts should take action to increase the proportion of infants breastfed during the first three days of life to 50% by 2003.	3.1	To better protect mothers' health and give babies a healthier start in life by increasing the proportion of infants breastfed during the first three days of life to 50% by 2003	
3.5	Boards and Trusts should take action to increase the proportion of infants breastfed at six weeks to 35% by March 2003.	3.2	To better protect mothers' health and give babies a healthier start in life by increasing the proportion of infants breastfed at six weeks from 25% in 1995 to 35% by March 2003.	
3.6	30% of 0-2 year olds and 68% of 3-5 year olds should be registered with dentists by December 2003.	3.3	By December 2003, to increase the percentage of children registered with dentists from 24% (December 2000) to 30% for 0-2 year olds and from 62% to 68% for 3-5 year olds.	
4	Family and Child Care			
4.1	Boards and Trusts should increase the coverage of the Sure Start programme, targeted at children under 4 in areas of social disadvantage, from 11,000 at March 2001 to 16,000 by March 2002.	4.1	To increase the coverage of the Sure Start programme, targeted at children under 4 in areas of social disadvantage, from 11,000 children at March 2001 to 16,000 children by March 2002.	
4.2	Trusts should provide an additional 40 residential care places by March 2002, towards an eventual 52 additional places by March 2003.	4.2	To increase the number of residential care places by 12 more than currently funded making a total increase of 52 by March 2003.	
4.3	Boards and Trusts should develop a strategy to improve recruitment and retention of staff in residential child care.			
4.4	Boards and Trusts should increase the number of looked after children who are adopted by 40 by March 2002.			
4.5	Boards and Trusts should increase the number of foster places by 40 by March 2002.	4.3	By March 2002, to increase the number of foster places by 40.	
4.6	Boards and Trusts should finalise plans to provide enhanced leaving care services for the 220 young people in this group each year.			
		4.4	By March 2002, to introduce legislation to help young people move from care to independent living.	

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PfA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
		4.5	By June 2001, to issue new Child Protection Guidance and, by September 2001, to introduce a Protection of Children and Vulnerable Adults Bill which will provide a statutory system for checking the suitability of people applying to work with children and vulnerable adults.	
		4.6	By December 2001, working with other agencies, to develop common standards for inspection in early education and child care settings.	
5	Mental Health			
5.1	Boards and Trusts should increase the number of child and adolescent psychiatric beds from 6 at 1 April 2000 to 16 by December 2001.	5.1	By December 2001, to increase the number of child and adolescent psychiatric beds from 6 at April 2000 to 16.	
5.2	Boards and Trusts should secure an additional 35,000 consultations for the mentally ill in the community.	5.2	In the course of 2001-02, to provide an additional 35,000 consultations for the mentally ill in the community.	
5.3	Boards and Trusts should finalise plans for the provision of a Medium Secure Unit by December 2001.	5.3	By December 2001, to finalise plans for the provision of a medium secure unit.	
		5.4	By March 2002 to initiate, and by September 2002 to complete, a review of current mental health legislation with a view to updating it to reflect advances in treatment and practice.	
6	Learning Disability			
6.1	Boards and Trusts should resettle 35 long stay patients from hospital into the community with appropriate support by March 2002.	6.1	During 2001-02, to support the resettlement of 35 long-stay patients from hospital, by providing for the necessary community teams comprising specialist professionals.	
6.2	Relevant Boards and the Trust concerned should develop the business case for the development of Muckamore Hospital by September 2001.	6.2	By December 2001 agree a business case for the redevelopment of Muckamore Hospital.	
6.3	Relevant Boards and the Trust concerned should complete the business case for the replacement of Stradreagh Hospital by April 2001.	6.3	By October 2001, finalise plans for the replacement of Stradreagh Hospital.	
7	Physical and Sensory Disability			
7.1	Boards and Trusts should finalise a business case for a Regional Traumatic Brain Injury Unit by December 2001.	7.1	By March 2002, to finalise plans for provision of a Regional Traumatic Brain Injury Centre.	
7.2	Boards and Trusts should provide 100 additional electrically powered indoor/outdoor wheelchairs in 2001/2002.	7.2	By March 2002, to increase the number of electric powered indoor/outdoor wheelchairs from nil at April 2001 to 100.	
7.3	Boards and Trusts should increase the number of Occupational Therapists by at least 20 by March 2002.	7.3	By March 2002, to increase the number of Occupational Therapists by 20.	
7.4	Boards and Trusts should reduce the numbers waiting for occupational therapy assessment for housing adaptation at April 2001 by 20% by March 2002.	7.4	By March 2002, to reduce the number of people waiting for occupational therapy assessments for housing adaptations at April 2001 by 20%.	
8	Health Development			
8.1	Boards and Trusts should support and facilitate the Investing for Health public engagement and consultation project and encourage the participation of the HPSS workforce in the consultation process.			

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PfA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
		8.1	By April 2001, to complete public consultation on developing a cross-cutting public health strategy, "Investing for Health"	
8.2	Boards with Trusts should make preparatory arrangements for the local Investment for Health Partnerships envisaged in the consultative documents.			
8.3	Boards, Trusts and the Family Health Services should aim to increase the uptake rates for breast screening from 73% in 1999 to 75% by March 2002.	8.2	By March 2002, to increase the uptake rate for breast screening from 73% in 1999 to 75%.	
8.4	Boards, Trusts and the Family Health Services should aim to increase the uptake rate for cervical screening of eligible women (aged 25-64) from 68% in 1999 to 75% by 2003.	8.3	By December 2003, to increase the uptake rate for cervical screening of women aged 25-64 from 68% in 1999 to 75%.	
8.5	Boards and Trusts should aim to reduce the death rate from Coronary Heart Disease amongst 65-74 year olds from 687 per 100,000 in 1999 to 633 per 100,000 by March 2002.	8.4	To reduce the death rate from Coronary Heart Disease among 65-74 year olds from 687 per 100,000 (1999) to 633 per 100,000 by March 2002, and to 620 per 100,000 by 2004.	
8.6	Boards and Trusts should aim to reduce the death rate from strokes amongst 15-74 year olds from 46.3 per 100,000 (1990) to 27 per 100,000 by March 2002.	8.5	To reduce the death rate from strokes amongst 15-74 year olds from 34.5 per 100,000 (1999) to 27 per 100,000 by March 2001.	
8.7	Boards and Trusts should aim to increase the proportion of the population who do not smoke from 71% in 1999 to 74% by 2003.	8.6	To increase the proportion of the population aged 16+ who do not smoke from 71% at March 1999 to 74% at March 2003 and to increase the proportion of the population aged 11-15 who do not smoke from 78% at March 1999 to 81% at March 2003.	
8.8	Boards and Trusts should aim to reduce the number of births to mothers under 20 by 10% by March 2002.	8.7	To reduce the number of births to mothers under 20 from 17 per 1,000 in 1998 to 15.3 per 1,000 by December 2002.	
8.9	Boards should work in conjunction with Trusts and primary care professionals to maintain a 92% uptake level of MMR at 24 months.			
		8.8	By September 2001, to complete feedback conference, equality impact assessment and implementation plan for the "Investing for Health" strategy.	
		8.9	By December 2001, to have in place an inter-agency planning system to implement the "Investing for Health" strategy.	
		8.10	To promote multi-sectoral working in line with the "Investing for Health" approach, and to further develop the health improvement agenda.	
		8.11	To reduce the percentage of young people under 25 reporting the use of illicit drugs, and delay age of first use of illicit drugs - the immediate aim being to establish, by September 2001, a baseline from which to measure change.	
		8.12	Take forward a work programme with the Republic of Ireland's Department of Health and Children which reflects mutual priorities, including anti-smoking publicity campaigns, assessment of training needs for those working in health promotion, workplace health initiatives and all-Ireland research into public health.	

PfA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
		8.13	To work with DCAL and in co-operation with District Councils, in their development, by December 2001, of a Strategy for improving health and well being through participation in culture and leisure activities and increased health-related physical activity.	
		8.14	To work with DoE in their preparation, by June 2001, of a Sustainable Development Strategy, incorporating a set of indicators of progress including health-related measures.	
		8.15	To work with DE in their revision and implementation, by 2003/4, of the curriculum for schools to enhance the status and impact of health education.	
		8.16	To work with DETI and the Health and Safety Executive to develop, by April 2005, an occupational health strategy for Northern Ireland.	
9	Family Health Services			
9.1	Boards, Trusts and primary care professionals should maintain a 97% uptake rate for all primary immunisations at 12 months.	9.1	To maintain a 97% uptake rate for all primary immunisations at 12 months.	
9.2	Boards and the CSA should take steps to reduce, by the end of 2003/2004, the estimated patient exemption fraud in the Family Health Services to 50% of the 1999-00 level, through the implementation of the Family Practitioner Services Fraud Action Plan.	9.2	By March 2004, reduce the estimated patient exemption fraud in the FHS to 50% of the 1999-00 level, through implementation of the Family Practitioner Services Fraud Action Plan.	
9.3	To continue to implement initiatives identified in the FPS Fraud Action Plan to ensure appropriate control is exercised over claims for payment from independent contractors.			
9.4	Boards should work with GPs to increase the percentage of GP practices using written protocols for repeat prescribing from 70% at 31 March 2000 to 80% by 31 March 2002.	9.3	By March 2002, to increase the percentage of GP practices using written protocols for repeat prescribing from 70% at March 2000 to 80%.	
9.5	Boards should work with GPs to increase the percentage of GP practices actively using a recognised prescribing formulary from 70% at 31 March 2000 to 80% by 31 March 2002.	9.4	By March 2002, to increase the percentage of GP practices actively using a recognised prescribing formulary from 70% at March 2000 to 80%.	
9.6	Boards should co-operate with the Department to extend and upgrade the secure HPSS telecommunications network to include linking of 100% of GP surgeries by December 2002.	9.5	By December 2002, to extend and upgrade the secure HPSS telecoms network to include linking of 100% of GP surgeries.	
9.7	Boards and Trusts should increase the number of nurses authorised to prescribe drugs from 293 in December 2000 to 500 by March 2002.			
9.8	Boards and Trusts should work with community pharmacists to ensure that the community pharmacy medicines management initiative is being delivered from at least 20% of community pharmacy practices by 31 March 2002.			
9.9	Boards should encourage anti-microbial prescribing in line with the document "The Path of Least Resistance" published by the Standing Medical Advisory Committee Sub-Group on Anti-Microbial Resistance in 1998.			

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PfA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
		9.6	To enhance the quality of services provided in primary care by investing in the staff employed in general practice, in the infrastructure that supports general practice (information technology and premises), and in the development of innovative primary care services.	
		9.7	To outline the strategy for putting in place new arrangements in primary care following the abolition of the GP Fundholding Scheme.	
10	Workforce			
10.1	The Department should increase the intake of student nurses to pre-registration education by a further 100 in 2001/2002 and the following 2 years to provide an output of 640 nurses per annum by 2003/2004.	10.1	To increase the intake of student nurses to pre-registration education by a further 100 in 2001/02 and the following two years to provide an output of 640 trained nurses per annum by 2003-04.	
10.2	The Department should increase the number of medical student places by 14 and Pre-registration House Officer posts by 7 to meet workforce requirements.	10.2	By March 2002, to increase the numbers of medical students and Pre-registration House Officers to meet workforce requirements.	
10.3	The Department should increase the number of Specialist Registrar posts by 15 to meet service developments.	10.3	By March 2002, to increase the number of specialist registrar posts to support strategic service developments.	
10.4	The Department should address the need to increase numbers of students pre and post-registration education in PAMs, Clinical Scientists and other health and social care professions to meet workforce requirements.	10.4	By March 2002, to increase numbers of students entering pre and post-registration education in the therapeutic professions allied to medicine, Clinical Scientist and other Health and Social Care professions to meet workforce requirements.	
10.5	Trusts should review the effectiveness and efficiency of their workforces and draw up action plans for improvement by December 2001. This should include the establishment of targets and action plans for the reduction of absenteeism.			
10.6	Trusts should implement the agreements on junior doctors' conditions and the changes to consultants' contracts within the specified timetables.			
10.7	Boards and Trusts should increase practice placements for student social workers by 15% by March 2002 to meet required increased intake to social work training.			
11	Capital Investment			
11.1	Boards and Trusts should participate in the consultation on the Capital Investment Strategy.			
11.2	Trusts should clearly identify, in Service Delivery Plans, capital investment proposals focused on reducing the backlog in meeting statutory standards.			
11.3	Trusts should identify, in Service Delivery Plans, proposals on how they will ensure that their estate and assets match their delivery needs.			
11.4	Boards and Trusts should finalise business cases for the continued expansion of residential child care envisaged by the Children Matter Task Force.	11.1	To support the implementation of Children Matter, through the construction of specialised children's homes.	
		11.2	By April 2001, to open the new Causeway Hospital replacing outmoded hospital facilities in North Antrim.	

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PfA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
		11.3	To finalise and begin implementation of a strategic development plan to modernise the forty-year old Ulster Hospital.	
		11.4	To develop and begin implementing an Imaging Modernisation Programme to replace ageing radiology equipment and expand the use of magnetic resonance imaging at lead cancer centres.	
		11.5	To reduce the backlog in essential health and safety 'at risk' work.	
12.	Information and Communications Technologies			
12.1	All HPSS organisations should contribute to a consultation process leading to the development and publication of an agreed HPSS ICT Strategy by September 2001.	12.1	By September 2001, agree a new strategy for the use of Information and Communication Technologies in the HPSS to improve the delivery of health and social care, and by December 2001 establish support mechanisms for an HPSS –wide e-mail directory.	
		12.2	By September 2002, to implement the Unique Patient/Client Identifier Project. This will electronically link patient/client records across the HPSS, leading to improved accuracy and reliability in information held for individual service users and thereby enhnce the quality of care.	
12.2	All HPSS organisations should take steps during 2001/2002 to improve and harmonise user data and modify their operational procedures to make most effective use of UPCI.			
12.3	All HPSS organisations should take steps to comply with the HPSS Network Security Policy by August 2001.			
12.4	All HPSS organisations should establish effective procedures and ICT mechanisms to support a comprehensive and accessible HPSS-wide electronic mail directory by the end of 2001.			
12.5	All HPSS organisations should ensure that their Intranet and Internet sites conform to the appropriate style and content guidelines by the end of 2001.			
13.	Partnership with the Voluntary and Community Sector			
13.1	Boards and Trusts should nominate a liaison officer as a first point of contact to assist voluntary and community organisations in obtaining assistance and information on policy and service-related issues by December 2001.			
14.	Equality			
14.1	HPSS organisations should contribute to the consultation process and the development of a synchronised programme of equality impact assessments, by June 2001.	14.1	Fulfill the statutory equality obligations placed on the Department by Section 75 of the Northern Ireland Act 1998 and in particular to finalise by June 2001 a phased programme of equality impact assessments, co ordinating with Boards and the NDPBs where possible.	
14.2	HPSS organisations should carry out equality impact assessments on those policies identified for year 1 of this programme, by March 2002.			
14.3	HPSS organisations should train staff on the new equality obligations, by March 2002.			

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PfA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
15	Human Rights			
15.1	HPSS organisations should conduct an audit of their policies and practices in order to assess whether they comply with the European Convention on Human Rights by 1 October 2001.			
15.2	HPSS organisations should develop and implement a programme of Human Rights awareness training for their staff, as well as more specialist training for groups of staff, by 31 December 2001.			
16	New TSN			
16.1	Boards and Trusts should identify all areas of their responsibility to which New TSN is relevant and draw on this information when establishing or implementing policy.			
16.2	HSS Boards, HSS Councils and the Health Promotion Agency should have New TSN Action Plans in place by 1 April 2001.	16.1	By April 2001, Health and Social Services (HSS) Boards, HSS Councils, the Health Promotion Agency and the Fire Authority for Northern Ireland to have New TSN Action Plans in place.	
16.3	HSS Trusts should develop and consult on New TSN Action Plans and have them in place by 1 April 2002.	16.2	By 1 April 2002, HSS Trusts to have New TSN Action Plans in place.	
17	North/South Co-operation			
17.1	Boards and Trusts should develop proposals for further local collaborative projects for accident and emergency services.			
17.2	Boards and Trusts should co-operate with the Regional Hospital Services Group in scoping the development of collaborative arrangements for renal transplantation and radiotherapy services.			
17.3	Boards and Trusts should ensure that relevant personnel have participated in a joint training programme on the management of major medical incidents by March 2002.			
17.4	Boards and Trusts should put in place arrangements that take account of recommendations and common protocols on hospital and community related responses to major incidents by March 2002.			
17.5	Boards and Trusts should ensure that relevant personnel have participated in pilot schemes to improve response times to life threatening emergency calls in rural, border areas by March 2002.			
17.6	HPSS organisations should contribute to the establishment of a joint High Technology Assessment Group to draw up protocols for the assessment/evaluation of emerging new technology.			
		17.1	To take forward work in the North South Ministerial Council giving immediate priority to cancer research, health promotion, accident and emergency planning, major emergencies and co-operation on high technology equipment.	
18	Additional Public Service Agreement Targets			
		18.1	Ensure effective financial management arrangements and appropriate accountability for all HPSS expenditure.	
		18.2	Strengthen performance management for the HPSS to ensure the delivery of efficient, effective and economic services, in order to maximise the level of resources going to frontline care.	

PIA	PRIORITIES FOR ACTION TARGET	PSA	PUBLIC SERVICE AGREEMENT TARGET	PROGRESS REPORT
		18.3	To put in place, by April 2002, a framework to raise the quality of service provided and tackle issues of poor performance across the HPSS	
		18.4	Over the three year period to 2003-03, implement the agreed recommendations of the Capitation Formula Review Group	
		18.5	To ensure that the Fire Authority for Northern Ireland meets national standards for 24-hour fire cover provision on fleet and crew availability	
		18.6	By March 2002, to increase the percentage of calls to fires at which national standards for attendance are met from 94% in 2000 to 95%	
		18.7	By March 2002, to reduce the number of accidental fires in dwellings by 9%, ie from 1,410 in 2000 to 1,285	
		18.8	By March 2002, to reduce the number of accidental fire deaths by 18%, ie from 28 in 2000 to 23	
		18.9	By March 2002, to reduce the number of serious non-fatal casualties caused by fire by 10% ie from 177 in 2000 to 160	
		18.10	By March 2002, reduce sickness levels throughout the Fire Service from 15% in 1999/2000 to 10%	