Witness Statement Ref. No. 348/1

DEPARTMENTAL AND GENERAL GOVERNANCE

Name: Alan Elliott

Title: Mr

Present position and institution:

Retired

Previous position and institution:
[Please provide your position in 1995, 1996, 2000, 2001 and 2003]

I became Permanent Secretary of the Department of Health and Social Services in July 1987 and ceased to hold that position in March 1997 when I retired at the age of 60.

Membership of Advisory Panels and Committees:
[Identify by date and title all of those in 1995, 1996, 2000, 2001 and 2003]

I represented the Department on the Policy Co-ordinating Committee of Permanent Secretaries and on the Advisory Panel on Senior Appointments. Within the Department I chaired the Top of the Office Group for HPSS and the Departmental Management Board which oversaw the overall governance of the DHSS.

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the children's deaths]

This is my first statement to the Inquiry.

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	**Date:**	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

DETAILS OF YOUR CAREER HISTORY

(1) State the dates on which:

(a) You became Permanent Secretary of the Department of Health, Social Services and Public Safety (DHSSPS)

Ans: I became Permanent Secretary of the Department in July 1987 and ceased to hold that position on 27 March 1997 on reaching age 60, the retirement age at the time.

(b) You ceased to hold that position.

Ans See (1) (a) above.

(2) Describe your career history prior to becoming Permanent Secretary of the DHSSPS.

Ans: I joined the Northern Ireland Civil Service in November 1959 as an Assistant Principal in the then Ministry of Health and Local Government. I moved through the ranks on the Health and Social Services side which transferred to the new DHSS, becoming an Assistant Secretary in 1971, Senior Assistant Secretary about 1980 before being appointed Permanent Secretary in 1987.

(3) Describe your career history since ceasing to be Permanent Secretary of the DHSSPS.

Ans: Since ceasing to be Permanent Secretary, I have carried out a number of part-time roles, including Chairman of the Chief Executives Forum and Chairman of the Public Examination Panel on the Government's draft Physical Development Strategy to 2015. From 2002 to 2008, I was Northern Ireland trustee of Leonard Cheshire Disability and latterly Vice-Chairman.

(4) In your capacity as Permanent Secretary, were you also Chief Executive of the Management Executive?

If not, please identify the Chief Executive(s) of the Management Executive during your time as Permanent Secretary.

Ans: I was not Chief Executive of the Management Executive. The first Chief Executive was John Hunter, who was succeeded by Paul Simpson.

(5) Please answer the following questions regarding the Management Executive:

(a) Please explain the role of the Management Executive.

Ans: The role of the HPSS Management Executive was to guide, direct and control the operation of the health and personal social services. I do not have access to any Departmental papers, but the paper on the role of the Management Executive (Tab 1)

and the Management Executive letter METL 2/1993 (Tab 2) enclosed with Dr McCormick's letter to me, setting out the accountability framework for Trusts, reflect my understanding of the position.

(b) Please explain what specific responsibilities were entailed in the role of Chief Executive of the Management Executive.

Ans: The role of the Chief Executive of the Management Executive was to lead the Executive in carrying out its responsibilities and act as designated Accounting Officer to Parliament for expenditure in the services.

(c) When did the Management Executive cease to exist?

Ans: As I retired in 1997, I do not know when the Management Executive ceased to exist, but its role was essentially subsumed within the Department.

(d) What was the Management Executive replaced by?

Ans: See (5) (c) above.

ACCOUNTABILITY ARRANGEMENTS IN THE HPSS

(6) Mr William McKee, former Chief Executive of the Royal Group of Hospitals HSS Trust, has told the Inquiry **(Ref: transcript day 76, 17th January 2013, page 6 lines1-4)** that *"in 1993/1994 ...and subsequently for many years I was specifically not held responsible for clinical safety, clinical quality, clinical matters."* He confirmed **(Ref: transcript day 76, 17th January 2013, page 16 line 4)** that the Board of the Trust had no such responsibility either. His evidence was that the Trust only became responsible for clinical quality in January 2003 when a circular was issued by the DHSSPS advising Trusts that they now had a duty of quality**(Ref: transcript day 76, 17th January 2013, page 7 lines 13-19 and page 8 lines 1-9).**

However, Mr Hugh Mills, former Chief Executive of the Sperrin Lakeland Trust, was asked by the Chairman if the Trust reported Lucy Crawford's death to the Western Board in 2000 *"because the Trust felt that it had a responsibility for clinical care"* and replied *"Oh, certainly the Trust had a responsibility for clinical care."* **(Ref: transcript day 110, 17th June 2013, page 45 lines 18-20)**. Arising from this, please answer the following:

(a) Do you agree with Mr McKee that, prior to the issue of HSS(PPM) 10/2002 on 13th January 2003 **[Ref: 306-119-001]** and the coming into operation of the statutory duty of quality in Article 34 of the Health and Personal Social Services (Quality Improvement and Regulation) Order 2003 in April 2003, the Royal Group of Hospitals HSS Trust had no responsibility for clinical care? Or do you agree with Mr Mills that in 2000 the Sperrin Lakeland Trust did have responsibility for clinical care? Please give reasons for your answer.

Ans: My understanding was and remains that standards of clinical care were and remain primarily the responsibility of the consultant medical staff of the hospitals under the control of the Trusts. Many other staff are of course involved, including junior Doctors working to Consultants; Nurses and Midwives; and a wide range of other professional staff. I would support Mr Hugh Mills' view, however, that the Trust Board had ultimate responsibility for "acts of commission and omission" in the standards of clinical care provided by all its professional employees. Mr McKee was saying, on my reading of the transcript, that until 2003 he as Chief Executive did not hold responsibility for clinical matters.

(b) Who did you consider had responsibility for clinical care in Health Service hospitals in Northern Ireland prior to the issue of HSS(PM) 10/2002 and the coming into operation of Article 34?

Ans: See (6) (a) above.

(c) How did that responsibility arise? For example, did you consider it to be statutory, or by virtue of a circular or direction, or by custom and practice? Please give details of any relevant statute, circular or direction.

Ans: I have no recollection of any statutory responsibility or any circular or direction which governed this and would surmise that it was an implicit duty arising from custom and practice.

(d) To whom did you consider that those who had responsibility for clinical care in Health Service hospitals in Northern Ireland prior to 2003 were responsible?

Ans: Essentially, junior staff work to the head of profession and consultant medical staff exercise their own judgement in clinical matters. Their professional bodies such as the General Medical Council could take disciplinary action in relation to individuals, with the ultimate power to remove their right to practice. There was a growing emphasis during this period on medical governance, meaning how Doctors exercised their responsibilities, so that medical staff Committees and Medical Directors increasingly monitored performance.

(e) Describe what arrangements were in place to ensure that those responsible for clinical care in Health Service hospitals in Northern Ireland discharged their responsibilities prior to 2003.

Ans: See (6) (d) above.

(f) If Trusts were responsible for clinical care prior to 2003, what was the purpose of the duty of quality in Article 34 and what difference did it make?

Ans: I have no knowledge of the purpose of the duty of quality in Article 34, which arose some years after my retirement.

(7) Mr Thomas Frawley, the former General Manager of the Western Health and Social Services Board, has told the Inquiry that the Department was responsible for *"holding whole system to account"* **[Ref: WS 308/1 page 11]**.

Arising from this, please answer the following:

(a) Do you agree with Mr Frawley that the Department was responsible for *"holding whole system to account"*? Please answer for the period during which you were Permanent Secretary. Please give reasons for your answer.

Ans: I agree with Mr Frawley that the Department was responsible for "holding [the] whole system to account". This is essentially because:

The Department is responsible to its Minister, and the Minister is answerable to Parliament (or now the local Assembly) for the operation and control of the Health and Personal Social Services.

(b) If it is the position that the Department was responsible for holding the system to account, please explain how the Department did so.

Ans: The Permanent Secretary or another Senior Officer is specifically designated Accounting Officer for all Departmental expenditure and is answerable personally to the Public Accounts Committee, formerly at Westminster and now at Stormont, for all the expenditure of the Department.

(c) Whether or not you agree that the Department was responsible for holding the system to account, please describe what arrangements were in place in the period during which you were Permanent Secretary to enable you personally and/or the Department to know what was going on in the HPSS and of issues affecting the HPSS.

Ans: The chief means of "keeping tabs" on the services in my time was a system of annual Accountability Reviews through which the Minister and/or the Permanent Secretary and senior officials met the Chairman and Senior Officers of each Board or Trust to work through an agenda of facts and questions, holding the body concerned to account. These in my experience were not a routine chore, but a serious piece of business. There were of course many less formal meetings and discussions with Board and Trust Officers.

ADDITIONAL QUERIES

(8) How and when did you first become aware of the deaths of:

(a) Adam Strain

(b) Claire Roberts

(c) Rachel Ferguson

(d) Lucy Crawford

Ans: The first two of these deaths took place during my time in office, but I have no recollection of being made aware of them. I only became aware of these and subsequent deaths when I read in the Press of the establishment of the Inquiry.

(9) Were you/the Department informed of the statement produced by the RBHSC following the Inquest of Adam Strain? **[Ref: 011-014-107a]** If not, would you have expected to have been so informed?

Ans: I had no knowledge of the RBHSC statement following the Inquest on Adam Strain. I would not have expected to be informed of it personally, but I would have expected the Department to be informed.

(10) 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?

Ans: There was no formal process in place in 1995 for sharing information on Coroners' Inquests with the Department.

(11) What was the role of the DHSSPS in reporting, analysing and disseminating the information referred to at (10) above and in ensuring that lessons learned would be fed into teaching/ training and the care of patients?

Ans: See (10) above.

(12) 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?

Ans: See (10) above.

(13) Explain in detail the relevant Policies, Guidelines, Protocols and Codes of Practice issued by the DHSSPS from 1995 to 2001 relating to the handling of complaints within the Health Service in Northern Ireland, including those by medical or nursing staff.

Ans: In relation to the handling of complaints within the Health and Personal Social Services, I attach a paper produced by the Department outlining the steps taken to develop procedures for dealing with complaints.

(14) During your time as Permanent Secretary, what policies were there for the dissemination of guidelines/protocols from the Department down to Boards / Trusts?

Ans: Guidance and information were issued to the relevant bodies by the relevant policy or profession Branch or Division of the Department. Each piece of guidance would have a separate distribution list depending on the subject matter. Distribution within the services would be a matter for Boards and Trusts. If an assurance was required by the Department, this would be stipulated in individual letters.

(15) How was the implementation of such guidelines and protocols by Boards and Trusts examined / assessed / monitored?

Ans: See (14) above.

(16) How would the Department be made aware of issues / areas that required dissemination of information / protocols? In particular, how would Boards / Trusts make the Department aware of such issues?

Ans: See (14) above.

(17) How would the Department be involved in the dissemination of materials amongst Boards/ Trusts?

Ans: See (14) above.

(18) Why was a formal approach not adopted for adverse incident reporting prior to 2002?

Ans: There was no evidence to suggest that a formal approach was needed. There was not such an approach in England prior to 2002.

(19) Prior to 2002, what would you have expected Trusts/Hospitals to have done (if anything) in regard to informing the Department when cases involving deaths due to possible medical mismanagement were involved in:

(a) Formal complaint procedures

(b) Coroner's Inquests

(c) Medical negligence actions

Ans: I would have expected the Department to have been informed of cases involving deaths due to possible medical mismanagement arising from complaints, Inquests and legal actions.

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

Signed: Alan Glasgow **Dated:** 19 September 2013

DF1/13/591345/CR-RL

ROLE OF HPSS MANAGEMENT EXECUTIVE

2.1 The Management Executive with a Chief Executive was established within the Department of Health and Social Services from 1 January 1990. Its creation separated the Department's policy making role from its management role.

2.2 The Management Executive believes that underlying all its activities is the fundamental goal of promoting the health and social well-being of the population of Northern Ireland.

2.3 Simply stated, the Management Executive's objectives are to achieve this goal, within Government policies, available resources and the Regional Strategy by:

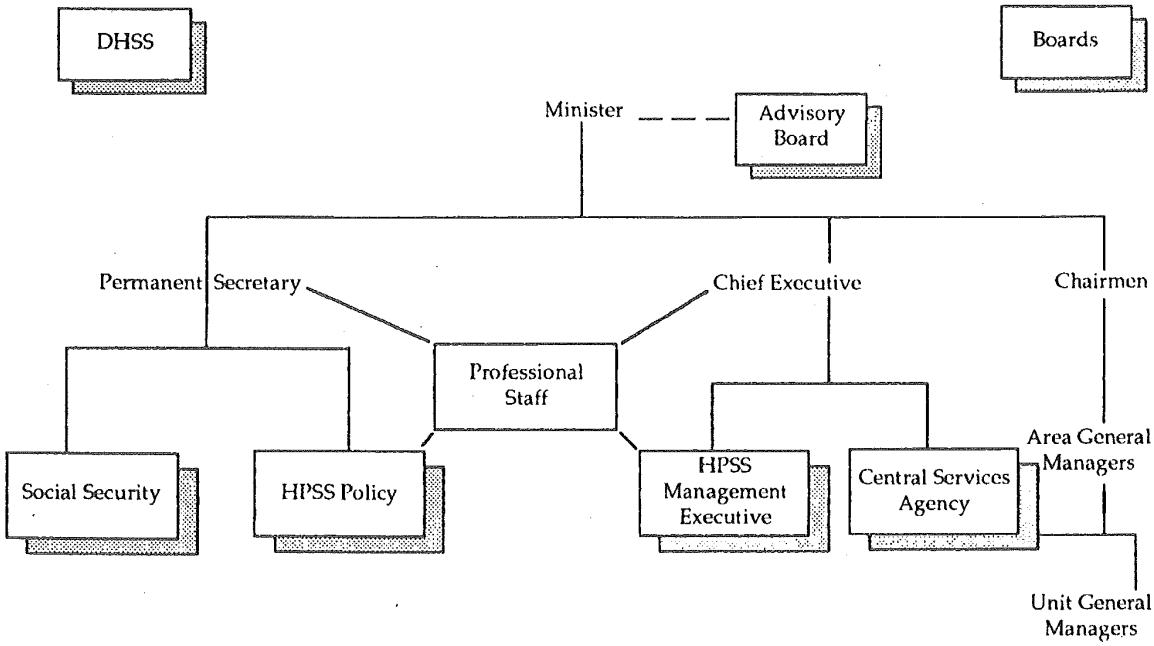
- developing the management strategy and the service culture necessary to secure quality health and social services;
- setting precise objectives and targets for Boards and monitoring their progress;
- allocating resources to achieve strategic goals; and
- providing certain regional support services to Boards (eg Estate, Information Systems and Efficiency Services).

2.4 In the achievement of these objectives, the Management Executive has a clear responsibility to provide corporate leadership and direction to the HPSS. It must work closely with Health and Social Services Boards and the Policy Group in the Department. Its approach must be informed by appropriate professional advice as it seeks to build formal quality assurance mechanisms and outcome measures into the HPSS at all levels. Crucially, the Management Executive must support those who are delivering services to patients and clients.

2.5 The Management Executive will encourage effective management and promote devolution of responsibility. This will require a significant investment in both training and management development in order to reap full advantage from the significant organisational changes which flow from the Government's recent major policy papers - notably "Promoting Better Health"; Working for Patients"; and "People First".

2.6 Each year the Chief Executive, supported by the Management Executive and in collaboration with Area General Managers, will define a three year Management Plan. The Plan will be based on available resources of manpower and money. The Plan enables the Management Executive to build cohesiveness with Boards, based on a greater shared ownership of issues and commonality of purpose.

ORGANISATION CHART



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Management Executive
Office of the Chief Executive

Chief Executives of HSS Trusts and Shadow Trusts - for action

Area General Managers)
UGMs) for information
GP Fundholders)

METL 2\93

6 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
LH 89 Dundonald House, Upper Newtownards Road, Belfast BT4 3SF. Tel: [redacted]

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

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.

Q13- Complaints

March 1992 - The Northern Ireland Health and Personal Social Services Charter for Patients and Clients issued. This set out the Government's commitment to the provision of quality services and indicated the rights and guarantees which were being introduced in relation to those services. The Charter also advised of the arrangements in place in Boards and Trusts to deal with complaints.

These arrangements were in force in 1995 and required all HPSS organisations to have clear procedures for dealing with complaints. In particular they were required to publicise the name, address and telephone number for a senior officer responsible for handling complaints and to make the necessary information available to all patients and clients. The complaint would be conducted in full by the complaints officer, who would provide the complainant with a written report explaining what went wrong and describing the action being taken. If the complainant was still dissatisfied, there was scope for the matter to be raised sequentially with the Chairman or General Manager of the Board and with the Chief Executive of the Management Executive in the Department. There was also scope for the complaint to be raised at any stage with the Commissioner for Complaints.

There were also special arrangements for dealing with complaints about, inter alia, the clinical judgement of hospital medical and nursing staff.

March 1995 -"Acting on Complaints" published. This set out the HPSS response to the work undertaken by Professor Alan Wilson, who published "Being Heard", a report on NHS complaints procedures (but which also embraced the HPSS in NI), in 1994.

March 1996 - Professor Wilson published "Guidance on Implementation of the HPSS Complaints Procedure". This document provided advice on how the policy objectives of "Acting on Complaints" were to be achieved.

April 1996 – A number of Directions were introduced under the Health and Personal Social Services Complaints Procedure Directors (Northern Ireland) 1996.

March 1996 - Publication "Complaints: Listening .... Acting .... Improving" issued. Together these introduced a mandatory framework for the HPSS Complaints Procedure and, as described in the published document, set out detailed arrangements to be implemented by all HSS Boards and Trusts.

These arrangements were further refined in the document "Guidance on Handling HPSS Complaints: Hospital and Community Health and Social Services" which was published in April 2000.

March 2002 - As part of the wider quality agenda, the Department initiated a review of the HPSS Complaints Procedure. A Regional Complaints Review Group was set up to consider the issues emerging from the UK national

evaluation of complaints and to draft a framework of proposals to improve the HPSS complaints procedure. As the Group undertook its work, it had to take account of some major emerging issues, including the Shipman Inquiry, the proposals for reorganisation within the Review of Public Administration and the establishment of the HPSS Regulation and Improvement Authority. A draft HPSS Complaints Procedure Consultation Paper was prepared and issued for consultation in November 2006.

February 1996 - Circular HSS(GEN1) 1/96 was issued with a document "Guidance for Staff on Relations with the Public and the Media". It was designed to encourage a climate of openness and dialogue within the HPSS so that staff could freely express their concerns to their managers as a means of contributing to the improvement of services.

October 1999 - The Public Interest Disclosure (Northern Ireland) Order 1998 became law. Circular HSS(GEN1) 1/2000 issued to the HPSS to draw attention to the provisions of this legislation. These so called "whistleblowing" arrangements provided for staff to be able to raise concerns about health and social care matters in a responsible way without fear of victimisation and required all HPSS organisations to have local policies and procedures in place to give effect to these arrangements.

In relation to concerns about the performance of doctors, the role of the General Medical Council provides for complaints about a doctor's competence or fitness to practice to be referred to the Fitness to Practice Committee. It is also the case that the HPSS arrangements for dealing with complaints set out in the 1995 document "Acting on Complaints" provide principles which, while primarily focused on complaints by patients and clients, are equally applicable to complaints and concerns from healthcare professionals.

1994 - The then CMO in England chaired a group to review the guidance and procedures relating to complaints and concerns about doctors whose performance appears to fall below acceptable standard. The final report of this group "Maintaining Medical Excellence" was issued to the HPSS by the Northern Ireland CMO in August 1995, with a covering letter underlining the professional responsibility of individual clinicians in the monitoring of standards. In November 1995, the GMC were given new powers to deal with doctors' performance. The Medical (Professional Performance) Act enabled the GMC to introduce new professional performance procedures and extended the GMC's existing powers to impose interim suspension or interim conditions pending a full hearing of a competence or conduct case. These new procedures came into effect in 1997.

Following the response from the profession to "Maintaining Medical Excellence", the CMO in England asked representatives of the medical profession and NHS employers to suggest how the report's recommendations might be taken forward. The group's conclusions were circulated to the HPSS by the Northern Ireland CMO under cover of a letter, HSS(MD) 3/97 in January 1997 asking that the agreed arrangements be put into effect in Northern Ireland.

October 1998 - The Government announced that it would be reviewing the suspensions procedures for hospital and community medical and dental staff. The CMO in England issued a consultation paper in November 1999, "Supporting Doctors, Protecting Patients" setting out a wide range of new proposals to assist with the prevention, early recognition and improved management of poor clinical performance of doctors. To address similar issues in Northern Ireland, the Department issued the consultation document "Confidence in the Future – for Patients and for Doctors" in October 2000.