HPSS MANAGEMENT PLAN
1995/96 - 1997/98

CONTENTS

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.

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

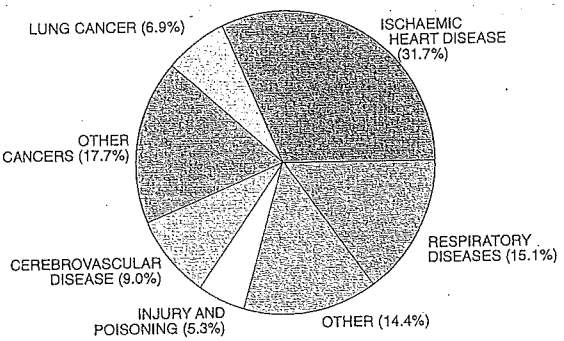
3.2.1 The number of deaths from ischaemic heart disease has fallen by around 30% over the past ten years. This exceeds the Change of Heart target, which the Department and Boards adopted in 1986, for a 15% reduction in premature deaths by 1997. Despite this encouraging trend, ischaemic heart disease 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.

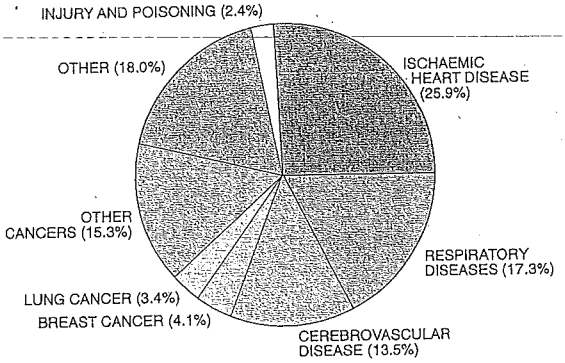
FIGURE 1

CAUSE OF DEATH
NORTHERN IRELAND 1992
BY SEX

MALES



FEMALES



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

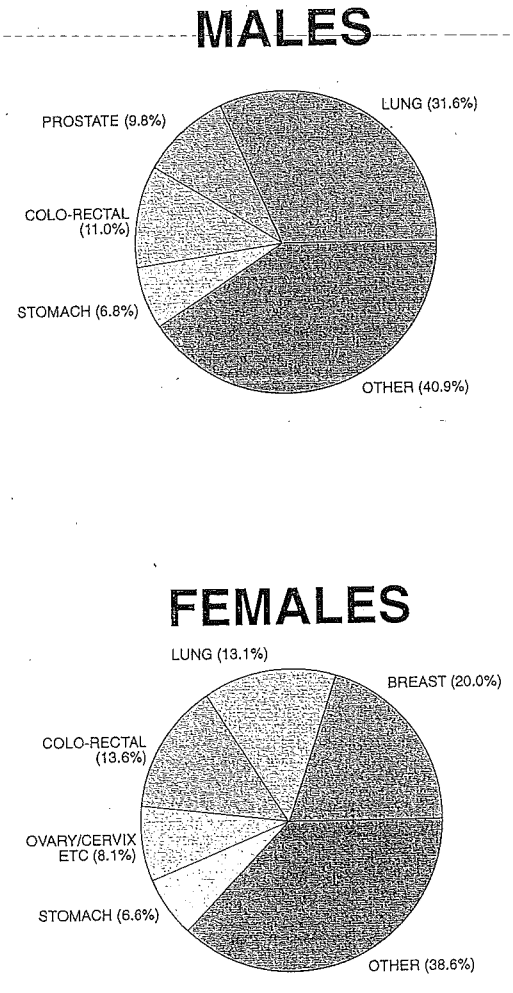
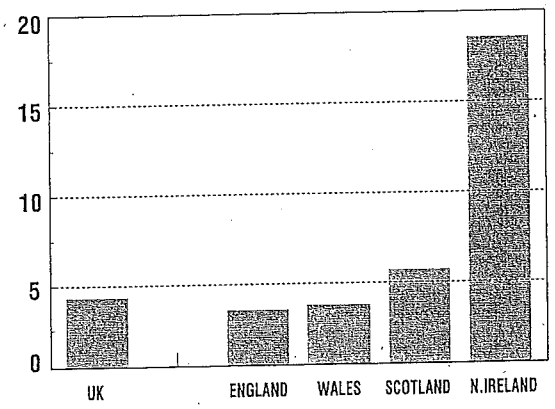


FIGURE 3

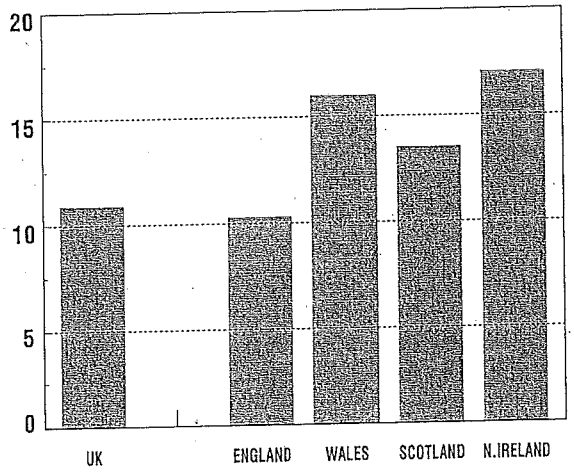
LONG TERM UNEMPLOYMENT (5+ Years)
Rate per 1,000 population of working age
United Kingdom, January 1993



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.

TOPIC	OBJECTIVE	TARGET 1995/96	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%	75%
	b. the proportion of children who have not started to smoke should have increased to:	92%	93%	94%
	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%	83%
	e. the proportion of energy derived from saturated fat in the diet should be reduced to less than:	15%	15%	15%
	and from total fats to less than:	36%	35%	34%
	f. the number of births to teenage mothers should be reduced by a further:	9%	15%	20%
	g. the proportion of adult men drinking more than the recommended limit (up to 21 units per week) should be reduced to:[1]	31%	25%	19%
	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%	5%

[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.

TOPIC	OBJECTIVE	TARGET 1995/96	TARGET 1996/97	TARGET 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%	70%	70%
Accidents and Trauma	5. Develop and implement programmes and improved treatment aimed at reducing the number of deaths from accidents and trauma by:	11%	15%	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:	35%	40%	45%
	8. Work with GPs to increase the percentage of practices actively using a practice prescribing formulary to:	30%	60%	70%
	9. Work with GPs to increase the percentage of practices using a protocol for repeat prescribing to:	30%	60%	80%
	10. Actively promote the Prescribing Incentive Scheme to achieve an uptake by non-fundholding GPs of:	30%	60%	70%
	11. Promote the GP fundholding scheme with the aim of increasing the number of GP fundholding practices by:	15%	25%	30%

TOPIC	OBJECTIVE	TARGET 1995/96	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

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	58
	b. Dermatology	26	28	28
	c. General Surgery/Urology	55	57	57
	d. T & O Surgery	36	39	39
	e. Cardiothoracic Surgery	43	44	44
	f. Gynaecology	80	82	82
	g. ENT	95	100	100
	h. Ophthalmology	95	100	100
	i. Plastic Surgery	55	57	57
	j. Neurosurgery	36	38	38

TOPIC	OBJECTIVE	TARGET 1995/96	TARGET 1996/97	TARGET 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)	15	17	19
	b. Dermatology	80	85	90
	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	TARGET 1996/97	TARGET 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.		*	