DIRECTIONS

HEALTH AND SOCIAL CARE

The Commissioning Plan Direction (Northern Ireland) 2010

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by section 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009**(a)**:

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Commissioning Plan Direction (Northern Ireland) 2010 and shall come into operation on 24 May 2010.

(2) In this Direction—

"HSC Trusts" means the Health and Social Care Trusts established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991;

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Health and Social Care Board under paragraph 7 of Schedule 1 to the Act;

"Regional Agency" means the Regional Agency for Public Health and Social Well being established under section 12 of the Act;

"Regional Board" means the Regional Health and Social Care Board established under section 7 of the Act.

Health and Social Care which the Regional Board is to include in its commissioning plan.

2. – (1) The commissioning plan to be prepared and published by the Regional Board as required under section 8(3) of the Act shall provide an overview of its commissioning intentions for health and social care services for the period 1 April 2010 to 31 March 2011 across each of the priority areas set out below and associated standards and targets defined within these in Priorities for Action 2010-11:

(a) Improving the health status of the population and reducing health inequalities

(b) Ensuring services are safe, sustainable, accessible and patient-centred

(c) Integrating primary, community and secondary care services

(d) Helping older people to live independently

(a) 2009 c.1 (N.I.)

(e) Improving children's health and well-being

(f) Improving mental health services and services for people with disabilities

(g) Ensuring financial stability and the effective use of resources

- (2) The commissioning plan shall contain the following sections:

(a) Strategic Context – the environmental factors influencing the future direction of travel for service development and design, taking account of the strategic policies and priorities set by the Department;

(b) Regional and local commissioning priorities;

(c) Public involvement in the commissioning of services;

(d) Specific commissioning intentions for the period 1 April 2010 to 31 March 2011 to deliver on each of the ministerial priority areas and targets;

(e) Financial management and effective use of resources

- (3) The commissioning plan shall fully reflect and be consistent with extant Departmental strategies and policies including Investing for Health Strategy, Young Peoples Drinking Action Plan, Hidden Harm Action Harm Action Plan, Mental Health and Wellbeing Strategy, Sexual Health Promotion Strategy , Safety First: A Framework for Sustainable Improvement in the HPSS, Families Matter and Care Matters, Co-Operating to Safeguard Children, Bamford Action Plan, Acquired Brain Injury Action Plan and ASD Strategic Action Plan.

Costs incurred in commissioning

3. The commissioning plan shall include details of how the total resources of £3,653.2m (£3,582.8m Regional Board resources and £70.4m Regional Agency resources) for the financial year from 1 April 2010 to 31 March 2011 have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board is to commission health and social care. This information shall be provided separately for each of the five LCGs and for services commissioned regionally by the Regional Board and the Regional Agency in the manner specified by the Department in its budget allocation letter**.**

General

4.The commissioning plan shall have due regard to extant policy guidelines and the specific requirements set out in the ministerial Priorities for Action and the Department's budget allocation letter for 2010/11.

5. The Regional Board, must, in drawing up the commissioning plan, consult the Regional Agency and have due regard to any advice or information provided by it and must not publish the commissioning plan unless approved by the Regional Agency.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 24 May 2010.

[Signed by Andrew McCormick]

A senior officer of the
Department of Health, Social Services and Punlic Safety

D I R E C T I O N S

2011 No. 13

The Commissioning Plan Direction (Northern Ireland) 2011

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by section 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009**(a)**:

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Commissioning Plan Direction (Northern Ireland) 2011 and shall come into operation on 24 June 2011.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"HSCB" means the Regional Health and Social Care Board established by section 7 of the Act.

"HSC Trusts" means the Health and Social Care Trusts established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Health and Social Care Board in accordance with section 9 of the Act;

"PHA" means the Regional Agency for Public Health and Social Well-being established by section 12 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the HSCB in accordance with section 8(3) of the Act.

Health and Social Care that the HSCB is to include in its commissioning plan

2.—(1) The Commissioning Plan shall provide details of the health and social care which it will commission for the period 1 April 2011 to 31 March 2012 for consideration and approval by the Minister.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the HSCB comply with extant statutory obligations, standards, Departmental Policy and Strategy and Departmental Guidance and Guidelines.

(3) The commissioning plan shall provide details of how the services being commissioned by the HSCB represent an equitable use of the resources made available for health and social care to the Northern Ireland population based on relative need. In doing so the HSCB must:

(a) Use an evidence based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCGs target fair share, and the actual resources deployed

(a) 2009 c.1 (N.I.)

for the respective population;

(b) Develop a commissioning strategy to address the gap; and

(c) Ensure that the resources allocated to each LCG, are reflective of the capitation formula, and benefit their respective population.

(4) The commissioning plan shall demonstrate how the commissioning proposals deliver on the following key themes and statutory obligations:

(a) Working in partnership across Central and Local Government to improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention;

The Commissioning Plan must demonstrate how the services to be commissioned reflect the contents of Investing for Health and are conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland to fulfil the requirements of Section 2(3)(g) of the Act.

(b) Improving the quality of services and outcomes for patients, clients and carers;

The Commissioning Plan must demonstrate how the HSCB will commission services to fulfil its statutory duty under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(**b**).

(c) Commissioning more innovative, accessible and responsive services, promoting choice and making more services available in the community;

The Commissioning Plan must demonstrate how the services commissioned will improve access to more primary care and community based services which prevent people unnecessarily entering hospital and enable them to return home safely as soon as they are fit to do so.

(d) Improving the involvement of individuals, communities and the independent sector in the design, delivery and evaluation of health and social care services through strengthened local commissioning and performance management systems;

The Commissioning Plan must demonstrate how the HSCB has fulfilled its statutory obligations under Sections 19 and 20 of the Act in the development of its proposals.

(e) Improving productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with Departmental priorities.

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must also demonstrate how the HSCB intend to ensure that HSC Trusts do not exceed budget allocations and how proposed expenditure makes best use of the resources available to meet its statutory obligations under Sections 8(2)(b)(iii) of the Act.

(5) The commissioning plan shall cover the following content:

(a) Strategic Context – the environmental factors influencing the future direction of travel for service development and design, taking account of the strategic policies and priorities set by the Department;

(**b**) 2003 S.I. 2003/ 431 (N.I. 9)

(b) Regional and local commissioning intentions under each of the priority areas set out above;

(c) Specific commissioning proposals for the period 1 April 2011 to 31 March 2012 to deliver on each of the targets set out in the Schedule.

Costs incurred in commissioning

3. The commissioning plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the HSCB and PHA for the financial year from 1 April 2011 to 31 March 2012 have been committed to the HSC Trusts or other persons or bodies, from which the HSCB and the PHA are to commission health and social care. This information shall be provided separately for each of the five LCGs and for services commissioned regionally by the HSCB and the PHA in the manner specified by the Department in its budget allocation letters**.**

General

4. The HSCB, must, in drawing up the commissioning plan, consult the PHA and have due regard to any advice or information provided by it and must not publish the commissioning plan unless approved by the PHA.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 24th June 2011.

Signed Andrew McCormick (Perm Sec)

A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Priority	*Target*
Working in partnership across Central and Local Government to improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention	By 31st December 2011, make arrangements for implementation of the Family Nurse Partnership a pilot programme for 100 pregnant mothers who will be recruited up to the 28th week of pregnancy at the first test site. Ensure that by the month of March 2012 the details of 100% of people presenting at A& E Departments who have self harmed are being added onto the deliberate self-harm registry. Ensure that by the 31st March 2012:- (a) 80 health professionals will be trained in delivering brief alcohol interventions; (b) GPs achieve a 40% uptake of seasonal flu vaccine by pregnant women; and (c) Trusts have achieved a level of performance that 3,000 children in vulnerable families are receiving family support interventions.
Improving the quality of services and outcomes for patients, clients and carers;	Ensure that Trusts maintain the standard that from April 2011: (a) the HSCB and PHA should ensure that Trusts achieve a performance level of no patient waiting longer than 9 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing sponylitis; (b) the HSCB and PHA should ensure that Trusts achieve a performance level of no patient waiting longer than 13 weeks to commence NICE recommended therapies for multiple sclerosis (MS) or therapies approved under the UK Risk Sharing Scheme for disease modifying treatments for MS (c) No patient waits longer than 9 weeks to commence specialist drug treatment for wet AMD for the first eye. (d) A 13-week maximum waiting time for 95% of all wheelchairs including basic wheelchairs; (e) 95 % of patients referred to the audiology department for hearing aids have those aids fitted within three months of the date of referral;

Priority	*Target*
	Ensure that Trusts maintain the standard that from April 2011: (a) 75% of patients admitted as mental health or learning disability inpatients for assessment and treatment are discharged within seven days of the decision to discharge; (b) All other mental health or learning disability patients being discharged within a maximum of 90 days of the decision to discharge (c) 90% of complex discharges from an acute hospital setting take place within 48 hours of decision to discharge; (d) All non-complex discharges from an acute hospital setting take place within six hours of being declared medically fit (Standard 100%); (e) No discharge from an acute hospital setting takes longer than seven days (100% standard). Ensure that by 31st March 2012 Trusts secure a reduction of 14% in the numbers of MRSA and Clostridium Difficile cases compared to 2010/11 From April 2011 ensure that the Belfast HSC Trust delivers a minimum of 50 live donor transplants.
Commissioning more innovative, accessible and responsive services, promoting choice and making more services available in the community;	From April 2011 ensure that Trusts achieve a level of performance that:- (a) provides sufficient treatment by allied health professionals to ensure that patients wait no longer than 9 weeks from referral to commencement of treatment; (b) older people with continuing care needs should have their needs assessment and the main components of their care needs met within 20 weeks of referral; From April 2011 ensure that Trusts achieve a level of performance that:- (a) all routine diagnostic tests are reported on within 4 weeks; (b) 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days;

Priority	*Target*
	(c) at least 50% of patients wait no longer than 9 weeks for a first outpatient appointment; (d) all patients are seen for a first outpatient appointment within 21 weeks; (e) 95% of patients attending any Types 1, 2 or 3 A&E departments are either treated and discharged home, or admitted, within four hours of their arrival in the department; (f) no patient attending any A&E department should wait longer than 12 hours either to be treated and discharged home, or admitted; (g) at least 50% of inpatients and daycases are treated within 13 weeks; (h) no patient waits longer than 36 weeks for treatment; (i) 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures; (j) no patient waits longer than 13 weeks to assessment and commencement of treatment (including psychological therapies); (k) 95% of lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate; (l) there is a 13-week maximum waiting time from referral to assessment and commencement of specialised treatment for acquired brain injury in 95% of cases; and (m) that both care management assessments are completed and the main component of the assessed care need - nursing home care, residential care or domiciliary care - will be delivered within 20 weeks of the assessment being initiated By 31st March 2012 ensure that Trusts:- (a) make direct payments in 2100 cases; (b) resettle at least an additional 45 long stay patients from learning disability hospitals to appropriate places in the

Priority	*Target*
	community compared to the end March 2011 figure; and (c) resettle 45 long-stay patients from mental health hospitals to appropriate places in the community compared to the end March 2011 figure.
Improving the involvement of individuals, communities and the independent sector in the design, delivery and evaluation of health and social care services through strengthened local commissioning and performance management system;	By 31st March 2012 publish and implement approved Public and Personal Involvement Consultation Schemes. By October 2011, establish 2 new clinical quality improvement collaboratives in priority topics, at least one of which should focus on primary and community care. From 1st October 2011 95% of project requirements over £20k in relation to supplies and services procurement and £30k for construction to be publicly advertised using eSourcingNI. From 1st October 2011 95% of contracts to include requirement for terms and conditions for sub-contracting
Improving productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with Ministerial priorities.	From April 2011 ensure that Trusts achieve a level of performance that increases the level of prescribing of generic medicines to 66% by the end of March 2012. By 31st March 2012 ensure that Trusts reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions compared to previous year. From April 2011 ensure that Trusts achieve a performance level of no discharge from an acute hospital setting taking longer than seven days. Ensure that Trusts enable 1,800 people to benefit from the provision of remote telemonitoring services by 31 March 2012. During 2011/12 the HSCB and PHA should ensure that Trusts achieve a level of performance that the number of excess bed days for the acute programme of care is reduced by 5% From April 2011 HSCB and PHA should ensure that Trusts achieve a level of performance that 75% of patients who are admitted electively have their surgery on the same day.

MAHI - STM - 089 - 223

Priority	*Target*

DIRECTION

2012 No. 1

The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2012

The Department of Health, Social Services and Public Safety makes the following direction in exercise of the powers conferred by section 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(**a**).

Citation, commencement and interpretation

1.—(1) This direction may be cited as the Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2012 and shall come into operation on 29 February 2012.

(2) In this direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board in accordance with section 8(3) of the Act.

Health and social care services that the Regional Board is to include in its Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board shall provide details of the health and social care services which it will commission for the period 1 April 2012 to 31 March 2013, in line with the targets set out in the Schedule, for consideration and approval by the Minister.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board align with the Executive's Programme for Government, the Economic Strategy and the Investment Strategy; the Minister's vision and priorities for Health and Social Care; extant statutory obligations including equality duties under the Northern Ireland Act 1998(**b**), requirements under Personal and Public Involvement (PPI), the standards, policies and strategies set by the Department, and Departmental Guidance and Guidelines.

(3) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board and the Regional Agency represent an equitable use of the resources made available for health and social care to the Northern Ireland population based on relative need. In doing so the Commissioning Plan must:

(a) include the strategic context - the environmental factors influencing the future service development and design, taking account of the strategic policies and priorities set by the Department;

(b) set out fully the services to be commissioned with details of specific commissioning intentions designed to deliver on targets and strategic priorities in this Direction. This should include a summary of the value and volume of services commissioned;

(a) 2009 c.1 (N.I.)
(b) 1998 c.47

(c) include LCG commissioning plans as a part of the Commissioning Plan and set out clearly how the LCG commissioning plans support the Commissioning Plan. This should reflect the use of an evidence-based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCGs target fair share, and the actual resources deployed for the respective population; and

(d) reflect the principles and values set out in the Quality 2020 Strategy in terms of protecting and improving quality.

3.—(1) The Commissioning Plan shall demonstrate how the commissioning proposals deliver on the following key strategic priorities and statutory obligations:

(a) to improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion and earlier intervention;

The Commissioning Plan must demonstrate how the services to be commissioned reflect the contents of Investing for Health and are conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland to fulfil the requirements of section 2(3)(g) of the Act.

(b) to improve the quality of services and outcomes for patients, clients and carers;

The Commissioning Plan must demonstrate how the Regional Board will commission services to fulfil its statutory duty under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (**a**). Continued research and innovation and the use of research evidence in the design and delivery of services will be essential.

(c) to develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community;

The Commissioning Plan must demonstrate how the services commissioned will improve access to primary care and community-based services which prevent people unnecessarily entering hospital and enable them to return home safely as soon as they are fit to do so.

(d) to improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities;

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must also demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act.

(e) to improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;

The Commissioning Plan must detail how the Regional Board proposes to take forward the design and delivery of services developed around the needs of patients through strengthened local commissioning and performance management systems. The Commissioning Plan should include proposals for taking forward the agreed recommendations from *Transforming Your Care.*

(f) To ensure that the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services;

The Commissioning Plan must demonstrate that the services being commissioned are sufficient to ensure that statutory responsibilities to assess needs, protect and support vulnerable groups will be met with a particular emphasis on prevention and early intervention.

(**a**) S.I.2003/431 (N.I. 9)

Costs incurred in commissioning

4.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1 April 2012 to 31 March 2013, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board and the Regional Agency commission health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

(3) This information shall be provided separately for each of the five LCGs and for services commissioned regionally by the Regional Board and the Regional Agency in the manner specified by the Department in its budget allocation letters.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 29 February 2012

Andrew McCormick
Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Priority	*Target*
To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention	**Bowel cancer screening** **1.** Extend the bowel cancer screening programme to invite 50% of all eligible men and women aged 60-71 by March 2013, with a screening uptake of at least 55% in those invited. **AAA screening** **2.** By June 2012, have in place a Northern Ireland-wide programme to screen men aged 65 for abdominal aortic aneurysm. **Public health** **3.** By March 2013, have in place a community pharmacy health promoting pharmacies programme. **4.** By March 2013, develop a costed implementation plan to take forward a new Public Health Strategic Framework and related population health strategies.
To improve the quality of services and outcomes for patients, clients and carers	**Fractures** **5.** From April 2012, 95% of patients, where clinically appropriate, wait no longer that 48 hours for inpatient treatment for hip fractures. **Cancer care services** **6.** From April 2012, ensure that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days. **Organ transplants** **7.** By March 2013, ensure delivery of at least 50 live donor transplants. **Accidents and emergency** **8.** From April 2012, 95% of patients attending any Type 1, 2 or 3 A&E Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours. **Elective care - outpatients/diagnostics/inpatients** **9.** From April 2012, at least 50% of patients wait no longer than nine weeks for their first outpatient appointment with no one waiting longer than 21 weeks, increasing to 60% by March 2013 and no one

Priority	*Target*
	waiting longer than 18 weeks. **10.** From April 2012, no patient waits longer than nine weeks for a diagnostic test (13 weeks for a daycase endoscopy), and all urgent diagnostic tests are reported on within 2 days of the test being undertaken. **11.** From April 2012, at least 50% of inpatients and daycases are treated within 13 weeks with no one waiting longer than 36 weeks, increasing to 60% by March 2013, and no patient waiting longer than 30 weeks for treatment. **Hospital readmissions** **12.** By March 2013, secure a 10% reduction in the number of emergency readmissions within 30 days. **Healthcare acquired infections** **13.** By March 2013, secure a reduction of x% in MRSA and Clostridium difficile infections compared with 2011/12.[Note: target level currently being set] **Medicines formulary** **14.** From April 2012, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care.
To develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community	**Specialist drugs** **15.** From April 2012, no patient should wait longer than 9 months to commence NICE-approved specialist therapies for rheumatoid arthritis, psoriatric arthritis or ankylosing sponylitis, decreasing to 3 months by September 2012. **16.** By March 2013, increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis. **Allied health professionals (AHP)** **17.** From April 2012, no patient waits longer than nine weeks from referral to commencement of AHP treatment. **Long Term Conditions** **18.** By March 2013, deliver 400,000 Monitored Patient Days (equivalent to approximately 2,200 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.
To improve the design, delivery and evaluation of health and social care	**Transforming Your Care** **19.** By June 2012, produce population plans for implementation

Priority	*Target*
services through involvement of individuals, communities and the independent sector	following the *Transforming Your Care* report. **20.** During 2012/13, develop and implement Integrated Care Partnerships in supporting the implementation of *Transforming Your Care.*
To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities	**Unplanned admissions** **21.** By March 2013, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions. **Unnecessary hospitals stays** **22.** By March 2013, reduce the number of excess bed days for the acute programme of care by 5%. **Patient discharge** **23.** From April 2012, ensure that all learning and disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge; 90% of complex discharges from an acute hospital take place within 48 hours; all non-complex discharges from an acute hospital take place within 6 hours; and no discharge from an acute hospital takes more than 7 days.
To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services	**Children in care** **24.** From April 2012, increase the number of children in care for 12 months or longer with no placement change to 82%. **25.** By March 2013, increase the number of care leavers aged 19 in education, training or employment to 62%. **26.** From April 2012, ensure a 3 year time-frame for all children to be adopted from care. **Community care** **27.** From April 2012, people with continuing care needs wait no longer than 8 weeks for assessment to be completed, and have the main components of their care needs met within a further 12 weeks. **Learning disability and mental health** **28.** By March 2013, 40% of the remaining long-stay patients in learning disability and psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015. **29.** From April 2012, no patient waits longer than 9 weeks to access child and adolescent or adult mental health services; and 13 weeks for psychological therapies (any age).

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2012

1. The direction sets out the focus for the Regional Board and Regional Agency in the commissioning of health and social care services during the year 1 April 2012 to 31 March 2013.

2. The Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for clients and patients and their carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

3. The Commissioning Plan needs to have a strong focus on outcomes through the quality of services delivered for patients and clients and their carers. This requires planning improvements in health and social well-being, including the promotion of civic responsibility and social inclusion, over the longer term, and specifying the contribution that each year's commissioning of services will make to the longer term goals. In this regard, the Quality 2020 Strategy and the work underway on a new Public Health Strategy to be completed by end 2012 should help inform the Regional Board and Regional Agency approach to commissioning.

4. Quality 2020 defines quality as :

Safety – *avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.*

Effective – *patients and clients receiving the right care, at the right time, in the right place, with the best outcome.*

Patient and Client Focused – *all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.*

5. It will be important to ensure that all three dimensions of quality are addressed in commissioning plans in a coherent and integrated manner. Likewise, Quality 2020 should be a reference point for all service development and delivery in future commissioning.

6. The outcomes sought for patients, clients and their carers across the integrated health and social care system are as follows:–

(a) preventing people from dying prematurely;

(b) helping people to recover from episodes of ill-health, or following injury or other traumatic event;

(c) treating and caring for people in a safer environment, empowering them and helping safeguard them from avoidable harm;

(d) enhancing the quality of life for people with long term conditions;

(e) ensuring people have a positive experience of treatment, care and support;

(f) helping to improve the wider determinants of health and social well-being and the promotion of healthy sustainable communities;

(g) improving life choices of children who are unable to live with their birth parents.

7. In pursuit of the achievement of outcomes, the Minister's priorities are to:–

(a) improve and protect health and social well-being and reduce inequalities through a focus on prevention, health promotion and earlier intervention;

(b) improve the quality of services and outcomes for patients, clients and carers;

(c) develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community;

(d) improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the independent sector;

(e) improve productivity by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities;

(f) ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services.

8. The intention is to have in place targets which reflect a strong outcome focus in helping to drive forward improvements in quality of care. The Quality 2020 commits to the identification and development of a set of quality indicators for use in monitoring strategic improvements in outcomes for future years embracing the 3 components of safety, effectiveness and patient/ client/carer experience. A regional annual quality report will be published covering all bodies from 2013/14 onwards.

9. Commissioning in 2012/13 must also support the direction set by *Transforming Your Care* which presents a model with the individual not the institution at the centre of the system, with care provided as close to the home as possible, and services which are safe, resilient and sustainable. This is reflected in the proposed reconfiguration of services which would see resources transfer from hospital services to primary and community services over the next five years.

10. The aim of the Commissioning Plan Direction for 2012/13 is to support the Minister's vision and priorities and pursuit of outcomes as set out above and use commissioning to help drive these changes. A relatively small number of targets have been identified in the direction to reflect the need to move to a focus more on the outcomes for the individual, and away from an over-emphasis on activities, rather than with the quality of care delivered. The targets and standards included in the Schedule to the direction do not imply that other services or standards are not important. Indeed, there needs to be a focus on improving performance across the system. They represent particular areas for focus in the coming year and are complemented by a number of indicators of performance included in the separate Indicators of Performance Direction. In line with the recommendations in the Quality 2020 Strategy a number of outcome measures will be developed over the coming year.

11. Effective performance management of the health and social care system requires availability of a range of indicators to help track trends. The Indicators of Performance Direction has been produced alongside the Commissioning Direction to ensure that the system has a shared understanding of the indicators which should be in place, on a common definition across the sector. The Regional Board, Regional Agency and HSC Trusts will be expected to monitor the trends in indicators, and take appropriate action.

12. The targets and indicators for 2012/13 are intended to provide a coherent and timely set of measures in key areas of HSC activity to inform assessments of the effectiveness of actions taken and use of resources, aligned to the Minister's strategic priorities for health and social care services.

DIRECTION

2013 No. 1

The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2013

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by section 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(a):

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2013 and shall come into operation on 28 January 2013.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board in accordance with section 8(3) of the Act.

Health and Social Care Services that the Regional Board is to include in its Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board shall provide details of the health and social care services which it will commission for the period 1st April 2013 to 31st March 2014, in line with the standards and targets set out in the Schedule, for consideration and approval by the Minister.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board align with and support the Executive's Programme for Government (PFG), its Economic Strategy and its Investment Strategy; the Minister's vision and priorities for health and social care; extant statutory obligations, including Equality duties under the Northern Ireland Act 1998(b); requirements under Personal and Public Involvement (PPI); the standards, policies and strategies set by the Department; and Departmental Guidance and Guidelines.

(3) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board and the Regional Agency represent an equitable use of the resources made available for health and social care to the Northern Ireland population, based on relative need. In doing so the Commissioning Plan must:

(a) include the Strategic Context – the environmental factors and drivers for change influencing the priorities and future service development and design, taking account of the strategic policies and priorities set by the Department;

(b) set out fully the services to be commissioned with details of specific commissioning intentions designed to deliver on targets, standards and strategic priorities in this Direction. This should include the values and volumes of services commissioned and how

(a) 2009 c.1 (N.I.)
(b) 1998 c.47

they relate directly to meeting the assessed needs of the population and the delivery of standards and targets;

(c) include the five LCG Commissioning Plans as a part of the Commissioning Plan and set out clearly how the LCG plans are reflected in the overall Plan. This should reflect the use of an evidence-based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCG's target fair share, and the actual resources deployed for the respective populations;

(d) reflect the principles, values and standards set out in the Quality 2020 Strategy to improve the safety, effectiveness and patient/client experience;

(e) support the aims and outcomes of the Public Health Strategic Framework 2012-22 and address health inequalities;

(f) support the implementation of agreed service delivery changes arising from the proposals set out in *Transforming Your Care*;

(g) demonstrate how the commissioning of services drives improvement and how performance management of the HSC Trusts and other providers is used to ensure that commissioning of services meets assessed needs and delivers the targets and standards through effective and efficient use of the available resources; and

(h) include specific commissioning intentions designed to support the six PFG commitments led by DHSSPS, to achieve PFG milestones for 2013/14, and also plan for the achievement of PFG milestones for 2014/15.

3.—(1) The Commissioning Plan shall demonstrate how the commissioning proposals deliver on the following key strategic priorities and statutory obligations:

(a) *To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion, anticipation and earlier intervention*;

The Commissioning Plan must demonstrate how the services to be commissioned reflect the contents of the Public Health Strategic Framework and related population health strategies and are conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland to fulfil the requirements of Section 2(3) (g) of the Act. There should be a strong focus in the Plan on the preventative and early intervention measures being taken by the Regional Board and Regional Agency.

(b) *To improve the quality of services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services*;

The Commissioning Plan must demonstrate how services to be commissioned will fulfil the statutory duty on the Regional Board under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(a). The Plan must explain the outcomes which will be delivered for patients and clients through commissioning. The design and delivery of services must be based on research and a sound evidence base. The Commissioning Plan should set out how commissioning of services will meet the assessed need and support the delivery of changes to health and social care services arising from the proposals in Transforming Your Care.

(c) *To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions*;

The Commissioning Plan must demonstrate how the services commissioned will improve access to treatment, care and support closer to home, and facilitate people to live as independently as possible in their own community. This should include preventing people unnecessarily entering hospital and enable them to return home safely as soon as they are

(a) S.I. 2003/431 (N.I. 9)

fit to do so. The Plan should set out how services being commissioned will meet the requirement for more effective chronic condition management. The Plan should demonstrate how fostering innovation in the delivery of services has been adopted working with a range of providers to improve patient and client care, including through the use of ehealth.

(d) *To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector*;

The Commissioning Plan must detail how the Regional Board propose to take forward the design and delivery of services developed around the local needs of patients and clients through strengthened local commissioning and performance management systems, and working in partnership with other organisations, as appropriate.

(e) *To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities*;

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations, and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act. It must also demonstrate how the Regional Board and Regional Agency will adopt and implement learning from relevant benchmarking studies; the experience of other organisations and how they intend to promulgate and share best practice.

(f) *To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services*;

The Commissioning Plan must demonstrate that the services being commissioned are sufficient to ensure that statutory responsibilities to assess needs, safeguard, protect and support vulnerable groups will be met. There should be an emphasis on prevention and early intervention, in particular in connection with those families whose children are on the edge of care. The Plan will demonstrate how all HSC Trusts, as corporate parents, will be expected to meet the specific needs of looked-after children by providing high quality, enduring placements for them and supporting their transition out of care and into adult life.

Costs incurred in commissioning

4.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1st April 2013 to 31st March 2014, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board and Regional Agency commission health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

(3) This information shall be provided separately for each of the five LCGs, for provider organisations and for services commissioned regionally by the Regional Board and Regional Agency in the manner specified by the Department in its budget allocation letters.

(4) This information shall include an analysis of how the Regional Board plans to shift the proportion of spend from hospital services to community services in accordance with *Transforming Your Care*.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 28 January 2013.

Andrew McCormick
Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Standards and Targets for 2013/14

Priority	*Standard/ Target*
To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention	**Bowel cancer screening** 1. The HSC will extend the bowel cancer screening programme to invite in 2013/14 50% of all eligible men and women aged 60-71, with a screening uptake of at least 55% in those invited; and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014. **Family Nurse Partnership** 2. By March 2014, improve long-term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site.
To improve the quality of services and outcomes for patients, clients and carers, through the provision of safe, resilient and sustainable services	**Hip fractures** 3. From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. **Cancer care services** 4. From April 2013, ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days. **Unscheduled care** 5. From April 2013, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours. **Hospital re admissions** 6. By March 2014, secure a 10% reduction in the number of emergency re admissions within 30 days.

	Elective care – outpatients / diagnostics / inpatients 7. From April 2013, at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014; and no patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014. 8. From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken. 9. From April 2013, at least 70% of inpatients and daycases are treated within 13 weeks, increasing to 80% by March 2014; and no patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014. **Healthcare acquired infections** 10. By March 2014, secure a further reduction of x% in MRSA and *Clostridium difficile* infections compared to 2012/13.**[x to be available in March 2013]** **Organ transplants** 11. By March 2014, 30% of kidneys retrieved in Northern Ireland through DCD are transplanted in Northern Ireland. **Specialist drugs** 12. From April 2013, no patient should wait longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis or ankylosing sponylitis; and no patient should wait longer than 9 months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013. **Stroke patients** 13. From April 2013, ensure that at least 10% of patients with confirmed ischaemic stroke receive thrombolysis.

	Medicines Formulary 14. From April 2013, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care.
To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions	**Allied Health Professionals (AHP)** 15. From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment. **Telemonitoring** 16. By March 2014, deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract. 17. By March 2014, deliver 720,000 Telecare Monitored Patient Days (equivalent to approximately 2,100 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract. **Long term conditions** 18. By March 2014, develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively. **Unplanned admissions** 19. By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.
To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the independent sector	**Integrated Care Partnerships** 20. During 2013/14, to implement Integrated Care Partnerships across Northern Ireland in support of Transforming Your Care.
To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities	**Unnecessary hospital stays** 21. By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.

	Patient discharge 22. From April 2013, ensure that 99% of all learning and disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.
To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across all our services	**Learning disability and mental health** 23. By March 2014, resettle 75 of the remaining long-stay patients in learning disability hospitals and 23 of the remaining long-stay patients in psychiatric hospitals to appropriate places in the community, with completion of the resettlement programme by March 2015. **Children in care** 24. From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%. 25. From April 2013 ensure a 3 year time-frame for 90% of all children to be adopted from care. 26. By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%. **Mental health services** 27. From April 2013, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; and 13 weeks to access psychological therapies (any age). **People with care needs** 28. From April 2013, people with continuing care needs wait no longer than 5 weeks for assessment to be completed, and have the main components of their care needs met within a further 8 weeks.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2013

1. The direction sets out the focus for the Regional Board and Regional Agency in the commissioning of Health and Social Care services during the year 1st April 2013 to 31st March 2014.

2. The Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for clients and patients and their carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

3. The Commissioning Plan needs to have a strong focus on improvement in outcomes and services for individuals, families and communities. This requires planning improvements in health and social well-being, including the promotion of civic responsibility and social inclusion, over the longer term, and specifying the contribution that each year's commissioning of services will make to the longer term goals. In this regard, the Quality 2020 Strategy including service frameworks, Public Health Strategic Framework 2012-22 and related population health and social care strategies should inform the Regional Board and Regional Agency approach to commissioning. The Plan should set out very clearly the linkages to these Strategies and to the relevant commitments included in the Executive's Programme for Government (see Annex A) and Economic Strategy.

4. Quality 2020 defines quality as:

   Safety – *avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.*

   Effective – *patients and clients receiving the right care, at the right time, in the right place, with the best outcome.*

   Patient and Client Focused – *all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.*

5. The three dimensions of quality need to be addressed in commissioning plans in a coherent and integrated manner. Quality 2020 should be a reference point for all service development and delivery in future commissioning.

6. The overall outcomes sought for patients, clients and their carers across the integrated health and social care services are as follows:-

   - preventing people from dying prematurely;
   - helping people to recover from episodes of ill-health, or following injury or other traumatic event;
   - treating and caring for people in a safer environment, empowering them and helping safeguard them from avoidable harm;
   - enhancing the quality of life for people with long term conditions;
   - ensuring people have a positive experience of treatment, care and support;
   - helping to improve the wider determinants of health and social well-being and the promotion of healthy sustainable communities;
   - improving life choices of children who are unable to live with their birth parents.

7. In pursuit of the achievement of these outcomes, the Minister's priorities are to:-

   a. improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion, anticipation and earlier intervention;

b. improve the quality of services and outcomes for patients, clients and carers, through the provision of safe, resilient and sustainable services;

c. improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions;

d. improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the independent sector;

e. improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities;

f. ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services.

8. Commissioning must also support the direction set by *Transforming Your Care* which presents a model with the individual not the institution at the centre of the system, with treatment, care and support provided as close to the home as possible, and services which are safe, resilient and sustainable. The Commissioning Plan should indicate how agreed service changes arising from the Transforming Your Care proposals will be supported by commissioning decisions. It should also recognise that service redesign must reflect evidence of good practice, innovation, workforce development and skills mix. Commissioning Plans each year will support the implementation of agreed changes arising from the TYC proposals and deliver the shift of resources from hospital to primary and community care services.

9. Transforming Your Care recommended the production of a Population Plan for each LCG area which were to assess the needs of the local population based on demographics and population health trends, and identify how those needs would be met in future. The Plans are complemented by an overarching Strategic Implementation Plan which draws together the key elements of the Population Plans, including cross-cutting regional aspects. The final agreed Strategic Implementation Plan and five Population Plans will inform the commissioning of services in 2013/14 and beyond.

10. The objective is to have in place standards and targets which reflect a strong outcome focus in helping to drive forward improvements in the quality and safety of care. Quality 2020 recognises the importance of standards (including service frameworks) and evidence of good practice. It commits to the identification and development of a set of quality indicators for use in monitoring strategic improvements embracing the 3 components of safety, effectiveness and patient / client / carer experience. A regional annual quality report will be published covering all bodies from 2013/14 onwards. The targets and standards should also reflect relevant actions for the Executive's Programme for Government Delivery Plans and the Economic Strategy Comprehensive Action Plan.

11. The Commissioning Plan Direction for 2013/14 supports the Minister's vision and priorities and pursuit of outcomes as set out above and the use of commissioning to help drive change. There should be a shift in focus from an over-emphasis on activities to the quality of care delivered. The targets and standards included in the Schedule to the Direction do not imply that other services or standards are less important. Indeed, there needs to be a focus on improving performance across the health and social care system. They represent particular areas for focus in the coming year and are complemented by identified indicators of performance included in a separate Indicators of Performance Direction to the Regional Board.

12. Effective performance management of the health and social care system requires availability of a range of indicators to help track trends. The Indicators of Performance Direction has been produced alongside the Commissioning Plan Direction to ensure that the HSC has a core set of indicators in place, on common definitions across the sector. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends

in indicators, and take appropriate and timely action as necessary in light of emerging trends.

13. The targets, standards and indicators for 2013/14 are intended to provide a coherent and timely set of measures in key areas of HSC activity, to inform assessments of the effectiveness of actions taken and use of resources, aligned to the Minister's strategic priorities for health and social care services. The Commissioning Plan and the commissioning intentions within the Plan should demonstrate an understanding of the relationship between the targets and indicators of performance and the delivery of the Minister's objectives and strategic direction. The Commissioning Plan should contain details of how the Regional Board intends to ensure that performance management information is used effectively in the decisions on the commissioning of services and that the best use is made of the resources available to achieve service improvements during 2013/14. The Plan should explain how the Regional Board will use analysis to investigate variations in unit cost and performance and detect deteriorating trends, and take early action to address them. This should particularly be the case in regards to emergency departments and waiting lists. There should be a clear explanation of the actions the Regional Board will take to address significant under performance against requirements by providers.

14. The Plan should include a review of what was achieved in 2012/13, including the effectiveness of actions which were taken to ensure that the targets were met and that standards maintained, and for relevant services, an assessment of why performances did not meet the levels set.

Annex A

PROGRAMME FOR GOVERNMENT (PFG) COMMITMENTS AND MILESTONES

The Department leads on six PFG Commitments each of which has three annual milestones. The Commissioning intentions within the Commissioning Plan must support the continued delivery of milestones set for 2012/13, must support the achievement of milestones during 2013/14 and also plan for the achievement of milestones in 2014/15. Specific attention should be given to the commissioning intentions relevant to the following Commitments (with associated milestones shown in italics for each):

PFG Commitment 22: Allocate an increasing percentage of the overall health budget to public health

2013/14 – The HSC will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from 1st April 2014

2014/15 – Invest an additional £10m in public health (increase based on 2011/12 spend)

PFG Commitment 22: Enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic management programme

2013/14 – Health and Social Care Board and Public Health Agency should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long-term conditions effectively, alongside full application of the Remote Telemonitoring contract

2014/15 – People with a long-term condition will be offered access to appropriate education, information and support programmes relevant to their needs, including innovative application of connected health

PFG Commitment 45: Invest £7.2 million in programmes to tackle obesity

2013/14 – Invest £2.4m in tackling obesity through support of Obesity Prevention Framework

2014/15 – Invest £2.8m in tackling obesity through support of Obesity Prevention Framework

PFG Commitment 61: Introduce a package of measures aimed at improving safeguarding outcomes for children and vulnerable adults across Northern Ireland

2013/14 - Open new Sexual Assault Referral Centre at Antrim Area Hospital

2014/15 – Develop an updated inter-departmental Child Safeguarding Policy Framework

PFG Commitment 79: Improve Patient and Client outcomes and access to new treatments and services

2013/14 – Improve long-term outcomes relating to health, well-being, education and employment for the children of teenage mothers from disadvantaged backgrounds by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site

2014/15 – Expand cardiac catheterisation capacity to improve access to diagnostic intervention and treatment and further develop the primary percutaneous coronary intervention (PPCI) service to reduce mortality and morbidity arising from myocardial infarction (heart attack)

PFG Commitment 80: Reconfigure, reform and modernise the delivery of Health and Social Care services to improve the quality of patient care

2013/14 – As part of a shift in the delivery of services to primary and community settings reduce by 2013/14, the number of days patients stay in acute hospitals unnecessarily (excess bed days) by 10% compared with 2011/12

2014/15 – Secure a shift from hospital-based services to community-based services together with an appropriate shift in the share of funding in line with the recommendations of Transforming Your Care

DIRECTION

2013 No. 13

The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by sections 6 and 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(a):

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014 and shall come into operation on 13 November 2013.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission for the period 1st April 2014 to 31st March 2015, for consideration and approval by the Minister. In doing so, it shall include the underpinning financial plan, and detail how commissioning will serve to deliver the planned transformation of services, including *Transforming Your Care* (TYC), and meet the standards and targets set out in the Schedule.

(2) The Commissioning Plan shall provide details of indicative commissioning intentions and associated indicative financial commitments for the period 1st April 2015 to 31st March 2016.

(3) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board and the underpinning financial plan align with and support the delivery of the Executive's Programme for Government (PFG) commitments and associated milestones, its Economic Strategy and its Investment Strategy; the Minister's vision and priorities for health and social care; extant statutory obligations, including Equality duties under the Northern Ireland Act 1998(b), the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); the standards, policies and strategies set by the Department; the agreed transformation of health and social care services including TYC; and Departmental guidance and guidelines.

(4) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board will deliver safe, effective and high quality care in the most appropriate

(a) 2009 c.1 (N.I.)
(b) 1998 c.47

setting, represent an equitable use of the resources made available for health and social care to the Northern Ireland population, based on relative need, and support the implementation of the agreed service delivery changes arising from planned transformation. In doing so the Commissioning Plan must:

(a) include the Strategic Context – the environmental factors and drivers for change influencing commissioning intentions and future service development and design, taking account of the strategic policies and priorities set by the Department;

(b) include the five LCG Commissioning Plans as part of the Commissioning Plan. These should reflect the use of an evidence-based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCG's target fair share, and the actual resources deployed for the respective populations;

(c) for all regional services and for each of the five Local Commissioning Groups, set out fully the services to be commissioned with details of specific commissioning intentions designed to deliver on the targets, standards and strategic priorities in this Direction for the year 1st April 2014 to 31st March 2015. This should include the values and volumes of services to be commissioned at LCG level and how they relate directly to meeting the assessed needs of the population and the delivery of standards and targets. The Plan should also provide indicative commissioning intentions for the year 1st April 2015 to 31st March 2016, to include a high level assessment of values and volumes of services to be commissioned;

(d) set out clear timescales and milestones for the delivery of the commissioning plan and underpinning financial plan as appropriate, and for the implementation of agreed service delivery changes arising from TYC;

(e) demonstrate how commissioning intentions take account of existing performance, and detail how performance management of HSC Trusts and other providers is used to ensure that assessed needs are met and targets and standards are being delivered through the effective and efficient use of the available resources. The Plan should explain how the Regional Board, in consultation with the Regional Agency as appropriate, will address significant under-performance against requirements by providers; and

(f) include specific commissioning intentions designed to support the six PFG commitments led by DHSSPS and the achievement of PFG milestones.

3.—(1) The Commissioning Plan shall demonstrate how the commissioning proposals deliver on the following key strategic priorities and statutory obligations:

(a) *To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion, anticipation and earlier intervention*;

The Commissioning Plan must demonstrate how the services to be commissioned support the aims and outcomes of the Public Health Strategic Framework 2013-23 and related population health strategies, and are conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland to fulfil the requirements of Section 2(3) (g) of the Act. There should be a strong focus in the Plan on how the services to be commissioned will prevent ill-health, anticipate the needs of local populations, and promote health and well-being. The Plan should also detail the early intervention measures being taken by the Regional Board and Regional Agency, where appropriate working in partnership with other organisations, and should demonstrate a commitment to address the wider determinants of health through, for example, the use of social clauses in procurement and service contracts where appropriate, and to maintaining and developing grassroots community and voluntary organisations.

(b) *To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting*;

The Commissioning Plan must demonstrate how the services to be commissioned will fulfil the statutory duty on the Regional Board under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(a); reflect the principles, values and standards set out in the Quality 2020 Strategy; improve the safety and effectiveness of services to deliver safe, high quality care that meets recognised standards, including those set out in Service Frameworks; and improve the patient and client experience, including implementation of the regional priorities identified in the PHA annual report (2013/14) on the Patient Experience Standards. The Plan must explain the outcomes which will be delivered for patients, clients and carers and outline how the Regional Board will take account of the views of patients, clients and carers in the commissioning of services. The Plan should also demonstrate that the design and delivery of services to be commissioned is based on the best available robust, research-informed evidence, in accordance with the objectives of the Department's strategy for Health and Social Care Research and Development.

(c) *To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions*;

The Commissioning Plan must demonstrate how the services commissioned will improve access to treatment, care and support closer to home, and facilitate people to live as independently as possible in their own community. This should include preventing people unnecessarily entering hospital and enabling them to return home safely as soon as they are fit to do so. The Plan should set out how services being commissioned will meet the requirement for more effective long-term condition management. The Plan should demonstrate how innovation in the delivery of services has been adopted, working with a range of providers to improve patient and client care, including through the use of innovative technologies to support people to manage their conditions at home.

(d) To promote social inclusion, choice, control, support and independence for people living in the community, especially older people, and those individuals and their families living with disabilities;

The Commissioning Plan must detail how the services to be commissioned will promote social inclusion and support people with health and care needs living in the community, particularly older people, and people with disabilities and their families. The Commissioning Plan should demonstrate an emphasis on home as the hub of care, including through the use of personal budgets, access to reablement services, age-appropriate day opportunities, enhanced provision of short breaks and the timely delivery of carers' assessments.

(e) *To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the community, voluntary and independent sector*;

The Commissioning Plan must detail how the Regional Board proposes to take forward the design and delivery of services developed around the local needs of patients, clients and carers through strengthened local commissioning and performance management systems, and working in partnership with other organisations as appropriate.

(f) *To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities*;

(a) S.I. 2003/431 (N.I. 9)

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations, and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act. It must also demonstrate how the Regional Board and Regional Agency will adopt and implement learning from relevant benchmarking studies; the experience of other organisations and how they intend to promulgate and share best practice.

(g) *To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services*;

The Commissioning Plan must demonstrate that the services being commissioned are sufficient to ensure that statutory responsibilities to assess needs, safeguard, protect and support vulnerable groups, including through the discharge of delegated statutory functions, will be met. There should be an emphasis on prevention and early intervention, in particular in connection with those families whose children are on the edge of care. The Plan will demonstrate how all HSC Trusts, as corporate parents, will be expected to meet the specific needs of looked-after children by providing high quality, enduring placements for them and supporting their transition out of care and into adult life.

Commissioning and the use of financial allocations

4.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1st April 2014 to 31st March 2015, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources. The Plan shall also provide details of indicative commitments for the financial year from 1st April 2015 to 31st March 2016.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

(3) This information shall be provided separately for each of the five LCGs, for provider organisations and for services commissioned regionally by the Regional Board in the manner specified by the Department in its budget allocation letters.

(4) This information shall include an analysis of how the Regional Board plans to shift the proportion of spend from hospital services to primary and community services in accordance with the planned transformation of health and social care services.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 13 November 2013.

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Standards and Targets for 2014/15

Priority	*Standard/ Target*
To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention	**Bowel cancer screening** 1. The HSC will extend the bowel cancer screening programme from April 2014 to invite, by March 2015, 50% of all eligible men and women aged 60-74, with an uptake of at least 55% of those invited. **Family Nurse Partnership** 2. By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust. **Substance misuse** 3. By March 2015, services should be commissioned and in place that provide seven day integrated and coordinated substance misuse liaison services within all appropriate HSC acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention programmes. **Tackling obesity** 4. By March 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.
To improve the quality of services and outcomes for patients, clients and carers, through the provision of timely, safe, resilient and sustainable services in the most appropriate setting.	**Hip fractures** 5. From April 2014, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. **Cancer care services** 6. From April 2014, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected

	cancer should begin their first definitive treatment within 62 days. **Unscheduled care** 7. From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours. 8. By March 2015, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area. **Hospital readmissions** 9. By March 2015, secure a 5% reduction in the number of emergency readmissions within 30 days (using 2012/13 data as the baseline). **Elective care – outpatients / diagnostics/ inpatients** 10. From April 2014, at least 80% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 15 weeks. 11. From April 2014, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken. 12. From April 2014, at least 80% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks **Healthcare acquired infections** 13. By March 2015, secure a further reduction of x% in MRSA and *Clostridium difficile* infections compared to 2013/14.**[x to be available in March 2014]** **Organ transplants** 14. By March 2015, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors. **Specialist drugs**

	15. From April 2014, no patient should wait longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis, ankylosing sponylitis or psoriasis. **Stroke patients** 16. From April 2014, ensure that at least 12% of patients with confirmed ischaemic stroke receive thrombolysis. **Pressure ulcers** 17. By March 2015, secure a 10% reduction in pressure ulcers in all adult inpatient wards. **Medicines Formulary** 18. From April 2014, ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area.
To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions	**Allied Health Professionals (AHP)** 19. From April 2014, no patient waits longer than nine weeks from referral to commencement of AHP treatment. **Telehealth** 20. By March 2015, deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract. **Unplanned admissions** 21. By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions (using 2012/13 data as the baseline).
To promote social inclusion, choice, control, support and independence for people living in the community, especially older people and those individuals and their families living with disabilities	**Carers' assessments** 22. By March 2015, secure a 10% increase in the number of carers' assessments offered. **Direct payments**

	23. By March 2015, secure a 5% increase in the number of direct payments across all programmes of care. **Telecare** 24. By March 2015, deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.
To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the community, voluntary and independent sector	**Patient experience** 25. The Regional Agency, in liaison with the Regional Board and HSC Trusts, to assist the Department to deliver a regional survey of inpatient and A&E patient experience during 2014/15, in order to baseline the position regarding patient experience and put in place a programme of work to secure improvements. **Integrated Care Partnerships** 26. By March 2015, 95% of patients within the four ICP priority areas [frail elderly, diabetes, stroke, respiratory] will have been identified and will be actively managed on the agreed Care Pathway.
To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities	**Delivering transformation** 27. By March 2015, transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. **Normative staffing** 28. The Regional Agency should continue to lead and monitor the programme of work to develop and implement Normative Nurse Staffing which should be used to commission and deliver services as follows: i. From April 2014, the Normative Nurse Staffing Tool should be applied to all inpatient general and specialist adult hospital medical and surgical care settings; ii. By March 2015 normative staffing

	ranges will be developed and introduced for Health Visiting within a range which secures the delivery of the service model detailed within the Departmental Strategy 'Healthy Futures'. **Unnecessary hospital stays** 29. By March 2015, reduce the number of excess bed days for the acute programme of care by 10% (using 2012/13 data as the baseline). **Cancelled clinics** 30. By March 2015, reduce the number of hospital cancelled consultant-led outpatient appointments by 17%. **Patient discharge** 31. From April 2014, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.
To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across all our services	**Learning disability and mental health** 32. By March 2015, resettle the remaining long-stay patients in learning disability and psychiatric hospitals to appropriate places in the community. **Mental health services** 33. From April 2014, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age). **Children in care** 34. From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%.

	35. By March 2015, ensure a three year time frame for 90% of children who are to be adopted from care. 36. From April 2014, ensure that all school-age children who have been in care for 12 months or longer have a Personal Educational Plan (PEP).

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2013

1. The Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister's vision and priorities during the year 1st April 2014 to 31st March 2015.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2014/15 financial year are resourced through the underpinning financial plan and will serve to deliver on the agreed planned transformation of services, including TYC. The Commissioning Plan shall provide details of indicative commissioning intentions and associated indicative commitments in 2015/16 to reflect the integrated nature of the Plan and the need to plan over the longer term timescale for effective implementation of agreed transformation.

4. The targets and standards included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year and are complemented by identified indicators of performance included in a separate Indicators of Performance Direction to the Regional Board.

5. Effective performance management of the health and social care system requires availability of a range of indicators to help track trends. An Indicators of Performance Direction will be produced alongside the Commissioning Plan Direction to ensure that the HSC has a core set of indicators in place, on common definitions across the sector. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

PROGRAMME FOR GOVERNMENT (PFG) COMMITMENTS AND MILESTONES

The Department leads on six PFG Commitments each of which has three annual milestones. The Commissioning intentions within the Commissioning Plan must support the continued delivery of milestones set for 2012/13and 2013/14, and the achievement of milestones for 2014/15.

PFG Commitment 22: Allocate an increasing percentage of the overall health budget to public health

2012//13 – Strengthen the cross-sectoral, cross-Departmental drive on improving health and mental wellbeing and reducing health inequalities by setting new policy direction and associated outcomes based on the most recent bodies of evidence available.

2013/14 – The HSC will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from 1st April 2014

2014/15 – Invest an additional £10m in public health (increase based on 2011/12 spend)

PFG Commitment 44: Enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic management programme

2012/13 – Identify and evaluate the current baseline of patient education and self management support programmes that are currently in place in each Trust area.

2013/14 – Health and Social Care Board and Public Health Agency should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long-term conditions effectively, alongside full application of the Remote Telemonitoring contract

2014/15 – People with a long-term condition will be offered access to appropriate education, information and support programmes relevant to their needs, including innovative application of connected health

PFG Commitment 45: Invest £7.2 million in programmes to tackle obesity

2012//13 – Invest £2 million in tackling obesity through support of Obesity Prevention Framework

2013/14 – Invest £2.4m in tackling obesity through support of Obesity Prevention Framework

2014/15 – Invest £2.8m in tackling obesity through support of Obesity Prevention Framework

PFG Commitment 61: Introduce a package of measures aimed at improving safeguarding outcomes for children and vulnerable adults across Northern Ireland

2012/13 - Develop a Strategic Plan for Adult Safeguarding in Northern Ireland and produce a joint Domestic and Sexual Violence and Abuse Strategy

2013/14 - Open new Sexual Assault Referral Centre at Antrim Area Hospital

2014/15 – Develop an updated inter-departmental Child Safeguarding Policy Framework

PFG Commitment 79: Improve Patient and Client outcomes and access to new treatments and services

2012/13 – Enhance access to life-enhancing drugs for conditions such as rheumatoid arthritis, cancer, inflammatory bowel disease and psoriasis and increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis

2013/14 – Improve long-term outcomes relating to health, well-being, education and employment for the children of teenage mothers from disadvantaged backgrounds by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site

2014/15 – Expand cardiac catheterisation capacity to improve access to diagnostic intervention and treatment and further develop the primary percutaneous coronary intervention (PPCI) service to reduce mortality and morbidity arising from myocardial infarction (heart attack)

PFG Commitment 80: Reconfigure, reform and modernise the delivery of Health and Social Care services to improve the quality of patient care

2012/13 – Development of a clear implementation and Population plan to ensure delivery of the new model of care as set out in the Transforming Your Care report

2013/14 – As part of a shift in the delivery of services to primary and community settings reduce by 2013/14, the number of days patients stay in acute hospitals unnecessarily (excess bed days) by 10% compared with 2011/12

2014/15 – Secure a shift from hospital-based services to community-based services together with an appropriate shift in the share of funding in line with the recommendations of Transforming Your Care

DIRECTION

2015 No. 1

The Health and Social Care Commissioning Plan Direction (Northern Ireland) 2015

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by sections 6 and 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(1):

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan Direction (Northern Ireland) 2015 and shall come into operation on 6 March 2015.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission regionally and for each of the five LCG areas, for the period 1st April 2015 to 31st March 2016, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include the underpinning financial plan, and set out how commissioning will serve to deliver the planned transformation of services, including *Transforming Your Care*. It should set out clear timescales and milestones for the delivery of commissioning intentions and the agreed service changes arising from the implementation of TYC.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board and the underpinning financial plan align with and support the delivery of the Executive's Programme for Government (PfG) commitments and associated milestones, its Economic Strategy and its Investment Strategy; the Minister's vision and priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998(2), the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); and Departmental standards, policies, strategies and guidelines.

3.—(1) The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will deliver the following three overarching strategic themes:

(a) *To improve and protect population health and wellbeing, and reduce health inequalities.*

(1) 2009 c.1 (N.I.) as amended by 2014 c.5
(2) 1998 c.47

The Commissioning Plan must demonstrate how the services to be commissioned will improve and promote the health and wellbeing of local populations, contribute to the prevention of ill health and reduce health inequalities, in accordance with Section 2(3) (g) of the Act. It should outline how commissioning will support the aims and outcomes of the Public Health Strategic Framework 2013-23 and related population health strategies, and indicate how the Regional Board and Regional Agency are working collaboratively with communities and partner organisations to address the determinants of health.

(b) *To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.*

The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board will deliver high quality, safe and effective care in the most appropriate setting. The Plan must demonstrate how services will be commissioned to improve access to treatment, care and support closer to home, and facilitate people to live as independently as possible in the community. This should include preventing people unnecessarily entering hospital, enabling them to return home safely as soon as they are fit to do so, and supporting people with health and care needs living in the community, as well as their families and carers. The Plan should set out how progress will be made towards implementing the Delivering Care Framework, including Delivering Care for Health Visiting, Delivering Care for Emergency Departments and Delivering Care for District Nursing. The Plan should also detail how commissioning will be used to promote innovation and appropriate use of technology in the delivery of health and social care services – on the basis of single solutions for the region.

The Commissioning Plan must demonstrate how the services to be commissioned will fulfil the statutory duty on the Regional Board under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(3); reflect the principles, values and standards set out in the Quality 2020 Strategy; improve the safety and effectiveness of services to deliver safe, high quality care that meets recognised standards, including those set out in Service Frameworks; and improve the patient and client experience. The Plan must explain the outcomes which will be delivered for patients, clients and carers and outline how the Regional Board will take account of their views in the commissioning of services, including through reference to reports produced and priorities highlighted by the Patient and Client Council, the outcomes of the 10,000 voices project and the audit of the five standards of patient experience.

The Commissioning Plan must demonstrate that the services being commissioned ensure that the most vulnerable in society, including children and adults at risk of harm, are looked after effectively across all our services, and detail how statutory responsibilities to assess needs, safeguard, protect and support vulnerable groups, including through the discharge of delegated statutory functions, will be met. There should be an emphasis on prevention and early intervention, in particular in connection with those families whose children are on the edge of care. The Plan will demonstrate how all HSC Trusts, as corporate parents, will be expected to meet the specific needs of looked-after children by providing high quality, enduring placements for them and supporting their transition out of care and into adult life.

(c) *To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.*

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations, and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act. The Plan should incorporate plans for each of the five LCGs, and should reflect the use of an evidence-based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCG's target fair share, and the actual resources deployed for the respective populations.

---

(3) S.I. 2003/431 (N.I. 9)

It must also demonstrate how the Regional Board will commission services in a cost effective manner, including commissioning across provider boundaries and utilising alternative providers where appropriate, and by ensuring that performance and costs are benchmarked and that best practice is shared and implemented across all HSC Trusts. The Plan should also explain how the Regional Board, in consultation with the Regional Agency as appropriate, will address significant under-performance against requirements by providers.

Commissioning and the use of financial allocations

4.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1st April 2015 to 31st March 2016, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

(3) This information shall be provided separately for each of the five LCGs, for provider organisations and for services commissioned regionally by the Regional Board in the manner specified by the Department in its budget allocation letters.

(4) This information shall include an analysis of how the Regional Board plans to shift the proportion of spend from hospital services to primary and community services in accordance with the planned transformation of health and social care services.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 6 March 2015.

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Standards and Targets for 2015/16

Theme	*Standard/ Target*
To improve and protect population health and wellbeing, and reduce health inequalities.	**Bowel cancer screening** 1. By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited. **Tackling obesity** 2. From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited. **Substance misuse** 3. During 2015/16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes. **Family Nurse Partnership** 4. By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme.
To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.	**Unplanned admissions** 5. By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas. 6. During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.

Carers' assessments

7. By March 2016, secure a 10% increase in the number of carers' assessments offered.

Direct payments

8. By March 2016, secure a 10% increase in the number of direct payments across all programmes of care.

Allied Health Professionals (AHP)

9. From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.

Hip fractures

10. From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Cancer services

11. From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Unscheduled care

12. From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.

13. By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.

Emergency readmissions

14. By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.

	Elective care – outpatients / diagnostics/ inpatients 15. From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks. 16. From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken. 17. From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks. **Organ transplants** 18. By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors. **Stroke patients** 19. From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis. **Healthcare acquired infections** 20. By March 2016 secure a reduction of x% in MRSA and *Clostridium difficile* infections compared to 2014/15. **[x to be available in April/May 2015 following analysis of 2014/15 performance and benchmarking process.]** **Patient discharge** 21. From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours. **Mental health services** 22. From April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to

	access psychological therapies (any age). **Children in care** 23. From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%. 24. By March 2016, ensure a three year time frame for 90% of children who are adopted from care. **Patient safety** 25. From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points. **Normative staffing** 26. By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.
To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.	**Excess bed days** 27. By March 2016, reduce the number of excess bed days for the acute programme of care by 10%. **Cancelled appointments** 28. By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment. **Delivering transformation** 29. By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model. **Pharmaceutical Clinical Effectiveness Programme** 30. By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE COMMISSIONING PLAN DIRECTION (NORTHERN IRELAND) 2015

1. This direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister's vision and priorities during the year 1st April 2015 to 31st March 2016.

2. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2015/16 financial year are resourced through the underpinning financial plan and will serve to deliver on the agreed planned transformation of services, including TYC.

3. The targets and standards included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.

4. Effective performance management of the health and social care system requires availability of a range of indicators to help track trends. An Indicators of Performance Direction will be produced alongside the Commissioning Plan Direction to ensure that the HSC has a core set of indicators in place, with common definitions applied across the sector. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

D I R E C T I O N

2016 No. 2

The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2016

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by sections 6, 8(3) and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009 (**1**):

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan Direction (Northern Ireland) 2016 and shall come into operation on 4 April 2016.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission, for the period 1st April 2016 to 31st March 2017, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include a summary of the financial allocations, and set out how commissioning will serve to deliver the planned transformation of services, including the continued delivery of the *Transforming Your Care* service model. It should set out clear timescales and milestones for the delivery of commissioning intentions and the transformation of services.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board align with and support the delivery of the Minister's vision and priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998(**2**), the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); and key Departmental standards, policies, strategies and guidelines.

3. The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will deliver the three overarching strategic themes:

(a) *To improve and protect population health and wellbeing, and reduce health inequalities*.

(b) *To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.*

(**1**) 2009 c.1 (N.I.) as amended by 2014 c.5
(**2**) 1998 c.47

(c) *To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred*.

Performance indicators

4.In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the objectives and associated quality and performance indicators for the period 1st April 2016 to 31st March 2017.

5.The Regional Board shall record the information against the objectives and associated quality and performance indicators for the period 1st April 2016 to 31st March 2017

Commissioning and the use of financial allocations

6.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1st April 2016 to 31st March 2017, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 4 April 2016

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Objectives and Indicators for 2016/17

Introduction

This Direction sets out the priorities, aims and improvement objectives for the HSC. It identifies specific areas of focus for the 2016/17 financial year but also seeks to set these within the context of the broader outcomes that the Minister, the Department and the HSC want to achieve as we work together to build a world-class health and social care service for the people of Northern Ireland.

The Direction is structured around three overarching and linked aims, which recognise the challenges facing the HSC in Northern Ireland and every health and social care system in the developed world—to improve the health of the population, to improve the quality of services, and to make the best and most efficient use of available resources.

Under each of these three aims are key outcomes that the HSC should deliver for the people of Northern Ireland. For each outcome, the Direction includes a number of related standards or goals for improvement, the achievement of which will contribute to the achievement of the overall outcome. While a number of the specific improvement goals set out in the document need to be achieved within 2016/17, we recognise that others will require a longer time to deliver results.

To allow progress towards each outcome to be tracked over time, we have identified a number of associated quality and performance indicators against which the HSC should monitor performance and take improvement action as required. It is important to note that these indicators do not represent the totality of the information available to the HSC and the Department to ensure the smooth running of the system or inform the development, implementation and evaluation of policy—rather, it is intended that the specific quality and performance indicators set out in this Direction will provide useful information to the HSC on the delivery of the required outcomes for the people of Northern Ireland.

The Commissioning Plan must demonstrate how the services to be commissioned regionally and by LCG's in 2016/17 will contribute to the delivery of the three aims, the identified outcomes and the specific objectives and goals for improvement set out below.

Aim: To improve and protect population health and wellbeing, and reduce inequalities.

A key aim of the entire health and social care system in Northern Ireland must be to improve the overall health and wellbeing of the population and to prevent ill-health. This means supporting people to take greater control over their own lives and enabling them to make healthy choices about how they live their lives as well as helping to create an environment that makes such choices easier. It also means working with other partners to tackle the root causes of ill-health and reduce health inequalities in Northern Ireland, while overall health has been improving too many people still die prematurely or live with conditions that could have been prevented. The health and social care service has an important role in addressing this, but it cannot do so in isolation. It must work with partners across government and other sectors to address the social, economic and environmental factors that impact on people's health and wellbeing.

Every contact with health and social care services has the potential to make a positive impact on the choices people make. As such, prevention and early intervention must be embedded in the commissioning of primary, community and secondary care services.

Making Life Better sets a clear direction for actions to improve health and reduce inequalities. Through this strategic framework, the Northern Ireland Executive has committed to creating the conditions for individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives. A key focus of *Making Life Better* is to strengthen co-ordination and collaboration in a whole of society, whole system approach.

Maintaining and strengthening inter-sectoral working is extremely important, particularly working with local government and participating in community planning to maximise the potential for improving the health and wellbeing of communities and tackling health inequalities at the local level.

Work to support and enable healthy lives must span the entire life course—for example helping pregnant women and their partners to make the choices that are best for them and their babies; ensuring that all children grow up in a stable and healthy environment, and are equipped for a healthy adulthood; and supporting people to continue to live active and healthy lives as they age.

Desired outcome 1: Health and social care services contribute to; reducing inequalities; ensuring that people are able to look after and improve their own health and wellbeing, and live in good health for longer.

Objectives/ goals for improvement:

1.1 In line with the Departmental strategy A Fitter Future For All, by March 2022 reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.

1.2 In line with the Department's policy framework, Living with Long Term Conditions, continue to support people to self manage their condition through increasing access to structured patient education programmes. In 2016/17, the focus will be on consulting on and taking steps to begin implementation of the Diabetes Strategic Framework and implementation plan with the aim that by 2020 all individuals newly diagnosed with diabetes will be offered access to diabetes structured education with 12 months of diagnosis.

1.3 In line with the Department's ten year Tobacco Control Strategy, by March 2020 reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.

1.4 By March 2020, to reduce the differential in the suicide rate across Northern Ireland and the differential in suicide rates between the 20% most deprived areas and the NI average. Areas of focus for 2016/17 should include early intervention and prevention activities, for example through improvement of self harm care pathways and appropriate follow-up services in line with NICE guidance.

1.5 By March 2018 ensure full delivery of the universal child health promotion framework for Northern Ireland, *Healthy Child, Healthy Future*. Specific areas of focus for 2016/17 should include the delivery of the required core contacts by health visitors within the pre-school child health promotion programme.

1.6 During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring that the proportion of children in care for 12 months or longer with no placement change is at least 85%.

1.7 During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring a three year time frame (from date of last admission) for 90% of children who are adopted from care.

Outcome 1 - Associated quality and performance indicators

Population health (general)

A1 Healthy life expectancy.

A2 Average life expectancy for men and women.

A3 Life expectancy differential between the least deprived and most deprived areas in Northern Ireland, for men and women.

A4 Potential years of life lost from causes considered amenable to healthcare.

A5 Infant mortality.

A6 Age standardised death rate for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas.

A7 Maintenance of population vaccination coverage as reported in PHA Annual Report.

A8 Proportion of adults (aged 16+) consuming the recommended five portions of fruit and vegetables each day.

A9 Level of overweight and obesity across the life course (2 – 15) year olds and 16+.

Smoking

A10 Proportion of adults who smoke.

A11 Number of pregnant women, children and young people, and adults from deprived areas (lower quintile) who set a quit date through cessation services.

Alcohol and substance misuse

A12 Proportion of adults who report having reached or exceeded the recommended weekly alcohol limit.

A13 Standardised rate of alcohol-related admissions to hospital within the acute programme of care.

A14 Standardised rate of drug-related admissions to hospital within the acute programme of care.

Suicide and self harm

A15 Number of ED repeat presentations due to deliberate self-harm.

A16 Self-reported mental health. (GHQ12 survey)

Child health and wellbeing

A17 Rate of births to mothers under 17 years of age (with breakdown against most deprived areas).

A18 Breastfeeding rate at discharge from hospital.

A19 Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.

A20 Proportion of looked after children who have experienced more than two placement changes. (Source is OC2)

MAHI - STM - 089 - 272

A21 Length of time for best interest decision to be reached in the adoption process.

A22 Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type.

A23 Proportion of school-aged children who have been in care for 12 months or longer, who have a personal education plan.

A24 Percentage of care leavers aged 16 – 18 in education, training or employment by placement type.

A25 Percentage of care leavers at age 18, 19 and 20 years in education, training or employment.

Aim: To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.

Everyone in Northern Ireland will use health and social care services at various points in their lives. When they do, it is vital that they are able to access high quality services in the most appropriate setting. As outlined in Quality 2020, this means that services must be safe—the care, treatment and support the HSC provides should never result in avoidable or preventable harm; they must be effective—everyone accessing HSC services should have the most appropriate treatment or care, in the most appropriate setting, with the best possible outcome; and they must be centred on the needs of the patient/ client—everyone using HSC services should be treated with dignity and respect and should be fully involved in decisions about their treatment, care and support.

In line with the strategic vision set out in *Transforming Your Care*, where appropriate to a person's needs, services should be provided at home or as close to home as possible. When admission to hospital is required, it is essential that people are treated safely and effectively, discharged home as quickly as possible, and supported back to health in the community. While it is recognised that some variations may be necessary to respond to specific local needs, services across Northern Ireland should be standardised as far as practicable so that everyone, regardless of where they live, can expect the same level of care and treatment.

The contribution of informal carers is crucial to the ever increasing number of people who require additional support and assistance to live independently in the community. It is important that carers are supported to enable a balance to be struck between the duties of the caring role and their right to live their own life and pursue their own goals and interests.

Everyone who uses HSC services should have a positive experience of the care or treatment they receive. Where things go wrong, it is important that the HSC listens to and learns from those mistakes and strives to continually improve the services offered to the NI population. Patients and clients should be at the centre of service planning and design.

Timely access to the most appropriate services is a key indicator of quality and the patient experience. People rightly have an expectation that they should be seen and treated within a reasonable time. However, over the last number of years meeting rising demand for health and social care services has been increasingly challenging and it is clear that it is not possible to keep doing what has always been done and continue to provide high quality services to the population. It will be essential, therefore, for the Commissioning Plan to demonstrate how alternative models of care are being embedded across Northern Ireland, with the aim of ensuring that more people can be seen and treated effectively, including on a same/ next day basis, improving the patient journey through hospitals, preventing unnecessary admissions to hospital, and supporting people to recover following periods of ill-health. This should include working towards the provision of the same level of care for inpatients seven days a week, the development of ambulatory care models, the utilisation of technology to provide timely access to specialist advice, and the rollout of the regional re-ablement model.

The improvement goals below represent the most realistic and achievable objectives for the coming year. The longer-term aim must be to significantly reduce waiting times for assessment, diagnosis and treatment and work towards the achievement of the maximum waiting times of nine, nine and thirteen weeks that have previously been achieved.

Desired outcome 2: People using health and social care services are safe from avoidable harm

Objectives/ goals for improvement:

2.1 In the year to 31 March 2017 secure a reduction of 25% in the total number of in-patient episodes of *Clostridium difficile* infection in patients aged 2 years and over and in-patient episodes of MRSA infection compared to 2015/16.

2.2 From April 2016, ensure that the clinical condition of all patients is regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.

2.3 By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services.

2.4 The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice.

2.5 The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice and that subsequently attract a notice of decision.

Outcome 2 - Associated quality and performance indicators

Patient safety

B1 Summary hospital-level mortality indicator rates.

B2 Number of incidents of hospital-acquired pressure ulcers (grade 3 and 4) occurring in all adult inpatient wards, and the number of those which were unavoidable.

B3 Percentage compliance with the falls safe improvement bundle.

B4 Number of emergency admissions returning within seven days and within 8-30 days of discharge.

B5 Clinical causes of emergency readmissions (as a percentage of all admissions) for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF).

B6 Number of emergency readmissions with a diagnosis of venous thromboembolism.

B7 Number of emergency admissions and readmissions in which medicines were considered to have been the primary or contributing factor.

Clinical Monitoring

B8 Number of records audited achieving 95% compliance of the accurately completed NEWS charts in all adult in-patient wards (excluding theatres and critical care departments).

Inspection standards

B9 Number of failure to comply notices issued to (i) residential homes, (ii) nursing homes, in 2015/16 and 2016/17, as published by RQIA.

B10 Number of failure to comply notices issued to the same (i) residential homes, (ii) nursing homes for identical issue, in 2015/16 and 2016/17, as published by RQIA.

B11 Number of revisits required to achieve compliance in (i) residential homes, (ii) nursing homes, in 2015/16 and 2016/17, as published by RQIA.

Staffing levels

B12 Staffing levels as reported in regular reports from PHA Delivering Care Implementation Board.

Desired outcome 3: People who use health and social care services have positive experiences of those services.

Objectives/ goals for improvement:

3.1 To support people with palliative and end of life care needs to be cared for in their preferred place of care. By March 2018 to identify individuals with a palliative care need and have arrangements in place to meet those needs. The focus for 2016/17 is to develop and implement appropriate systems to support this.

3.2 By March 2017, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need (or alternatively timely access to treatment).

3.3 Where patients are cared for in mixed gender accommodation, all Trusts must have policies in place to ensure that patients' privacy and dignity are protected.

3.4 HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.

3.5 By March 2018, to increase by 40% the total number of patients across the region participating in the PHA Biennial Patient Experience Survey, with particular emphasis on engaging patients in areas of low participation.

Outcome 3 - Associated quality and performance indicators

Palliative Care

C1 To have implemented the Key Information Summary system.

C2 Implementation of a protocol to support the identification of patients with palliative and end of life care needs in Primary Care systems. [Source: PHA/ HSCB evaluation report of agreed protocol]

Mixed Gender Accommodation

C3 PHA report on compliance with same gender accommodation by Trusts.

C4 PHA report on Trust compliance with requirement to have policy in place for the provision of Safe and Effective Care and Treatment in Mixed Gender Accommodation, which reflects the DHSSPS Guiding Principles for Mixed Gender Inpatient Accommodation.

Desired outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Objectives/ goals for improvement:

4.1 By March 2020 to have increased access to services delivered by GP practices. The focus for 2016/17 is on developing a comprehensive baseline of such activity, to be used to inform future work.

4.2 From April 2016, 95% of acute/ urgent calls to GP OOH should be triaged within 20 minutes.

4.3 From April 2016, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.

4.4 From April 2016, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.

4.5 By March 2017, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

4.6 From April 2016, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

4.7 From April 2016, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

4.8 By March 2017, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.

4.9 By March 2017, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

4.10 By March 2017, 55% of patient should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.

4.11 From April 2016, all urgent diagnostic tests should be reported on within two days.

4.12 From April 2016, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

4.13 From April 2016, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Outcome 4 - Associated quality and performance indicators

Primary Care

D1 Number of available appointments per 1,000 patients per week, for each GP practice as reported in HSCB annual survey of GP practices.

D2 Percentage of routine GP "out of hours" calls triaged within one hour.

D3 Total out of hours GP attendances.

D4 Number of GP referrals to emergency departments.

NI Ambulance Service

D5 Number of ambulance responses where the outcome is that the patient does not attend hospital.

D6 (i) Patient handover times and (ii) ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes).

D7 Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital.

Acute Care

D8 Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to 12 hours and 12 hours or more, before being treated and discharged or admitted.

D9 Total time spent in emergency departments including the median, 95th percentile and single longest time spent by patients in the department, for admitted and non-admitted patients.

D10 (a)Number and percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes; (b) time from arrival to triage (initial assessment) for (i) ambulance arrivals and (ii) all arrivals; and (c) time from triage (initial assessment) to start of treatment in emergency departments.

D11 Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage scale at Type 1 or 2 Emergency Departments.

D12 Time waited in emergency departments between decision to admit and admission including the median, 95th percentile and single longest time.

D13 Percentage of people who leave the emergency department before their treatment is complete.

D14 Percentage of unplanned re-attendances at emergency departments within seven days of original attendance.

Stroke

D15 Average length of stay for stroke patients.

Elective pathway

D16 Number of GP and other referrals to consultant-led outpatient services.

D17 Percentage of routine diagnostic tests reported on (i) within two weeks and (ii) within four weeks of the test being undertaken.

Specialist drug therapies

D18 Number of patients waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.

D19 Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for Multiple Sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.

D20 Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye, and six weeks for the second eye.

Maternity

D21 Intervention rates, including percentage of babies born by caesarean sections.

D22 Number of babies born in midwife-led units.

Desired outcome 5: People, including those with disabilities or long term conditions, or who are frail, are supported to recover from periods of ill health and are able to live independently and at home or in a homely setting in the community.

Objectives/ goals for improvement

5.1 From April 2016, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

5.2 By March 2017, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions.

5.3 By March 2017, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

5.4 By March 2017, secure a 10% increase in the number of direct payments to all service users.

5.5 By March 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.

Outcome 5 - Associated quality and performance indicators

Patient Discharge

E1 Percentage of learning disability and mental health discharges that take place within seven days of the patient being assessed as medically fit for discharge.

E2 Number of learning disability and mental health discharges that take place after 28 days of the patient being assessed as medically fit for discharge.

E3 Number of client referrals passed to reablement; number of clients starting a reablement scheme; and number of clients discharged from reablement with no on-going care package required'.

Desired outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being

Objectives/ goals for improvement

6.1 By March 2017, secure a 10% increase in the number of carers' assessments offered to carers for all service users.

6.2 By March 2017, secure a 5% increase in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.

6.3 By March 2017, establish a baseline of the number of carers who have had a carers assessment completed and:

- **I. the need for further advice, information or signposting has been identified;**
- **II. the need for appropriate training has been identified;**
- **III. the need for a care package has been identified;**
- **IV. the need for a short break has been identified;**
- **V. the need for financial assistance has been identified.**

Outcome 6 - Associated quality and performance indicators

F1 Number of carers assessments received, by Programme of Care.

F2 Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.

Aim: To ensure that services are efficient and provide value for money in terms of outcomes achieved and costs incurred.

The goals and objectives set out in the previous sections are aimed at improving the health of the Northern Ireland population and improving the quality of health and social care services provided to people here. It is essential that these overarching aims are achieved within the resources available to the HSC. This means that services must operate as efficiently as possible, making the best use of available resources including the HSC estate. It means that all interventions must be effective and result in the best possible outcomes for patients. The Commissioning Plan should demonstrate that commissioned services represent the most efficient use of resources and it should outline how benchmarking of productivity and efficiency measures across providers has informed commissioning decisions. In addition, it should detail how innovative approaches, including the use of technology and the implementation of best practice in relation to medicines optimisation, are enabling services to be provided more efficiently and effectively—on the basis of single solutions for the region.

As outlined above, an important area of focus for the HSC in the coming year will be to address the large numbers of people waiting too long for outpatient assessment, diagnosis and treatment. As the HSC works to improve waiting times, it will be important to ensure that processes are in place to maximise throughput of elective patients. All urgent patients must be prioritised and, thereafter, that all routine patients must be seen in strict chronological order. To minimise non-attendance rates, outpatient appointment dates should be booked no more than six weeks in advance. Outpatient review appointments should only take place where there is a clear clinical need.

The most valuable resource the HSC has is its people. Everyone working in the sector makes an essential contribution to the health and wellbeing of the population, and it is vital that their own health and wellbeing is valued and protected. All staff must be provided with the skills and training necessary to perform their roles well and should be supported to develop those skills throughout their working lives. In addition, it is important that the workforce is sufficiently stable to meet the demands placed on it and to continue to provide safe, high quality services. For its part, the Department is committed to ensuring that the workforce meets the needs of today's patients whilst delivering the future workforce in a way that not only maintains safe staffing levels but supports the service transformation necessary to improve quality of care. The Commissioning Plan must provide assurances to the Department that commissioners have worked with providers to ensure that an appropriate workforce, with the right skills mix to optimise efficiency, is in place to deliver commissioned services, and that any longer-term workforce implications will be notified to the Department as appropriate.

Desired outcome 7: Resources are used effectively and efficiently in the provision of health and social care services.

Objectives/ goals for improvement:

7.1 By March 2017, reduce by 20% the number of hospital-cancelled consultant-led outpatient appointments.

7.2 From April 2016, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

7.3 By March 2017, attain efficiencies totalling at least £20m through the Pharmacy Efficiency Programme, separate from PPRS receipts.

7.4 By March 2017, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

Outcome 7 - Associated quality and performance indicators

Hospital efficiency

G1 Number, rate and ratio of new and review outpatient appointments cancelled by hospitals.

G2 Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient.

G3 Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust.

G4 Number of outpatient appointments with procedures (for selected specialties).

G5 Day surgery rate for each of a basket of 24 elective procedures to continue monitoring performance and enable continued benchmarking with rest of UK.

G6 Percentage of patients admitted electively who have their surgery on the same day as admission.

G7 Elective average pre-operative stay.

G8 Percentage of operations cancelled for non-clinical reasons.

G9 Elective average length of stay in acute programme of care.

G10 Excess bed days for the acute programme of care.

G11 Cost of a basket of 24 elective procedures (Day surgery as per G5) by Trust.

Prescribing efficiency

G12 Level of compliance of GP practices and HSC Trusts with the NI Medicines Formulary; and prescribing activity for generic prescribing and dispensing rates.

Desired outcome 8: People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide

Objectives/ goals for improvement

8.1 By December 2016 ensure at least 40% of Trust staff have received the seasonal flu vaccine.

8.2 By March 2017, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2015/16 figure.

8.3 During 2016/17, HSC employers should ensure that they respond to issues arising from the 2015 Staff Survey, with the aim of improving local working conditions and practices and involving and engaging staff.

8.4 By March 2017, Trusts are required to develop operational Workforce Plans, utilising qualitative and quantitative information that support and underpin their Trust Delivery Plans.

8.5 By March 2017, 10% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework.

8.6 By March 2017, to have reduced the number of patient and service user complaints relating to attitude, behaviour and communication by 5% compared to 2015/16. This will require a renewed focus on improving the Patient and Client Experience Standards.

Outcome 8 - Associated quality and performance indicators

Sickness Absence

H1 Uptake of seasonal flu vaccine by frontline health and social care workers (as reported in PHA return to Dept).

H2 Percentage of HSC hours lost due to sick absence.

Engaging Staff

H3 Reports to HR Directors Forum on Staff survey findings and actions for improvement.

Trust Workforce Plans

H4 Report on Workforce Review Planning programme to department led Regional Workforce Planning Group.

Patient Care

H5 Number of complaints received, by each Trust, relating to attitude, behaviour and communication (as set out in the "5 Standards of Care") as reported in Trust complaint reports, compared to 2015/16.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2016

1. The Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister's vision and priorities during the year 1st April 2016 to 31st March 2017.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2016/17 financial year are resourced.

4. The objectives and indicators included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.

5. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

DIRECTION

2017 No. X

The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2017-2018

The Department of Health (DoH) [(1)], makes the following Direction in exercise of the powers conferred by sections 6, 8(3) and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009 [(2)]:

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan Direction (Northern Ireland) 2017- 2018 and shall come into operation on 1 XXX 2017.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission, for the period 1 April 2017 to 31 March 2018, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include a summary of the financial allocations and set out how commissioning will serve to support the implementation of the Minister's strategic vision (as set out in Delivering Together) to transform the delivery of health and social care services. It should set out clear timescales and milestones for the delivery of commissioning intentions and the transformation of services.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board align with and support the implementation of the Minister's vision and delivery of priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998[(3)],

1 Departments Act(Northern Ireland) 2016 c.5
2 2009 c.1 (N.I.) as amended by 2014 c.5
3 1998 c.47

the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); and key Departmental standards, policies, strategies and guidelines.

3. The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will deliver the four overarching strategic themes:

(a)*To improve the health of our citizens*.

(b)*To improve the quality and experience of health and social care.*

(c)*To ensure the sustainability of health and social care services provided*.

(d)*To support and empower staff delivering health and social care services*.

Performance indicators

4.In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the objectives and associated quality and performance indicators for the period April 2017 to March 2018.

5.The Regional Board shall record the information against the objectives and associated quality and performance indicators for the period April 2017 to March 2018

Commissioning and the use of financial allocations

6.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from April 2017 to March 2018, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

Sealed with the Official Seal of the Department of Health on xxxxxx

Permanent Secretary
A senior officer of the Department of Health

Table of Contents

SCHEDULE

Objectives and Indicators for 2017 - 2018

Introduction

This Direction sets out the priorities, aims and improvement objectives for the HSC for the 2017/18 financial year. The achievement of the objectives set out in this Direction will; support the realisation of the Minister's vision for the future of health and social care as set out in "Health and Wellbeing 2016: Delivering Together"; contribute to the attainment of the aims of the 2016 – 2021 Programme for Government and in particular Outcome 4 – "We enjoy long, healthy, active lives", and underpin the Executive's population health framework "Making Life Better".

The Direction is structured around four overarching and linked aims identified in Delivering Together, which acknowledge the challenges facing HSC organisations in the North and health and social care systems across the developed world, namely:

- to improve the health of the population;
- to improve the quality and experience of care;
- to ensure the sustainability of the services delivered; and
- to support and empower the staff delivering health and social care services.

Set out under each of the four aims are key outcomes that balance improvement in the delivery of existing services with support for transformation actions that will bring about the person centred model of care set out in Delivering Together: moving from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

To allow progress towards each outcome to be tracked over time a number of associated quality and performance indicators have been identified against which the HSC should monitor progress and take improvement action as required. It is important to note that these indicators do not represent the totality of the information available to the HSC and the Department to ensure the smooth running of the system or inform the development, implementation and evaluation of policy.

The Commissioning Plan, developed in response to this Direction, must demonstrate how the services commissioned regionally and by LCG's in 2017/18 and beyond will contribute to the delivery of the four aims, contribute to the identified outcomes, sustain the pace of transformation and meet or exceed the specific objectives set out below in response to opportunities, such as approval for the implementation of the Elective Care Plan.

Aim: To improve the health of the population

A key aim of the entire health and social care system in Northern Ireland is to improve the overall health and wellbeing of the population and to prevent ill-health. Whilst improvements have been noted, too many people still die prematurely or live with conditions that could have been prevented.

The Minister's strategic vision for future health and social care services seeks to support people to take greater control over their own lives and enable them to make healthy choices about how they live their lives as well as helping to create an environment that makes such choices easier.

As highlighted in the 2016-2021 Programme for Government, the health and social care service cannot do this in isolation. Successful achievement of this aim means working with other partners across government and other sectors to tackle the root causes of ill-health and reduce health inequalities in the North. Maximising the potential of the local government community planning process will be an important enabler. Through empowering people to maintain their own health through initiatives such as; active ageing and age-friendly communities; increasing physical activity & active travel; improving mental health & wellbeing, & improving the early years of life we can promote healthier communities.

The population health framework *"Making Life Better"* set the strategic context for the actions required from health organisations and other public bodies to improve health and reduce inequalities. Through implementation of this strategic framework, the Department of health and other public bodies can create the conditions for individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives.

Key actions required of the HSC for the period 2017/18 and beyond, to improve the health of the population, are contained in the objectives set out in Outcome 1 – Reduction of Health Inequalities.

Outcome 1: Reduction of health inequalities

Successful implementation of Delivering Together will see the creation of the circumstances for people to stay healthy, well, safe and independent. Health and Social Care services should strive to anticipate the needs of individuals for support and care and this new model of person-centre care should seek to intervene early to avoid deterioration.

Work to support and enable healthy lives and tackle the causes of health inequality spans the entire life course—for example helping pregnant women and their partners to make the choices that are best for them and their babies; ensuring that all children grow up in a stable and healthy environment, ensuring our young people are equipped for a healthy adulthood; and supporting people to continue to live active and healthy lives as they age.

Objectives/ goals for improvement:

Population Health

1.1 By March 2018, to have delivered the "Choose to Lose" community weight loss programme. This programme as one element of the Departmental strategy A Fitter Future For All, aims, by March 2020, to reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children

1.2 By March 2020, in line with the Department's ten year Tobacco Control Strategy, to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.

Supporting Children and Young People

1.3 By March 2018, to have further developed, tested and implemented a "Healthier Pregnancy Programme" to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation

1.4 By March 2019, ensure the full delivery of the universal child health promotion programme for Northern Ireland, *Healthy Child Healthy Future*. By that date:

- The antenatal contact will be delivered to all first time and vulnerable mothers.
- 95% of two year old reviews must be delivered.

These activities will include the delivery of core contacts by Health Visitors and School Nurses, which will enable and support children and young adults to be successful healthy adults through the promotion of health and wellbeing.

1.5 By March 2018, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers are offered a place. The successful delivery of this objective will directly contribute to the PfG Outcome to provide "a Healthier Pregnancy" and give our children and young people the best start in life.

1.6 By March 2018, to increase the number of families utilising Family Support Hubs by 5% over the 2016/17 figures and work to deliver a 10% increase in the number

of referrals by March 2010. By improving access to, co-ordination of, and awareness of early intervention family support services the aim is to create the conditions to enable families to remain together and to provide loving, caring and nurturing environments for their children.

1.7 By March 2018, the proportion of children in care for 12 months or longer with no placement change is at least 85%; and 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer them greater stability while in care.

Improving Mental Health

1.8 By March 2018, to have enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis. This is an important element of the work to reduce the differential in suicide rates between the 20% least deprived areas and 20% most deprived areas by March 2020.

Supporting those with Long Term Conditions

1.9 By March 2018, to have devised an agreed implementation plan and outcome measures for the delivery of Phase 1 of the Diabetes Strategic Framework along with establishing a Diabetes Network Board and governance arrangements to support the Framework. Phase 1 will focus on implementation of a foot care pathway and revision of structured education.

Associated quality and performance indicators

Population health (general)

A1 Healthy life expectancy.

A2 Average life expectancy for men and women.

A3 Life expectancy differential between the least deprived and most deprived areas in Northern Ireland, for men and women.

A4 Potential years of life lost from causes considered amenable to healthcare.

A5 Infant mortality.

A6 Age standardised death rate for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas.

A7 Maintenance of population vaccination coverage as reported in PHA Annual Report.

A8 Proportion of adults (aged 16+) consuming the recommended five portions of fruit and vegetables each day.

A9 Level of overweight and obesity across the life course (2 – 15) year olds and 16+.

Smoking

A10 Proportion of adults who smoke.

A11 Number of pregnant women, children and young people, and adults from deprived areas (lower quintile) who set a quit date through cessation services.

A12 Proportion of pregnant women who smoke.

Alcohol and substance misuse

A13 Proportion of adults who report having reached or exceeded the recommended weekly alcohol limit.

A14 Standardised rate of alcohol-related admissions to hospital within the acute programme of care.

A15 Standardised rate of drug-related admissions to hospital within the acute programme of care.

Child health and wellbeing

A16 Rate of births to mothers under 17 years of age (with breakdown against most deprived areas).

A17 Breastfeeding rate at discharge from hospital.

A18 Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.

A19 Proportion of looked after children who have experienced more than two placement changes. (Source is OC2)

A20 Length of time for best interest decision to be reached in the adoption process.

A21 Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type.

A22 Proportion of school-aged children who have been in care for 12 months or longer, who have a personal education plan.

A23 Percentage of care leavers aged 16 – 18 in education, training or employment by placement type.

A24 Percentage of care leavers at age 18, 19 and 20 years in education, training or employment.

Suicide and self-harm

A25 Achievement of the full implementation of Protect Live 2 Strategy Action Plan (source Quarterly Project Board Highlight Reports)

A26 Number of ED repeat presentations due to deliberate self-harm.

A27 Self-reported mental health. (GHQ12 survey)

Long Term Conditions

A28 The number of unplanned admissions to hospital for adults with specified long-term conditions.

Aim: To improve the quality and experience of health and social care.

Delivering Together set out the Minister's intention to transform health and social care services to deliver an integrated service capable of responding to future needs. Everyone in Northern Ireland will make use of those services at different points in their lives.

It is important that the HSC listens to and learns from those experiences, whether services are delivered well or things go wrong, and ensures that everyone has a positive experience of the care or treatment they receive.

Quality 2020 provides the framework for the delivery of such services that are:

- centred on the needs of the patient/ client—everyone using HSC services should be treated with dignity and respect and should be fully involved in decisions about their treatment, care and support.
- safe—the care, treatment and support the HSC provides should never result in avoidable or preventable harm;
- effective—everyone accessing HSC services should have the most appropriate treatment or care, in the most appropriate setting, with the best possible outcome; and

"Delivering Together" confirmed the Minister's intention to build on Q2020 and other quality improvement work and to establish an Improvement Institute to better align existing resources in this important area.

Objectives to improve the quality and experience of health and social care are contained in Outcomes:

2 - People using health and social care services are safe from avoidable harm

3 - Improve the quality of the healthcare experience

4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

5 - People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

6 - Supporting those who care for others

Outcome 2: People using health and social care services are safe from avoidable harm

It is widely recognised that the design and delivery of health and social care must have quality and safety at its heart. The Expert Panel that produced “Systems not Structures” report were clear that “any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this”.

To meet this challenge the HSC needs to ensure alignment between quality improvement, partnership with those who use our services, and how we regulate those services. HSC working practices should proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs.

Objectives/ goals for improvement:

Safe in Primary Care Settings

2.1 By March 2018, 100% of GP practices to have access to a practice based pharmacist.

Safe in Hospital Settings

2.2 By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services.

2.3 By 31 March 2018, to secure a regional aggregate reduction of 15% in the total number of in-patient episodes of Clostridium Difficile infection in patients aged 2 years and over and in-patient episodes of MRSA infection compared to 2016/17.

2.4 By March 2018, to ensure that all patients treated in Type 1 Emergency Departments and identified as “at risk of Sepsis” receive the “Sepsis bundle”

2.5 Throughout 2017/18 the clinical condition of all patients must be regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.

2.6 By March 2018, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016. Reports to be provided every six months through the Medicines Optimisation Steering Group.

Safe in Community Settings

2.7 During 2017/18 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.

Associated quality and performance indicators

Hospital Care

B1 Staffing levels as reported in regular reports from PHA Delivering Care Implementation Board.

B2 Number of records audited achieving 95% compliance of the accurately completed NEWS charts in all adult in-patient wards (excluding theatres and critical care departments).

B3 Number of incidents of hospital-acquired pressure ulcers (grade 3 and 4) occurring in all adult inpatient wards, and the number of those which were unavoidable.

B4 Percentage compliance with the falls safe improvement bundle.

B5 Number of emergency admissions returning within seven days and within 8-30 days of discharge.

B6 Clinical causes of emergency readmissions (as a percentage of all admissions) for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF).

B7 Number of emergency readmissions with a diagnosis of venous thromboembolism.

B8 Number of emergency admissions and readmissions in which medicines were considered to have been the primary or contributing factor.

Community Care

B9 Number of revisits required to achieve compliance in (i) residential homes, (ii) nursing homes, in 2015/16 and 2016/17, as published by RQIA.

Outcome 3: Improve the quality of the healthcare experience.

The Health and Social Care system belongs to everyone and those providing services or availing of services can bring valuable insights into how it can best be organised and improved. Through working in partnership and utilising coproduction techniques - patients, service users, families, staff and politicians – can participate in the development of a person centred service which benefits us all. In undertaking such work everyone who uses and delivers health and social care services should be treated with respect, listened to and supported to work as real partners.

Staff and patient voices from across the system should be aligned closely to the quality improvement, inspection and regulation systems to ensure issues are raised in as timely a manner as possible and addressed early before they escalate to a complaint.

Objectives/ goals for improvement:

3.1 By March 2018, to have reported on the evaluation of the impact of Understanding the Needs of Children in Northern Ireland (UNOCINI) on improving outcomes for children and families.

3.2 During 2017/18 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.

3.3 By March 2018, patients in all Trusts will have access to the Dementia portal.

3.4 By March 2018, to have arrangements in place to identify individuals with a palliative care need in order to support people to be cared for in a way that best meets their needs. In 2017/18, the focus will be on undertaking and evaluating a pilot identification project.

Associated quality and performance indicators

Mixed Gender Accommodation

C1 PHA report on compliance with same gender accommodation by Trusts.

C2 PHA report on Trust compliance with requirement to have policy in place for the provision of Safe and Effective Care and Treatment in Mixed Gender Accommodation, which reflects the DHSSPS Guiding Principles for Mixed Gender Inpatient Accommodation.

Palliative Care

C3 Implementation of a protocol to support the identification of patients with palliative and end of life care needs in Primary Care systems. [Source: PHA/ HSCB evaluation report of agreed protocol]

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

Timely access to the most appropriate services is considered a key indicator of quality and the patient experience. People rightly have an expectation that they should be seen and treated within a reasonable time in the most appropriate location. Prompt, early diagnosis and intervention can avoid the need for scarce acute sector services while supporting a high quality of life.

The way services are designed and delivered will change, focussed on providing continuity of care in an organised way. Such transformation will increasingly require working across traditional organisational boundaries and to develop an environment characterised by trust, partnership and collaboration.

However during the period of transition to the new model of care it will be important that existing services continue to be delivered in a safe and timely fashion.

Objectives/ goals for improvement:

Primary Care Setting

4.1 By March 2018, to increase the number of available appointments in GP practices compared to 2016/17

4.2 By March 2018, to have 95% of acute/ urgent calls to GP OOH triaged within 20 minutes.

The NI Ambulance Service faces growing demand for the services they provide. In response to this and other challenges the NIAS are transforming how they deliver their services. Although the introduction of new ways of working, such as Alternative (or Appropriate) Care Pathways, has contributed to a reduction in the use of Acute Care facilities demand remains high for a prompt response to life threatening events.

4.3 From April 2016, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.

Hospital Care Setting – Acute Care

When patients and service users need urgent treatment only provided in acute sector settings they often are frustrated by apparently lengthy treatment delays due the failure of the current service delivery model to provide a high quality service in a timely fashion.

In responding to the objectives below it will be essential for the Commissioning Plan to demonstrate how such services are being transformed, with alternative models of care embedded across Northern Ireland. Thus ensuring more people can be seen and treated effectively (including on a same/ next day basis), preventing unnecessary

admissions to hospital, and supporting people to recover following periods of ill-health.

Proposals should include working towards the provision of the same level of care for inpatients seven days a week, the deployment of ambulatory care models, the utilisation of technology to provide timely access to specialist advice, and the scaling up and rollout of proven new ways of care delivery.

4.4 By March 2018, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.

4.5 By March 2018, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

4.6 By March 2018, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

4.7 By March 2018, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

4.8 By March 2018, all urgent diagnostic tests should be reported on within two days.

4.9 During 2017/18, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Hospital Care Setting – Elective Care

Often patients are referred to specialists for medical or surgical treatment of non-urgent or non-life threatening conditions that nevertheless require medical or surgical intervention. People rightly have an expectation that they should be seen and treated within a reasonable time. However, over the last number of years meeting the rising demand has been challenging and it is clear that the current service model is no longer suitable.

The longer term goal set out in Delivering Together is to significantly reduce the current waiting times for assessment, diagnosis and treatment, which have been described by the Minister as unacceptable. The aim of the introduction of new ways of working, such as Elective Care Centres and Assessment and Treatment Centres, is to return to the maximum waiting times of nine, nine and thirteen weeks that have previously been achieved.

In recognition that the introduction of a sustainable model, in a safe manner, must be undertaken methodically, the goals below represent realistic and achievable objectives that deliver stability prior to the implementation of the Elective Care Plan.

4.10 By March 2018, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.

4.11 By March 2018, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

4.12 By March 2018, 55% of patient should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.

4.13 By March 2018, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Associated quality and performance indicators

Primary Care

D1 Number of available appointments per 1,000 patients per week, for each GP practice as reported in HSCB annual survey of GP practices.

D2 Percentage of routine GP "out of hours" calls triaged within one hour.

D3 Total out of hours GP attendances.

D4 Number of GP referrals to emergency departments.

NI Ambulance Service

D5 Number of ambulance responses where the outcome is that the patient does not attend hospital.

D6 (i) Patient handover times and (ii) ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes).

D7 Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital.

Acute Care

D8 Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to 12 hours and 12 hours or more, before being treated and discharged or admitted.

D9 Total time spent in emergency departments including the median, 95th percentile and single longest time spent by patients in the department, for admitted and non-admitted patients.

D10 (a)Number and percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes; (b) time from arrival to triage (initial assessment) for (i) ambulance arrivals and (ii) all arrivals; and (c) time from triage (initial assessment) to start of treatment in emergency departments.

D11 Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage scale at Type 1 or 2 Emergency Departments.

D12 Time waited in emergency departments between decision to admit and admission including the median, 95th percentile and single longest time.

D13 Percentage of people who leave the emergency department before their treatment is complete.

D14 Percentage of unplanned re-attendances at emergency departments within seven days of original attendance.

Stroke

D15 Average length of stay for stroke patients.

Elective Care

D16 Number of GP and other referrals to consultant-led outpatient services.

D17 Percentage of routine diagnostic tests reported on (i) within two weeks and (ii) within four weeks of the test being undertaken.

Specialist drug therapies

D18 Number of patients waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.

D19 Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for Multiple Sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.

D20 Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye, and six weeks for the second eye.

Maternity

D21 Intervention rates, including percentage of babies born by caesarean sections.

D22 Number of babies born in midwife-led units.

Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

Successful implementation of Delivering Together to provide a person centred model of care, focussed on prevention, early intervention, supporting independence and wellbeing requires the creation of the circumstances for people to stay healthy, well, safe and independent.

It will be important that the principle of coproduction is at the heart of new initiatives for those with long term conditions, and that patients and service users are partners in the care they receive with a focus on increased self-management and choice.

Objectives/ goals for improvement

Sustaining Good Health

5.1 By October 2017, to have Healthier Care Programme objectives set for the first phase of work to reorient services to better support those living with long term conditions. Proposals developed by local partnership to enable early adopters to implement from February 2018..As the work underpins the delivery of Programme for Government Outcome 4, reporting will be through established PfG mechanisms.

Increased Choice

5.2 By March 2018, secure a 10% increase in the number of direct payments to all service users.

5.3 By March 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.

Access to Services

5.4 By March 2018, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

Care in Acute Settings

5.5 During 2017/18, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

Outcome 5 - Associated quality and performance indicators

Supporting Independence

E1 Number of client referrals passed to reablement; number of clients starting a reablement scheme; and number of clients discharged from reablement with no on-going care package required'.

Patient Discharge

E2 Percentage of learning disability and mental health discharges that take place within seven days of the patient being assessed as medically fit for discharge.

E3 Number of learning disability and mental health discharges that take place after 28 days of the patient being assessed as medically fit for discharge.

Outcome 6: Supporting those who care for others

For an increasing number of people who require additional support and assistance the primary care or community care teams cannot fully meet their needs but it isn't appropriate for them to be admitted to a hospital or residential accommodation. In such cases ongoing support is provided by family or friends. The contribution of these informal carers is crucial to the ability of such people to live independently in the community.

Delivering Together is clear that the HSC should be organised to support that independence and to provide appropriate assistance to those who care.

It is important that these carers are supported to enable a balance to be struck between the duties of the caring role and their right to live their own life and pursue their own goals and interests.

Objectives/ goals for improvement

6.1 By March 2018, secure a 10% increase (based on 2016/17 figures) in the number of carers' assessments offered to carers for all service users.

6.2 By March 2018, secure a 5% increase (based on 2016/17 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.

6.3 By March 2018, secure a 5% increase (based on 2016/17 figures) in the number of short break hours (i.e. non-residential respite) received by young carers

6.4 By March 2018, secure a 10% increase in the number of Understanding the Needs of Children in Northern Ireland (UNOCINI) assessments provided to young carers (against the 2016/17 figures)

Outcome 6 - Associated quality and performance indicators

F1 Number of carers assessments offered, by Programme of Care.

F2 Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.

Aim: Ensure the sustainability of health and social care services provided

The objectives set out under the first two aims seek to improve the health of the Northern Ireland population and the quality of health and social care services provided to patients and service users. It is essential that these overarching aims are achieved within the resources available to the HSC.

The existing pressures and challenges arising from growing demand, patients living longer with complex needs and an aging population have not diminished therefore services must operate as efficiently and effectively as possible and result in the best possible outcome for patients.

However operating existing services efficiently is not enough to meet the growing demand and the Minister is clear that the HSC must change how health and social care services are delivered.

The Commissioning Plan therefore should demonstrate that currently commissioned services represent the most efficient use of resources and outline how benchmarking of productivity and efficiency measures across providers has informed commissioning decisions. In addition, it should detail the steps being taken to bring about change that will provide the highest quality care in a cost effective manner—on the basis of single solutions for the region.

Key actions required of the HSC for the period 2017/18 and beyond, to provide sustainable health and social care services, are contained in the objectives set out in Outcome 7 – Ensure the sustainability of health and social care services.

Outcome 7: Ensure the sustainability of health and social care services

Established health and social care services are often accompanied by a plethora of checks, lists and forms developed over time to address particular issues. Transforming such services and the bureaucracy around them through making better use of technology to collect and analyse such information is essential as we move to a person centred model.

While these new solutions are being designed and introduced it remains important that we operate effective services, to prioritise all urgent patients and, thereafter, that all routine patients are seen in strict chronological order.

To reduce the impact of long waiting lists it will be important to minimise non-attendance rates, with outpatient appointment dates booked no more than six weeks in advance, and outpatient review appointments only taking place where there is a clear clinical need.

Objectives/ goals for improvement

Primary and Community setting

7.1 By October 2017 extend access to the Electronic Care Record (ECR) to Community Pharmacists and to have a pilot programme in place to test appropriate access for independent optometrists. Reporting to be provided via ECR Project structures

7.2 By March 2018 to have concluded discussions on the future of community pharmacy services; to have new arrangements agreed, and commenced implementation of contract arrangements or frameworks.

7.3 By March 2018, to review the reporting arrangements for Delegated Statutory Functions (DSF), to produce an interim reporting framework that will demonstrate the impact and outcome of services on the health and wellbeing of service users, and by March 2019 to have established the outcomes framework and the baseline activity to measure this.

Hospital Setting

While demand for services continues to grow it is imperative that, in the short term, the HSC makes efficient use of the resources available. In the medium term the transformation set out in Delivering Together will introduce new ways of working that will provide a health and social care system capable of withstanding future demands.

7.4 By March 2018, reduce by 20% the number of hospital-cancelled consultant-led outpatient appointments.

7.5 By March 2018, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

7.6 By March 2018, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

7.7 By March 2018, to obtain savings of at least £38m through the Regional Medicines Optimisation Efficiency Programme as a portion of the £90m prescribing efficiencies sought, separate from PPRS receipts by March 2019.

Associated quality and performance indicators

Hospital efficiency

G1 Number, rate and ratio of new and review outpatient appointments cancelled by hospitals.

G2 Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient.

G3 Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust.

G4 Number of outpatient appointments with procedures (for selected specialties).

G5 Day surgery rate for each of a basket of 24 elective procedures to continue monitoring performance and enable continued benchmarking with rest of UK.

G6 Percentage of patients admitted electively who have their surgery on the same day as admission.

G7 Elective average pre-operative stay.

G8 Percentage of operations cancelled for non-clinical reasons.

G9 Elective average length of stay in acute programme of care.

G10 Excess bed days for the acute programme of care.

G11 Cost of a basket of 24 elective procedures (Day surgery as per G5) by Trust.

Prescribing efficiency

G12 Level of compliance of GP practices and HSC Trusts with the NI Medicines Formulary; and prescribing activity for generic prescribing and dispensing rates.

Aim: Support and empower staff delivering health and social care services

The Minister is clear on her support for those who work to provide our health and social care services and considers that the most valuable resource the HSC has is its people. It is vital that the HSC while investing in their future ensures their health and wellbeing is valued and protected.

As the implementation of Delivering Together moves forward it is important to have a workforce, with the right skills mix in place to deliver both the existing, commissioned services and support the transformation work. Therefore the Commissioning Plan must provide assurances to the Department that commissioners have worked with providers to ensure that appropriate staff are in place. It will be important that any longer-term workforce implications be notified to the Department.

While HSC staff include some of the most capable, committed and enthusiastic people in the public sector the Bengoa Report was clear that in order to bring about the required transformation they would be asked to change how they undertake their work and would need to develop new skills.

In order to embed the required culture of learning, quality improvement and partnership working throughout the HSC it will be necessary to develop Leadership and Change Management skills, critical to the successful delivery of the required transformation, across the range of health and social care staff and key independent practitioners. These skills will be delivered through the implementation of the HSC-wide Leadership Strategy and the Commissioning Plan should detail how resources will allocated to support the implementation of this work.

Finally as many HSC staff work directly with patients and service users they often see opportunities to improve “what we do and how we do it”. It will be important, going forward, that an infrastructure that capable of developing and distributing those ideas is provided.

Key actions required of the HSC for the period 2017/18 and beyond, to support and develop the capabilities of HSC staff, are contained in the objectives set out in Outcome 8 – Supporting the HSC workforce.

Outcome 8: Supporting the HSC workforce

The Minister is clear in her wish that the HSC becomes an employer of choice; leading by example; investing in the wellbeing of staff, and making a tangible and positive contribution to the health and wellbeing of not only health and social care staff but society as a whole.

The HSC can realise these goals through supporting staff who deliver vital health and social care services, seeking to bring about positive change. Continued investment in training and development initiatives, such as the Quality 2020 Attributes Framework, along with the development of new multidisciplinary training programmes that maximise the effectiveness of the workforce will assist in achieving those outcomes.

Objectives/ goals for improvement

Supporting our staff

8.1 By December 2017, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.

8.2 By March 2018, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2016/17 figure.

Investing in our staff

8.3 By March 2018, 30% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2.

8.4 By March 2018, to enhance the programme of suicide awareness and intervention training for staff across the HSC.

.

Associated quality and performance indicators

Sickness Absence

H1 Uptake of seasonal flu vaccine by frontline health and social care workers (as reported in PHA return to Dept).

H2 Percentage of HSC hours lost due to sick absence.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2017

1. The Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister's vision and priorities during the year 1st April 2017 to 31st March 2018.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2017/18 financial year are resourced.

4. The objectives and indicators included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.

5. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

DIRECTION

2018 No. X

The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2018-2019

The Department of Health (DoH) [a], makes the following Direction in exercise of the powers conferred by sections 6, 8(3) and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009 [b]:

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2018- 2019 and shall come into operation on 1 XXX 2018.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission, for the period 1 April 2018 to 31 March 2019, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include a summary of the financial allocations and set out how commissioning will serve to support the implementation of the Minister's strategic vision (as set out in Delivering Together) to transform the delivery of health and social care services. It should set out clear timescales and milestones for the delivery of commissioning intentions and the transformation of services.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board align with and support the implementation of the Minister's vision and delivery of priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998[c],

(a) Departments Act(Northern Ireland) 2016 c.5
(b) 2009 c.1 (N.I.) as amended by 2014 c.5
(c) 1998 c.47

the discharge of statutory duty of quality, delegated statutory functions and requirements under Personal and Public Involvement (PPI); and key Departmental standards, policies, strategies and guidelines.

3. The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will contribute to the four overarching strategic themes:

(a)*To improve the health of our citizens*.

(b)*To improve the quality and experience of health and social care.*

(c)*To ensure the sustainability of health and social care services provided*.

(d)*To support and empower staff delivering health and social care services*.

Performance indicators

4.In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the objectives and associated quality and performance indicators for the period April 2018 to March 2019

5.The Regional Board shall record the information against the objectives and associated quality and performance indicators for the period April 2018 to March 2019

Commissioning and the use of financial allocations

6.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from April 2018 to March 2019, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

Sealed with the Official Seal of the Department of Health on xxxxxx

Permanent Secretary
A senior officer of the Department of Health

Table of Contents

SCHEDULE

Objectives and Indicators for 2018 - 2019

Introduction

This Direction sets out the priorities, aims and improvement objectives for the HSC for the 2018/19 financial year. The achievement of the objectives set out in this Direction will; support the realisation of the vision for the future of health and social care as set out in "Health and Wellbeing 2016: Delivering Together"; contribute to the attainment of the aims of the draft 2016 – 2021 Programme for Government and in particular Outcome 4 – "We enjoy long, healthy, active lives", and underpin the Executive's population health framework "Making Life Better".

The Direction is structured around the four overarching and linked aims identified in Delivering Together, which acknowledge the challenges facing health and social care namely:

- to improve the health of the population;
- to improve the quality and experience of care;
- to ensure the sustainability of the services delivered; and
- to support and empower the staff delivering health and social care services.

Set out under each of the four Delivering Together aims are key objectives/goals that will progress the work to meet the future needs of the population and bring about the person centred model of care set out in Delivering Together: moving from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

To allow progress towards each outcome to be tracked over time a number of associated quality and performance indicators have been identified against which the HSC should monitor progress and take improvement action as required. It is important to note that these indicators do not represent the totality of the information available to the HSC and the Department to ensure the smooth running of the system or inform the development, implementation and evaluation of policy.

The Commissioning Plan, developed in response to this Direction, must demonstrate how the services commissioned regionally and by LCG's in 2018/19 and beyond will contribute to the delivery of the four aims, contribute to the identified outcomes, sustain the pace of transformation and meet or exceed the specific objectives set out below.

Aim: To improve the health of the population

A key aim of the entire health and social care system in Northern Ireland is to improve the overall health and wellbeing of the population and to prevent ill-health. Whilst improvements have been noted, too many people still die prematurely or live with conditions that could have been prevented.

The strategic vision for future health and social care services seeks to support people to take greater control over their own lives and enable them to make healthy choices as well as helping to create an environment that makes such choices easier.

It is accepted that the health and social care service cannot do this in isolation and that in order to achieve this aim will require us to work with other partners across government and other sectors in tackling the root causes of ill-health and reducing health inequalities. Maximising the potential of the local government community planning process will be an important enabler. We will support the development of thriving and inclusive communities through working in partnership with communities and with other sectors.

The population health framework *"Making Life Better"* set the strategic context for the actions required from health organisations and other public bodies to improve health and reduce inequalities. Through implementation of this strategic framework, the Department of Health and other public bodies can create the conditions for individuals, families and communities to take greater control over their lives and be empowered and supported to lead healthy lives.

Key objectives/goals for the HSC for the period 2018/19 and beyond, to improve the health of the population, are set out at Outcome 1 – Reduction of Health Inequalities.

Outcome 1: Reduction of health inequalities

Achieving the aims of Delivering Together will result in the creation of an environment where people are supported to keep well in the first place. Through ensuring that people have the information, education and support to make informed choices around lifestyle, healthy eating, and the adoption of preventative actions such as maintaining good oral health we will empower people to take control of their own health and wellbeing and support them to stay healthy, well, safe and independent.

Work to support & enable healthy lives and tackle the causes of health inequality spans the entire life course; helping pregnant women and their partners to make the choices that are best for them and their babies; ensuring that all children grow up in a stable and healthy environment; intervening early to provide support to families before issues become complex and difficult to reverse; supporting infant mental health; ensuring our young people are equipped for a healthy adulthood, and supporting people to continue to live active and healthy lives as they age. Although we seek to address the needs of the entire population there are those who, at times, may require more focussed support such as prisoners, the homeless, the travelling community and LBGT people.

Objectives/ goals for improvement:

Population Health

1.1 By March 2020, in line with the Department's ten year "*Tobacco Control Strategy*", to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.

1.2 By March 2019 to have expanded the "*Weigh to a Healthy Pregnancy*" to now include women with a BMI over 38. This programme is one element of the Departmental strategy "*A Fitter Future for All*", which aims by March 2020, to reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.

1.3 By March 2019, through continued promotion of breastfeeding to increase in the percentage of infants breastfed, (i) from birth, and (ii) at 6 months. This is an important element in the delivery of the "*Breastfeeding Strategy*" objectives for achievement by March 2025.

1.4 By March 2019, establish a minimum of 2 "Healthy Places" demonstration programmes working with General Practice and partners across community, voluntary and statutory organisations.

1.5 By March 2019, to ensure appropriate representation and input to the PHA/HSCB led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach.

1.6 By March 2019, to establish a baseline of the number of teeth extracted in children aged 3-5 years - as phase 1 of the work to improve the oral health of young children in Northern Ireland over the next 3 years and seek a reduction in extractions of 5%, against that baseline, by March 2021.

Supporting Children and Young People

1.7 By March 2019, to have further developed, and implemented the "*Healthier Pregnancy*" approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation.

1.8 By March 2019, ensure the full delivery of the universal child health promotion programme for Northern Ireland, "*Healthy Child Healthy Future*". By that date:

- The antenatal contact will be delivered to all first time mothers.
- 95% of two year old reviews must be delivered.

These activities include the delivery of core contacts by Health Visitors and School Nurses which will enable and support children & young adults to become successful, healthy adults through the promotion of health and wellbeing.

1.9 By March 2019, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 "We give our children and young people the best start in life".

1.10 By March 2019, the proportion of children in care for 12 months or longer with no placement change is at least 85%; and 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer them greater stability while in care.

Improving Mental Health

1.11 By March 2019, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a "street triage" pilot and a "Crisis De-escalation Service" pilot. This work builds on previous investments in community mental health crisis teams and is an important element of the work to reduce the suicide rate by 10% by 2022 in line with the draft "*Protect Life 2 Strategy*".

1.12 By September 2018, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol and drug related harm and to reduce drug related deaths.

Supporting those with Long Term Conditions

1.13 By July 2018, to provide detailed plans (to include financial profiling) for the regional implementation of the diabetes feet care pathway. Consolidation of preparations for regional deployment of the care pathway will be an important milestone in the delivery of the "*Diabetes Strategic Framework*".

Associated quality and performance indicators

Population health (general)

A1 Healthy life expectancy.

A2 Average life expectancy for men and women.

A3 Life expectancy differential between the least deprived and most deprived areas in Northern Ireland, for men and women.

A4 Potential years of life lost from causes considered amenable to healthcare.

A5 Infant mortality.

A6 Age standardised death rate for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas.

A7 Maintenance of population vaccination coverage as reported in PHA Annual Report.

A8 Proportion of adults (aged 16+) consuming the recommended five portions of fruit and vegetables each day.

A9 Level of overweight and obesity across the life course (2 – 15) year olds and 16+.

Smoking

A10 Proportion of adults who smoke.

A11 Number of pregnant women, children and young people, and adults from deprived areas (lower quintile) who set a quit date through cessation services.

A12 Proportion of pregnant women who smoke.

Alcohol and substance misuse

A13 Proportion of adults who report having reached or exceeded the recommended weekly alcohol limit.

A14 Standardised rate of alcohol-related admissions to hospital within the acute programme of care.

A15 Standardised rate of drug-related admissions to hospital within the acute programme of care.

Child health and wellbeing

A16 Rate of births to mothers under 17 years of age (with breakdown against most deprived areas).

A17 Breastfeeding rate at discharge from hospital.

A18 Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.

A19 Proportion of looked after children who have experienced more than two placement changes. (Source is OC2)

A20 Length of time for best interest decision to be reached in the adoption process.

A21 Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type.

A22 Proportion of school-aged children who have been in care for 12 months or longer, who have a personal education plan.

A23 Percentage of care leavers aged 16 – 18 in education, training or employment by placement type.

A24 Percentage of care leavers at age 18, 19 and 20 years in education, training or employment.

Suicide and self-harm

A25 Achievement of the implementation of Protect Live 2 Strategy Action Plan (source Quarterly Project Board Highlight Reports)

A26 Number of ED repeat presentations due to deliberate self-harm.

A27 Self-reported mental health. (GHQ12 survey)

Long Term Conditions

A28 The number of unplanned admissions to hospital for adults with specified long-term conditions.

Aim: To improve the quality and experience of health and social care.

Delivering Together set out the roadmap for the transformation of health and social care services to deliver an integrated service capable of responding to future needs. Everyone in Northern Ireland will make use of those services at different points in their lives.

It is important that the HSC listens to and learns from their experiences, whether services are delivered well or things go wrong, and strives to ensure that everyone has a positive experience of the care or treatment they receive.

Quality 2020 provides the framework for the delivery of such services that are:

- centred on the needs of the patient/ client—everyone using HSC services should be treated with dignity and respect and should be fully involved in decisions about their treatment, care and support.
- safe—the care, treatment and support the HSC provides should never result in avoidable or preventable harm; and
- effective—everyone accessing HSC services should have the most appropriate treatment or care, in the most appropriate setting, with the best possible outcome;

"Delivering Together" confirmed the Minister's intention to build on Q2020 and other quality improvement work and to establish an Improvement Institute to better align existing resources in this important area.

Objectives/goals to address the quality and experience of health and social care are contained in the following Outcomes:

2 - People using health and social care services are safe from avoidable harm

3 - Improve the quality of the healthcare experience

4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

5 - People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

6 - Supporting those who care for others

Outcome 2: People using health and social care services are safe from avoidable harm

It is widely recognised that the design and delivery of health and social care must have quality and safety at its heart. The Expert Panel who produced the "*Systems not Structures*" report were clear that "any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this".

To meet this challenge the HSC needs to ensure alignment between quality improvement, partnership with those who use our services, and how we regulate those services. HSC working practices should proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs.

Objectives/ goals for improvement:

Safe in all Settings

2.1 By March 2019 all HSC Trusts should have fully implemented phases 2, 3 and 4 of *Delivering Care*, to ensure safe and sustainable nurse staffing levels across all emergency departments, health visiting and district nursing services.

2.2 By 31 March 2019:

- Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 2%, as per the established recurring annual targets, taking 2015/16 as the baseline figure; and
- Taking 2017/18 as the baseline figures, secure in secondary care:
    - a reduction in total antibiotic use of 1%, measured in DDD per 1000 admissions;
    - a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions;
    - a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions, and
    - EITHER
        - that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category,

        OR

        - an increase of 3% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use.

With the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 10% by 31 March 2021.

**For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.*

Safe in Hospital Settings

Reducing Gram-negative bloodstream infections

2.3 By 31 March 2019 By 31 March 2019 secure an aggregate reduction of 11% of *Escherichia coli*, *Klebsiella spp*. and *Pseudomonas aeruginosa* bloodstream infections acquired after two days of hospital admission, compared to 2017/18.

2.4 In the year to March 2019 the Public Health Agency and the Trusts should secure a reduction of 7.5% in the total number of in-patient episodes of *Clostridium difficile* infection in patients aged 2 years and over, and in-patient episodes of Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection compared to 2017/18.

2.5 Throughout 2018/19 the clinical condition of all patients must be regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.

2.5 By March 2019, review and regionally agree standardised operational definitions and reporting schedules for falls and pressure ulcers.

2.6 By March 2019, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group.

Safe in Community Settings

2.6 During 2018/19 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.

Associated quality and performance indicators

Hospital Care

B1 Staffing levels as reported in regular reports from PHA Delivering Care Implementation Board.

B2 Number of records audited achieving 95% compliance of the accurately completed NEWS charts in all adult in-patient wards (excluding theatres and critical care departments).

B3 Number of incidents of hospital-acquired pressure ulcers (grade 3 and 4) occurring in all adult inpatient wards, and are classed as unavoidable from the current baseline data.

B4 Percentage compliance with the falls safe improvement bundle specified settings including adult acute inpatient and elderly care settings.

B5 Number of emergency admissions returning within seven days and within 8-30 days of discharge.

B6 Clinical causes of emergency readmissions (as a percentage of all admissions) for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF).

B7 Number of emergency readmissions with a diagnosis of venous thromboembolism.

B8 Number of emergency admissions and readmissions in which medicines were considered to have been the primary or contributing factor.

Community Care

B9 Number of revisits required to achieve compliance in (i) residential homes, (ii) nursing homes, in 2015/16 and 2016/17, as published by RQIA.

Outcome 3: Improve the quality of the healthcare experience.

The Health and Social Care system belongs to everyone and those providing services or availing of services can bring valuable insights into how it can best be organised and improved. Through working in partnership and utilising coproduction; patients; service users; families; staff, and politicians can participate in the development of a person centred service which benefits us all. In undertaking such work everyone who uses and delivers health and social care services should be treated with respect, listened to and supported to work as real partners.

Staff and patient voices from across the system should be aligned closely to the quality improvement, inspection and regulation systems to ensure issues are raised in as timely a manner as possible and addressed early: before they escalate to a complaint.

Objectives/ goals for improvement:

3.1 By March 2019, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment.

3.2 During 2018/19 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.

3.3 By March 2019, patients in all Trusts should have access to the Dementia portal.

3.4 By March 2019, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.

3.5 By March 2019 the HSC should ensure that the Co-production model is adopted when designing and delivering transformational change. This will include integrating PPI, co-production, patient experience into a single organisational plan.

Associated quality and performance indicators

Palliative Care

C1 Implementation of a protocol to support the identification of patients with palliative and end of life care needs in Primary Care systems. [Source: PHA/ HSCB evaluation report of agreed protocol]

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

Timely access to the most appropriate services is considered a key indicator of quality and the patient experience. People rightly have an expectation that they should be seen and treated within a reasonable time in the most appropriate location. Prompt, early diagnosis and intervention can avoid the need for scarce acute sector services while supporting a high quality of life.

The way services are designed and delivered will continue to change, focussed on providing continuity of care in an organised way. Transformation will increasingly require working across traditional organisational boundaries within and outside the HSC and the development of an environment characterised by trust, partnership and collaboration.

It will be important during the transition period that existing services are delivered to agreed standards, in a safe and timely fashion. The introduction of new performance/ accountability arrangements and associated Performance Improvement Trajectories will assist in securing steady improvement in existing services. Initially introduced in mid-2017/18 (covering elective, ED, Cancer services, mental health services and ambulance response times) the intention is to expand the arrangements to cover other, CPD standards during 2018/19.

Objectives/ goals for improvement:

Primary Care Setting

4.1 By March 2019, to increase the number of available appointments in GP practices compared to 2017/18

4.2 By March 2019, to have 95% of acute/ urgent calls to GP OOH triaged within 20 minutes.

The NI Ambulance Service faces growing demand for the services they provide. In response to this and other challenges the NIAS are transforming how they deliver their services. Although the introduction of new ways of working, such as Alternative (or Appropriate) Care Pathways, has contributed to a reduction in the use of Acute Care facilities demand remains high for a prompt response to life threatening events.

4.3 From April 2018, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.

Hospital Care Setting – Acute Care

When patients and service users need urgent treatment only provided in acute sector settings they often are frustrated by apparently lengthy treatment delays due the failure of the current service delivery model to provide a high quality service in a timely fashion.

The reform of community and hospital services so that they are organised to provide care where and when it is needed, in the most efficient manner, is a high priority. It is inevitable

that the role of our hospitals will change as they focus on delivering the highest quality of specialist and acute care for patients across Northern Ireland. In responding to the objectives below it will be essential for the Commissioning Plan to demonstrate how such services are being transformed, with alternative models of care embedded across Northern Ireland: ensuring more people can be seen and treated effectively (including on a same/ next day basis), preventing unnecessary admissions to hospital, and supporting people to recover following periods of ill-health.

Proposals should include working towards the provision of the same level of care for inpatients seven days a week, the deployment of ambulatory care models, the utilisation of technology to provide timely access to specialist advice, cross trust collaboration, and the scaling up and rollout of proven new ways of care delivery.

4.4 By March 2019, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.

4.5 By March 2019, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

4.6 By March 2019, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

4.7 By March 2019, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

4.8 By March 2019, all urgent diagnostic tests should be reported on within two days.

4.9 During 2018/19, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Hospital Care Setting – Elective Care

Often patients are referred to specialists for medical or surgical treatment of non-urgent or non-life threatening conditions that nevertheless require medical or surgical intervention. People rightly have an expectation that they should be seen and treated within a reasonable time. However, over the last number of years, meeting the rising demand has been challenging and it is clear that the current service model is no longer suitable.

The longer term goal set out in Delivering Together is to significantly reduce the current waiting times for assessment, diagnosis and treatment that have been described as unacceptable. The aim of the introduction of new ways of working, such as Elective Care Centres and Assessment and Treatment Centres, is to return to the maximum waiting times of nine, nine and thirteen weeks that have previously been achieved.

In recognition that the introduction of a sustainable model, in a safe manner, must be undertaken methodically, the goals below represent realistic and achievable objectives that deliver stability.

4.10 By March 2019, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.

4.11 By March 2019, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

4.12 By March 2019, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.

4.13 By March 2019, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Associated quality and performance indicators

Primary Care

D1 The number of contacts per 1,000 patients per week, for each GP practice contracting to provide the NILES Demand Management, through submission of a survey to HSCB.

D2 Percentage of routine GP "out of hours" calls triaged within one hour.

D3 Total out of hours GP attendances.

D4 Number of GP referrals to emergency departments.

NI Ambulance Service

D5 Number of ambulance responses where the outcome is that the patient does not attend hospital.

D6 (i) Patient handover times and (ii) ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes).

D7 Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital.

Acute Care

D8 Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to 12 hours and 12 hours or more, before being treated and discharged or admitted.

D9 Total time spent in emergency departments including the median, 95th percentile and single longest time spent by patients in the department, for admitted and non-admitted patients.

D10 (a)Number and percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes; (b) time from arrival to triage (initial assessment) for (i) ambulance arrivals and (ii) all arrivals; and (c) time from triage (initial assessment) to start of treatment in emergency departments.

D11 Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage scale at Type 1 or 2 Emergency Departments.

D12 Time waited in emergency departments between decision to admit and admission including the median, 95th percentile and single longest time.

D13 Percentage of people who leave the emergency department before their treatment is complete.

D14 Percentage of unplanned re-attendances at emergency departments within seven days of original attendance.

Stroke

D15 Average length of stay for stroke patients.

Elective Care

D16 Number of GP and other referrals to consultant-led outpatient services.

D17 Percentage of routine diagnostic tests reported on (i) within two weeks and (ii) within four weeks of the test being undertaken.

Specialist drug therapies

D18 Number of patients waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.

D19 Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for Multiple Sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.

D20 Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye, and six weeks for the second eye.

Maternity

D21 Intervention rates, including percentage of babies born by caesarean sections.

D22 Number of babies born in midwife-led units.

Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

Successful implementation of a person centred model of care will rely on a comprehensive understanding of what is important to those delivering care and those receiving that care. It will therefore be important that the principle of coproduction is at the heart of new initiatives for those with long term conditions, and that patients and service users are partners in the care they receive with a focus on increased self-management and choice.

Objectives/ goals for improvement

Increased Choice

5.1 By March 2019, secure a 10% increase in the number of direct payments to all service users.

5.2 By March 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.

Access to Services

5.3 By March 2019, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

5.4 By March 2019, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.

5.5 By March 2019, Direct Access Physiotherapy service will be rolled out across all Health and Social Care Trusts.

5.6 By May 2018, to have delivered the Children & Young People's Developmental & Emotional Wellbeing Framework along with a costed implementation plan

Care in Acute Settings

5.7 During 2018/19, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

Associated quality and performance indicators

Supporting Independence

E1 Number of client referrals passed to reablement; number of clients starting a reablement scheme; and number of clients discharged from reablement with no on-going care package required'.

Patient Discharge

E2 Percentage of learning disability and mental health discharges that take place within seven days of the patient being assessed as medically fit for discharge.

E3 Number of learning disability and mental health discharges that take place after 28 days of the patient being assessed as medically fit for discharge.

Outcome 6: Supporting those who care for others

Carers are vital partners in providing care and it is important that they are supported while carrying out their caring responsibilities. The contribution of informal carers is crucial to the ability of people who require assistance to live independently in the community. As the needs of carers continues to change, the type of support required must keep pace with that change. It will be important that they can strike a balance between the duties of the caring role and their right to live their own life and pursue their own goals and interests.

Objectives/ goals for improvement

6.1 By March 2019, secure a 10% increase (based on 2017/18 figures) in the number of carers' assessments offered to carers for all service users.

6.2 By March 2019, secure a 5% increase (based on 2017/18 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.

6.3 By March 2019, to create a baseline for the number of young carers receiving short breaks (ie non-residential respite).

Associated quality and performance indicators

F1 Number of carers assessments offered, by Programme of Care.

F2 Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.

Aim: Ensure the sustainability of health and social care services provided

The objectives set out under the first two aims seek to improve the health of the Northern Ireland population and the quality of health and social care services provided to patients and service users. It is essential that these overarching aims are achieved within the resources available to the HSC.

The existing pressures and challenges arising from growing demand, patients living longer with complex needs, and an aging population have not diminished therefore services must operate as efficiently and effectively as possible and provide in the best possible outcome for patients.

However operating existing services efficiently is not enough to meet the growing demand and it is clear that the HSC must change how health and social care services are delivered.

The Commissioning Plan should demonstrate that currently commissioned services represent the most efficient use of resources and outline how benchmarking of productivity and efficiency measures across providers has informed commissioning decisions. In addition, it should detail the steps being taken to bring about change that will provide the highest quality care in a cost effective manner—on the basis of single solutions for the region.

Key actions required of the HSC for the period 2018/19 and beyond, to provide sustainable health and social care services, are contained in the objectives set out in Outcome 7 – Ensure the sustainability of health and social care services.

Outcome 7: Ensure the sustainability of health and social care services

Established health and social care services are often accompanied by a plethora of checks, lists and forms developed over time to address particular issues. Transforming such services and the bureaucracy around them, through investment in technology enabled business solutions such as Encompass, will harmonise and standardise care and information processes. Such investment will ensure our staff have the required information at hand and are empowered to efficiently deliver a person centred model of care.

While awaiting the introduction of new business solutions it remains important to maximise the impact of the available resources to deliver the best patient outcomes, particularly in the facing of increasing financial pressures. HSC Trusts should therefore continue to develop multi-disciplinary, team-based approaches to delivering care aligned with GP Practices.

The HSCB, PHA and Trusts should demonstrate how they ensure services are operated in an optimal manner and that all urgent patients referrals are prioritised and, thereafter, that all routine patients are seen in strict chronological order.

To reduce the impact of long waiting lists it will be important to maximise -attendance rates, with outpatient appointment dates booked no more than six weeks in advance, and outpatient review appointments only taking place where there is a clear clinical need.

Objectives/ goals for improvement

Primary and Community setting

7.1 By March 2019, to have commenced implementation of new contractual arrangements for community pharmacy services.

7.2 By March 2019 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users and the baseline activity to measure this.

Hospital Setting

While demand for services continues to grow it is imperative that, in the short term, the HSC makes efficient use of the resources available.

7.3 By March 2019, to establish a baseline of the number of hospital cancelled, consultant led, outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment and by March 2020 seek a reduction of 5%.

7.4 By March 2019, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

7.5 By March 2019, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

7.6 By March 2019, to have obtained savings of at least £90m through the 2016-19 Regional Medicines Optimisation Efficiency Programme, separate from PPRS receipts.

Associated quality and performance indicators

Hospital efficiency

G1 Number, rate and ratio of new and review outpatient appointments cancelled by hospitals.

G2 Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient.

G3 Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust.

G4 Number of outpatient appointments with procedures (for selected specialties).

G5 Day surgery rate for each of a basket of 24 elective procedures to continue monitoring performance and enable continued benchmarking with rest of UK.

G6 Percentage of patients admitted electively who have their surgery on the same day as admission.

G7 Elective average pre-operative stay.

G8 Percentage of operations cancelled for non-clinical reasons.

G9 Elective average length of stay in acute programme of care.

G10 Excess bed days for the acute programme of care.

G11 Cost of a basket of 24 elective procedures (Day surgery as per G5) by Trust.

Prescribing efficiency

G12 Level of compliance of GP practices and HSC Trusts with the NI Medicines Formulary; and prescribing activity for generic prescribing and dispensing rates.

Aim: Support and empower staff delivering health and social care services

Those who work tirelessly, and with great skill and dedication, to provide our health and social care services are the HSC's most valuable resource. It is vital that the HSC invests in their future and ensures their health and wellbeing is valued and protected.

As the implementation of Delivering Together moves forward it is important to have an optimally sized and resourced workforce, with the right skills mix in place to deliver both the existing, commissioned services, promote health and wellbeing and support the transformation work.

In 2018, the Department will, as an outworking of Delivering Together, publish a Workforce Strategy, which aims to meet our workforce needs – and the needs of the workforce. The Commissioning Plan will need to take the aim, objectives, themes and actions of the strategy into account, and detail how resources will be allocated to support the implementation of the strategy.

While HSC staff include some of the most capable, committed and enthusiastic people in the public sector the Bengoa Report was clear that in order to bring about the required transformation they would be asked to change how they undertake their work and would need to develop new skills.

In order to embed the required culture of learning, quality improvement and partnership working throughout the HSC it will be necessary to develop Leadership and Change Management skills, critical to the successful delivery of the required transformation, across the range of health and social care staff and key independent practitioners. These skills will be delivered through the implementation of the HSC-wide Collective Leadership Strategy and the Commissioning Plan should detail how resources will allocated to support the implementation of this work.

Key actions required of the HSC for the period 2018/19 and beyond, to support and develop the capabilities of HSC staff, are contained in the objectives set out in Outcome 8 – Supporting and transforming the HSC workforce.

Outcome 8: Supporting and transforming the HSC workforce

The HSC competes with other employers to secure the skills and talents of the best people. It must therefore become an employer and trainer of choice; leading by example; investing in the wellbeing of staff, and making a tangible and positive contribution to the health and wellbeing of not only health and social care staff but society as a whole.

The HSC can realise these goals through supporting the staff who deliver vital health and social care services and seeking to bring about positive change. Continued investment in training and development initiatives, along with the development of new multidisciplinary training programmes that maximise the effectiveness of the workforce will assist in achieving those outcomes.

Objectives/ goals for improvement

The implementation of the Workforce Strategy will demonstrate to our health and social care workers that the transformation set out in Delivering Together is underway. The actions for 2018/19 described below will contribute to ensuring that an adequately-resourced and skilled workforce is available to take forward work to discharge departmental Programme for Government commitments.

Implementing the Workforce Strategy

8.1 By June 2018, to provide appropriate representation on the programme board overseeing the implementation of the health and social care Workforce Strategy.

Attracting, recruiting and retaining staff

8.2 By June 2018, to provide appropriate representation on the project board to establish a health and social care careers service.

Effective workforce planning

8.3 By March 2019, to have completed the first phase of the implementation of the domiciliary care workforce review.

8.4 By June 2018, to provide appropriate representation to the project to produce a health and social care workforce model.

Build on, consolidate and promote workforce health and wellbeing and staff engagement

8.5 By March 2019, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10 – 14 of the Workforce Strategy.

Improving business intelligence

8.6 By December 2018, to provide the information required to facilitate the proactive use of business intelligence information and provide appropriate personnel to assist with the analysis.

Supporting our staff

8.7 By December 2018, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.

8.8 By March 2019, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2017/18 figure.

8.9 By March 2019, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG.

8.10 By March 2019 to pilot an OBA approach to strengthen supports for the social work workforce

Investing in our staff

8.11 By March 2019, 50% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2 by March 2020.

8.12 By March 2019, to have developed and commenced implementation of a training plan on suicide awareness and suicide intervention for all HSC staff with a view to achieving 50% staff trained (concentrating initially on frontline staff) by 2022 in line with the draft Protect Life 2 strategy.

8.13 By March 2019, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts.

Associated quality and performance indicators

Sickness Absence

H1 Uptake of seasonal flu vaccine by frontline health and social care workers (as reported in PHA return to Dept).

H2 Percentage of HSC hours lost due to sick absence.

H3 Percentage of HSC staff trained in suicide awareness / prevention.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2018/19

1. The vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the vision and priorities during the year 1st April 2018 to 31st March 2019.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2018/19 financial year are resourced.

4. The objectives and indicators included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.

5. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

DIRECTION

2019 No. X

The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2019-2020

The Department of Health (DoH) [(a)], makes the following Direction in exercise of the powers conferred by sections 6, 8(3) and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009 [(b)]:

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2019 - 2020 and shall come into operation on 1 XXX 2019.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission, for the period 1 April 2019 to 31 March 2020, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include a summary of the financial allocations and set out how commissioning will serve to support the implementation of the Minister's strategic vision (as set out in Delivering Together) to transform the delivery of health and social care services. It should set out clear timescales and milestones for the delivery of commissioning intentions and the transformation of services.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board align with and support the implementation of the Minister's vision and delivery of priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998[(c)],

(a) Departments Act(Northern Ireland) 2016 c.5
(b) 2009 c.1 (N.I.) as amended by 2014 c.5
(c) 1998 c.47

the discharge of statutory duty of quality, delegated statutory functions and requirements under Personal and Public Involvement (PPI); and key Departmental standards, policies, strategies and guidelines.

3. The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will contribute to the four overarching strategic themes:

(a)*To improve the health of our citizens*.

(b)*To improve the quality and experience of health and social care.*

(c)*To ensure the sustainability of health and social care services provided*.

(d)*To support and empower staff delivering health and social care services*.

Performance indicators

4.In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the objectives and associated quality and performance indicators for the period April 2019 to March 2020.

5.The Regional Board shall record the information against the objectives and associated quality and performance indicators for the period April 2019 to March 2020.

Commissioning and the use of financial allocations

6.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from April 2019 to March 2020, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

Sealed with the Official Seal of the Department of Health on xxxxxx

Permanent Secretary
A senior officer of the Department of Health

Table of Contents

SCHEDULE

Objectives and Indicators for 2019 - 2020

Introduction

This Direction sets out the priorities, aims and improvement objectives for the HSC for the 2019/20 financial year. The achievement of the objectives set out in this Direction will; support the realisation of the vision for the future of health and social care as set out in "*Health and Wellbeing 2016: Delivering Together*"; contribute to the attainment of the aims of the *draft 2016 – 2021 Programme for Government* (in particular Outcome 4: "We enjoy long, healthy, active lives"), and underpin the Executive's population health framework "*Making Life Better*".

The Direction is structured around the four overarching and linked aims identified in *Delivering Together*, which acknowledge the challenges facing health and social care namely:

- to improve the health of the population;
- to improve the quality and experience of care;
- to ensure the sustainability of the services delivered; and
- to support and empower the staff delivering health and social care services.

Set out under each of the four *Delivering Together* aims are key objectives / goals that will progress the work to meet the future needs of the population and bring about a person centred model of care, including a shift from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

To allow progress towards each outcome to be tracked over time a number of associated quality and performance indicators have been identified against which the HSC should monitor progress and take improvement action as required. It is important to note that these indicators do not represent the totality of the information available to the HSC and the Department to ensure the smooth running of the system or inform the development, implementation and evaluation of policy.

The Commissioning Plan, developed in response to this Direction, must demonstrate how the services commissioned regionally and by LCGs in 2019/20 and beyond will contribute to the delivery of the four aims set out in *Delivering Together*, contribute to the identified outcomes in an integrated manner, sustain the pace of transformation and meet or exceed the specific objectives set out below.

Aim: To improve the health of the population

A key aim of the entire health and social care system in Northern Ireland is to improve the overall health and wellbeing of the population and to prevent ill-health. Whilst improvements have been noted, too many people still die prematurely or live with conditions that could have been prevented.

The strategic vision for future health and social care services seeks to support people to take greater control over their own lives and enable them to make healthy choices as well as helping to create an environment that makes such choices easier.

It is accepted that the health and social care service cannot do this in isolation and to achieve this aim we need to work with other partners across government and other sectors to tackle the root causes of ill-health and reduce health inequalities. Maximising the potential of the community planning process and other partnerships will be an important enabler. We will support the development of thriving and inclusive communities through working in partnership with communities and with other sectors.

The population health framework *"Making Life Better"* set the strategic context for the actions required from health organisations and other public bodies to improve health and reduce inequalities. Through implementation of this strategic framework, the Department of Health and other public bodies can create the conditions for individuals, families and communities to take greater control over their lives and be empowered and supported to lead healthy lives.

Key objectives/goals for the HSC for the period 2019/20 and beyond, to improve the health of the population, are set out at **Outcome 1 – Reduction of Health Inequalities.**

Outcome 1: Reduction of health inequalities

Achieving the aims of *Delivering Together* will result in the creation of an environment where people are supported to keep well in the first place. Through ensuring that people have the information, education and support to make informed choices around lifestyle, healthy eating, and the adoption of preventative actions such as maintaining good oral health we will empower people to take control of their own health and wellbeing and support them to stay healthy, well, safe and independent.

Work to support and enable healthy lives, and tackle the causes of health inequality spans the entire life course:

- helping pregnant women and their partners to make the choices that are best for them and their babies;
- ensuring that all children grow up in a stable and healthy environment;
- intervening early to provide support to families before issues become complex and difficult to reverse;
- supporting infant mental health;
- ensuring our young people are equipped for a healthy adulthood, and
- supporting people to continue to live active and healthy lives as they age.

Although we seek to address the needs of the entire population there are those who, at times, may require more focussed support such as people detained in prisons, the homeless, the travelling community and LGBT people.

Objectives/ goals for improvement:

Population Health

1.1 By March 2020, in line with the Department's ten year "*Tobacco Control Strategy*", to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.

1.2 By March 2020, to have commissioned an early years obesity prevention programme and rolled out a regionally consistent Physical Activity Referral Scheme. These programmes form part of the Departmental strategy, A Fitter Future for All, which aims by March 2022, to reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.

1.3 By March 2020, through implementation of the NI Breastfeeding Strategy increase the percentage of infants breastfed at discharge and 6 months as recorded in the Child Health System (CHS). This is an important element in the delivery of the "*Breastfeeding Strategy*" objectives for achievement by March 2025.

1.4 By March 2020, establish 3 "Healthy Places" demonstration programmes working with specialist services and partners across community, voluntary and statutory organisations to address local needs.

1.5 By March 2020, to ensure appropriate representation and input to the PHA/HSCB led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach.

1.6 By March 2020, to establish a baseline of the number of teeth extracted in children aged 3-5 years - as phase 1 of the work to improve the oral health of young children in Northern Ireland over the next 3 years and seek a reduction in extractions of 5%, against that baseline, by March 2021.

1.7 By March 2020, to commence the implementation of a regional prototype bariatric service, subject to the outcome of public consultation, business case approval and available funding in line with the implementation of recommendations set out in the Departmentally endorsed NICE guidance on weight management services.

Supporting Children and Young People

1.8 By March 2020, to have further developed, and implemented the "*Healthier Pregnancy*" approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation.

1.9 By March 2020, ensure the full delivery of the universal child health promotion programme for Northern Ireland, "*Healthy Child Healthy Future*". By that date:

- The antenatal contact will be delivered to all first time mothers.
- 95% of two year old reviews must be delivered.

These activities include the delivery of core contacts by Health Visitors and School Nurses which will enable and support children & young adults to become successful, healthy adults through the promotion of health and wellbeing.

1.10 By March 2020, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 "We give our children and young people the best start in life".

1.11 By March 2020 each HSC Trust will have established an Infant Mental Health Group and produced an Action Plan consistent with and informed by the "Infant Mental Health Framework for Northern Ireland" 2016."

1.12 By March 2020, the proportion of children in care for 12 months or longer with no placement change is at least 85%; and 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer them greater stability while in care.

Improving Mental Health

1.13 By March 2020, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a

Multi Agency Triage Team pilot (SEHSCT) and two Crisis De-escalation Service pilots (BHSCT & WHSCT) to test different models and approaches. Learning from these pilots should inform the development of crisis intervention services and support the reduction of the suicide rate by 10% by 2022 in line with the draft "*Protect Life 2 Strategy*".

1.14 By March 2020, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol and drug related harm and to reduce drug related deaths.

Supporting those with Long Term Conditions

1.15 By July 2020, to provide detailed implementation plans (to include recruitment status) for the regional implementation of the diabetes foot care pathway, plans should demonstrate an integrated approach making best use of all providers. Regional deployment of the care pathway will be an important milestone in the delivery of the "*Diabetes Strategic Framework*"

Associated quality and performance indicators

Population health (general)

A1 Healthy life expectancy.

A2 Average life expectancy for men and women.

A3 Life expectancy differential between the least deprived and most deprived areas in Northern Ireland, for men and women.

A4 Potential years of life lost from causes considered amenable to healthcare.

A5 Infant mortality.

A6 Age standardised death rate for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas.

A7 Maintenance of population vaccination coverage as reported in PHA Annual Report.

A8 Proportion of adults (aged 16+) consuming the recommended five portions of fruit and vegetables each day.

A9 Level of overweight and obesity across the life course (2 – 15) year olds and 16+.

Smoking

A10 Proportion of adults who smoke.

A11 Number of pregnant women, children and young people, and adults from deprived areas (lower quintile) who set a quit date through cessation services.

A12 Proportion of pregnant women who smoke.

Alcohol and substance misuse

A13 Proportion of adults who report having reached or exceeded the recommended weekly alcohol limit.

A14 Standardised rate of alcohol-related admissions to hospital within the acute programme of care.

A15 Standardised rate of drug-related admissions to hospital within the acute programme of care.

Child health and wellbeing

A16 Rate of births to mothers under 17 years of age (with breakdown against most deprived areas).

A17 Breastfeeding rate at discharge from hospital.

A18 Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.

A19 Proportion of looked after children who have experienced more than two placement changes. (Source is OC2)

A20 Length of time for best interest decision to be reached in the adoption process.

A21 Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type.

A22 Proportion of school-aged children who have been in care for 12 months or longer, who have a personal education plan.

A23 Percentage of care leavers aged 16 – 18 in education, training or employment by placement type.

A24 Percentage of care leavers at age 18, 19 and 20 years in education, training or employment.

Suicide and self-harm

A25 Achievement of the implementation of Protect Live 2 Strategy Action Plan (source Quarterly Project Board Highlight Reports)

A26 Number of ED repeat presentations due to deliberate self-harm.

A27 Self-reported mental health. (GHQ12 survey)

Long Term Conditions

A28 The number of unplanned admissions to hospital for adults with specified long-term conditions.

Aim: To improve the quality and experience of health and social care.

Delivering Together set out the roadmap for the transformation of health and social care services to deliver an integrated service capable of responding to future needs. Everyone in Northern Ireland will make use of those services at different points in their lives.

It is important that the HSC listens to and learns from their experiences, whether services are delivered well or things go wrong, and strives to ensure that everyone has a positive experience of the care or treatment they receive.

Quality 2020 provides the framework for the delivery of such services that are:

- centred on the needs of the patient/ client—everyone using HSC services should be treated with dignity and respect and should be fully involved in decisions about their treatment, care and support.
- safe—the care, treatment and support the HSC provides should never result in avoidable or preventable harm; and
- effective—everyone accessing HSC services should have the most appropriate treatment or care, in the most appropriate setting, with the best possible outcome.

Delivering Together confirmed the Minister's intention to build on Q2020 and other quality improvement work and to establish an Improvement Institute to better align existing resources in this important area.

Objectives / goals to address the quality and experience of health and social care are contained in the following Outcomes:

2 - People using health and social care services are safe from avoidable harm

3 - Improve the quality of the healthcare experience

4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

5 - People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

6 - Supporting those who care for others

Outcome 2: People using health and social care services are safe from avoidable harm

It is widely recognised that the design and delivery of health and social care must have quality and safety at its heart. The Expert Panel who produced the "*Systems not Structures*" report were clear that "any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this".

To meet this challenge the HSC needs to ensure alignment between quality improvement, partnership with those who use our services, and how we regulate those services. HSC working practices should proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs.

Objectives/ goals for improvement:

Safe in all Settings

2.1 By March 2020 all HSC Trusts should ensure safe and sustainable nurse staffing, including working towards the full implementation of phases 2, 3 and 4 of Delivering Care, maximising the use of any current or new funding, with an annual report submitted to HSC Trust Boards.

2.2 By 31 March 2020:

- Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 3%, as per the established recurring annual targets, taking 2018/19 as the baseline figure; and
- Using 2018/19 as the baseline, by March 2020 Trusts should secure the following in secondary care:
    - a reduction in total antibiotic prescribing (DDD per 1000 admissions) of 1-2%;
    - a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions;
    - a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions, and

    and EITHER

    - that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category,

    OR

    - an increase of 2% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use,

with the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 15% by 31 March 2024.

**For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.*

Safe in Hospital Settings

Reducing Gram-negative bloodstream infections

2.3 By 31 March 2020 secure an aggregate reduction of 17% of *Escherichia coli, Klebsiella spp.* and *Pseudomonas aeruginosa* bloodstream infections acquired after two days of hospital admission, compared to 2018/19.

2.4 In the year to March 2020 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of *Clostridium difficile* infection in patients aged 2 years and over, and in-patient episodes of Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection compared to 2018/19.

2.5 Throughout 2019/20 all clinical care teams should comprehensively scale and spread the implementation the NEWS KPI, and ensure effective and robust monitoring through clinical audit and ensure timely action is taken to respond to any signs of deterioration.

2.6 By March 2020, achieve full implementation of revised regionally standards, operational definitions and reporting schedules for falls and pressure ulcers across all adult inpatient areas.

2.7 By March 2020, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group.

Safe in Community Settings

2.8 During 2019/20 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.

Associated quality and performance indicators

Hospital Care

B1 Staffing levels as reported in regular reports from PHA Delivering Care Implementation Board.

B2 Number of records audited achieving 95% compliance of the accurately completed NEWS charts in all adult in-patient wards (excluding theatres and critical care departments).

B3 Number of incidents of hospital-acquired pressure ulcers (grade 3 and 4) occurring in all adult inpatient wards, and are classed as unavoidable from the current baseline data.

B4 Percentage compliance with the falls safe improvement bundle specified settings including adult acute inpatient and elderly care settings.

B5 Number of emergency admissions returning within seven days and within 8-30 days of discharge.

B6 Clinical causes of emergency readmissions (as a percentage of all admissions) for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF).

B7 Number of emergency readmissions with a diagnosis of venous thromboembolism.

B8 Number of emergency admissions and readmissions in which medicines were considered to have been the primary or contributing factor.

Community Care

B9 Number of revisits required to achieve compliance in (i) residential homes, (ii) nursing homes, in 2016/17 and 2017/18, as published by RQIA.

Outcome 3: Improve the quality of the healthcare experience.

The Health and Social Care system belongs to everyone and those providing services or availing of services can bring valuable insights into how it can best be organised and improved. Through working in partnership and utilising coproduction, patients, service users, families, staff, and politicians can all participate in the development of a person centred service which benefits us all.

In undertaking such work everyone who uses and delivers health and social care services should be treated with respect, listened to and supported to work as real partners.

Staff and patient voices from across the system should be aligned closely to the quality improvement, inspection and regulation systems to ensure issues are raised in as timely a manner as possible and addressed early: before they escalate to a complaint.

Objectives/ goals for improvement:

3.1 By March 2020, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment.

3.2 During 2019/20 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.

3.3 By September 2019, patients in all Trusts should have access to the Dementia portal.

3.4 By March 2020, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.

3.5 By March 2020 the HSC should ensure that the Regional Co-Production Guidance has been progressively implemented and embedded across all programme of care, this will include integrating PPI, Co-Production, and patient experience into a single organisational plan.

Associated quality and performance indicators

Palliative Care

C1 Implementation of a protocol to support the identification of patients with palliative and end of life care needs in Primary Care systems. [Source: PHA/ HSCB evaluation report of agreed protocol]

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

Timely access to the most appropriate services is considered a key indicator of quality and the patient experience. People rightly have an expectation that they should be seen and treated within a reasonable time in the most appropriate location. Prompt, early diagnosis and intervention can avoid the need for scarce acute sector services while supporting a high quality of life.

The way services are designed and delivered will continue to change, focussed on providing continuity of care in an organised and integrated way. Transformation will increasingly require working across traditional organisational boundaries within and outside the HSC, and the development of an environment characterised by trust, partnership and collaboration.

It will be important during the transition period that existing services are delivered to agreed standards, in a safe and timely fashion. The continued deployment of new performance/ accountability arrangements and associated Performance Improvement Trajectories will assist in securing steady improvement in existing services. Initially introduced in mid-2017/18 (covering elective, ED, Cancer services, mental health services and ambulance response times) the intention is to expand the arrangements to cover other CPD standards during 2018/19 and beyond.

Technology and new ways of working have a key role to play in transforming General Practice, including increasing access to GP services. Evidence from practices that have introduced telephone triage such as Ask My GP for example, suggests that this has helped increase the capacity to manage demand and consideration should be given to how such initiatives can be further developed and implemented.

Objectives/ goals for improvement:

<u>Primary Care and Community Setting</u>

4.1 By March 2020, to increase the number of available appointments in GP practices compared to 2018/19.

4.2 By March 2020, to have 95% of acute/ urgent calls to GP OOH triaged within 20 minutes.

4.3 By March 2020, reduce the number of unallocated family and children's social care cases by 20%.

<u>Ambulance Services</u>

The NI Ambulance Service faces growing demand for the services they provide. In response to this and other challenges the NIAS are transforming how they deliver their services. Although the introduction of new ways of working, such as Alternative

(or Appropriate) Care Pathways, has contributed to a reduction in the use of Acute Care facilities demand remains high for a prompt response to life threatening events.

4.4 Until the proposed adoption of a new clinical response model, when 72.5% of Category A (life threatening) calls should be responded to within 8 minutes, 67.5% in each LCG area, the HSCB should continue to work with the Trust to ensure performance is maintained at the previous target level.

Hospital Care Setting – Acute Care

When patients and service users need urgent treatment only provided in acute sector settings they often are frustrated by apparently lengthy treatment delays due the failure of the current service delivery model to provide a high quality service in a timely fashion.

The reform of community and hospital services so that they are organised to provide care where and when it is needed, in the most efficient manner, is a high priority. It is inevitable that the role of our hospitals will change as they focus on delivering the highest quality of specialist and acute care for patients across Northern Ireland. In responding to the objectives below it will be essential for the Commissioning Plan to demonstrate how such services are being transformed, with alternative models of care embedded across Northern Ireland: ensuring more people can be seen and treated effectively (including on a same/ next day basis), preventing unnecessary admissions to hospital, and supporting people to recover following periods of ill-health.

Proposals should include working towards the provision of the same level of care for inpatients seven days a week, the deployment of ambulatory care models, the utilisation of technology to provide timely access to specialist advice, cross trust collaboration, and the scaling up and rollout of proven new ways of care delivery.

4.5 By March 2020, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.

4.6 By March 2020, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

4.7 By March 2020, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

4.8 By March 2020, ensure that at least 16% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

4.9 By March 2020, all urgent diagnostic tests should be reported on within two days.

4.10 During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently

referred with a suspected cancer should begin their first definitive treatment within 62 days.

Hospital Care Setting – Elective Care

Often patients are referred to specialists for medical or surgical treatment of non-urgent or non-life threatening conditions that nevertheless require medical or surgical intervention. People rightly have an expectation that they should be seen and treated within a reasonable time. However, over the last number of years, meeting the rising demand has been challenging and it is clear that the current service model is no longer suitable.

The longer term goal set out in *Delivering Together* is to significantly reduce the current waiting times for assessment, diagnosis and treatment that have been described as unacceptable. The aim of the introduction of new ways of working, such as Elective Care Centres and Assessment and Treatment Centres, is to return to the maximum waiting times of nine and thirteen weeks that have previously been achieved.

In recognition that the introduction of a sustainable model, in a safe manner, must be undertaken methodically, the goals below represent realistic and achievable objectives that deliver stability.

4.11 By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.

4.12 By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

4.13 By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.

4.14 By March 2020, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Associated quality and performance indicators

Primary Care

D1 The number of contacts per 1,000 patients per week, for each GP practice contracting to provide the NILES Demand Management, through submission of a survey to HSCB.

D2 Percentage of routine GP "out of hours" calls triaged within one hour.

D3 Total out of hours GP attendances.

D4 Number of GP referrals to emergency departments.

NI Ambulance Service

D5 Number of ambulance responses where the outcome is that the patient does not attend hospital.

D6 (i) Patient handover times and (ii) ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes).

D7 Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital.

Acute Care

D8 Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to 12 hours and 12 hours or more, before being treated and discharged or admitted.

D9 Total time spent in emergency departments including the median, 95th percentile and single longest time spent by patients in the department, for admitted and non-admitted patients.

D10 (a)Number and percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes; (b) time from arrival to triage (initial assessment) for (i) ambulance arrivals and (ii) all arrivals; and (c) time from triage (initial assessment) to start of treatment in emergency departments.

D11 Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage scale at Type 1 or 2 Emergency Departments.

D12 Time waited in emergency departments between decision to admit and admission including the median, 95th percentile and single longest time.

D13 Percentage of people who leave the emergency department before their treatment is complete.

D14 Percentage of unplanned re-attendances at emergency departments within seven days of original attendance.

Stroke

D15 Average length of stay for stroke patients.

D16 90% admission to stroke unit within 4 hours of arrival.

D17 60% discharged to community stroke teams and 40% of these should be Early Supported Discharge.

D18 100% of eligible patients should be reviewed at 6 months.

[As reported in HSCB Stroke Dashboard]

Elective Care

D19 Number of GP and other referrals to consultant-led outpatient services.

D20 Percentage of routine diagnostic tests reported on (i) within two weeks and (ii) within four weeks of the test being undertaken.

Specialist drug therapies

D21 Number of patients waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.

D22 Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for Multiple Sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.

D23 Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye, and six weeks for the second eye.

Maternity

D24 Intervention rates, including percentage of babies born by caesarean sections.

D25 Number of babies born in midwife-led units.

Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

Successful implementation of a person centred model of care will rely on a comprehensive understanding of what is important to those delivering care and those receiving that care.

It will therefore be important that the principle of coproduction is at the heart of new initiatives for those with long term conditions, and that patients and service users are partners in the care they receive with a focus on increased self-management and choice.

Objectives/ goals for improvement

Increased Choice

5.1 By March 2020, secure a 10% increase in the number of direct payments to all service users.

5.2 By September 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.

Access to Services

5.3 By March 2020, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

5.4 By March 2020, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.

5.5 By March 2020, Direct Access Physiotherapy service will be rolled out across all Health and Social Care Trusts on a state of readiness basis.

5.6 By March 2020, to have published the Children and Young People's Emotional Health and Wellbeing Framework for school-aged children and young people in Northern Ireland.

Care in Acute Settings

5.7 During 2019/20, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

Associated quality and performance indicators

Supporting Independence

E1 Number of client referrals passed to reablement; number of clients starting a reablement scheme; and number of clients discharged from reablement with no on-going care package required'.

Patient Discharge

E2 Percentage of learning disability and mental health discharges that take place within seven days of the patient being assessed as medically fit for discharge.

E3 Number of learning disability and mental health discharges that take place after 28 days of the patient being assessed as medically fit for discharge.

Outcome 6: Supporting those who care for others

Carers are vital partners in providing care and it is important that they are supported while carrying out their caring responsibilities. The contribution of informal carers is crucial to the ability of people who require assistance to live independently in the community.

As the needs of carers continues to change, the type of support required must keep pace with that change. It will be important that they can strike a balance between the duties of the caring role and their right to live their own life and pursue their own goals and interests.

Objectives/ goals for improvement

6.1 By March 2020, secure a 10% increase (based on 2018/19 figures) in the number of carers' assessments offered to carers for all service users.

6.2 By March 2020, secure a 5% increase (based on 2018/19 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.

6.3 By March 2020, secure a 5% increase on the number of young carers attending day or overnight short break activities.

Associated quality and performance indicators

F1 Number of carers assessments offered, by Programme of Care.

F2 Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.

Aim: Ensure the sustainability of health and social care services provided

The objectives set out under the first two aims seek to improve the health of the Northern Ireland population and the quality of health and social care services provided to patients and service users. It is essential that these overarching aims are achieved within the resources available to the HSC.

The existing pressures and challenges arising from growing demand, patients living longer with complex needs, and an aging population have not diminished. Therefore services must operate as efficiently and effectively as possible, and provide the best possible outcome for patients.

However, operating existing services efficiently is not enough to meet the growing demand and it is clear that the HSC must change how health and social care services are delivered.

This will mean working with a system focus and in an integrated way that makes best use of the expertise and resources of all health and social care providers, and allows innovative ways of working to develop.

The Commissioning Plan should demonstrate that currently commissioned services represent the most efficient use of resources and outline how benchmarking of productivity and efficiency measures across providers has informed commissioning decisions. In addition, it should detail the steps being taken to bring about change that will provide the highest quality care in a cost effective manner—on the basis of single solutions for the region.

Key actions required of the HSC for the period 2019/20 and beyond, to provide sustainable health and social care services, are contained in the objectives set out in **Outcome 7 – Ensure the sustainability of health and social care services.**

Outcome 7: Ensure the sustainability of health and social care services

Established health and social care services are often accompanied by a plethora of checks, lists and forms developed over time to address particular issues.

Transforming such services and the bureaucracy around them, through investment in technology enabled business solutions such as encompass, will harmonise and standardise care and information processes. Such investment will ensure our staff have the required information at hand and are empowered to efficiently deliver a person centred model of care.

While awaiting the introduction of new business solutions it remains important to maximise the impact of the available resources to deliver the best patient outcomes, particularly in the facing of increasing financial pressures. HSC Trusts should therefore continue to develop multi-disciplinary, team-based approaches to delivering care aligned with GP Practices.

The HSCB, PHA and Trusts should demonstrate how they ensure services are operated in an optimal manner, and that all urgent patients referrals are prioritised and, thereafter, that all routine patients are seen in strict chronological order.

To reduce the impact of long waiting lists it will be important to maximise attendance rates, with outpatient appointment dates booked no more than six weeks in advance, and outpatient review appointments only taking place where there is a clear clinical need.

Objectives/ goals for improvement

Primary and Community setting

7.1 By March 2020, to ensure delivery of community pharmacy services in line with financial envelope.

7.2 By March 2020 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users and the baseline activity to measure this.

Hospital Setting

While demand for services continues to grow it is imperative that, in the short term, the HSC makes efficient use of the resources available.

7.3 By March 2020, to establish a baseline of the number of hospital cancelled, consultant led, outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment and by March 2020 seek a reduction of 5%.

7.4 By March 2020, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

7.5 By March 2020, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

7.6 By March 2020, to have obtained savings of at least £20m through the Medicines Optimisation Programme, separate from PPRS receipts.

Associated quality and performance indicators

Hospital efficiency

G1 Number, rate and ratio of new and review outpatient appointments cancelled by hospitals resulting in the patient waiting longer.

G2 Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient resulting in the patient waiting longer.

G3 Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust.

G4 Number of outpatient appointments with procedures (for selected specialties).

G5 Day surgery rate for each of a basket of 24 elective procedures to continue monitoring performance and enable continued benchmarking with rest of UK.

G6 Percentage of patients admitted electively who have their surgery on the same day as admission.

G7 Elective average pre-operative stay.

G8 Percentage of operations cancelled for non-clinical reasons.

G9 Elective average length of stay in acute programme of care.

G10 Excess bed days for the acute programme of care.

G11 Cost of a basket of 24 elective procedures (Day surgery as per G5) by Trust.

Prescribing efficiency

G12 Level of compliance of GP practices and HSC Trusts with the NI Medicines Formulary; and prescribing activity for generic prescribing and dispensing rates.

Aim: Support and empower staff delivering health and social care services

Those who work tirelessly, and with great skill and dedication, to provide our health and social care services are the HSC's most valuable resource. It is vital that the HSC invests in their future and ensures their health and wellbeing is valued and protected.

As the implementation of *Delivering Together* moves forward it is important to have an optimally sized and resourced workforce, with the right skills mix in place to deliver both the existing, commissioned services, promote health and wellbeing and support the transformation work.

In May 2018, the Department, as an outworking of Delivering Together, published the 'health and social care Workforce Strategy 2026', with the aim of meeting our workforce needs – and the needs of the workforce. The Commissioning Plan needs to take the aim, objectives, themes and actions of the strategy into account, and detail how resources will be allocated to support the implementation of the strategy.

While HSC staff include some of the most capable, committed and enthusiastic people in the public sector, the Expert Panel Report was clear that in order to bring about the required transformation they would be asked to change how they undertake their work and would need to develop new skills.

In order to embed the required culture of learning, quality improvement and partnership working throughout the HSC it will be necessary to develop Leadership and Change Management skills, critical to the successful delivery of the required transformation, across the range of health and social care staff and key independent practitioners. These skills will be delivered through the implementation of the HSC-wide Collective Leadership Strategy, and the values which underpin it. The Commissioning Plan should detail how resources will allocated to support the implementation of this work.

Key actions required of the HSC for the period 2019/20 and beyond, to support and develop the capabilities of HSC staff, are contained in the objectives set out in **Outcome 8 – Supporting and transforming the HSC workforce.**

Outcome 8: Supporting and transforming the HSC workforce

The HSC competes with other employers to secure the skills and talents of the best people. It must therefore become an employer and trainer of choice; leading by example; investing in the wellbeing of staff, and making a tangible and positive contribution to the health and wellbeing of not only health and social care staff but society as a whole.

The HSC can realise these goals through supporting the staff who deliver vital health and social care services and seeking to bring about positive change. Continued investment in training and development initiatives, along with the development of new multidisciplinary training programmes that maximise the effectiveness of the workforce will assist in achieving those outcomes.

The implementation of the Workforce Strategy will demonstrate to our health and social care workers that the transformation set out in *Delivering Together* is underway. The actions for 2019/20 described below will contribute to ensuring that an adequately-resourced and skilled workforce is available to take forward work to discharge departmental Programme for Government commitments.

Objectives/ goals for improvement

Implementing the Workforce Strategy

8.1 Contribute to delivery of Phase One of the single lead employer project by 31 July 2019 and Phase 2 by 31 January 2020; in line with the requirements set down by the Department.

Attracting, recruiting and retaining staff

8.2 By June 2019, to provide appropriate representation on the project board to establish a health and social care careers service.

Effective workforce planning

8.3 By March 2020, to have completed the first phase of the implementation of the domiciliary care workforce review.

8.4 By June 2019, to provide appropriate representation to the project to produce a health and social care workforce model.

Build on, consolidate and promote workforce health and wellbeing and staff engagement

8.5 By March 2020, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10 – 14 of the Workforce Strategy.

Supporting our staff

8.6 By January 2020, to ensure at least 50% of Trust frontline healthcare staff and at least 40% of Trust frontline social care staff have received the seasonal flu vaccine.

8.7 By March 2020, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2018/19 figure.

8.8 During 2019/2020 a workforce review of the social work workforce will be progressed to inform future supply needs and commissioning of professional training (subject to resource availability).

8.9 By March 2020, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG.

8.10 Improve take up in annual appraisal of performance during 2019/20 by 5% on previous year towards meeting existing targets (95% of medical staff and 80% of other staff).

Investing in our staff

8.11 By March 2020, 60% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2 by March 2020.

8.12 By March 2020, to have developed and commenced implementation of a regional training framework which will include suicide awareness and suicide intervention for all HSC staff with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services & mental health/addiction services) by 2022 in line with the draft Protect Life 2 strategy.

8.13 By March 2020, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts.

Associated quality and performance indicators

Sickness Absence

H1 Uptake of seasonal flu vaccine by frontline health and social care workers (as reported in PHA return to Dept).

H2 Percentage of HSC hours lost due to sick absence.

H3 Percentage of HSC staff trained in suicide awareness / prevention.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2019/20

1. The vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the vision and priorities during the year 1st April 2019 to 31st March 2020.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2019/20 financial year are resourced.

4. The objectives and indicators included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.

5. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

Department of
Finance and
Personnel
www.dfpni.gov.uk

Managing Public Money Northern Ireland

June 2008

MAHI - STM - 089 - 389

CONTENTS

CONTENTS

CONTENTS

CONTENTS

PLEASE NOTE THAT THE ANNEXES TO THIS DOCUMENT HAVE NOT BEEN PUBLISHED, AS THEY WILL BE REVISED PERIODICALLY.

THEY ARE AVAILABLE ONLINE AT **WWW.AASDNI.GOV.UK**

FOREWORD

i This document sets out the main principles for dealing with resources used by public sector organisations in Northern Ireland (NI). Its origin lies in the requirements for departments in central government, however, the same basic principles generally apply in all parts of the NI public sector, with adjustments for context as necessary. And everyone working in public services in NI should be aware of the need to manage and deploy public resources responsibly in the public interest.

ii Vital as these principles are, the advice in this document cannot stand forever. The law moves forward; the standards used in business and public life evolve; new techniques emerge; and public expectations change. Through all these shifts, the Assembly rightly expects that public funds, whether raised through taxation or public sector charges, will be used properly. And the Assembly looks to the Department of Finance and Personnel (DFP) to help the Executive and its public servants meet these expectations in a transparent, responsible and consistent fashion. So it will expect the guidance and standards in this document to be followed.

iii The duty to safeguard public funds is invariant. But how it is carried out will change over time. Public sector organisations can and should innovate in carrying out their responsibilities, using new technology and taking advantage of best practice in business efficiency. This could mean new kinds of organisation, new institutional arrangements or new delivery methods. Each will need to be evaluated and implemented carefully to protect the Assembly's rights to authorise and oversee use of public resources.

iv Nothing in this document is intended to prevent such healthy developments.

v Nor should anything in this document discourage the application of sheer common sense.

1. RESPONSIBILITIES

Under the Northern Ireland Act 1998, the relationship between the Northern Ireland Executive, exercising through ministers the executive power in transferred matters, and the Northern Ireland Assembly with legislative powers, representing the public in relation to those matters, is central to how public finances are managed. Ministers seek to implement policies and deliver public services through public servants; but are able to do so to the fullest extent only when the Assembly grants the right to commit and expend resources. It falls to the Department of Finance and Personnel to respect and secure the rights of both the Assembly and the Executive in this process (and, where appropriate, to ensure compliance with HM Treasury guidance). Resources are provided by central government and hence it is expected that the public sector in Northern Ireland will operate within the broad framework established by HM Treasury.

1.1 Managing public money: principles

1.1.1 The principles which apply to managing public resources run right across the many diverse organisations delivering public services in Northern Ireland (NI). There are requirements for each kind of body, reflecting its duties, its responsibilities and public expectations. The standards which the public services should seek to deliver are set out in box 1.1. These are generally understood to be demanding.

1.1.2 At a high level the principles in this handbook apply to public services in NI, complementing the guidance on good governance in the Code of Good Practice on Corporate Governance in Central Government Departments (the Corporate Governance Code).

Box 1.1: standards expected of all public service

- honesty
- impartiality
- openness
- accountability
- accuracy
- fairness
- integrity
- transparency
- objectivity
- reliability

carried out

- in the spirit of, as well as to the letter of, the law
- in the public interest
- to high ethical standards
- achieving value for money

1.1.3 Much of this document is about meeting the expectations of the Assembly. Many of the disciplines should also deliver accountability to the general public. The delivery channels used evolve as technology permits. Public services should carry on their businesses and account for their stewardship of public resources in ways appropriate to their duties and context.

1.2 Ministers

1.2.1 The Northern Ireland Act 1998, the Ministerial Code and the Departments (Northern Ireland) Order 1999 specify the duties and responsibilities of Ministers of the Northern Ireland Assembly.

1.2.2 The Minister in charge of a department is responsible for its policy and business. He or she:

- determines the department's policies;
- chooses which areas of business to delegate to the department's officials, and with what conditions;
- looks to the department's Accounting Officer (see chapter 3) to delegate responsibility within the department to deliver the Minister's decisions and to support the Minister in making policy decisions; and
- may also have general oversight of other bodies on whose behalf he or she may answer in the Assembly.

1.2.3 The Accounting Officer is always responsible for the organisation of the officials in the department. The Minister in the department may give directions to the Accounting Officer. Ministers are not accountable to the Accounting Officer.

1.2.4 Ministers have wide powers to make policies and to issue instructions to their officials. However, specific legislation is required to authorise expenditure of public funds to pursue their objectives (see section 2.1).

1.3 The Assembly

1.3.1 The Assembly enacts the legislation which empowers ministers to carry out their policies. It finances services for all devolved matters when it approves Requests for Resources, including approval of net cash resources, year by year[1]. Further information about this process is in the *Estimates Manual*.

1.3.2 From time to time the Assembly may examine particular policies or delivery of services. In addition, departmental committees may examine policies, expenditure, administration and service delivery in particular sectors. Of these, the Public Accounts Committee (PAC - see section 3.5) has a special role in examining financial accounts and scrutinising value for money.

1 As a devolved administration, the total amount of resources available is determined mainly by the Barnett Formula giving NI its population share of any change in spending on a comparable English programme

1.4 DFP

1.4.1 The Assembly looks to the Department of Finance and Personnel (DFP) to make sure that:

- departments use their powers only as it has intended; and
- expenditure is within the agreed limits.

1.4.2 Hence it falls to DFP to:

- set the ground rules for the administration of public money; and
- account to the Assembly for doing so.

1.4.3 This document sets out how DFP seeks to meet these Assembly expectations. The key requirements are regularity, propriety (see box 2.4) and value for money (see 3.3.3). Supporting this, DFP:

- manages the budget process;
- oversees the operation of the Estimates presented by departments to obtain authority to spend year by year. The Estimates Manual contains more detail about the requirements;
- issues any amendments to the *Government Financial Reporting Manual (FReM)* required for NI purposes setting the standards to which departments, non-departmental public bodies (NDPBs) and other parts of the public sector publish annual reports and accounts. The *FReM* adapts generally accepted accounting practice (GAAP) to take account of the public sector context; and
- sets Accounts Directions for the different kinds of central government organisations whose accounts are laid in the Assembly.

1.5 Departments

1.5.1 Within the standards expected by the Assembly, and subject to the overall control and direction of their Ministers, departments have considerable freedom about how they organise, direct and manage the resources at their disposal. It is for the Accounting Officer in each department, acting within Ministers' instructions, to control and account for the department's business.

1.5.2 The *Corporate Governance* Code encourages departments to use a departmental board as a disciplined way of leading and managing the department's business. The character and organisation of the board in a department will vary according to the nature of its business (see section 4.1). Boards can be valuable in bringing to bear a range and variety of skills and experiences from elsewhere in, and outside of, the public sector.

1.5.3 Within a department, its staff, resources and assets should be organised to deliver the agreed Programme for Government and any associated objectives. There should be adequate delegations, controls and reporting arrangements to provide assurance to the

board, the Accounting Officer[2] and ultimately ministers about what is being achieved, to what standards and with what effect. In turn these arrangements should provide the management information to enable delivery plans to be adjusted as necessary. Similar feedback should enable ministers to reconsider policies where the evidence shows that this is appropriate. This is discussed further in chapter 4.

1.5.4 In supporting ministers, civil servants in a department should provide politically impartial advice. Should they be asked to carry out duties which appear incompatible with this obligation, the Accounting Officer should take the matter up with the Minister concerned in accordance with Chapter 3 of this document (see also the NICS Code of Ethics at annex 4.2).

1.5.5 Departments often operate with and through a variety of partners to deliver their Ministers' policies. It is important that these relationships too operate in the public interest: see chapter 7.

1.6 The Comptroller and Auditor General for Northern Ireland (C&AG)

1.6.1 Supported by the Northern Ireland Audit Office (NIAO), the Comptroller and Auditor General for Northern Ireland (C&AG) helps the Assembly scrutinise how public funds have been deployed in practice. Independent of government, the C&AG is the external auditor of most bodies in central government in Northern Ireland. To help carry out this important role, the C&AG has significant and far reaching rights to inspect the books of a wider variety of public bodies. Further information about the role of the NIAO is available on their website[3] and in annex 1.1.

1.6.2 The C&AG provides the Assembly with two sorts of audit:

- financial audit of the accounts of departments, agencies, NDPBs and health and personal social services bodies, covering:
  - assurance that their accounts have been properly prepared and are free from material misstatements[4]; and
  - confirmation that the underlying transactions have appropriate Assembly authority;
- value for money reports assessing the economy, efficiency and effectiveness with which public money has been deployed in selected areas of public business. A rolling programme of these reviews covers a wide variety of subjects over a period, taking account of the risks to value for money and the Assembly's interests.

2 If there is a change of Accounting Officer in the course of the year, the Accounting Officer in place at the year end takes responsibility for the whole year's resource accounts, using assurances as necessary

3 The NIAO website address is.www.niauditoffice.gov.uk

4 See Audit Practice Note 10 of the Audit Practices Board on the FRC website at http://www.frc.org.uk

1.7 The Northern Ireland Ombudsman

1.7.1 Public sector organisations are expected to deliver reliable services of good quality. Independent of both the government and the Health Service (HS), the Northern Ireland Ombudsman[5] provides a service to the public by investigating complaints that government departments, a range of other public organisations in NI and the HS in NI have not acted properly or fairly, or have provided a poor service. The role of the NI Ombudsman is discussed further in section 4.13.

Annex 1.1 The Comptroller and Auditor General For Northern Ireland

5 This is the popular title for two offices – The Assembly Ombudsman and the Commissioner for Complaints

2. USE OF PUBLIC RESOURCES

This chapter explains the process for Assembly authorisation of public resources. The Assembly expects DFP to oversee the operation of these controls. The Assembly consents in principle to the use of public funds through legislation to enable specified policies. It approves use of public resources to carry out those policies year by year. Only in very limited circumstances can lesser authority suffice. Where there are uncertainties the Assembly should be given meaningful information about what is likely to be involved. At the close of each financial year, the Assembly expects a clear account of the use of the public funds it has authorised for use. The Public Accounts Committee (PAC) may investigate specific issues further.

2.1 Power to commit public funds

2.1.1 The Northern Ireland Departments are statutory corporations and as such have no powers except those which are conferred on them by or under statute. Even if they have the legal power to do something they will only be able to pay for it if they have the financial authority to expend the money. This must be provided through the Assembly which provides the necessary resources through the Supply Estimate system and confirming Budget Act unless, exceptionally, a statute authorises a direct charge on the NI Consolidated Fund. In the Concordat of 1932[6] (see annex 2.1) the Treasury undertook to aim that departments would respect this requirement. DFP has agreed to observe this principle. Therefore for expenditure to be properly incurred, there should be specific statutory authority for the activity or service as well as authority through the Budget Act for the related expenditure.

2.1.2 DFP controls public expenditure, therefore all legislation with expenditure implications, both primary and secondary, must have the support of DFP (see annex 2.2).

2.1.3 Box 2.1 outlines how public expenditure is controlled by DFP, authorised by the Assembly and accounted for in public. It is important to note that DFP agreement to budget provision in spending reviews does not alone provide adequate authorisation, nor does the existence of specific legal authority. Assembly approval for drawdown of funds is also essential. The Estimates process is designed to achieve this. Chapter 5 examines this further.

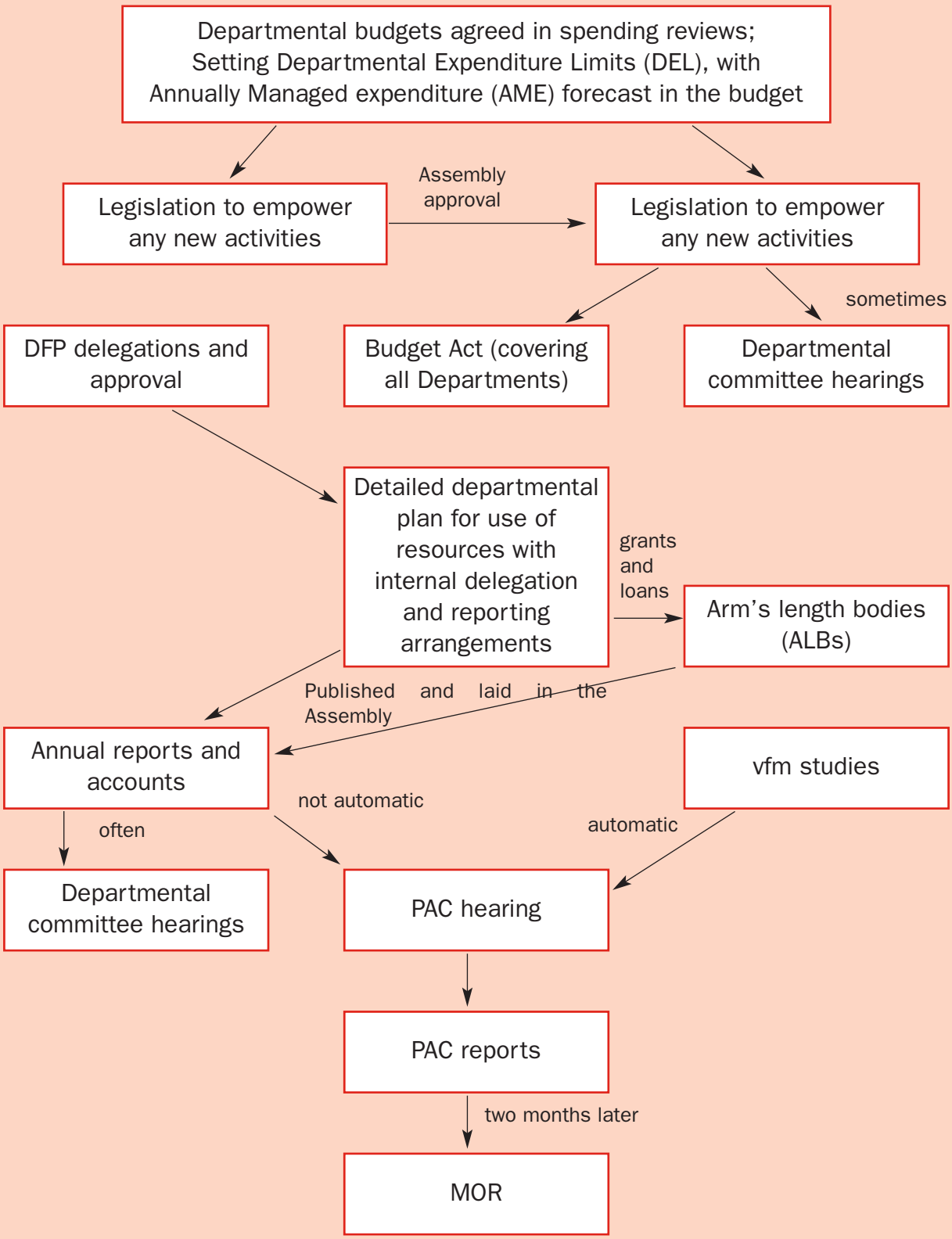
2.1.4 The Accounting Officer of a department (see chapter 3) is responsible for ensuring that:

- the Estimate(s) presented to the Assembly for the department's annual expenditure are consistent with the statutory powers and with the Executive's expenditure plans; and
- use of resources in the department is consistent with the Estimate(s);

and must answer to the Assembly for stewardship of these responsibilities.

6 Also known as the Baldwin convention

Box 2.1: Schematic account of how central government expenditure is authorised and accounted for



2.1.5 In addition, departments need DFP consent before undertaking expenditure or committing to other resource consumption. Usually DFP agrees general approvals for resource consumption subject to delegated limits and/or exclusions. This avoids the need for specific consent to each item. Some common approaches to setting delegations are suggested in box 2.2 and are discussed further in annex 2.3. Whatever form they take, it is good practice to review these delegated authorities from time to time to make sure that they remain up to date and appropriate.

2.1.6 Similarly, departments should agree with any bodies to which they provide resources, or over which they have oversight, how their resources should be used. Chapter 7 discusses how such relationships should work in greater depth.

Box 2.2: examples of approaches to delegated authorities

- objective criteria for exceptions requiring specific DFP scrutiny; and/or
- a sampling mechanism to allow specimen cases to be checked; and/or
- a threshold above which certain kinds of projects must achieve specific consent.

2.1.7 There is an important category of resource commitments for which DFP cannot delegate responsibility. It is transactions which set precedents, are novel, potentially contentious, or could cause repercussions elsewhere in the public sector - see box 2.3. Departments should always obtain DFP consent to resource commitments of this kind before proceeding, even for transactions within the agreed delegated limits which appear to offer value for money. If there is any doubt as to whether DFP approval is required, Departments should discuss the issue with DFP, as it is ultimately DFP, on behalf of the Assembly, which determines what falls into this category.

2.1.8 Some legislation calls for explicit DFP consents, e.g. for certain large projects. In such cases proceeding without DFP approval is unlawful. In other cases resource consumption without DFP approval is irregular.

2.1.9 Neither unlawful nor irregular expenditure can be authorised by Assembly approval for the relevant Estimate, so the resource account must be noted accordingly. When such expenditure comes to light, both DFP and the NIAO should be alerted. If DFP gives retrospective consent to irregular expenditure, the transaction is treated in the resource accounts as if it had achieved consent in time. Where there is a statutory requirement for DFP consent, however, retrospective authority for improper (unlawful) expenditure is not possible. Section 5.3 explores this further.

Box 2.3: some transactions requiring specific DFP consent

- extra statutory payments in settlement of legal disputes out of court
- certain private expenses of employees made necessary because of their public duties
- severance payments in excess of the employer's contractual commitment
- non-standard payments in kind
- unusual financing transactions, especially those with lasting commitments

2.2 Regularity, propriety and value for money

2.2.1 Accounting Officers must make sure that their organisations' activities achieve high and reliable standards of regularity and propriety (see HM Treasury booklet entitled "Regularity and Propriety"). These important terms, which are often used together because they are so closely linked, are defined in box 2.4.

Box 2.4: regularity and propriety

- **Regularity**: resource consumption should accord with the relevant legislation, the relevant delegated authority and this document.
- **Propriety**: patterns of resource consumption should respect the Assembly's intentions, conventions and control procedures, including any laid down by the PAC.

2.2.2 The concept of regularity and propriety is powerful. The Assembly has consistently interpreted it as delivering public sector values in the round, encompassing the qualities summarised in box 1.1. Supporting this concept are the Seven Principles of Public Life (the Nolan Principles - see annex 2.4), which apply to the public sector at large. In striving to meet these standards, central government departments should give a lead to the partners with which they work.

2.2.3 Each departmental Accounting Officer should make sure that the Minister in his or her department appreciates:

- the importance of operating with regularity and propriety; and
- the need for efficiency, economy, effectiveness and prudence in the administration of public resources, to deliver value for money.

2.2.4 Should a Minister seek a course of action which the Accounting Officer cannot reconcile with any of these requirements, he or she should seek a direction in writing from the Minister before proceeding (see chapter 3).

2.2.5 Should departments need to resolve an issue about regularity or propriety, they should consult the relevant DFP Supply Officer. Similarly, arm's length bodies (ALBs - NDPBs, companies in which the department has a significant shareholding and other sponsored bodies) should consult their sponsor departments about such issues, and the department concerned may need in turn to consult DFP.

2.3 Using the authority of the Budget Act

2.3.1 In certain limited circumstances departments may obtain authorisation for their planned expenditure not through specific empowering legislation but by relying just on the authority of the Budget Act. Such Acts cover the whole range of voted expenditure in Estimates. The Assembly does not normally authorise consumption of public resources through these instruments alone because the approval process does not provide a meaningful opportunity for detailed scrutiny.

2.3.2 The Budget Act for a given year provides Assembly approval for the year's Estimates, authorising resource consumption one year at a time. By convention, this is sufficient authority for expenditure on administration. The same convention also allows departments to seek Assembly authority to use resources one year at a time for administration where there is a more lasting commitment of some kind. Some examples are mentioned in box 2.5. The list is not exhaustive.

2.3.3 With DFP approval, it is sometimes possible to rely on the Budget Act alone for certain other expenditure in order to avoid an undue burden on the Assembly timetable. So the Assembly is routinely prepared to authorise certain expenditure through the Budget Act alone, subject to the conditions:

- the expenditure is below the threshold set by DFP (see annex 2.5.15)
- it is expected to last for no more than two years, e.g. to finance a pilot study;

and

- any existing explicit statutory limits are respected; and
- no specific legislation on the matter in question is before the Assembly (though see annex 2.5).

Box 2.5: resource use which a Budget Act may authorise

- expenditure on administration: employment costs, rent, cleaning etc
- lease agreements, eg for photocopiers
- contractual obligations to purchase goods or services (where it might be poor value for money to agree single year contracts only)
- employing staff with significant notice periods
- supporting capital projects lasting for more than a year
- staged grants phased over more than a single financial year
- resources used under prerogative powers such as international treaty obligations

2.4 New services

2.4.1 When Ministers decide on a new activity, such a new service normally requires both specific legislative authority and cover in the Budget Act. However, the authority of the Budget Act alone can suffice if the conditions in paragraph 2.3.3 are satisfied. This of course is not adequate for any new policy which is intended to last more than a couple of years.

2.4.2 Nevertheless, sometimes ministers are anxious to make an early start on a new activity which is expected to continue but for which explicit Assembly authority has not yet been secured. In these circumstances there are limited steps that can be taken to make the new service ready for delivery when the Assembly has assented. Specific Assembly consent is always required.

2.4.3 Relying on the Budget Act ahead of full and specific legal authority will often mean borrowing from the Northern Ireland Consolidated Fund under paragraph 6 of the Financial Provisions (NI) Order 1998 (see annex 2.5). Access to this Fund is controlled by DFP and cannot be assumed. To obtain such an advance the proposal must pass two main tests:

- the proposed expenditure must be genuinely urgent and in the public interest, i.e. there must be wider benefits to outweigh the convention of awaiting Assembly authority; and
- the planned legislation must be certain, or virtually certain, to pass into law, for example, the Bill must have successfully passed Second Stage in the Assembly i.e. there is an Assembly expression of support for the principle of the Bill.

Annex 2.1 The PAC concordat of 1932

Annex 2.2 DFP approval of legislation

Annex 2.3 DFP approval of Expenditure

Annex 2.4 The Seven Principles of Public Life (the Nolan Principles)

Annex 2.5 The new services rules

3. ACCOUNTING OFFICERS

This chapter sets out the personal responsibilities of all Accounting Officers, both in government departments and in other parts of central government. Essentially Accounting Officers must be able to assure the Assembly and the public of high standards of probity in the management of public funds. This chapter is drawn to the attention of all Accounting Officers when they are appointed.

3.1 Role of the Accounting Officer

3.1.1 Each organisation in central government - department, agency, trading fund, HSC body, NDPB or significant arm's length body - must have an Accounting Officer. This person is usually the senior official in the organisation. In line with the *Code of Good Practice on Corporate Governance in Central Government Departments*, it is now usual for the Accounting Officer to be supported by a board whose structure should be agreed with the responsible minister(s) where it is not set in statute. Arrangements for leadership and accountability may be slightly different in other parts of the public sector.

3.1.2 Formally the Accounting Officer is someone who may be called to account in the Assembly for the stewardship of the resources within the organisation's control. The standards the Accounting Officer is expected to deliver in the organisation are summarised in box 3.1. The senior business managers of other public sector organisations are expected to deliver similar standards.

3.2 Appointment of Accounting Officers

3.2.1 DFP appoints the permanent head of each central government department to be its Accounting Officer. Where there are several Accounting Officers in a department, the permanent head is the Principal Accounting Officer.

3.2.2 Within departments, DFP also appoints the chief executive of each trading fund as its Accounting Officer; and may also appoint Additional Accounting Officers with responsibility for certain Requests for Resources.

3.2.3 In turn the Accounting Officer of each department normally appoints the permanent heads:

- of its executive agencies, as Agency Accounting Officers for their agencies; and
- of all its NDPBs[7], and of most other significant arm's length bodies, as Accounting Officers for these bodies.

7 In certain NDPBs with small budgets, an Accounting Officer in the sponsor department may assume the role of the Accounting Officer for the NDPB, with the costs of the NDPB charged directly to the sponsor department's Estimate. This is the usual arrangement for advisory bodies and Royal Commissions.

Box 3.1: standards expected of the Accounting Officer's organisation

Acting within the authority of the Minister(s) to whom he or she is responsible, the Accounting Officer should ensure that the organisation, and any subsidiary to it or organisation sponsored by it, operates effectively and to a high standard of probity. The organisation should:

governance

- have a governance structure which transmits, delegates, implements and enforces decisions
- have trustworthy internal controls to safeguard, channel and record resources as intended
- operate with propriety and regularity in all its transactions
- treat its customers and business counterparties fairly and honestly
- offer redress for failure to meet agreed customer standards where appropriate
- give timely, transparent and realistic accounts of its business, underpinning public confidence;

decision-making

- support its Ministers with clear, well reasoned, timely and impartial advice
- make all its decisions in line with the strategy, aims and objectives of the organisation set by ministers and/or in legislation
- meet DFP's requirements about limits on use of public resources
- manage its staff fairly, with inclusive policies designed to promote and integrate diversity having regard to Section 75 of the Northern Ireland Act
- communicate its decisions openly and transparently;

financial management

- use its resources efficiently, economically and effectively, avoiding waste and extravagance
- carry out procurement and project appraisal objectively and fairly, seeking good value for the public sector as a whole
- use management information systems to secure assurance about value for money and the quality of delivery and so make timely adjustments
- avoid overdefining detail and imposing undue compliance costs, either on its own staff or on its customers and stakeholders
- have practical documented arrangements for working in partnership with other organisations
- use internal and external audit to improve its internal controls and performance.

3.3 Special responsibilities of Accounting Officers

3.3.1 It is important that each Accounting Officer takes personal responsibility for ensuring that the organisation he or she manages delivers the standards in box 1.1. In particular, the Accounting Officer must personally sign:

- the organisation's accounts;
- the annual report;
- the statement on internal control (SIC);

and, having been satisfied that they have been properly prepared to reflect the business of the organisation, must personally approve any Request(s) for Resources.

3.3.2 In the case of Accounting Officers of corporate arm's length bodies, the Accounting Officer should also arrange for a board member to sign the accounts as well, if (unusually) he or she is not a member of the board.

3.3.3 There are several other areas where the Assembly expects Accounting Officers to take personal responsibility:

- *regularity and propriety* (see box 2.4), including seeking DFP approval for any expenditure outside the normal delegations or outside the subheads of Estimates, and carried through with appropriate disclosures in the resource accounts;
- selection and appraisal of programmes and projects: using the *Green Book* (supported by *additional DFP guidance*) to evaluate alternatives, and good quality project and programme management techniques, such as Office of Government Commerce (OGC) Gateways™, to track and where necessary adjust progress;
- *value for money*: ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed to provide confidence about suitability, effectiveness, prudence, quality, good value and avoidance of error and other waste, judged for the public sector as a whole, not just for the Accounting Officer's organisation;
- management of *opportunity and risk* to achieve the right balance commensurate with the institution's business and risk appetite;
- *learning from experience*, both using internal feedback, and from right across the public sector; and
- accounting accurately for the organisation's *financial position and transactions*: to ensure that the government published financial information is transparent and up to date, and that the organisation's efficiency in the use of resources is tracked and recorded.

3.4 Advice to Ministers

3.4.1 Each departmental Accounting Officer should take care to bring to the attention of the Minister to whom he or she is responsible any conflict between the Minister's instructions and his or her duties as set out in this chapter. Examples of concerns where this procedure is appropriate are in box 3.2 but the ultimate judgement must lie with the Accounting Officer personally.

3.4.2 There is no set form for doing this, though the Accounting Officer should be specific about the nature of his or her objections and where possible set these out in writing. Before doing so it is good practice for an Accounting Officer to discuss the matter with DFP if time permits. It may also be necessary to discuss the issue with officials from the Office of First Minister and Deputy First Minister to determine if the matter needs to be brought to the Executive Committee under the terms of the Ministerial Code.

3.4.3 If, despite the Accounting Officer's advice, the Minister decides to continue with a course the Accounting Officer has advised against, the Accounting Officer should ask for a formal Ministerial Direction to proceed. This can be oral but, if so, should be confirmed in writing as soon as possible. Directions of this kind are rare but the acid test is whether the Accounting Officer could justify the proposed activity if asked to defend it.

3.4.4 Such a direction is likely to mean that the associated expenditure is novel or contentious and therefore outside of the departmental delegated expenditure. Having received a Direction from the Departmental Minister, in these circumstances, the Accounting Officer should seek DFP approval.

3.4.5 A Minister may decide, in these circumstances, that the issue should be discussed by the Executive. If this happens and a decision reached at the Executive is to agree to the course of action proposed by the Departmental Minister it will be recorded in the minutes which can be treated as formal approval. The DFP Minister, as part of the Executive, is bound by this decision and in these circumstances it is not envisaged that it will be necessary for the Accounting Officer to seek a formal written approval from DFP. If the Executive decides not to proceed the Accounting Officer should abide by the Executive's decision and not undertake any course of action which could be seen as contrary to the decision.

3.4.6 When a Ministerial Direction is confirmed by the DFP Minister or Executive Committee as appropriate, the Accounting Officer should:

- write to the C&AG with the relevant details of the issue. This correspondence should be copied to DFP. The C&AG will normally draw the matter to the attention of the PAC, who will attach no blame to the Accounting Officer;
- follow the direction without further ado; and
- if asked, explain the Ministers/Executive's course of action. This respects Ministers' rights to frank advice, while protecting the quality of internal debate.

Box 3.2: examples when Accounting Officers should seek a direction *reflecting previous cases*

- **Irregularity**: if a proposal is outside the legal powers, Assembly consents, or DFP delegations.
- **Impropriety**: if a proposal would breach Assembly control procedures.
- **Poor value for money**: if an alternative proposal, or doing nothing, would deliver better value, e.g. a cheaper or higher quality outcome.

3.5 Public Accounts Committee

3.5.1 The PAC may hold public hearings on the accounts of central government organisations laid in the Assembly (see section 1.6). In practice most PAC hearings focus on NIAO value for money studies. The PAC expects that NIAO will agree the texts of these reports with the Accounting Officer(s) of the organisation(s) concerned so there is a clear evidence base for their scrutiny to proceed.

3.5.2 When a hearing is scheduled, the PAC normally invites the Accounting Officer(s) of the relevant institution(s) to attend as witness(es). An Accounting Officer may be accompanied by appropriate officials. Where it is appropriate, and the PAC agrees, the Accounting Officer may send a substitute. In answering questions, the Accounting Officer should take responsibility for the organisation's business, even if it was delegated or if the events in question happened before he or she was appointed Accounting Officer.

3.5.3 The PAC expects witnesses to give clear, accurate and complete evidence. If evidence is sensitive, witnesses may ask to give it in private. It is also acceptable to offer supplementary notes if a witness does not have the detail to hand at the hearing. Where such notes are offered, they should be provided within two weeks and with attention to the PAC's concerns in asking for the information. If the evidence might take longer to prepare, witnesses may seek an extension. They should do so without delay.

3.5.4 The Treasury Officer of Accounts (TOA) (a DFP official who answers questions on behalf of DFP as the central department concerned with financial matters) or his/her nominee attends all PAC hearings. This allows scope for the PAC to explore any issues of more general application arising out of the subject of the hearing. Other responsibilities of the TOA are listed in Box 3.3.

3.6 When the Accounting Officer is not available

3.6.1 Each organisation must have an Accounting Officer available for advice or decision as necessary at short notice.

3.6.2 When the Accounting Officer is absent and cannot readily be contacted, another senior official should deputise. If a significant absence of more than 4 weeks is planned, the Accounting Officer, should invite DFP (or the sponsor department, as the case may be) to appoint a temporary acting Accounting Officer.

Box 3.3: Specific responsibilities of the TOA

To supply advice on:

- the principles underlying the resource accounting system;
- the responsibilities and appointment of Accounting Officers;
- the responsibilities of Finance Directors;
- policy on internal audit and the prevention of fraud;
- propriety, in terms consistent with the Assembly's requirements for the conduct of financial business and whether, and in what form, specific authority for expenditure is required;
- financial provisions in Assembly Bills affecting public funds, accounting and audit arrangements, and acceptance of contingent liabilities;
- contingent liabilities generally and on the use of commercial insurance;
- fees and charges issues; and
- the departmental use of banks

In addition the TOA is also Head of Finance Profession for the Northern Ireland Civil Service.

3.7 Conflicts of interest

3.7.1 If an Accounting Officer faces an actual or potential conflict of interest, it is essential to find a way of eliminating it. There must be no doubt that the Accounting Officer meets the standards described in box 3.1 without divided loyalties. Possible ways of managing this issue include:

- for a significant but temporary conflict, inviting DFP (or sponsor department, as the case may be) to appoint an interim Accounting Officer for the period of the conflict of interest;
- for a minor conflict, arranging for someone other than the Accounting Officer to make the key decisions on the issue(s) in question; or
- for serious and lasting conflicts, resignation.

3.8 Arm's length bodies

3.8.1 The responsibilities of Accounting Officers in departments and in ALBs are essentially very similar. But Accounting Officers in ALBs must also take account of their special responsibilities and powers. In particular, they must respect the legislation (or equivalent) establishing the organisation and the terms of the Management Statement/Financial Memorandum (MS/FM) agreed with the sponsor department. The relationship between sponsor departments and their ALBs is discussed further in chapter 7.

3.8.2 The Accounting Officer of a department which sponsors an ALB should, in addition, make arrangements to satisfy himself or herself that the Accounting Officer of the ALB is carrying out his or her responsibilities. Similarly, the Accounting Officer of an ALB with a subsidiary should have some meaningful oversight of the subsidiary. This means taking steps to gain assurance that public resources in the ALB, or its subsidiary, are being managed to appropriate standards (see box 3.1). It is not acceptable to establish ALBs, or subsidiaries to ALBs, in order to avoid or weaken Assembly scrutiny.

3.8.3 The MS/FM agreed between an ALB and its sponsor always envisages the sponsor department exercising meaningful oversight of the ALB's strategy and performance, pay arrangements and/or major financial transactions, e.g. by monthly returns, standard delegations, exception reporting or other techniques. ALBs should refer to their sponsor departments any activities which appear novel, contentious or repercussive; in turn the sponsor department may need to seek DFP consent.

3.8.4 There are some sensitivities about the role of the Accounting Officer in an ALB which is governed by an independent board, e.g. a charity or a company. The Accounting Officer, who will normally be a member of the board, must take care that his or her personal responsibilities do not conflict with his or her duties as board member. In particular, the Accounting Officer should vote against any proposal which appears to cause such a conflict; it is not sufficient to abstain.

3.8.5 Moreover, if the chair or board of such an ALB is minded to instruct the Accounting Officer to carry out some course which appears inconsistent with the standards in box 3.1, then the Accounting Officer should make his or her reservations clear, preferably in writing. If the board is minded nevertheless to proceed, the Accounting Officer should then:

- inform the Accounting Officer of the sponsor department without undue delay who will need to consider intervening to resolve the difference of view, preferably in writing;
- if the board's decision stands, seek its written direction to carry it out, asking the sponsor department to inform DFP;
- proceed to implement without delay; and
- inform the C&AG of what has happened.

3.8.6 This process is similar to what happens in departments (section 3.4), allowing for the special position of the organisation's board, which will often have been appointed under statute.

3.9 In the round

3.9.1 It is not realistic to set firm rules for every aspect of the business with which an Accounting Officer may deal. Sometimes the Accounting Officer may need to take a principled decision on the facts in circumstances where precedents are of limited value. Should that happen, the Accounting Officer should be guided by the standards in box 3.1, adapted if need be to suit the issue. Where time permits, DFP stands ready to help Accounting Officers think through and decide upon an appropriate course of action.

4. INTERNAL MANAGEMENT

This chapter discusses how public sector organisations should manage their governance, systems and processes. In general it is for each public sector organisation to define its own standards within the policy framework set by ministers and public expectations of public services, including openness about governance and public sector activities generally. There are some specific requirements for central government organisations, notably reporting to the Assembly.

4.1 Governance structure

4.1.1 Each public sector organisation needs explicit arrangements for its internal governance, complemented by appropriate accountability. Most will have some key ground rules laid down in statute or by convention. But significant discretion usually remains. Those running the organisation should make, and then periodically review, decisions about how in practice the organisation should operate.

4.1.2 Box 4.1 contains a checklist of decisions that the governing body of each public sector organisation should take to clarify how it should operate. In a government department this will be for the management board or its equivalent; in many ALBs it will be for a statutory board of some kind.

Box 4.1: checklist of key governing body decisions

- its role and responsibilities
- its remit and objectives
- the scope of its delegations
- its procedures and processes
- arrangements for monitoring performance and reporting back
- control and management of relationships with ALBs and other partners
- the organisation's risk appetite and risk control procedures
- how it should account for its decisions and actions – to its Ministers, to its staff, and to the wider public
- how, and how often, its membership should be refreshed to furnish the desired skill set
- how, and how often, it should review its working practices

4.1.3 In central government departments, it may be necessary to clear these decisions with ministers. It is good practice to document the chain of responsibilities and the processes by which they will be delivered. There should be clear records of the processes for reporting to the board, taking forward board decisions, and resolving disputes and uncertainties.

4.1.4 In central government departments, the board should be guided by the *Corporate Governance Code*. In particular, the board of a central government department should include a professional finance director (FD) (see guidance in annex 4.1). With appropriate adjustments, the same principles should apply in other kinds of organisation in the public sector.

4.1.5 The governing body of each public sector organisation should have clear arrangements for resolving disputes, including any concerns that the Accounting Officer may have. It should always be possible for the Accounting Officer to seek a written direction, if need be, from the appropriate authority, e.g. the Minister in the case of a department. Sections 3.4 and 3.8 expand on this.

4.1.6 It is good practice to define the roles of the different kinds of board members, typically:

- executives drawn from the organisation's staff;
- executives from operationally independent internal units, e.g. people from agencies within a department;
- non-executives from connected organisations, e.g. people from NDPBs (or other ALBs) sponsored by a department;
- independent non-executives, among whom a senior non-executive may be appointed as primary spokesperson; or
- (sometimes) members with specific responsibilities, e.g. for regional or professional issues.

4.2 Processes

4.2.1 Each public sector organisation should strive to attain and maintain the standards described in box 3.1, adopting or adapting good modern commercial practice where it makes sense to do so. The *NICS Code of Ethics* (annex 4.2) shows what is expected of civil servants. Annex 4.3 sets out some standards against which services may be judged in the event of failure of delivery or complaint.

4.2.2 Each public sector organisation should have robust and effective systems for decision making. Box 4.2 sets out some key essentials. Some organisations may require special additional processes, e.g. where it is important to integrate scientific, artistic or other professional standards with administrative procedure.

4.2.3 A key concept in the use of public funds is achieving value for money. It bears on nearly all aspects of deployment of public resources: procurement, asset management, disposals, administrative systems and financing arrangements such as leases and PFI transactions. This means finding solutions which achieve the best mix of quality and effectiveness for the least outlay. This may not always mean choosing the immediately cheapest option since, for instance, it may be more cost effective to buy a more reliable service or a better quality asset with lower maintenance costs and a longer operating life. The Executive's policy on procurement is to achieve "best" value for money having regard to the twelve guiding principles which govern the administration of public procurement in Northern Ireland. The concept of "best" value for money is defined as "the optimum combination of whole life cost and quality (or fitness for purpose) to meet the customer's requirements". This allows a public body to compile a procurement specification which includes social, economic and environmental policy objectives within the procurement process. More guidance on procurement can be found in annex 4.4.

4.2.4 As part of reaching and maintaining high standards of ethical behaviour, all central government organisations should support DFP in meeting its obligations under the Concordat (see annex 2.1). It is important that they are able to provide timely and accurate information to DFP about their planned and actual use of public funds (see section 5.1). So:

- departments should provide DFP with high level information about in-year developments of their expenditure, performance against objectives and evolution of risk (e.g. serious unforeseen events or discovery of proven or suspected fraud);
- ALBs should provide their sponsor departments with similar information; and
- the established mechanisms for controlling and reporting public expenditure, including DFP support or approval where necessary, should be respected.

Box 4.2: essentials of effective internal decision making

choice

- active management of the portfolio of risks and opportunities, drawing on the Orange Book
- appraisal of alternative courses of action using the techniques in the Green Book (supported by *additional DFP guidance*), and including assessment of feasibility
- where appropriate, use of pilot studies to provide evidence on which to make decisions among policy or project choices
- active steering of initiatives, e.g. using Gateway™ reviews to help guide progress at critical points of projects

operation

- appropriate internal delegations
- regular and meaningful management information on costs (including unit costs), efficiency, quality and performance against targets to enable assessment of value for money
- proportionate administration and enforcement mechanisms, without unnecessary complexity
- periodic assessment of whether decisions taken remain appropriate, drawing on feedback from internal and external audit and elsewhere
- systematic iterative appraisal of risk, to track changes and make adjustments in response

afterwards

- after the event evaluation of policy, project and programme outputs and outcomes, including whether to continue, adjust or cease any lasting activities
- arrangements to draw out and propagate lessons from experience

4.2.5 In particular, departments should consult DFP (and ALBs their sponsor departments) at an early stage about proposals to undertake unusual transactions or financing techniques. This applies especially to any transactions which may have wider implications elsewhere in the public sector (see paragraph 2.1.7 and box 2.3).

4.2.6 One such class of transactions is those involving tax planning or tax avoidance on the part of the supplier, often in the context of procurement. Generally, public sector organisations should avoid using tax advisers or tax avoidance schemes as any apparent savings can only be made at the expense of other taxpayers or other parts of the public sector.

4.2.7 It is important to assess the impact on the public sector as a whole in considering proposals for non-standard tax treatment. It is good practice to seek expert advice from Her Majesty's Revenue and Customs (HMRC) before proceeding. DFP approval is nearly always required because such transactions tend to be novel, contentious, or both (see section 2.1). Annex 4.4 discusses this further.

4.3 Opportunity and risk

4.3.1 Embedded in each public sector organisation's internal systems there should be arrangements for recognising, managing and tracking its opportunities and risks. Each organisation's governing body should make a considered choice about its desired risk profile, taking account of its legal obligations, Ministers' policy decisions, its business objectives, and public expectations of what it should deliver. This can mean that different organisations take very different approaches to the same risks.

4.3.2 There should be a regular discipline of reappraising the opportunities and risks facing the organisation as both alter with time and circumstances, as indeed the chosen responses may do too. In the public sector there is a common risk to reputation, since poor performance could undermine the credibility, and ultimately the creditworthiness, of the public sector as a whole. It is also important to be aware that excessive caution can be as damaging as unnecessary risk taking.

4.3.3 Decisions on how to control and manage risk generally draw from the five standard responses outlined in box 4.3. In choosing among them, factors to consider include cost, feasibility, probability and the potential impact. For routine processes, it is a good discipline to consider building in safeguards to manage risk out, or at least downwards, so that some protection is automatic. For other risks, it can be useful to consider the scope for risk sharing, or for copying or adapting the conditions imposed by commercial insurers, who often keep their premiums down by reducing risk potential.

4.3.4 Evidence from internal and external audit is especially valuable for those making decisions about how to manage and control opportunity and risk. Audit can provide specific, objective and well-informed insight to help an organisation evaluate its effectiveness in achieving the outcomes it seeks. It can be helpful for the audit committee to advise the governing board of a public sector organisation on the key decisions it must make on governance and managing opportunities and risks. In turn the board should support the Accounting Officer in drawing up the Statement on Internal Control (SIC), which forms part of the resource accounts. Further information on this important discipline is in the *Orange Book*.

Box 4.3: responses to risk

- **take opportunities**: for circumstances where the potential gain seems likely to outweigh the potential downside
- **tolerate**: for unavoidable risks, or those so mild or remote as to make avoidance action disproportionate or unattractive
- **treat**: for risks that can be reduced or eliminated by prevention or other control action
- **transfer**: where another party can take on some or all of the risk more economically or more effectively, e.g. through insurance, sharing risk with a contractor, or management techniques such as public-private partnership
- **terminate**: for intolerable risks, but only where it is possible for the organisation to exit (note that some risks can only be assumed by the public sector)

4.4 Insurance

4.4.1 It is generally not good value for money for central government organisations to take out commercial insurance. This is because the public sector has a wide and diversified asset portfolio as well as a reliable income by virtue of the ability to raise revenue through taxation. So the public purse is uniquely able to finance the repair or replacement of damaged assets or deal with other crystallised risks, even very large ones. If the government were to insure its large range of risks, it would add to its costs, even allowing for the expense of remedying damage, because it would also have to meet the costs and profit margins of the commercial insurers.

4.4.2 However, there are some limited circumstances in which it is appropriate for public sector organisations to insure. They include legal obligations (such as public liability insurance) and, depending on the circumstances, wider markets activities (see section 7.11). In the latter case, it is important that the value or availability of public assets is not damaged by activities outside statutory requirements. Further information about insurance generally is in annex 4.5.

4.5 Control of expenditure

4.5.1 DFP coordinates a system through which departments are allocated administrative control totals for their public expenditure. Each department's allocation covers its own spending and that of its associated ALBs. Within the agreed totals, it has considerable discretion over setting priorities to deliver the public services for which it is responsible. Public sector organisations should keep their use of public resources within the agreed budgets, and take them into account when entering into commitments.

4.5.2 Public sector organisations should also ensure that their use of resources is properly authorised and controlled. The nature of these arrangements will depend on the range of payments to be made, the techniques available and the risks to be managed (annex 4.6 provides advice on types of payments). It is good practice to review these systems from

time to time to check that they are fit for purpose and deliver good value. A checklist of essential features is at box 4.4. Advice about countering and dealing with fraud is at annex 4.7.

Box 4.4: essentials of systems for committing and paying funds

- Internal controls to provide authority for acquiring the goods or services to be purchased (including controls on new suppliers), within any legal constraints.
- Authorisation for payment separated from the process of making the payment, with appropriate validation and recording at each step.
- Checks that the goods or services acquired have been supplied in accordance with the relevant agreement(s) before paying for them.
- Payment terms chosen or negotiated to provide good value.
- Invoices paid accurately when mature, once and on time, avoiding late payment penalties.
- A balance of preventive and detective controls to tackle and deter fraud, corruption, etc.
- Audit trails, which can readily be checked and reported upon both internally and externally.
- Periodic reviews to bring to bear any lessons from internal audit examination or other relevant experience, or to implement developments in good practice.

4.5.3 Where an organisation discovers an underpayment, the deficit should be made good as soon as is practicable and in full. If there has been a lapse of time, for example caused by legal action to establish the correct position, it may be appropriate to consider paying ex gratia interest, depending on the nature of the commitment to the payee and taking into account the reputation of the organisation and value for money for the public sector as a whole (see also section 4.11).

4.6 Receipts

4.6.1 Similarly, public sector organisations should have arrangements for identifying, collecting and recording all amounts due to them promptly and in full. Outstanding amounts should be followed up diligently. Key features of internal systems of control are suggested in box 4.5.

Box 4.5: essential features of systems for collecting sums due

- Adequate records to enable claims to be made and pursued in full.
- Routines to prevent unauthorised deletions and amendments to claims.
- Credit management systems to manage and pursue amounts outstanding.
- Controls to prevent diversion of funds and other frauds.
- Clear lines of responsibility for making decisions about pressing claims increasingly more firmly, and for deciding on any abatement or abandonment of claims which may be merited.
- Decisions about any fees and charges made in line with the principles in chapter 6.
- Audit trails which can readily be checked and reported upon both internally and externally.

4.7 Unusual circumstances

4.7.1 Sometimes public sector organisations face a dilemma in dealing with transactions in public funds. They may have a legal or business obligation which it would be uneconomic or inappropriate to carry out assiduously to the letter. In such cases it may be right to seek a just, pragmatic and transparent alternative approach, appropriately reported to the Assembly and set out in the organisation's report and accounts. One-off schemes of this kind are nearly always novel and so require DFP approval, not least because they may also require legislation or have to rest on the authority of the Budget Act. Box 4.6 suggests precedented examples.

Box 4.6: examples of one-off pragmatic schemes

- A court ruling could mean that a public sector organisation owed each of a large number of people a very small sum of money. It might cost more to set up and operate a payment scheme than the total payable. The organisation could instead make one-off donation(s) equal to the sum outstanding to one or more charities connected with the recipient group.
- A dispute with a contractor might conclude that the contractor owed a public sector body an amount too big for it to meet in a single year while staying solvent. The customer organisation might agree more favourable payment terms for the remainder of an existing contract instead, provided it was satisfied that this arrangement would be value for money, and with appropriate safeguards.

4.8 Dealing with initiatives

4.8.1 Public sector organisations need to integrate all the advice in this handbook when introducing new policies or planning projects. Each is unique and will need bespoke treatment. The checklist in box 4.7 may help to bring all the different factors together. It applies primarily to central government organisations but the principles will be of value elsewhere.

Box 4.7: factors to consider when planning policies or projects

design

- Has the proposal been evaluated against alternative options, including doing nothing?
- Is there a case for pilot testing before full roll out?
- Are the controls documented clearly?
- Have the risks and opportunities been considered systematically? How will they be managed? Is the process resilient to shocks? What contingencies might arise?
- Is the intended policy proportionate to the perceived need for intervention?
- Will the outcome(s) to be delivered achieve adequate standards?
- Could the proposal be simplified without loss of function?
- If it is to operate with one or more partners, is the allocation of responsibilities documented?
- Will the proposal be efficient, effective and offer good value for money?
- Is the policy sustainable in the broadest sense? Should it have a sunset clause?
- Does the planned activity meet high standards of probity, integrity and honesty?
- Will the proposal deliver the desired outcome to time and cost in a feasible fashion?

control

- Is the proposal empowered in legislation? If not, what steps are needed to secure the necessary vires?
- Is the policy or project within European law, including limits on state aids?
- How will the proposal be financed? Is there budget and Estimate cover?
- Is the proposed action within the department's delegated authorities?
- What DFP agreement is required, if any?
- How will the internal governance and delegation work? Will it be effective? Is it transparent?
- What financial techniques will be used to manage rollout and implementation?
- Are project and programme management techniques likely to be useful?
- How will the intended new arrangements be monitored and efficiency measured?

- Are there arrangements to use feedback to improve outcomes?
- What safeguards are planned to encourage proper and accurate use of resources, prevent misuse and counter fraud?
- How will the associated risks be tracked and the responses adjusted?
- What intervention will be possible if things go off track?

accountability

- Should the Assembly/Executive/Departmental Committee be told of the proposal? If so how?
- How will the Assembly/Executive/Departmental Committee be kept informed of progress?
- What targets will be used? Are they stretching? Do they need to be linked to any PSAs?
- Should there be customer standards? Should there be feedback to learn from complaints?
- Should there be arrangements for redress after poor delivery?
- Is enforcement required? If so, is it proportionate?
- Is public access called for? How?
- Will any new policy or service be administered and enforced openly, fairly and impartially?
- Is an appeal mechanism needed?
- Is any regulatory oversight called for?

learning lessons

- What audit arrangements (internal and external) are intended?
- What information about and records of the activity will be published? How and how often?
- When and how will the policy or project be evaluated to assess its cost and benefits and to determine whether it should continue, be adjusted, replaced or ceased?

4.9 Staff

4.9.1 Each public sector organisation should have sufficient staff with the skills and expertise to manage its business efficiently and effectively. The span of skills required will depend on its objectives, responsibilities and resources. There should be an appropriate balance between those with professional, practical or operational skills and policy makers, recognising the value of each discipline. Succession and disaster planning should ensure that the organisation can cope robustly with changes in the resources available, including unforeseen disruption.

4.9.2 Public sector organisations should seek to be fair, honest and considerate employers. Some desirable characteristics are suggested in box 4.8.

Box 4.8: public sector organisations as good employers

- fairness, integrity, honesty, impartiality and objectivity
- clear lines of reporting and responsibility
- equal access to development opportunities to make good use of staff potential
- diversity valued and personal privacy respected
- processes to identify and deal with poor performance
- discipline to underpin the department's integrity
- mechanisms to support efficient working practices, both normally and under pressure
- arrangements for whistle blowers to raise worries privately without personal repercussions

4.9.3 Similarly, public sector employers have a right to expect good standards of conduct from their employees. The qualities and standards expected of civil servants are set out in the *NICS Code of Ethics* (annex 4.2). Other public sector employees should strive for similar standards, appropriate to their context.

4.10 Assets

4.10.1 All public sector organisations own or use a range of assets. Each organisation needs to devise an appropriate asset management strategy to define how it acquires, maintains, tracks, deploys and disposes of the various kinds of assets it uses. Annex 4.8 discusses some features that are usually worth covering in such a strategy.

4.10.2 An important part of asset management is good procurement delivering best value for money. Public sector organisations should normally acquire goods and services through fair and open competition, having regard to the twelve guiding principles which govern the administration of public procurement in Northern Ireland and using the guidance on procurement which is issued by the Central Procurement Directorate (CPD) to determine best

practice. Annex 4.4 offers further advice on techniques. It is important to ensure that procurement is in line with European law, including restrictions on state aids, discussed further in annex 4.9.

4.10.3 It is good practice for public sector organisations to take stock of their assets from time to time and reconsider whether they are being used efficiently. If there is irreducible spare capacity there may be scope to use part of it for other government activities, or to exploit it commercially for non-statutory business - sometimes called wider markets activity. These can generate additional income for the organisation, improving its efficiency (see section 7.11).

4.11 Non-standard transactions

4.11.1 From time to time public sector organisations may find it makes sense to carry out transactions outside the usual planned range, e.g.:

- write-offs of unrecoverable debts or overpayments;
- recognising losses of stocks or other assets;
- long term loans of assets; or
- gifts of assets.

4.11.2 In each case it is important to deal with the issue in the public interest, with due regard for probity and value for money. Annexes 4.10 to 4.13 set out what is expected when such transactions take place in central government, including notifying the Assembly.

4.11.3 Similarly, public sector organisations may have reason to carry out current transactions which would not normally be planned for. These might be:

- extra contractual payments to service providers;
- extra-statutory payments to claimants;
- ex gratia payments to customers; or
- severance payments to employees leaving voluntarily before retirement or the end of their contract.

4.11.4 Again it is important that these payments are made in the public interest, objectively and without favouritism. The disciplines the Assembly expects of central government entities are set out in annex 4.13, which explains the notification procedure to be followed for larger one-off transactions of this kind. The steps to be considered when setting up compensation schemes, both statutory and ex gratia, are discussed in annex 4.14. In most cases DFP approval will be required for such transactions as they would fall within the definition of “novel or contentious”.

4.12 Standards of service

4.12.1 The Assembly and the public do not find poor quality public services acceptable. Public sector organisations should therefore define what their customers, business counterparties and other stakeholders can expect of them.

4.12.2 Standards of this kind can be expressed in a number of ways. Examples include guidelines (e.g. response times), targets (e.g. take-up rates) or a collection of customer rights in a charter. In central government these will sometimes be defined in departmental strategic objectives or public service agreements (PSAs). Even where standards are not set explicitly, they may sometimes be inferred from the way the provider organisation carries out its responsibilities.

4.12.3 Whatever standards are set, they should be defined in a measurable way, with plans for recording performance, so that delivery can be readily gauged. It is good practice to use customer feedback, including from complaints, to reassess from time to time whether they remain appropriate and meaningful to customers.

4.12.4 Where public sector organisations fail to meet their standards, or where they fall short of reasonable behaviour in relation to those they do business with, it may be appropriate to consider offering remedies. These can take a variety of forms, including apologies, restitution (e.g. supplying a missing licence) or in more serious cases financial payments beyond what the law or contract strictly requires. When deciding whether financial remedies might be appropriate, each organisation should consider the legal rights of the other party or parties, the potential effects on its reputation and the impact on its future business.

4.12.5 When central government organisations consider making such payments, whether statutory or ex gratia, they should follow the guidance in annex 4.14. Any schemes of financial redress which are unusual or could have implications elsewhere should be discussed with DFP before commitments are made, just as with any other public expenditure out of the normal pattern (see sections 2.1 and 2.2).

4.13 Complaints

4.13.1 The Northern Ireland Ombudsman is the popular name for two offices, the Assembly Ombudsman and the Northern Ireland Commissioner for Complaints. He/she investigates complaints that government departments, a range of other public organisations in NI (including the Health Service in the role of Commissioner for Complaints) have not acted properly or fairly, or have provided a poor service. In the light of the investigation of a case, the NI Ombudsman decides whether those complaining have suffered injustice or hardship because of maladministration or service failure, and whether any injustice or hardship has been, or will be, remedied. The NI Ombudsman's view is final, subject to judicial review by the courts.

4.13.2 Where maladministration or service failure is found, the NI Ombudsman may recommend that the public organisation concerned should provide redress for those complaining, and for any others who may have suffered in the same way. Further guidance about redress is at annex 4.14. Departments proposing to reject an Ombudsman recommendation should consult OFMDFM before doing so, copying the correspondence to their DFP Supply Officer. If the NI Ombudsman considers that the injustice has not been, or will not be, remedied, he/she may lay a special report before the Assembly. The power to make a special report is not available to the NI Ombudsman in his/her role as Commissioner for Complaints.

4.13.3 There are a number of other organisations charged with investigating complaints and recommending further action where it is merited. Some of these are also called Ombudsmen. In general they operate according to similar principles to those governing the NI Ombudsman, though not with the same reporting arrangements to the Assembly.

4.13.4 Further information on the role of the NI Ombudsman can be found at http://www.ni-ombudsman.org.uk/index.htm .

4.14 Transparency

4.14.1 All public sector organisations should operate as openly as is compatible with the requirements of their business. In line with public rights under the Freedom of Information Act 2000, the Data Protection Act 1998, the Environmental Information Regulations 2004, and the Re-use of Public Sector Information Regulations 2005, they should make available timely information about their services, standards and performance. This material should strike an appropriate balance between protecting confidentiality and open disclosure in the public interest. It is good practice to adopt a publication scheme routinely offering information about the organisation's activities.

4.14.2 All public sector organisations should also publish regular information about their plans, performance and use of public resources. For instance, box 4.9 shows what is expected of central government departments.

Box 4.9: annual publications by central government departments

- Estimates
- resource accounts, including a Statement on Internal Control and a management commentary (including a statement on corporate governance), subject to DFP direction

4.14.3 In certain areas of public business it is also important or desirable to provide adequate public access to physical assets. Unnecessary or disproportionate restrictions should be avoided. Managed properly, this can be a valuable mechanism to promote inclusion and enhance public accountability.

5. FUNDING

This chapter explores the means by which central government organisations may obtain funds, and the framework for controlling expenditure so financed. In line with the Concordat, DFP operates disciplines to respect the Assembly's concern to prevent unauthorised expenditure.

5.1 The framework for public expenditure control in NI

5.1.1 Departments' centrally allocated budgets for use of resources (see para 4.5.1) are split into resource and capital totals. Each department's budget is in turn split between a departmental expenditure limit (DEL) and annually managed expenditure (AME). The totals of DEL and AME together make up total managed expenditure (TME). More information is in box 5.1.

Box 5.1: elements of resource budgets

Departmental expenditure limits (DEL): provision planned and managed over three years, with some scope (subject to DFP agreement and rules) for carrying forward unspent provision into future years. Usually comprises most of each department's resource budget. Includes limits on near-cash expenditure and on the cost of administration.

Annually managed expenditure (AME): expenditure which is not as readily controlled as DEL is, but which must be budgeted for each year, including social security expenditure

Both DEL and AME may include capital and current resource provision.

5.1.2 In turn each central government department allocates its budget among its own responsibilities, cascading provision appropriately to those which receive grants from it, e.g. NDPBs. Annex 5.1 discusses the principles on which grants (for specific purposes) and grants-in-aid (unspecific support) should be based. In general it is sensible to consider arrangements for protecting the public purse through clawback of specific grants should the purposes for which they are agreed not materialise (annex 5.2).

5.1.3 Within the resource budgeting framework, a variety of mechanisms are used to encourage the wise and effective deployment of public expenditure to meet the Assembly's objectives including:

- *administration budgets*: limiting the amount of resource DEL provision that can be used for basic support services such as salaries;
- *asset management strategies (including the Investment Strategy for NI)*: plans to build and manage capital assets through investment;
- *public service agreements (PSAs)*: performance targets for public services, such as waiting times or educational standards.

5.1.4 The budgeting framework is explained in the *Consolidated Budgeting Guidance* and the current In-year Monitoring of Public Expenditure Guidelines.

5.2 Estimates

5.2.1 The agreed departmental budgets do not of themselves confer authority to spend or commit resources. That requires Assembly agreement through the Estimates process and the Budget Acts. Departmental Estimates containing one or more Requests for Resources (RfRs) are put to the Assembly covering one financial year at a time. In turn many departments' Estimates also contain provision for cash and other resources to finance their ALBs through grants or loans.

5.2.2 Once agreed, the Estimates become the expenditure limits voted by the Assembly, set in the Budget Acts. These provide the legal authority for public expenditure within the ambit of each RfR. The ambit describes the activities on which expenditure is permitted by the RfR. There is some scope for transferring (viring) provision from one section or subhead to another within the same RfR. Details are in the *Estimates Manual*.

5.2.3 Agreed Estimate provision for one year cannot be carried forward to the next. If a department needs to spend resources it did not consume in a previous year, and provided the budget will bear it, authority to spend in a subsequent year must be requested afresh. Annex 5.3 explains the treatment of receipts, in particular when they can score as accruing resources, so reducing the gross provision for resource consumption for which Assembly approval must be sought.

5.2.4 There are some limited exceptions to the need for Estimates, the main one being various NICF Standing Services.

5.2.5 The annual expenditure which the Assembly authorises in Estimates is not calculated in quite the same way as multi year resource budgets. Annex 5.4 explains how the two are related. Detailed information on the operation of Estimates is in the *Estimates Manual*.

5.3 Excess votes

5.3.1 Accounting Officers have an important role in overseeing the overall accuracy of the presentation of the RfRs for which they are responsible. In particular, Accounting Officers are responsible for ensuring that actual spending is within the ambit of each RfR, is regular (see box 2.4), and does not exceed the amount of Estimate provision. DFP presents the Assembly each year with a Statement of Excesses to request retrospective authority for the unauthorised resources (or cash or income) consumed above the relevant limits.

5.3.2 This statement identifies two kinds of excess expenditure:

- expenditure outside the ambit (EOTA)
- spending above the amount provided in an RfR.

5.3.3 The Assembly would regard EOTA as particularly unsatisfactory because it means that the department concerned has flouted the intentions that the Assembly has set in statute. It is important to note that an RfR may be noted for EOTA for any excess not covered by suitable statutory powers, even if the total amount spent does not exceed the Budget Act limit.

5.3.4 Expenditure in excess of provision is also to be avoided since the authority of the Budget Act is required just as much as specific statutory authority. It is possible, with DFP agreement, to raise the amount in an RfR during the course of the year through a Supplementary Estimate. But if need be, Accounting Officers should reduce or postpone use of resources to keep within the provision the Assembly has agreed.

5.3.5 The C&AG reports both kinds of excess vote to the Assembly. The PAC may examine the responsible Accounting Officers to see whether there is evidence of some underlying weakness of control.

5.4 Commitments

5.4.1 Just as Assembly authority is required for use of public funds in a given financial year, so the Assembly also expects advance notice of any commitment to the future use of public funds for which there is no active request for resources through Estimates.

5.4.2 Ministers may agree policies with financial implications without statutory authority, but in time they translate into resource consumption. So all commitments should be scrutinised and appraised as stringently as specific proposals for resource consumption (box 4.7 may help). It is essential for departments to have budget cover and DFP agreement before going firm. It is best practice then to obtain statutory authority before entering into all commitments to future deployment of public resources

5.4.3 As the Concordat (annex 2.1) notes, the Assembly is not bound to honour commitments unless and until there are statutory powers to meet them and it authorises public funds to finance them in a given year. So it is essential to give the Assembly prompt and timely notice of any significant commitments, including contingent liabilities (above a specified threshold) into which the department or its bodies intends to enter. This is especially important if the business in question is outside the department's existing statutory powers. The process for informing the Assembly is set out in annex 5.5.

5.4.4 The general rule is to err on the side of caution in keeping the Assembly informed of emerging contingent liabilities. It is impossible to generalise about every possible set of circumstances but some guidance is in box 5.2.

5.5 Public dividend capital

5.5.1 Certain public sector businesses, notably trading funds, are set up with public dividend capital (PDC) in lieu of equity. Like equity, PDC should be serviced, though not necessarily at a constant rate. PDC is not a soft option: in view of the risk it carries, it should deliver a rate of return comparable to commercial equity investments carrying a similar level of risk. There is scope for the return to vary to reflect market conditions and investment patterns; but persistent underperformance against the agreed rate of return should not be tolerated.

Box 5.2: contingent liabilities: notifying the Assembly

- The Assembly should be notified of uncertain liabilities in a way that is meaningful without attempt at spurious accuracy. It is good practice to notify the Assembly if the estimated liability changes significantly, or can be clarified.
- If a contingent liability affects several departments but cannot confidently be allocated among them, the relevant Minister should inform the Assembly in a way which offers pragmatic information while recognising the scope for variation.
- If, exceptionally, the liability needs to remain confidential, the Minister should inform the chairs of the relevant departmental committees and the PAC; then inform the Assembly openly if the need for confidentiality lifts.
- Ministers should inform the Assembly if an NDPB assumes a contingent liability which it could not absorb within its own resources, since the risk ultimately lies with the sponsor department's budget.

5.5.2 A department needs specific statutory power to issue PDC to an arm's length body, together with Estimates cover to pay it out of the NICF. Sometimes instead of a specific issue of PDC, the legislation establishing (or financially reconstructing) a public sector business deems an issue of PDC to the new business. Dividends on PDC, and any repayments of PDC, are paid to the sponsor department of the business.

5.5.3 Further information about the use of PDC is in section 7.5 (trading funds) and in the *Estimates Manual*.

5.6 Borrowing by public sector organisations

5.6.1 Some public sector organisations, e.g. certain trading funds, are partly financed through loans provided through the sponsor department's Estimate "Voted Loans"; or from the NICF. DFP consent and specific legal powers are always required. Limits and other conditions are common. Further discussion is at annex 5.6.

5.6.2 Every loan by a department should be made with reasonable expectation that it will be serviced and repaid on the agreed schedule. Departments are responsible for scrutinising borrowers' creditworthiness, not relying solely on their track record. If timely repayment could not realistically be expected, the loan could be unlawful. Should a sponsor department become aware of concerns about the security of outstanding loans, it should warn DFP promptly and consider what action it can take to minimise any potential loss.

5.6.3 Arrangements for borrowing mirror closely those that apply in Great Britain and are subject to change. Details of these at any point in time can be obtained from Government Accounts Branch in DFP which should also be consulted on any proposals for premature repayment.

5.6.4 As a general rule, departments should ensure that they obtain specific statutory powers to make loans. Departments are also responsible for ensuring that the borrower has any necessary statutory authority to borrow. Such loans should be made not only on the sole

authority of the Budget Act but also only where the conditions specified by Government Accounts Branch within DFP would be satisfied and with the prior approval of the relevant Supply Officer in DFP.

5.6.5 Departments should consult the appropriate Supply Officer about any proposals for the premature repayment of loans.

5.6.6 The treatment of repayments and interest payments in Estimates and resource accounts is discussed in the *Consolidated Budgeting Guidance*, the *Estimates Manual* and the *FReM*. DFP also accounts for NICF transactions in the Public Income & Expenditure Account. Any proposed write-offs must be notified to the Assembly after obtaining DFP agreement: see annex 5.6.

5.7 External borrowing

5.7.1 Public sector organisations may borrow from private sector sources only if they can achieve better value for money for the public sector as a whole by doing so. In practice it is usually difficult to satisfy this condition unless efficiency gains arise in the delivery of a project because of the introduction of externally raised debt (e.g. PFI). DFP Supply agreement to any such borrowing for ALBs is essential, and must be justified on value for money grounds. Nevertheless it can sometimes be expedient for public sector bodies to borrow short term, for example by overdraft.

5.7.2 When a sponsor department's ALB borrows in this way, the department should normally arrange to guarantee the loan to secure a fine rate. There may sometimes be overriding constraints, e.g. where such a guarantee would rank as a state aid (see annex 4.9). A department which guarantees a loan needs a specific statutory power as well as Estimate provision. On rare and exceptional occasions temporary non-statutory loans may be possible. In either case, DFP Supply must be notified when a loan guarantee is given (before giving it in the case of non-statutory loans), using the reporting procedures in annex 5.5. The Assembly should be notified in all cases where a loan is guaranteed.

5.7.3 Occasionally there is a case for a sponsored body to borrow in foreign currency in its own name rather than the Executive's. Because this can affect the credit standing of the United Kingdom public sector as a whole, and may well cost more, it is essential to consult DFP Supply beforehand.

5.7.4 The same principles apply to the borrowing of any bodies, such as subsidiaries, for which a sponsor department's ALBs are responsible. This is because their borrowing affects the creditworthiness of their sponsor department and thus of the UK as a sovereign borrower.

5.8 Banking

5.8.1 Departments need to control access to central government accounts in order to undertake the processes of making payments and collecting receipts in ways which protect public funds and obtain good value for money for the NICF as a whole. Public monies should be held centrally by DFP to the maximum possible extent consistent with value for money. It

is therefore important that receipts and other funds which are surplus to immediate requirements are credited to the Paymaster General's Account or other government bank accounts at the earliest, practicable and cost effective opportunity thereby reducing the amount and cost of the Government's borrowing or increasing its income from interest.

5.8.2 There is an agreement whereby a specified list of central and departmental accounts have their balances pooled for charging purposes. Provided the pool is not overdrawn the accounts in the pool are exempt from charges. If overnight the pool as a whole is overdrawn interest is charged to the NICF at a special rate. To ensure value for money, departments should bank under this contract. The contract and pool arrangement are controlled by Government Accounts Branch within DFP therefore any changes to the arrangements must be done through DFP. Departments must also seek DFP approval if they wish to open an account outside the pool.

5.8.3 It is essential for departments and NDPBs to minimise the balances in their bank accounts. Were each to retain a significant sum in its own account with such banks, the amount of net government borrowing outstanding on any given day would be appreciably higher, adding to interest costs and hence worsening the fiscal balance.

5.8.4 Each department is advised to have a strategy for cash management including banking arrangements and to ensure that it is formally documented. The strategy should reflect the size of the body and the scale and complexity of its transactions and include arrangements for measuring and reviewing performance against objectives. See annex 5.7 for guidance. Sponsor departments should make sure that their ALBs are aware of the importance of managing this aspect of their business efficiently and effectively (see box 7.2).

5.9 Other financing techniques

5.9.1 Depending on its circumstances, purposes and risk profile, a public sector organisation may consider using financial instruments provided by the commercial markets. Among the techniques which may merit consideration are foreign currency transactions and various hedging instruments designed to control or limit business risks, for example those arising out of known requirements for specific future purchases of market priced commodities. Another possibility is permitting payments by various electronic means, including credit cards.

5.9.2 As with making decisions about other policies and projects, an organisation considering using an unfamiliar financing technique should evaluate it carefully. The checklists in boxes 4.3 and 4.7 have reminders of factors that may need to be considered. If the proposed transaction(s) are novel, contentious or repercussive, it is essential to consult DFP. Any organisation using a new technique should ensure that it has the competence to manage, control and track its use and any resulting financial exposures, which may vary with time. In particular, departments should consult DFP (and ALBs their sponsoring departments) before using derivatives for the first time.

5.9.3 When assessing an unfamiliar financial technique, it is important to remember that providers of finance and complex financial instruments intend to profit from their business. And providers' costs of finance are always inferior to the UK government's cost of

borrowing. So it is usually right to be cautious about novel financial techniques. DFP will always refuse proposals to speculate. Offers which appear too good to be true usually are.

5.9.4 A simple example is the use of credit cards to pay debts owed to public sector organisations. When evaluating the options, it is important to balance any extra cost against the value of additional or faster flows of funds expected by offering this facility. There may be a case for limiting the transactions acceptable in this way, e.g. for payments up to certain amounts, or only using certain cards (depending on the commercial deals that can be negotiated). The Assembly expects the public sector to make shrewd and well-informed decisions based on sound commercial principles.

5.9.5 A more complex example is deals financed under the Private Finance Initiative. There is more about this in section 7.10.

5.9.6 As with managing other business, the Assembly may ask Accounting Officers to justify any decisions about use of financial transactions, especially if with hindsight they have not achieved good value for money.

Annex 5.1 Grants and grants-in-aid

Annex 5.2 Protecting public investments (clawback)

Annex 5.3 Treatment of income and receipts

Annex 5.4 How Estimates provision is derived from departmental budgets

Annex 5.5 Liabilities

Annex 5.6 Lending to Public Bodies

Annex 5.7 Banking

Annex 5.8 The Northern Ireland Consolidated Fund (NICF)

6. FEES, CHARGES AND LEVIES

Where a fee is charged for access to public goods or services, there are some specific rules about how the charge should be determined. It is important to protect the Assembly's right to decide which services should be charged for, and how public resources are to be allocated.

6.1 Basic policy

6.1.1 Many departments and public bodies charge for publicly provided goods and services. This approach helps allocate use of goods or services in a rational way because it prevents waste through excessive or badly targeted consumption. It also makes for easier comparisons with the private sector, promotes competition and helps develop markets.

6.1.2 The norm is to charge at full cost. Some exceptions are noted in box 6.1.

Box 6.1: exceptions to full cost charging

- **Subsidised services**: where departments decide to spend public resources on lowering costs for some or all consumers of public services, e.g. free prescriptions for children.
- **Taxation**: where the Assembly authorises charges above cost, e.g. vehicle excise duty.
- **Information services**: where charges are generally low or minimal as a matter of policy, e.g. most freedom of information (FoI) requests.
- Certain discretionary services provided in **competition** with the private sector, where a commercial rate is normally charged, e.g. letting out public space for private use.
- **Levies**: licences to operate using public goods, often set to recover associated costs such as supervision by a regulator, e.g. gambling licences.

6.1.3 The guidance in this chapter applies to all charges and levies set by ministers or by an extensive range of public bodies: departments, trading funds, NDPBs, health and social care organisations, and most public corporations. It also applies to charges for goods and services one central government organisation supplies to another; and to certain other statutory charges set by ministers, e.g. some local government fees. Those setting up a service carrying a charge may find the checklist in annex 6.1 useful.

6.1.4 Central government bodies usually need primary legislation to charge for a service provided to the public since the Assembly expects to control use of public resources. Except in the case of commercial services (see section 6.4), if the charge exceeds the cost of supply, the excess must be remitted to the NI Consolidated Fund. If the excess is significant, the Office of National Statistics (ONS) may classify the whole charge as a tax.

6.2 Setting the charge

6.2.1 Setting a fee for a public service normally[8] requires powers in primary legislation. These powers are usually fairly general, with the fee structure and each fee set in secondary legislation. Prior DFP approval is required for primary legislation empowering charges. Even if the primary legislation does not call for it, the delegated authorities within which the organisation operates (see paragraph 2.1.5) will often insist upon DFP consent for charges.

6.2.2 In a limited range of cases, it may be possible to rely on secondary (rather than primary) legislation. One such group of cases is implementation of EU legislation. Depending on the policy to be implemented, it may be possible to use secondary orders under s2(2) of the European Communities Act 1972 for the substantive policy and under s56 of the Finance Act 1973 to set charge levels.

6.2.3 In certain other cases, charges can be adjusted where otherwise primary legislation would be necessary by using an order under the Fees and Charges (Northern Ireland) Order 1988 No.929 (N.I.8). Because such orders amend primary legislation, they would be unpopular in the Assembly and should therefore be used rarely. Box 6.2 explains the routine. Use of this procedure often indicates that the fee is classified as a tax.

Box 6.2: restructuring charges using the Fees and Charges (Northern Ireland) Order 1988 No.929 (N.I.8).

- Explicit prior DFP agreement is essential.
- The order can vary or extend the powers in existing primary legislation by permitting specified factors to be taken into account in setting fees, e.g. to restructure fees to recover costs not directly related to the current costs of the service, or to recover past deficits.

But

- The Order cannot undermine primary legislation, e.g. it cannot authorise a charge for which no primary legislation exists, nor lift explicit statutory restrictions on which groups of consumers should pay a charge for a service.

6.2.4 When deciding the level of a charge, it is important to define:

- the range(s) of services for which a charge is to be made; and
- how any different categories of service are to be differentiated, if at all, in setting charges.

6.2.5 Normally the same charge should apply to all users of a defined category of service. The policy might be to charge at a uniform rate for all varieties of a service; or different fees may be set for objectively different categories of service costing different amounts to provide. Box 6.3 has some acceptable distinctions. It is often helpful to consult

8 This requirement does not apply to discretionary services: see section 6.4

DFP as the categories to bear different charge levels are developed. This is essential if the proposed arrangements entail any features which could affect other parts of the public sector or set precedents for them.

6.2.6 Annex 6.2 contains guidance about how full cost should be measured for the purpose of setting charges. Special rules apply to charges for information services: see annex 6.3.

Box 6.3: possible ways of setting charge for different categories of service

- Supply differences, e.g. in person, through the post, over the telephone or using the internet.
- Priority, e.g. where consumers pay more for a faster, more expensive, service.
- Scale or value, e.g. where a premium service offers more facilities to the customer than others.
- Structural, where it costs more to supply some consumers with a consistent service.

But not

- Differentiation by different kinds of customer, e.g. less for personal consumers and more for corporates (unless permitted or required by the primary powers).

6.2.7 Once defined, the full cost of each category of service should be measured realistically and objectively: see annex 6.2. The cost should be estimated, extrapolating past trends and forecasting future consumption patterns. The calculation should take full account of non-cash items e.g. depreciation, the cost of capital and the notional cost of insurance where applicable. There is some limited flexibility about the charge in any single year, since demand cannot be forecast precisely and it may make practical sense to round charges. But neither factor can justify planning to recover less or more than 100% of costs.

6.2.8 If ministers decide on a financial target short of full cost recovery, there should be a plan to achieve full cost recovery within a reasonable period. If this is not intended, it is important to decide (and document) clearly why and how long any deliberate public subsidy should last.

6.2.9 In general, cross subsidies are not good practice, e.g. businesses subsidising individuals or large businesses subsidising small ones. They may foster inefficient or wasteful patterns of consumption. Thus they always require explicit Ministerial agreement and primary legislation (or use of the Fees and Charges (Northern Ireland) Order 1988 No.929 (N.I.8)). And such charges are often classified as taxes.

6.2.10 Charges within and among central government organisations should be made at full cost, including the standard cost of capital. To charge otherwise would risk creating unwarranted subsidies or distorting competition.

6.3 Levies

6.3.1 Compulsory levies, e.g. licences to operate charged by statutory regulators, or to support industry specific research foundations, are normally classified as taxation. Such licences are justified in the wider public interest and not to provide a beneficial service to those who pay them. DFP may allow such bodies to retain the fees charged if this approach is efficient and in the public interest.

6.3.2 As with other fees and charges, levies of this kind should be designed to recover the full costs of the service provided. If the legislation permits, these costs can include the costs of the statutory body, e.g. a regulator could be empowered to recover the cost of supervision as well as registration to provide a licence. It may be appropriate to charge different levies to different kinds of licensees, depending on the cost of providing the licence.

6.4 Commercial services

6.4.1 Some public sector services are discretionary, i.e. no statute requires them. Services of this kind are often supplied into competitive markets, though sometimes the public sector supplier has a monopoly or other natural advantage. The key steps to take before setting up such a service are outlined in box 6.4.

Box 6.4: setting up a commercial service

- Check whether the service is supplied in a competitive market.
- Establish whether adequate statutory authority exists for undertaking the planned activity.
- Consider whether Estimate authority is required to use public resources to supply the service.
- Agree the required rate of return with DFP.
- Obtain DFP consent for any adjustment to the supplier's financial objective.
- If the intended commercial service is likely to be significant and to endure, tell the Assembly of the plan to provide it.

6.4.2 For these services, the charges should be set at a commercial rate, including delivering a proper return on the use of resources acquired with public funds. So the financial target should be in line with market prices, using an appropriate risk weighted rate of return on capital. The rate of return used in pricing calculations for sales into commercial markets should be:

- for sales into commercial markets, in line with competitors' assessment of their business risk, rising to higher rates for more risky activities; or
- where a public sector body supplies another, or operates in a market without competitors, the standard rate for the cost of capital (see annex 6.2).

6.4.3 If a publicly provided commercial service does not deliver its target rate of return, outstanding deficits should be recovered, e.g. by adjusting charges. Any objective short of achieving the target rate of return calls for Ministerial agreement, and should be approved by DFP. In particular, discretionary services should never undermine the supplier organisation's public duties, including its financial objective(s).

6.4.4 It is important for public suppliers of commercial services to respect competition law. Otherwise public services using resources acquired with public funds might disturb or distort the fair operation of the market, especially where the public sector provider might be in a dominant position: see annex 6.4.

6.4.5 Wider markets activities are a special case of commercial services. See annex 7.6 for a fuller discussion.

6.5 Taking stock

6.5.1 As with any other use of public resources, it is important to monitor performance so that the undertaking can be adjusted as necessary to stay on track. It is good practice to review the service routinely at least once a year, to check, and if appropriate revise, the charging level. At intervals, a more fundamental review is usually appropriate, e.g. on a timetable compatible with the dynamics of the service. Box 6.5 suggests some issues to examine.

Box 6.5: reviewing a public service for which a charge is made

- Is it still right for a public sector organisation to use public resources to supply the service?
- Does the business structure still make sense? Are the assets used for the service adequate?
- Would another business model (e.g. licensing, contracting out, privatising) be more satisfactory?
- For services supplied within the public sector, is there scope to supply others to take advantage of economies of scale?
- Is the financial objective right?
  - for a statutory service (or one supplied to another public organisation) if full costs are not recovered, why not?
  - for a commercial service, does the target rate of return still reflect market rates?
- Can efficiency and effectiveness be improved?
- Looking ahead, what developments might change the business climate?
- Do any discretionary services remain a good fit for the business model and wider objectives?
- Should any underused assets be redeployed, used for wider markets activity, or sold?

6.6 Accounts

6.6.1 As with public expenditure, the resources used in supplying public services and the proceeds of charges should be properly recorded and accounted for. Each service should keep records of its costs and the associated receipts. A memorandum trading account (MTA) prepared in accordance with GAAP and any relevant accounts direction is often a convenient way of doing this (see annex 6.5). Because MTAs record how the costs and revenues evolve, they help generate the end year resource accounts, whether the operation of the service is consolidated with the parent department's business or not.

6.6.2 The FReM discusses audit and reporting of trading funds in more detail.

Annex 6.1 Checklist for setting up new services

Annex 6.2 How to calculate fees

Annex 6.3 Charging for information

Annex 6.4 Competition law

Annex 6.5 Memorandum Trading Accounts (Operating Accounts)

Annex 6.6 Interdepartmental Transactions

7. WORKING WITH OTHERS

This chapter considers the working partnerships that public sector organisations may establish in order to deliver their objectives more effectively than they could acting alone. There are some common features to competent management of these relationships, and some specifics which apply to certain sorts of relationships. It is essential that the public interest and value for public resources are given a high priority in the management of all these relationships.

7.1 The case for working partnerships

7.1.1 The Assembly and the public expect high quality public services, adapted flexibly to suit the needs of different kinds of customers. It can make sense for public sector organisations to work with partners to deliver these services. The partners may be other public sector organisations, commercial organisations, or bodies from the third sector such as charities and voluntary groups. In this way the public sector can harness skills appropriate to the purpose in hand.

7.1.2 There are many different kinds of partnership. Each involves some tension between autonomy and accountability with scope for conflict if the terms of engagement are not resolved openly at the outset. Box 7.1 outlines some key areas that need to be decided early in the relationship. Each partnership requires its own customised terms to work effectively. One size does not fit all.

Box 7.1: issues for every partnership with a public sector member

- As for projects, the decision to engage with a partner should rest on a business case in the public interest, evaluated against a range of alternative courses, including doing nothing.
- Conflicts of interest, including reputation risks, should be consciously recognised and dealt with, e.g. through explicit safeguards in the terms of the partnership.
- The cultural fit of the partners should be good enough to give each party confidence about trusting the other(s).
- The partnership framework should be documented and the terms of engagement kept up to date so that there is no doubt about responsibilities.
- Partnerships should not be a way of weakening accountability for the use of public resources, including reporting to the Assembly.

7.2 Setting up new arm's length bodies

7.2.1 When a department sets up a new arm's length body (ALB), it needs to decide which kind of body it should be. Each has its strengths and merits. In general it makes sense to let the functions of the new body determine its form. DFP approval is required to establish such bodies and it may be helpful if DFP is consulted early in the process. Annex 7.1 suggests sources of guidance on some common types of ALB, while annex 7.2 outlines how to determine whether a new ALB should be an agency, an NDPB or a non-Ministerial department.

7.2.2 Designing a new body for partnership with a public sector organisation always requires careful planning. It is important to ensure that the new arrangement will deliver the intended outcome(s) without unnecessary and confusing complexity. The sponsor department is responsible in the first instance for ensuring that the budgetary control and internal disciplines of new ALBs are satisfactory. It is desirable to arrange for a clear line of sight between those making the key decisions and the machinery for implementing them.

7.2.3 While the established models of public sector bodies are often useful, it can sometimes make sense to design new kinds of ALB. When departments plan to innovate in this way, it is usually necessary to consider whether primary legislation is required and to secure appropriate Estimate cover. Additional DFP approval for any innovative development will also be required.

7.3 What to clarify

7.3.1 When documenting an agreement with a partner, public sector organisations should analyse the relationship and consider how it might evolve. The terms of the agreement must be clearly understood by each party to avoid confusion as the partnership develops. Box 7.2 lists terms which should always be considered for inclusion in partnership agreements. The list is not exhaustive.

7.3.2 In framing founding documentation of this kind, the partners should adopt a proportionate approach in line with the scale and risk of the business involved. The Assembly expects that public funds will be used in a way that gives reasonable assurance that public resources will be used to deliver the intended objectives. It is good practice to develop structured arrangements for regular dialogue between the parties to avoid misunderstandings and surprises.

7.3.3 In this process the aim should be to put the Accounting Officer(s) of the parties in a position to take a well-informed view on the status of the relationship, enabling timely adjustments to be made as necessary. So there might initially be a significant degree of reporting and other exchanges, with potential for intervention, underpinning a venture which is large, experimental and/or risky; and scaling back later if experience gives confidence about performance. Conversely, a partnership following a well-tested pattern in a familiar area might call for less intervention.

7.3.4 Where a new partnership is being developed, it may be necessary or desirable to devise bespoke working arrangements sensitive to the position of each of the partners. Box 7.1 may not cover every angle. For instance, a partnership with a charity will need to be compatible with the charity's purposes and constitution, while safeguarding the public investment.

7.4 Agencies

7.4.1 Each agency is either part of a central government department or a department in its own right. Agencies are intended to bring professionalism and customer focus to the management and delivery of central government services, operating with a degree of independence from the centre of their home departments. Some are also trading funds.

7.4.2 Each agency is established with a framework document on the lines sketched out in box 7.2. With the exception of those agencies which are trading funds (see section 7.5), they are normally funded through public expenditure supplied by Estimates. DFP approval is required for all such framework documents and it may be helpful for Departments to consult DFP at an early stage in their preparation.

7.4.3 Depending on the scale and nature of an agency's responsibilities, it may be appropriate for a senior official of an agency to be a member of the sponsor department's departmental board. It may also be appropriate for a representative of the sponsor department to join the agency's board, as part of the sponsor department's responsibilities for strategy, performance, risk taking and delivery within the department.

7.5 Trading funds

7.5.1 A trading fund is either part of a department or a department in its own right. Its business must finance most or all of its operations.

7.5.2 Each trading fund is set up through an order under the Financial Provisions (Northern Ireland) Order 1993, subject to affirmative resolution procedure. Before such an order can be laid in the Assembly, DFP will need to be satisfied that a proposed trading fund can satisfy the statutory requirement that it is likely to deliver better efficiency and effectiveness. A period of shadow operation as a pilot trading fund may help inform this assessment.

7.5.3 Each trading fund must primarily be financed out of its trading income like any other enterprise. In particular, each trading fund is expected to generate a financial return commensurate with the risk of the business in which it is engaged. In practice this means the target rate of return should be no lower than its cost of capital. The actual return achieved may vary a little from one year to the next, reflecting the vagaries of the market in which the trading fund operates.

7.5.4 The possible sources of capital for trading funds are shown in box 7.3. They are designed to give trading funds freedom from the discipline of annual Estimate funding. The actual mix for a given trading fund must be agreed with the sponsor department (if there is one) and with DFP.

7.5.5 Further detail about trading funds is in annex 7.3. Guidance on setting charges for the goods and services trading funds sell is in chapter 6.

7.5.6 Some trading funds move on to become wholly owned companies within the public sector. When this process is in prospect, the appropriate disciplines (see section 7.8) should be adopted.

Box 7.2: framework terms for partnership agreements

purpose

- The aims of the relationship, its working remit, standards, and the key objectives and targets.

governance and accountability

- The statutory position, including any financial or other limits and any regulatory requirements.
- The governance of the partnership: the terms of engagement of the partners and any arrangements for appointment (or approval) of the senior people in the other partner.
- The extent to which any department is responsible to the Assembly for the conduct of a partner (this is always appropriate for partnerships with departments' ALBs).
- Any other important features of the sponsorship role of the public sector partner, e.g. acting as intelligent shareholder or consulting third parties.
- Any arrangements for successor activity, e.g. establishing similar partnerships elsewhere.

decision making

- How strategic decisions about the future of the partnership will be made, with timetable, terms for intervention, break points, dispute resolution procedures, termination process, and so on.
- How the chain of responsibility should work, e.g. stewardship reporting, keeping track of efficiency, risk assessment, project appraisal, management of interdependencies, and so on.
- How the partnership will identify, manage and track opportunities and risks.
- The status of the staff; and how they are to be hired, managed and remunerated.
- How any professional input (e.g. medical, scientific) is to be managed and quality assured.
- Arrangements for taking stock of performance and learning lessons from it.

financial management

- The financial relationship of the partners, e.g.:
  - any founding capital (including assets, goods, financial sums or other valuables)
  - any grants, one off or periodic, and their terms
  - how any charges to customers or users are to be set
  - how the partnership's corporate plan and annual target(s) are to be agreed
  - how asset management and capital projects are to be decided and managed
  - how cashflow is to be managed, and current expenditure financed
  - the distribution of income and profit flows
  - any financial target, e.g. return on capital employed (ROCE)
  - terms for disposal of assets acquired with public funds
  - any agreed limits on the partnership's business.
- Monitoring, reporting, regular liaison and any other tracking arrangements.
- Internal and external audit arrangements, with any relevant accounts directions.

Box 7.3: sources of finance for trading funds

- public dividend capital (equivalent to equity, bearing dividends - see annex 7.3)
- reserves built up from trading surpluses
- long or short term borrowing (either voted from a sponsor department or direct from the Northern Ireland Consolidated Fund)
- temporary subsidy from a sponsor department, voted in Estimates
- finance leases

7.6 Departments working together

7.6.1 To promote better delivery and enhance efficiency, departments often find it useful to work with other government departments (or NDPBs - see section 7.7). This can make sense where responsibilities overlap, or both operate in the same geographical areas or with the same client groups - arrangements loosely categorised as joined up government. Another model might entail sharing common services, perhaps in a common building. Such arrangements offer opportunities for departments to reduce costs overall while each department plays to its strengths.

7.6.2 Such relationships can be constituted in a number of different ways. Some models are sketched in box 7.4. The list is not exhaustive.

7.6.3 Shared services often need funding to set up infrastructure, e.g. specialist IT for procurement. This could be agreed in a spending review, or customers could buy in by transferring budget provision to the lead provider. Each of the Accounting Officers involved will need assurance that the project offers value for money for the public sector as a whole. The provider's charges should be at cost, following the standard fees and charges rules within central government (see chapter 6).

7.6.4 If the PAC decides to investigate joined up activity, the Accounting Officers of each of the participants should expect to be summoned as witnesses.

Box 7.4: example models of joined up activities in central government

- one partner can act as lead provider selling services (such as IT, HR, finance functions) to other(s) as customers, operating under service level agreement(s)
- cost sharing arrangements for common services (e.g. in a single building), allocated in line with an indicator such as numbers of staff employed or areas of office space occupied
- joint procurement using a collaborative protocol
- a joint venture project with its own governance, e.g. an agency or company, selling services to a number of organisations, some or all of which may be public sector
- an outsourced service, delivering to several public sector customers

7.7 Non-departmental public bodies

7.7.1 Non-departmental public bodies (NDPBs) may take a number of legal forms, including various corporate models and/or charities. Most executive NDPBs have a bespoke framework in legislation or its equivalent (e.g. a Royal Charter). This framework may specify in some detail what the NDPB is to do, what powers are invested in it, and how it should be financed. Annex 7.1 has links to further information about NDPBs.

7.7.2 Each NDPB is a special purpose body which plays a part in the process of government. Each has a sponsor department charged with general oversight and responsibility for reporting its activity to DFP. So sponsor departments should have appropriate arrangements for regular monitoring with scope for steering the NDPB's performance as necessary. Sometimes other departments also take an interest in particular aspects of an NDPB's business.

7.7.3 NDPBs' sources of finance vary according to their constitution and function. Box 7.5 shows the main options available.

Box 7.5: sources of finance for NDPBs

- specific conditional grant(s) from the sponsor department (and/or other departments)
- general (less conditional) grant-in-aid from the sponsor department
- income from charges for goods or services the NDPB may sell
- public dividend capital

7.7.4 In practice NDPBs operate with some independence and are not under day-to-day ministerial control. Nevertheless, ministers are ultimately accountable to the Assembly for NDPBs' efficiency and effectiveness. This is because ministers: are responsible for NDPBs' founding legislation; have influence over NDPBs' strategic direction; (usually) appoint their boards; and have the ultimate sanction of winding up unsatisfactory NDPBs.

7.7.5 As with agencies (see 7.4.3) there may be value in some cross membership of an NDPB board with its sponsor department's board. This can foster mutual confidence and provide valuable insight for both parties. In any case sponsor departments need arrangements to monitor and understand their NDPBs' strategy, performance and delivery, usually built around a Management Statement/Financial Memorandum (MS/FM) which includes terms on the lines of box 7.2 (see annex 7.4 for a suggested outline and a specimen example). In practice these arrangements can be very similar to those departments need for their relationships with agencies (see section 7.4).

7.7.6 Whether in the usual form of a MS/FM or other format, all such agreements must be approved by DFP.

7.8 Public corporations

7.8.1 Some departments own controlling shareholdings in public corporations or Companies Act companies, perhaps (but not necessarily) as a step toward disposal. Except where a public corporation's powers are defined in statute, such a company is subject to all the disciplines of corporate legislation; and may also be an NDPB. Advice on shareholdings of this kind can be obtained from the Shareholder Executive.

7.8.2 To manage relationships of this kind, departments need to adapt the framework in box 7.2 to suit the corporate context while delivering public sector disciplines. The financial performance expected of a public corporation should give the shareholding department a fair return on the public funds invested in the business. Box 7.6 offers a checklist. The same approach may be appropriate for a trading fund, especially if it is expected to become a Companies Act company in time.

Box 7.6: outline terms for a relationship with a public corporation

- the shareholder's strategic vision for the business, including the rationale for public ownership and the public sector remit of the business
- the capital structure of the business and the agreed dividend regime, with suitable incentives for business performance
- the business objectives the enterprise is expected to meet, balancing policy, customer, shareholder and any regulatory interests
- the department's rights and duties as shareholder, including:
  - governance of the business
  - procedure for appointments
  - performance monitoring
  - any necessary approvals processes
  - the circumstances of, and rights upon, intervention

7.8.3 A shareholder department may also use a company it owns as a contractor or supplier of goods or services. It is a good discipline to separate decisions about the company's commercial performance from its contractual commitments, so avoiding confusion about objectives. So there should be clear arm's length contracts between the company and its customer departments defining the customer-supplier relationship(s).

7.9 Outsourcing

7.9.1 Public sector organisations often find it useful to outsource some non-core services or functions rather than provide them internally. Typical candidates include cleaning, catering and IT support. A much wider range of services is potentially suitable, depending on the nature of the organisation's business. The first step in setting up any outsourcing agreement should be to specify the service(s) to be provided and the length of contract to be sought.

7.9.2 It is good practice to arrange some form of competition for all outsourcing and advice should be sought from Central Procurement Directorate. In most cases, it is legally essential to open the competition to all firms in the EU (see annex 4.4). Where the organisation foresees the need to hire services at short notice, for example legal services to support opportunities, threats or other business pressures which emerge with little warning, it is good practice to arrange a competition to establish a standing panel of providers from which services can be called upon to deal with rapidly emerging needs.

7.9.3 In choosing partners to provide outsourced services, public sector organisations should seek the best value available. This may not be the same as the cheapest price.

7.10 PPPs and PFIs

7.10.1 Public private partnerships (PPPs) use structured arrangements between the public and private sectors to secure an outcome delivering good value for money for the public sector. These arrangements use private sector management skills, with suitable arrangements to protect staff terms and conditions. Various different business models are possible.

7.10.2 One special kind of PPP is the private finance initiative (PFI). In such deals a public sector organisation contracts with a private sector entity to construct a facility and provide associated services of a specified quality over a sustained period. Because the private sector contractor puts its own funds at risk, it has powerful incentives to deliver to time and cost, and can thus offer value for money. Such contracts should normally be built up using standard terms published by the Treasury (see annex 7.5).

7.10.3 PFI procurement is a flexible, versatile and often effective technique. But it is not appropriate for every project. Annex 7.5 discusses when PFI is worth considering and how it should best be used for good results.

7.11 Wider markets activity

7.11.1 Wider markets activity is part of good asset management in the public sector (see annex 4.8). Significant projects nearly always require some form of public-private partnership to operate and grow successfully, e.g. harnessing a private sector firm's marketing reach. In this way public sector organisations can make use of private sector expertise and finance to exploit the commercial potential of government assets. A great variety of business models is possible.

7.11.2 When public bodies have assets which are not fully used but are to be retained, it is good practice to consider exploiting the spare capacity to generate a commercial return in the public interest. Any kind of public sector asset can and should be considered. These can include both physical and intangible assets, for example land, buildings, equipment, software and intellectual property.

7.11.3 Such commercial services always go beyond the public sector supplier's core duties. Nevertheless the assets concerned have been acquired with public funds. So it is important that services are priced fairly: see chapter 6. It is also important to respect the

rules on state aids: see annex 4.9. In planning any wider markets activity, central government organisations should work through the checklist at box 7.7 and the guidance in annex 7.6. Further advice can be obtained from the Economic Policy Unit within OFMDFM.

Box 7.7: planning wider market activities

- define the service to be provided
- establish that any necessary vires and (if necessary) Estimate provision exist
- identify any prospective business partners and run a selection process
- if the proposed activity is novel, contentious, or likely to set a precedent elsewhere, obtain DFP approval. DFP approval is also required where the full annual cost or aggregated annual income from services exceeds, or is expected to exceed, certain financial limits. Current applicable limits can be obtained from DFP Supply.
- take account of the normal requirements for propriety, regularity and value for money

7.11.4 While it makes sense to make full use of assets acquired with public resources, such activity should not squeeze out, or risk damaging, a public sector organisation's main objectives and activities. Similarly, it is not acceptable to acquire assets just for the purpose of engaging in, or extending, wider markets activity. If a public sector supplier's wider markets activity reaches a point where further investment is needed to keep it viable, reappraisal is usually appropriate. This should consider alternatives such as selling the business, licensing it, bringing in private sector capital, or seeking other way(s) of exploiting the underused potential in the assets or business.

7.11.5 It is a matter of judgement when departments should inform the Assembly of the existence, or growth, of significant wider markets ventures. It is good practice to consult DFP in good time on this point so that the Assembly can be kept properly informed and not misled.

7.12 Working with third sector bodies

7.12.1 Central government organisations may also find it helpful to form working relationships with third sector bodies: that is, charities, social, voluntary or community institutions, mutual organisations and other not-for-profit bodies. Partnership with such bodies can achieve more than either the public or the third sector can achieve alone. For example, it can offer an extra dimension by providing insight into what particular groups and communities want, and what they can contribute, to the delivery of public services.

7.12.2 In this kind of relationship it is common for a public sector funder to make resources available to a third sector partner. These could be payments for services, assets, grants or other transfers for particular purposes. It is usual to include safeguards to ensure that any grants are used for the intended purpose (see annex 5.2). Otherwise the Assembly might not be confident that its approval of voted resources is being honoured.

7.12.3 The safeguards to be applied should be agreed at the start of the relationship. They should be designed to suit the purpose and circumstances of the transaction. It is often

right to agree terms in which public sector donors reclaim the proceeds if former publicly owned assets are sold (clawback). But it can be appropriate and valuable to set more flexible terms and conditions so long as they ensure that publicly funded assets are used for the intended purposes in broad terms. This is explored further in annex 7.7.

GLOSSARY

Accounting Officer — A person appointed by DFP or designated by a department to be accountable for the operations of an organisation and the preparation of its accounts. The appointee is, by convention, usually the Head of a department or other organisation or the Chief Executive of a non-departmental public body (NDPB). See chapter 3.

Accounts direction — A direction issued setting out the accounts which a body must prepare, and the form and content of those accounts.

Accruing Resources — Income received by a department which it is authorised to retain (rather than surrender to the NI Consolidated Fund) to offset related expenditure. Such income is voted by the Assembly and accounted for in departmental resource accounts.

Affirmative resolution — An Assembly procedure for exercising control over secondary legislation (i.e. a Statutory Rule in the form of an Order or Regulations). The positive approval of the Assembly is required before the instrument can take effect.

Annually Managed Expenditure, AME — Spending included in Total Managed Expenditure (TME), which does not fall within Departmental Expenditure Limits (DELs). Expenditure in AME is less predictable and controllable than expenditure in DEL.

Arm's length bodies, ALBs — NDPBs, companies in which the department has a significant shareholding and other sponsored bodies.

Assembly authority — The Assembly's formal agreement to authorise an activity or expenditure.

Budget Acts — Annual Acts of the Assembly, which give formal approval to departmental Supply Estimates. The Budget Bill when enacted becomes the Budget Act.

Capital Spending — Spending on the purchase of assets, above a certain threshold, which are expected to be used for a period of at least one year. It includes the purchase of buildings, equipment and land. The threshold is set by each body: items valued below it are not counted as capital assets, even if they do have a productive life of more than one year.

CCAB	Consultative Committee of Accounting Bodies comprising CIPFA, ICAEW, ICAI, ICAS, ACCA and CIMA.
Central government bodies	Departments and departmental executive agencies, non-departmental public bodies, and health and social care organisations.
Chief Executive	Title for the head of an arm's length body, normally appointed as accounting officer.
Civil Service Code of Ethics	A concise statement which sets out the framework within which all NI civil servants work and the core values and standards they are expected to uphold (see annex 4.2).
Clawback	The concept that where an asset financed by public money is sold, all or part of the proceeds of the sale should be returned to the NICF.
Commercial banks	Bodies which provide banking services, including private sector banks and building societies.
Commissioner of Public Appointments for NI	http://www.ocpani.gov.uk/ an independent body which monitors, regulates, reports and advises on Ministerial appointments to public bodies in Northern Ireland.
Common Law	One of the historical sources of law in the United Kingdom. Often used to distinguish judge made case-law and longstanding legal principles from legislation.
Comptroller and Auditor General, C&AG	The head of the Northern Ireland Audit Office, appointed by the Crown, and an Officer of the Assembly. As Comptroller, the C&AG's duties are to authorise the issue by DFP of public funds from the NI Consolidated Fund to government departments and others; as Auditor General, the C&AG certifies the accounts of all government departments and most other public bodies, and carries out value-for-money examinations. See annex 1.1.
Concordat	A long-standing agreement between the Treasury and the Public Accounts Committee that continuing functions of government should be defined in specific statute. See annex 2.1.

Consolidated Fund Extra Receipts, CFERs

Receipts realised or recovered by departments in the process of conducting services charged on public funds which are not authorised to be used to offset expenditure. Examples include excess accruing resources.

Consolidated Fund standing services

Payments for services which the Assembly has decided by statute should be met directly from the NI Consolidated Fund, rather than financed annually by voted money.

Contingent liabilities

Potential liabilities that are uncertain but recognise that future expenditure may arise if certain conditions are met or certain events happen.

Control total

The measure used by the government to plan public expenditure for the medium term, and monitor and control it within each financial year.

Corporate governance

The system by which organisations are directed and controlled.

Cost of capital

The cost to the government of financing investment, i.e. the rate at which it borrows. This is charged to departments to improve transparency under resource accounting and encourage efficient use of assets. It is included in the calculation when setting fees and charges and is calculated as a percentage of the net asset value.

Data Protection Act

Legislation (1998) which governs how organisations can use personal information which they hold.

Delegated authority

A standing authorisation by DFP under which a body may commit resources or incur expenditure from money voted by the Assembly without specific prior approval from DFP. Delegated authorities may also authorise commitments to spend (including the acceptance of contingent liabilities) and to deal with special transactions (such as write-offs) without prior approval.

Departmental Expenditure Limit, DEL

Expenditure limit within which a department has responsibility for resource allocation (subject to DFP agreement and rules), though some elements may be demand led.

Depreciation — A measure of the wearing out, consumption or other reduction in the useful life of a fixed asset whether arising from use, passage of time or obsolescence through technological or market changes.

Derivative — A financial instrument derived from another, usually sold singly or in packages to promote hedging, e.g. interest rate and exchange rate options.

Detective controls — Controls designed to detect error, fraud, irregularity or inefficiency.

Discretionary services — Services that are not required by statute but are provided, often into competitive markets.

Estimate — A statement of how much money departments need in the coming financial year, and for what purpose(s), by which Assembly authority is sought for the planned level of expenditure and receipts in a department.

Estimates Manual — A practical reference guide issued by the Treasury which provides detailed information on the Supply Estimates process. A Northern Ireland version should be issued in 2009.

Excess Vote — A request for resources which, after the year end, is found to have financed expenditure not agreed by the Assembly, whether because it exceeds the prescribed amount of expenditure or because part is outside the descriptions the Assembly has approved. See section 5.3.

Expenditure outside the ambit of a vote, EOTA — Expenditure outside the ambit of a vote, i.e. resources spent on matters which were not included in the relevant ambit in the departmental Estimate and therefore the Assembly has not authorised. See section 5.3.

Framework document — A document setting out the key principles of accountability for agencies.

Freedom of Information — Legislation (2000) designed to promote public access to a wide range of public sector data and information (but not personal data).

Full cost

The total cost of all the resources used in providing a good or service in any accounting period (usually one year). This will include all direct and indirect costs of producing the output (both cash and non-cash costs), including a full proportional share of overhead costs and any selling and distribution costs, insurance, depreciation, and the cost of capital, including any appropriate adjustment for expected cost increases.

Funding

Transferring monies to an account, so that they are available when needed for payments.

Gateway™

A review process operated under OGC rules in which people not associated with a programme, policy or project assess its progress and offer pointers to improve its delivery.

Generally accepted accounting practice, GAAP

UK GAAP refers to the accounting and disclosure requirements of the Companies Act and pronouncements by the Accounting Standards Board (principally accounting standards and Urgent Issues Task Force abstracts), supplemented by accumulated professional judgement.

International GAAP in the context of use in the public sector refers to international accounting standards, that have been adopted by the European Commission (principally accounting standards and International Financial Reporting Interpretations Committee interpretations), supplemented by accumulated professional judgement.

The Chancellor announced in March 2008 that public bodies would move to preparing their accounts under International GAAP for the financial year 2009/10.

Grant

Payments made by departments to outside bodies to reimburse expenditure on agreed items or functions.

Grant in aid

Regular payments made by departments to outside bodies (usually non-departmental public bodies) to finance expenditure on agreed items or functions.

Hedging

Transaction(s) designed to reduce or eliminate financial risk, e.g. because of interest rate or exchange rate fluctuations.

Joined-up government

Arrangements under which policy-making and service delivery are unhindered by departmental boundaries.

Judicial review

A procedure by which the courts can review the legality of the decisions and actions of public authorities, including the government. Judicial review looks at the fairness of the decision-making process rather than the merits of the decision itself.

Levies

Licences to operate public goods, often set to recover associated costs such as supervision by a regulator. See section 6.3.

Maladministration

Any form of administrative failing or bad practice. Maladministration can be investigated by various complaints handling authorities, including the Northern Ireland Ombudsman.

Management statement/ financial memorandum, MS/FM

A document setting out the strategic control framework within which a non-departmental public body (NDPB) is required to operate, including the conditions under which any government funds are provided to the NDPB.

Memorandum trading accounts, MTAs

An informal working document, prepared before the start of the financial year in the form of a forecast to determine the appropriate level of fees and charges for a repayment service, and after the end of the year in the form of an outturn statement to provide a record of performance.

Misstatement

A statement which is untrue. The maker of a misstatement can be sued for damages by those who have relied on the misstatement, but only if in the circumstances it was reasonable to rely on it.

Near-cash

Resource expenditure that has a related cash implication, even though the timing of the cash payment may be slightly different. For example, expenditure on gas or electricity supply is incurred as the fuel is used, though the cash payment might be made in arrears on a quarterly basis. Other examples of near-cash expenditure are: pay, rental.

Net cash requirement, NCR

The upper limit agreed by the Assembly on the cash which a department may draw from the Northern Ireland Consolidated Fund to finance the expenditure within the ambit of its Request for Resources. It is equal to the agreed amount of net resources and net capital less non-cash items and working capital movements.

Non-cash cost

Costs where there is no cash transaction but which are included in a body's accounts (or taken into account in charging for a service) to establish the true cost of all the resources used.

Non-departmental public body, NDPB

A body which has a role in the processes of government, but is not a government department or part of one. NDPBs accordingly operate at arm's length from NI Departments.

Northern Ireland Practical Guide to the New Green Book

DFP's primary guide to the appraisal, evaluation, approval and management of policies programmes and projects, introduced in 2003. It is due to be replaced by the Northern Ireland Guide to Expenditure Appraisal in 2009.

Northern Ireland Audit Office, NIAO

Office of the Comptroller and Auditor General, which audits resource accounts. See annex 1.1.

Northern Ireland Consolidated Fund, NICF

The Assembly's "current account", kept by DFP, through which pass most of the Assembly's payments and receipts.

Northern Ireland Consolidated Fund for Contingencies

Where the requirement for resources and associated expenditure on some services is so urgent that it cannot await the normal Supply procedure, DFP may use the NICF to make repayable cash advances in anticipation of provision for those services by the Assembly.

Northern Ireland National Insurance Fund, NINIF

A government fund used to meet the cost of contribution-based benefits, financed mainly by contributions paid by employers and individuals.

Notional cost of insurance

A cost which is taken into account in setting fees and charges to improve comparability with private sector service providers. The charge takes account of the fact that public bodies do not generally pay an insurance premium to a commercial insurer.

Office of Government Commerce, OGC

An office of the Treasury, with a status similar to that of an agency, which aims to maximise the government's purchasing power for routine items and provide professional expertise on capital projects.

Orange Book

The informal title for *Management of Risks*: *Principles and Concepts*, which is published by the Treasury for the guidance of public sector bodies.

Overdraft

An account with a negative balance.

Prerogative powers

Powers exercisable under the Royal Prerogative, i.e. powers which are unique to the Crown, as contrasted with common-law powers which may be available to the Crown on the same basis as to natural persons.

Primary legislation

Acts which have been passed by the Westminster Parliament and, where they have appropriate powers, the Scottish Parliament and the Northern Ireland Assembly. Begin as Bills until they have received Royal Assent.

Private Finance Initiative, PFI

Arrangements under which a public sector organisation contracts with a private sector entity to construct a facility and provide associated services of a specified quality over a sustained period. See annex 7.5.

Propriety

The principle that patterns of resource consumption should respect the Assembly's intentions, conventions and control procedures, including any laid down by the PAC. See box 2.4.

Public Accounts Committee, PAC

A committee of the Assembly which examines the accounting for and the regularity and propriety of the Executive expenditure. It also examines the economy, efficiency and effectiveness of expenditure.

Public Corporation

A trading body controlled by central government, local authority or other public corporation that has substantial day to day operating independence. See section 7.8.

Public dividend capital, PDC

Finance provided by the Executive to public sector bodies as an equity stake; an alternative to loan finance.

Public/Private partnership, PPP

A structured arrangement between a public sector and a private sector organisation to secure an outcome delivering good value for money for the public sector. It is classified to the public or private sector according to which has more control.

Public Service Agreement, PSA

Sets out what the public can expect the Executive to deliver with its resources. Every large government department has a PSA which sets out a single aim, a number of objectives, and targets linked to the objectives.

Rate of return

The financial remuneration delivered by a particular project or enterprise, expressed as a percentage of the net assets employed.

Regularity

The principle that resource consumption should accord with the relevant legislation, the relevant delegated authority and this document. See box 2.4.

Request for Resources, RfR — The functional level into which departmental Estimates may be split. RfRs contain a number of functions being carried out by the department in pursuit of one or more of that department's objectives.

Resource account — An accruals account produced in line with the Government Financial Reporting Manual (FReM).

Resource accounting — The system under which budgets, Estimates and accounts are constructed in a similar way to commercial audited accounts, so that both plans and records of expenditure allow in full for the goods and services which are to be, or have been, consumed – i.e. not just the cash expended.

Resource Budget — The means by which the Executive plans and controls the expenditure of resources to meet its objectives.

Restitution — A legal concept which allows money and property to be returned to its rightful owner. It typically operates where another person can be said to have been unjustly enriched by receiving such monies.

Return on capital employed, ROCE — The ratio of profit to capital employed of an accounting entity during an identified period. Various measures of profit and of capital employed may be used in calculating the ratio.

Royal charter — The document setting out the powers and constitution of a corporation established under prerogative power of the monarch acting on Privy Council advice.

Secondary legislation — Laws, including orders and regulations, which are made using powers in primary legislation. Normally used to set out technical and administrative provision in greater detail than primary legislation. They are subject to a less intense level of scrutiny.

Second Stage — The second time a Bill enters the Assembly. Debate on the Bill is held and the whole principle on which it is based is either affirmed or denied by the Assembly.

Service-level agreement — Agreement between parties, setting out in detail the level of service to be performed. Where agreements are between central government bodies, they are not legally a contract but have a similar function.

Shareholder Executive	A body created to improve the government's performance as a shareholder in businesses.
Spending review	Sets out the key improvements in public services that the public can expect. It includes a thorough review of departmental aims and objectives to find the best way of delivering the government's objectives, and sets out the spending plans for the given period.
State Aid	State support for a domestic body or company which could distort EU competition and so is not usually allowed. See annex 4.9.
Statement of Excess	A formal statement detailing departments' overspends prepared by the Comptroller and Auditor General as a result of undertaking annual audits.
Statement on Internal Control, SIC	An annual statement that Accounting Officers are required to make as part of the accounts on a range of risk and control issues.
Subhead	Individual elements of departmental expenditure identifiable in Estimates as single cells, for example cell A1 being administration costs within a particular line of departmental spending.
Supply	Resources voted by the Assembly in response to Estimates, for expenditure by government departments.
Supply Estimates	A statement of the resources the Executive needs in the coming financial year, and for what purpose(s), by which Assembly authority is sought for the planned level of spending.
Supply Resolution	The process where the NI Assembly are asked to consider and vote on a motion seeking their approval to the total amounts of cash and resources in the Estimates.
Target rate of return	The rate of return required of a project or enterprise over a given period, usually at least a year.
Third sector	Private sector bodies which do not act commercially, including charities, social and voluntary organisations and other not-for-profit collectives. See annex 7.7.
Total Managed Expenditure, TME	A Treasury budgeting term which covers all current and capital spending carried out by the public sector (i.e. not just by central departments).

Trading fund

An organisation (either within a government department, or forming one) which is largely or wholly financed from commercial revenue generated by its activities. Its Estimate shows its net impact, allowing its income from receipts to be devoted entirely to its business.

Value for money

The process under which organisation's procurement, projects and processes are systematically evaluated and assessed to provide confidence about suitability, effectiveness, prudence, quality, value and avoidance of error and other waste, judged for the public sector as a whole.

Virement

The process through which funds are moved between subheads such that additional expenditure on one is met by savings on one or more others.

Vote

The process by which the Assembly approves funds in response to supply Estimates.

Voted expenditure

Provision for expenditure that has been authorised by the Assembly. The Assembly 'votes' authority for public expenditure through the Supply Estimates process. Most expenditure by central government departments is authorised in this way.

Wider market activity

Activities undertaken by central government organisations outside their statutory duties, using spare capacity and aimed at generating a commercial profit. See annex 7.6.

Windfall

Monies received by a department which were not anticipated in the spending review.

PROGRAMMES OF CARE

DEFINITIONS AND GUIDANCE

VERSION 3 – FEBRUARY 1996

DATA ADMINISTRATION BRANCH

CONTENTS

LIST OF APPENDICES

PROGRAMMES OF CARE

INTRODUCTION

1. This document (Version 3, December 1995) updates PoC guidance in line with changes in definition since Version 2 was published in February 1994. This version does not fundamentally change existing definitions, but takes account of some minor changes as outlined below.

a) Review of Policy for People with a Learning Disability (1995); this report recommended that the term "mental handicap" should be replaced by the term "learning disability". The Royal College Specialty of Mental Handicap remains unchanged. Details of this change were outlined in Data Administration Bulletin BL 2/95 issued in March 1995. PoC formerly known as Mental Handicap has therefore been changed to Learning Disability

b) Dementia Scrutiny Report (May 1995); this report recommended that dementia patients should be allocated to PoC 4 (Elderly Care). However, Down's Syndrome patients who develop dementia should be allocated to PoC 6 (Learning Disability). Data Administration Bulletin BL 10/95, issued in October 1995, includes full details of this change.

c) Specialty of Sick Babies (422); this specialty ceased from 1 April 1995 and activity is now recorded against the paediatric specialty (420). Details of this change were issued in Data Administration Bulletins BL 4/95 and BL 7/95 issued in May 1995 and September 1995 respectively.

2. The definitions in this document should be read in conjunction with the definitions given in Appendix B. Reference should also be made to previous versions of this guidance i.e Version 1 issued December 1992 and Version 2 issued February 1994. A revised set of algorithms is included in Appendix D which can be used as an aid to allocate contacts to the appropriate PoC. Enquiries about the definitions of Programmes of Care should be referred to:

Data Administration Branch
Annexe 2
Castle Buildings
Stormont
Belfast BT4 3UD
Tel: 01232 522523 or 522805.

CLASSIFICATION

3. There are nine separate Programmes of Care. They are:-

PoC 1 Acute Services

PoC2 Maternity & Child Health

PoC3	Family & Child Care
PoC4	Elderly Care
PoC5	Mental Health
PoC6	Learning Disability
PoC7	Physical and Sensory Disability
PoC8	Health Promotion & Disease Prevention
PoC9	Primary Health & Adult Community

ALLOCATION OF ACTIVITY AND COSTS

4. All activity and direct costs within the Northern Ireland HPSS should be allocated to a Programme of Care. Items of expenditure not directly concerned with service delivery, such as Board HQ costs, STAR, Other Training etc, should be excluded from Programmes of Care. There has been considerable discussion on how various areas of work should be allocated. The object of this guidance is to provide a set of rules which will enable all Units and Boards to adopt a consistent approach.

5. The PoC definitions may change as their usage increases and as information systems become more sophisticated, or to reflect the way in which HPSS services are provided.

OVERHEADS AND SUPPORT SERVICES

6. All overheads such as staff and estate costs, plus all support services should be allocated to a PoC based on the activity to which they relate.

APPORTIONMENT

7. The HPSS information and information systems which are currently available do not permit all activity and related costs to be allocated to a specific PoC. To overcome this, it will be necessary to apportion activity based on locally available data and experience.

VOLUNTARY ORGANISATIONS

8. Resources allocated to voluntary organisations for the purchase of direct patient/client care should be allocated to the appropriate PoC based on the attached definitions.

PROGRAMME OF CARE 1 – ACUTE SERVICES

9. Include all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in an acute specialty.

10. Acute specialties are all hospital specialties with the exception of the following:-

SPECIALTY CODE	SPECIALTY
430	Geriatric Medicine
501	Obstetrics
510	Obstetrics (Ante Natal)
520	Obstetrics (Post Natal)
540	Well Babies (Obstetric)
550	Well Babies (Paediatric)
610	GP Maternity
700	Mental Handicap
710	Mental Illness
711	Child & Adolescent Psychiatry
712	Forensic Psychiatry
713	Psychotherapy
715	Old Age Psychiatry

11. Specialty is determined solely by the specialty indicated on the contract of the consultant who has responsibility for the patient. Specialty is not determined by the condition/illness or age of the patient.

12. Include all activity, and resources used, by a hospital consultant in an acute specialty, in relating to an outpatient episode, day case, regular day admission, regular night admission or day care etc.

13. Includes all activity, and resources used, by any health professional as part of a joint consultation with a hospital consultant at an outpatient attendance.

14. See Appendix A for a complete list of all specialties and the PoC to which they should be allocated. See also Appendix D, algorithm 2.

EXCEPTIONS TO THE SPECIALTY RULE

15. It is acknowledged that Geriatric Medicine and Old Age Psychiatry patients may be treated in a general medical ward under the care of a general physician. On the basis of specialty alone, general medical patients would be allocated to PoC 1 (Acute Services) when in fact it is considered more appropriate that these patients should be included in PoC 4 (Elderly Care). To overcome this anomaly, it has been decided that if a ward, clinic or unit in the specialty of General Medicine is concerned solely with elderly patients (ie over 65) that the

activity and associated resources can be included in PoC 4 (Elderly Care), despite the patient being under the care of a general physician.

16. Similarly, to ensure compliance with the recommendations of the Dementia Policy Scrutiny, published in May 1995, units/wards/clinics used solely for dementia patients, under the care of a consultant in an acute specialty, should be allocated to PoC 4 (elderly care).

17. Physical and/or Sensory disabled patients in hospital, are treated in a wide range of specialties such as Rehabilitation (314) and Neurology (400). This makes it impossible to extract these patients and clients on the basis of specialty. It has therefore been decided that only where an individual hospital ward, clinic or unit can be identified as treating Young Physically Disabled (YPD) patients exclusively, should this activity be allocated to PoC 7. The term YPD is used as only those under 65 should be allocated to PoC 7 (Physical & Sensory Disability). All Physical and Sensory Disabled patients over 65 should be allocated to PoC 4 (Elderly).

PROGRAMME OF CARE 2 – MATERNITY & CHILD HEALTH

18. Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties only:-

SPECIALTY CODE	SPECIALTY
501	Obstetrics
510	Obstetrics (Ante Natal)
520	Obstetrics (Post Natal)
540	Well Babies (Obstetric)
550	Well Babies (Paediatric)
610	GP Maternity

19. Specialty is determined solely by the specialty indicated on the contract of the consultant who has responsibility for the patient. Specialty is <u>not</u> determined by the patient's condition/illness or age.

20. Include all activity, and resources used, by a hospital consultant, in one of the above specialties only, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

21. It should be noted that the specialty of "sick babies" ceased from 1 April 1995. This activity is now recorded under the specialty of paediatrics (420) which is PoC 1 (acute services).

22. Includes all activity, and resources used, by any health professional as part of a joint consultation with a hospital consultant, in one of the above specialties, at an outpatient consultation.

23. Includes all community contacts by any health professional where the primary reason for the contact was for maternity or child health reasons.

24. Includes all community contacts to children under 16 if the reason for the contact was not related to mental illness, mental handicap or physical and sensory disability.

25. Includes treatment by community dentists to children under 16 but excludes community dental screening and disease prevention which is included in PoC 8 (Health Promotion and Disease Prevention).

26. Excludes hospital paediatric specialties and gynaecology which are included in PoC 1 (Acute Services).

27. Excludes school health. This is included in PoC 8 (Health Promotion and Prevention).

PROGRAMME OF CARE 3 – FAMILY AND CHILD CARE

28. This programme is mainly concerned with activity and resources relating to the provision of social services support for families and/or children. This includes:

Children in Care

Child Protection

Child Abuse

Adoption

Fostering

Day Care

Woman's Hostels/Shelters

Family Centre

29. This is not intended to be a definitive list of the type of support which may be offered under this programme. It is understood that other areas of work may also be appropriate to PoC 3. See Appendix D, algorithm 1 & 3.

30. Hospital inpatient related activity should be allocated to the appropriate PoC depending on the specialty of the consultant (see Appendix A).

31. Include community contacts by any health professional where the primary reason for the contact is because of family or child care issues should be allocated to PoC 3.

PROGRAMMES OF CARE 4 – ELDERLY CARE

32. Include all activity, and resources used, by any health professional, relating to an inpatient episode, where the consultant in charge of the patient is a specialist in one of the following specialties:-

SPECIALTY CODE	SPECIALTY
430	Geriatric Medicine
715	Old Age Psychiatry

33. Specialty is determined solely by the specialty indicated on the contract of the consultant who has responsibility for the patient. Specialty is not determined by the patient's condition/illness or age.

34. Include all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

35. Includes all activity, and resources used, by a health professional, as part of an outpatient joint consultation with a hospital consultant in one of the above specialties.

36. Include all community contacts to those aged 65 and over except where the reason for the contact was because of mental illness or learning disability.

37. Include all community contacts where the reason for the contact was dementia, regardless of the patient's age. However, Down's Syndrome patients who develop dementia should remain in PoC 6 for any dementia related care or treatment.

38. Include all Physical and/or Sensory disabled patients aged 65 and over.

39. Include hospital patients under the care of a general physician and in a ward, unit or clinic solely for the elderly.

40. Units/Wards/Clinics solely for dementia patients under the care of a consultant in any other specialty, should be included.

41. Include all work relating to homes for the Elderly, including those for the Elderly Mentally Infirm.

42. Age alone is not the determining factor in allocating patients and clients to PoC 4 in that not everyone aged over 65 will automatically be included. For example hospital services are allocated by the specialty of the consultant which could mean that patients under 65 and under the care of a geriatrician will be

located to PoC 4 while patients over 65 but allocated to say a general surgeon will be allocated to PoC 1. Similarly, community contacts are allocated by the primary reason for the contact which could result in an over 65 being allocated to say PoC 5 if the reason for the contact was because of mental illness.

PROGRAMME OF CARE 5 – MENTAL HEALTH

43. Include all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties:-

SPECIALTY CODE	SPECIALTY
710	Mental Illness
711	Child & Adolescent Psychiatry
712	Forensic Psychiatry
713	Psychotherapy

Note that the specialty of Old Age Psychiatry is **excluded** from PoC 5. It is included in PoC 4 (Elderly).

44. Specialty is determined solely by the specialty on the contract of the consultant who has responsibility for the patient. Specialty is <u>not</u> determined by the patient's condition/illness or age.

45. Include all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

46. Exclude the activity and resources used by a unit/ward/clinic for dementia patients by a consultant in one of the above specialties. This activity is allocated to PoC 4 (Elderly Care).

47. Include all activity, and resources used by any health professional as part of a joint consultation with a consultant at an outpatient consultation.

48. Include all community contacts by any health professional where the primary reason for the contact was due to mental health.

49. If the reason for the community contact is that the patient has dementia, the activity should be allocated to PoC 4 (Elderly Care). However, Down's Syndrome patients who develop dementia should remain in PoC 6, Learning Disability (See appendix D, algorithm 3).

50. Exclude all work and resources relating to residential accommodation for the Elderly Mentally Infirm. This is included in PoC 4 (Elderly).

PROGRAMME OF CARE 6 – LEARNING DISABILITY

51. Include all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient has as a main specialty mental handicap (specialty code 700).

52. Specialty is determined solely by the specialty on the contract of the consultant who has responsibility for the patient. Specialty is not determined by the patient's condition/illness or age.

53. Include all activity, and resources used, by a hospital consultant in the specialty of mental handicap, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

54. Include all activity, and resources used, by any health professional as part of a joint consultation with a hospital consultant in the specialty of mental handicap, at an outpatient consultation.

55. Includes all community contacts by any health professional where the primary reason for the contact was learning disability, regardless of age.

56. Include community contacts with Down's Syndrome patients who develop dementia, for any dementia related care or treatment.

57. Include all contacts in learning disability homes and units.

PRORGRAMME OF CARE 7 – PHYSICAL AND SENSORY DISABILITY

58. It is not possible to use hospital specialty to extract from PoC 1 (Acute Services) those patients who are receiving hospital treatment because of a physical and/or sensory disability. Hospital activity and related costs can only be allocated to PoC 7 (Physical & Sensory Disability) on the basis of entire wards, clinics or hospitals which treat only physical and/or sensory disabled patients. Such activity should be removed from PoC 1 (Acute Services) in order to avoid double counting.

59. Include all community contacts by any health professional where the primary reason for the contact is physical and/or sensory disability.

60. Exclude all patients and clients aged 65 and over. These contacts should be allocated to PoC 4 upon reaching 65.

61. For the purposes of Programmes of Care, the following definition can be used to <u>assist</u> health professionals identify patients and clients who can be allocated to PoC 7.

"A permanent physical impairment resulting in a dependency in areas such as mobility, self-care, communication and social/leisure activities.

Examples of services provided might be: rehabilitation for independent living, employment rehabilitation, care services and family support.

The patient/client should be under 65 years old."

PROGRAMME OF CARE 8 – HEALTH PROMOTION & DISEASE PREVENTION

62. PoC 8 classifies all hospital, community and GP based activity relating to health promotion and disease prevention. This includes all screening services, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisations and community dental screening and prevention work.

63. Work by Health Promotion Officers and much of the work (although not necessarily all) of Community Addiction Teams would naturally fall into PoC 8. Work by other staff such as health visitors, community nurses and professionals allied to medicine may have some of their work allocated to PoC 8. Most work allocated to PoC 8 will form part of recognised programmes at which people will receive advice or support specifically for health promotion or disease prevention.

64. It is recognised that most health professionals routinely offer advice on health promotion and disease prevention to patients and clients as part of contacts for other reasons. It is not necessary to allocate these isolated contacts to PoC 8 unless health promotion was the primary reason for the contact.

PROGRAMME OF CARE 9 – PRIMARY HEALTH AND ADULT COMMUNITY

65. Primary Health includes all work, except screening services, carried out by:

General Medical Practitioners

General Dental Practitioners

General Ophthalmic Practitioners

Pharmacists

66. Other staff such as chiropractitioners and homeopathic practitioners may be included in PoC 9, provided the work concerned is on behalf of and directly funded by the HPSS.

67. Patients receiving community based care from community nurses, practice nurses, health visitors, professions allied to medicine, social services etc should be allocated to the appropriate Programmes based on the primary reason for the contact.

68. Community patients aged between 16 and 64, for whom the primary reason for the contact is <u>other than</u> mental illness, learning disability, dementia or physical and sensory disablement should be allocated to PoC 9.

Appendix A

HOSPITAL SPECIALTIES AND THE PoC TO WHICH THEY SHOULD BE ALLOCATED

PoC 1 – ACUTE SERVICES

100 General Surgery
101 Urology
110 Trauma & Orthopaedic Surgery
120 ENT
130 Ophthalmology
140 Oral Surgery
141 Restorative Dentistry
142 Paediatric Dentistry
143 Orthodontics
150 Neurosurgery
160 Plastic Surgery
170 Cardiac Surgery
171 Paediatric Surgery
172 Thoracic Surgery
180 Accident & Emergency
190 Anaesthetics
300 General Medicine
301 Gastroenterology
302 Endocrinology
303 Haematology (Clinical)
304 Clinical Physiology
305 Clinical Pharmacology
310 Audiological Medicine
311 Clinical Genetics
312 Clinical Genetics and Molecular Genetics
313 Clinical Immunology and Allergy
314 Rehabilitation
315 Palliative Medicine
320 Cardiology
330 Dermatology
340 Thoracic Medicine
350 Infectious Diseases
360 Genito-Urinary Medicine
361 Nephrology
370 Medical Oncology
371 Nuclear Medicine

PoC 1 – ACUTE SERVICES /cont

400 Neurology
401 Clinical Neuro-Physiology
410 Rheumatology
420 Paediatrics
421 Paediatric Neurology
450 Dental Medicine Specialties
502 Gynaecology
620 GP Other
800 Radiotherapy
810 Radiology
820 General Pathology
822 Chemical Pathology
823 Haematology
824 Histopathology
830 Immunopathology
832 Neuropathology
901 Occupational Medicine
990 Joint Consultant Clinic
999 Other

PoC 2 – MATERNITY & CHILD HEALTH

501 Obstetrics
510 Obstetrics (Ante Natal)
520 Obstetrics (Post Natal)
540 Well Babies (Obstetrics)
550 Well Babies (Paediatrics)
610 GP Maternity

PoC 4 – ELDERLY CARE

430 Geriatric Medicine
715 Old Age Psychiatry

PoC 5 – MENTAL HEALTH

710 Mental Illness
711 Child & Adolescent Psychiatry
712 Forensic Psychiatry
713 Psychotherapy

PoC 6 – LEARNING DISABILITY

700 Mental handicap

Appendix B

DEFINITION OF TERMS USED IN PROGRAMMES OF CARE

HOSPITAL ACTIVITY IN A PROGRAMME OF CARE

All activity by a consultant regardless of location, plus

All activity by any health professional during an inpatient episode, plus

All activity by any health professional during a joint outpatient consultation.

COMMUNITY CONTACT IN A PROGRAMME OF CARE

Excludes all work by hospital based medical staff. Includes all activity for all other health professionals outside an inpatient episode, except where the work is part of a joint consultant clinic.

HEALTH PROFESSIONAL

For the purposes of Programmes of Care, a health professional is any professional involved in the health and/or social care of patients and clients.

JOINT CONSULTATION

An outpatient consultation where the patient is seen by a clinician plus another health professional at the same time, for the purposes of giving joint advice and or treatment.

Appendix C

ANSWERS TO QUESTIONS RECEIVED DURING THE REVIEW ABOUT ALLOCATION OF WORK TO PROGRAMMES OF CARE

Q1. SHOULD PREVENTATIVE WORK IN COMMUNITY DENTISTRY BE ALLOCATED BY REASON FOR REFERRAL OR AGE?

A All community contacts are initially allocated by the primary reason for referral. If the reason is not due to a mental illness, mental handicap or physical and sensory disability the contact will be allocated by age i.e PoC 2 for children, PoC 4 for the elderly and PoC 9 for all others.

Q2. HOW ARE COMMUNITY CONTACTS ALLOCATED WHEN THE CLIENT HAS MIXED MENTAL AND PHYSICAL HANDICAPS?

A As programmes of care relate to one client group or disability only, the health professional responsible must make a judgement as to the PRIMARY reason for the contact and allocate to the main PoC.

Q3. DOES HEALTH PROMOTION INCLUDE CARDIAC REHABILITATION AND EDUCATION CLASSES?

A Depends on how this advice is given. If it is part of an inpatient episode it should be allocated to PoC 1. If it is part of an outpatient attendance with professional other than a consultant it is likely to be PoC 9 (unless the patient is a child or elderly) and if it takes place in a special group session it could be PoC 8 (Health Promotion).

Q4. HOW SHOULD ATTENDANCES TO ANTE NATAL CLASSES BE RECORDED AND SHOULD PARTNERS BE COUNTED ALSO?

A Allocate to PoC 2 and do not include contacts with partners.

Q5. HOW SHOULD THE WORK OF COMMUNITY ADDICTION TEAMS BE ALLOCATED?

A Not all work by community addiction teams will fall into one PoC. For example talks to groups re healthy lifestyles etc would be PoC 8 while other work could be PoC 5 or PoC 9.

Q6. HOW TO ALLOCATE COMMUNITY CARE CONTACTS TO UNDER 16 YEAR OLDS.

A If the reason for the contact is not because of any mental illness, mental handicap, or physical/sensory disability, allocate to PoC 2 (See appendix D, algorithm 3).

Q7. CAN PHYSICALLY DISABLED CHILDREN ALLOCATED TO PoC 7?

A Yes. In a hospital setting provided the child is being treated in a unit, ward or clinic solely for the physically disabled and for community contacts provided the primary reason for the contact was because of physical disability.

Q8. HOW ARE CHILDREN ALLOCATED DURING ASSESSMENT WHEN A DIAGNOSIS HAS NOT YET BEEN MADE?

A Until a diagnosis has been made allocated by age.

Q9. HOW SHOULD WORK BY PRACTICE NURSES BE ALLOCATED?

A Treat as a community contact and allocate by reason for the contact. (This work is not collected on Korner returns).

Appendix D

ALGORITHMS