Learning Disability spend by return type and Trust

Financial Year	Return type	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
19/20	Community	£11,050,666	£9,607,035	£5,841,185	£7,803,565	£4,687,817	£38,990,268
	Hospital	£33,752,426	£0	£0	£3,133,619	£3,828,479	£40,714,523
	Personal Social Services (PSS)	£77,033,230	£69,620,521	£60,820,674	£64,511,060	£60,862,229	£332,847,713
	Total	**£121,836,321**	**£79,227,556**	**£66,661,859**	**£75,448,244**	**£69,378,525**	**£412,552,505**
18/19	Community	£10,279,845	£8,621,592	£6,049,917	£7,630,860	£4,173,565	£36,755,779
	Hospital	£30,081,340	£0	£0	£2,900,791	£3,439,109	£36,421,240
	Personal Social Services (PSS)	£67,156,718	£59,941,430	£55,825,271	£58,746,185	£54,595,063	£296,264,667
	Total	**£107,517,903**	**£68,563,021**	**£61,875,188**	**£69,277,836**	**£62,207,737**	**£369,441,685**
17/18	Community	£9,876,728	£7,916,021	£5,757,065	£7,314,264	£4,079,258	£34,943,336
	Hospital	£28,014,989	£6,349	£0	£2,488,096	£3,161,218	£33,670,652
	Personal Social Services (PSS)	£60,505,477	£55,597,682	£51,855,953	£54,369,213	£47,408,017	£269,736,342
	Total	**£98,397,194**	**£63,520,052**	**£57,613,019**	**£64,171,573**	**£54,648,493**	**£338,350,330**
16/17	Community	£7,577,518	£7,394,533	£5,155,541	£6,592,792	£3,845,348	£30,565,732
	Hospital	£28,407,974	£6,282	£0	£2,251,419	£2,939,535	£33,605,210
	Personal Social Services (PSS)	£56,935,140	£51,977,067	£48,148,267	£50,202,698	£42,578,141	£249,841,312
	Total	**£92,920,632**	**£59,377,882**	**£53,303,808**	**£59,046,909**	**£49,363,024**	**£314,012,254**
15/16	Community	£8,155,641	£6,200,969	£5,107,998	£6,417,874	£3,671,238	£29,553,719
	Hospital	£28,050,276	£10,363	£0	£2,021,208	£2,978,460	£33,060,306
	Personal Social Services (PSS)	£53,501,751	£47,634,872	£46,544,389	£46,607,749	£38,166,226	£232,454,987
	Total	**£89,707,668**	**£53,846,204**	**£51,652,387**	**£55,046,830**	**£44,815,924**	**£295,069,012**
14/15	Community	£6,859,209	£5,475,464	£5,840,192	£6,215,168	£3,287,422	£27,677,455
	Hospital	£27,772,633	£6,783	£0	£2,415,932	£3,060,370	£33,255,718
	Personal Social Services (PSS)	£48,437,600	£46,029,737	£41,400,712	£43,917,782	£35,353,170	£215,139,000
	Total	**£83,069,442**	**£51,511,984**	**£47,240,903**	**£52,548,883**	**£41,700,962**	**£276,072,174**
13/14	Community	£6,702,941	£5,591,029	£4,530,905	£6,042,973	£3,344,050	£26,211,897
	Hospital	£29,227,351	£6,363	£0	£5,600,229	£3,296,097	£38,130,040
	Personal Social Services (PSS)	£44,141,567	£44,521,930	£37,684,306	£42,085,797	£33,894,242	£202,327,842
	Total	**£80,071,859**	**£50,119,322**	**£42,215,211**	**£53,728,998**	**£40,534,389**	**£266,669,779**
12/13	Community	£5,029,593	£4,827,352	£3,963,247	£6,027,695	£4,000,202	£23,848,089
	Hospital	£28,921,201	£13,772	£0	£8,288,453	£3,232,305	£40,455,731
	Personal Social Services (PSS)	£45,517,207	£42,586,679	£33,231,691	£37,775,239	£31,842,916	£190,953,731
	Total	**£79,468,000**	**£47,427,802**	**£37,194,938**	**£52,091,387**	**£39,075,423**	**£255,257,551**
11/12	Community	£4,331,524	£5,891,927	£4,121,017	£6,649,147	£3,788,424	£24,782,039
	Hospital	£28,762,036	£14,649	£0	£8,008,952	£3,315,181	£40,100,818
	PSS	£40,568,716	£41,655,332	£35,507,346	£35,127,901	£29,764,243	£182,623,537
	Total	**£73,662,276**	**£47,561,908**	**£39,628,363**	**£49,785,999**	**£36,867,848**	**£247,506,394**
10/11	Community	£3,284,046	£5,919,093	£3,793,550	£6,598,374	£3,218,889	£22,813,952
	Hospital	£30,000,660	£16,942	£0	£8,371,849	£4,594,599	£42,984,051
	Personal Social Services (PSS)	£38,427,111	£40,989,092	£32,773,926	£34,136,778	£27,952,695	£174,279,602
	Total	**£71,711,818**	**£46,925,127**	**£36,567,476**	**£49,107,001**	**£35,766,183**	**£240,077,605**
09/10	Community	£3,109,412	£5,372,531	£3,802,014	£6,207,181	£3,395,595	£21,886,733
	Hospital	£29,316,014	£25,677	£0	£8,287,224	£4,453,859	£42,082,774
	Personal Social Services (PSS)	£35,849,311	£37,997,035	£31,947,397	£33,072,231	£25,277,280	£164,143,254
	Total	**£68,274,737**	**£43,395,243**	**£35,749,411**	**£47,566,636**	**£33,126,734**	**£228,112,762**
08/09	Community	£3,383,587	£4,788,076	£3,611,221	£5,150,563	£2,644,323	£19,577,770
	Hospital	£29,049,197	£7,318	£0	£8,846,233	£4,635,446	£42,538,194
	Personal Social Services (PSS)	£33,228,329	£35,357,670	£28,681,151	£31,313,029	£24,480,303	£153,060,482
	Total	**£65,661,113**	**£40,153,064**	**£32,292,372**	**£45,309,825**	**£31,760,072**	**£215,176,446**
	Community	£3,159,498	£4,134,548	£3,545,915	£5,116,470	£2,196,883	£18,153,314

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Learning Disability spend by return type and Trust

Financial Year	Return type	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
07/08	Hospital	£27,673,085	£0	£0	£7,841,799	£4,487,144	£40,002,028
	PSS	£31,446,004	£32,513,035	£27,530,343	£27,879,985	£22,532,650	£141,902,017
	Total	**£62,278,587**	**£36,647,583**	**£31,076,258**	**£40,838,254**	**£29,216,677**	**£200,057,359**
06/07	Community	£2,436,148	£3,792,773	£3,405,177	£4,988,604	£2,237,289	£16,859,992
	Hospital	£24,795,159	£395	£0	£8,820,964	£4,350,395	£37,966,913
	Personal Social Services (PSS)	£27,884,514	£32,156,671	£24,781,150	£25,612,695	£20,174,757	£130,609,787
	Total	**£55,115,821**	**£35,949,839**	**£28,186,327**	**£39,422,263**	**£26,762,441**	**£185,436,692**
05/06	Community	£2,974,052	£3,597,336	£3,256,814	£4,470,201	£2,156,449	£16,454,851
	Hospital	£23,700,402	£688	£0	£8,717,392	£3,977,316	£36,395,798
	Personal Social Services (PSS)	£26,699,676	£30,309,380	£23,861,527	£22,845,243	£18,836,663	£122,552,489
	Total	**£53,374,130**	**£33,907,404**	**£27,118,341**	**£36,032,836**	**£24,970,428**	**£175,403,138**
04/05	Community	£2,761,903	£3,034,734	£3,163,220	£3,941,169	£1,867,679	£14,768,705
	Hospital	£22,313,920	£0	£0	£8,630,768	£3,456,781	£34,401,469
	Personal Social Services (PSS)	£24,838,190	£26,855,010	£22,828,830	£21,202,699	£16,746,041	£112,470,769
	Total	**£49,914,013**	**£29,889,744**	**£25,992,050**	**£33,774,636**	**£22,070,501**	**£161,640,944**
03/04	Community	£2,321,150	£2,748,726	£2,876,174	£3,833,234	£1,811,906	£13,591,190
	Hospital	£22,568,347	£0	£0	£8,646,889	£3,089,555	£34,304,791
	Personal Social Services (PSS)	£23,146,776	£25,362,140	£20,328,361	£19,502,836	£15,199,236	£103,539,349
	Total	**£48,036,273**	**£28,110,867**	**£23,204,535**	**£31,982,959**	**£20,100,697**	**£151,435,331**
02/03	Community	£1,719,999	£3,235,463	£2,665,537	£2,990,623	£1,642,781	£12,254,403
	Hospital	£21,431,754	£246,286	£0	£8,375,464	£2,908,440	£32,961,944
	Personal Social Services (PSS)	£21,043,553	£20,390,705	£17,854,671	£17,720,104	£14,224,606	£91,233,639
	Total	**£44,195,306**	**£23,872,453**	**£20,520,208**	**£29,086,191**	**£18,775,827**	**£136,449,985**
01/02	Community	£1,555,777	£2,992,233	£2,292,176	£2,931,805	£1,471,271	£11,243,262
	Hospital	£21,995,426	£94,440	£10,789	£7,355,078	£2,795,628	£32,251,361
	Personal Social Services (PSS)	£17,008,325	£15,882,660	£14,179,558	£13,671,745	£10,432,958	£71,175,246
	Total	**£40,559,528**	**£18,969,333**	**£16,482,523**	**£23,958,628**	**£14,699,857**	**£114,669,869**
00/01	Community	£1,389,806	£2,248,682	£1,705,620	£2,223,760	£1,292,115	£8,859,983
	Hospital	£18,940,055	£89,437	£10,526	£6,803,274	£2,757,117	£28,600,409
	Personal Social Services (PSS)	£14,950,324	£13,855,988	£12,568,757	£12,400,932	£9,277,956	£63,053,957
	Total	**£35,280,185**	**£16,194,107**	**£14,284,903**	**£21,427,966**	**£13,327,188**	**£100,514,349**
99/00	Community	£1,476,846	£2,788,902	£1,219,892	£1,813,213	£1,156,069	£8,454,922
	Hospital	£18,789,311	£126,932	£34,181	£6,292,445	£2,550,978	£27,793,847
	Personal Social Services (PSS)	£13,348,619	£18,709,002	£6,489,741	£10,928,682	£8,547,236	£58,023,280
	Total	**£33,614,776**	**£21,624,836**	**£7,743,814**	**£19,034,340**	**£12,254,283**	**£94,272,049**

Source: Trust Financial Returns (TFR H,C&P)

Please note:

Hospital, Community and PSS is sourced from annual Trust Financial Returns (TFRs). 2019/20 is latest year information is available

1999/00 to 2002/03 are not directly comparable to later years as the figures above represent Total Expenditure (including adjustment for sub commissioning spend), whereas later years excludes this element of expenditure

Mental Health spend by return type and Trust

MAHI - STM - 089 - 504

Financial Year	Return type	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
2019/20	Community	£19,754,761	£28,441,769	£16,279,106	£22,984,030	£22,159,587	£109,619,253
	Hospital	£55,240,060	£17,547,659	£18,917,923	£14,258,257	£12,806,329	£118,770,228
	PSS	£26,197,090	£22,808,008	£11,236,674	£19,159,801	£14,845,578	£94,247,151
	Total	**£101,191,912**	**£68,797,436**	**£46,433,703**	**£56,402,088**	**£49,811,494**	**£322,636,632**
2018/19	Community	£16,822,367	£25,180,246	£13,195,531	£19,196,630	£19,265,169	£93,659,944
	Hospital	£45,898,767	£15,386,846	£18,817,362	£12,691,721	£12,269,883	£105,064,578
	PSS	£23,627,611	£21,129,080	£9,828,647	£16,856,678	£13,794,471	£85,236,487
	Total	**£86,348,745**	**£61,696,173**	**£41,841,540**	**£48,745,028**	**£45,329,523**	**£283,961,009**
2017/18	Community	£17,889,670	£21,378,024	£11,228,849	£18,564,630	£16,102,344	£85,163,516
	Hospital	£44,200,782	£18,760,070	£18,971,348	£11,657,615	£14,565,968	£108,155,781
	PSS	£20,800,290	£20,648,709	£9,559,831	£15,837,376	£12,227,486	£79,073,691
	Total	**£82,890,741**	**£60,786,802**	**£39,760,027**	**£46,059,620**	**£42,895,798**	**£272,392,988**
2016/17	Community	£16,392,312	£19,296,503	£10,910,391	£16,917,446	£15,020,253	£78,536,905
	Hospital	£42,111,916	£18,980,536	£18,000,039	£10,500,523	£14,593,017	£104,186,031
	PSS	£18,086,005	£19,482,575	£9,049,678	£14,573,750	£11,664,400	£72,856,408
	Total	**£76,590,234**	**£57,759,614**	**£37,960,107**	**£41,991,719**	**£41,277,670**	**£255,579,344**
2015/16	Community	£17,720,770	£20,584,073	£10,078,189	£15,461,266	£14,382,523	£78,226,821
	Hospital	£42,320,680	£19,313,433	£17,451,426	£10,563,028	£14,116,084	£103,764,652
	PSS	£16,576,677	£18,180,111	£8,334,667	£13,326,300	£11,011,885	£67,429,640
	Total	**£76,618,127**	**£58,077,618**	**£35,864,282**	**£39,350,594**	**£39,510,492**	**£249,421,113**
2014/15	Community	£16,130,600	£18,951,149	£9,451,423	£14,222,689	£13,806,294	£72,562,156
	Hospital	£42,647,618	£19,905,724	£17,595,340	£11,507,348	£13,751,210	£105,407,239
	PSS	£15,349,279	£18,564,402	£7,341,002	£12,967,230	£11,445,548	£65,667,461
	Total	**£74,127,496**	**£57,421,275**	**£34,387,764**	**£38,697,268**	**£39,003,052**	**£243,636,856**
2013/14	Community	£15,781,596	£18,768,822	£8,982,071	£12,870,153	£12,758,779	£69,161,420
	Hospital	£41,999,290	£19,284,490	£17,595,256	£11,578,096	£13,725,939	£104,183,070
	PSS	£13,975,076	£14,998,357	£7,209,190	£12,612,219	£11,639,490	£60,434,332
	Total	**£71,755,962**	**£53,051,669**	**£33,786,517**	**£37,060,467**	**£38,124,208**	**£233,778,822**
2012/13	Community	£16,514,176	£17,529,073	£8,559,343	£12,130,278	£12,323,137	£67,056,006
	Hospital	£40,633,820	£20,745,323	£17,593,134	£12,598,545	£13,178,571	£104,749,393
	PSS	£13,950,035	£13,909,126	£5,805,969	£12,543,635	£11,831,486	£58,040,251
	Total	**£71,098,030**	**£52,183,522**	**£31,958,446**	**£37,272,458**	**£37,333,194**	**£229,845,649**
2011/12	Community	£11,993,516	£16,559,277	£8,802,044	£12,433,486	£15,463,300	£65,251,623
	Hospital	£41,585,280	£18,861,631	£16,326,278	£12,648,173	£12,479,705	£101,901,067
	PSS	£13,263,935	£14,823,142	£7,709,079	£12,325,211	£12,179,078	£60,300,446
	Total	**£66,842,732**	**£50,244,049**	**£32,837,401**	**£37,406,871**	**£40,122,083**	**£227,453,136**
2010/11	Community	£12,113,547	£16,286,910	£9,188,756	£12,232,049	£14,058,680	£63,879,942
	Hospital	£43,152,018	£19,289,673	£16,354,077	£12,594,666	£12,066,491	£103,456,925
	PSS	£14,247,675	£14,280,031	£6,838,274	£12,077,740	£13,217,151	£60,660,871
	Total	**£69,513,239**	**£49,856,615**	**£32,381,107**	**£36,904,455**	**£39,342,322**	**£227,997,738**
2009/10	Community	£11,823,548	£13,884,367	£7,502,819	£11,783,677	£12,777,760	£57,772,171
	Hospital	£42,658,244	£21,289,418	£16,397,815	£12,964,297	£13,729,077	£107,038,851
	PSS	£13,328,430	£12,686,571	£6,437,397	£14,805,414	£12,226,596	£59,484,408
	Total	**£67,810,222**	**£47,860,356**	**£30,338,031**	**£39,553,388**	**£38,733,433**	**£224,295,430**
2008/09	Community	£12,438,298	£11,301,935	£7,139,649	£10,074,240	£12,177,565	£53,131,687
	Hospital	£45,091,129	£21,740,142	£16,433,192	£12,337,428	£13,887,319	£109,489,209
	PSS	£12,713,706	£12,792,203	£6,949,390	£14,188,172	£12,184,846	£58,828,317
	Total	**£70,243,133**	**£45,834,280**	**£30,522,231**	**£36,599,840**	**£38,249,730**	**£221,449,213**
2007/08	Community	£11,663,095	£9,415,287	£7,042,550	£8,319,216	£10,388,659	£46,828,807
	Hospital	£36,011,247	£19,655,468	£15,601,726	£12,286,184	£12,257,025	£95,811,650
	PSS	£13,232,736	£12,305,971	£6,509,846	£9,848,762	£11,148,938	£53,046,253
	Total	**£60,907,078**	**£41,376,726**	**£29,154,122**	**£30,454,162**	**£33,794,622**	**£195,686,710**
	Community	£8,409,238	£9,414,157	£6,035,362	£6,510,265	£9,351,038	£39,720,060

Mental Health spend by return type and Trust

MAHI - STM - 089 - 505

Financial Year	Return type	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
2006/07	Hospital	£36,118,122	£18,958,636	£15,836,344	£12,375,323	£12,260,384	£95,548,809
	PSS	£14,430,098	£11,051,211	£5,761,358	£10,185,633	£10,544,072	£51,972,372
	Total	**£58,957,458**	**£39,424,005**	**£27,633,064**	**£29,071,220**	**£32,155,494**	**£187,241,240**
2005/06	Community	£8,048,898	£8,454,064	£5,704,055	£5,729,246	£9,761,718	£37,697,980
	Hospital	£34,618,531	£18,584,261	£14,943,656	£12,050,314	£13,505,703	£93,702,465
	PSS	£12,165,228	£10,566,149	£5,460,714	£9,672,693	£9,671,482	£47,536,266
	Total	**£54,832,657**	**£37,604,473**	**£26,108,424**	**£27,452,253**	**£32,938,903**	**£178,936,711**
2004/05	Community	£6,912,807	£7,438,294	£4,711,680	£4,940,774	£9,730,084	£33,733,639
	Hospital	£33,148,526	£18,504,539	£14,861,774	£11,407,747	£12,748,952	£90,671,538
	PSS	£11,550,042	£10,771,713	£5,098,501	£8,383,296	£9,232,289	£45,035,841
	Total	**£51,611,375**	**£36,714,546**	**£24,671,954**	**£24,731,817**	**£31,711,325**	**£169,441,018**
2003/04	Community	£6,022,393	£6,911,009	£4,131,926	£4,429,906	£7,971,618	£29,466,852
	Hospital	£30,187,481	£17,876,103	£14,526,188	£11,258,752	£11,377,948	£85,226,473
	PSS	£10,749,427	£9,983,686	£5,032,311	£8,088,342	£9,146,540	£43,000,306
	Total	**£46,959,301**	**£34,770,799**	**£23,690,425**	**£23,776,999**	**£28,496,106**	**£157,693,631**
2002/03	Community	£6,694,348	£3,714,352	£3,931,506	£4,138,285	£6,921,951	£25,400,442
	Hospital	£28,781,250	£18,967,626	£16,524,239	£10,428,539	£10,894,975	£85,596,629
	PSS	£9,594,644	£9,258,947	£4,106,990	£7,619,145	£9,195,935	£39,775,661
	Total	**£45,070,242**	**£31,940,925**	**£24,562,735**	**£22,185,969**	**£27,012,861**	**£150,772,732**
2001/02	Community	£6,555,287	£3,915,515	£5,009,793	£3,373,961	£6,477,918	£25,332,474
	Hospital	£26,007,875	£18,175,270	£13,327,244	£9,438,989	£11,546,666	£78,496,044
	PSS	£8,668,612	£7,163,693	£4,072,573	£7,319,929	£8,292,075	£35,516,882
	Total	**£41,231,774**	**£29,254,478**	**£22,409,610**	**£20,132,879**	**£26,316,659**	**£139,345,400**
2000/01	Community	£5,904,505	£3,207,267	£4,561,621	£2,467,115	£6,079,541	£22,220,049
	Hospital	£27,316,574	£16,871,161	£12,393,509	£9,702,727	£11,916,091	£78,200,062
	PSS	£7,872,687	£6,886,588	£3,589,258	£5,959,028	£8,478,092	£32,785,653
	Total	**£41,093,766**	**£26,965,016**	**£20,544,388**	**£18,128,870**	**£26,473,724**	**£133,205,764**
1999/00	Community	£4,990,477	£5,615,295	£1,443,845	£2,210,745	£6,369,674	£20,630,036
	Hospital	£25,807,758	£18,297,764	£9,023,448	£9,111,018	£11,208,263	£73,448,251
	PSS	£6,354,869	£7,906,601	£2,294,456	£5,486,979	£7,911,994	£29,954,899
	Total	**£37,153,104**	**£31,819,660**	**£12,761,749**	**£16,808,742**	**£25,489,931**	**£124,033,186**

Source: Trust Financial Returns (TFR

Please note:

Hospital, Community and PSS is sourced from annual Trust Financial Returns (TFRs). 2019/20 is latest year information is available

1999/00 to 2002/03 are not directly comparable to later years as the figures above represent Total Expenditure (including adjustment for sub commissioning spend), whereas later years excludes this element of expenditure

MAHI - STM - 089 - 506

BUDGET AND COSTS MUCKAMORE ABBEY HOSPITAL 2016/17 to 2018/19

Account area	Account Description	2016/17 Total Budget	2016/17 Total Expenditure	2016/17 Variance (over) / under spend	2016/17 Funded Staff Level	2017/18 Total Budget	2017/18 Total Expenditure	2017/18 Variance (over) / under spend	2017/18 Funded Staff Level	2018/19 Total Budget	2018/19 Total Expenditure	2018/19 Variance (over) / under spend	Funded Staff Level
STAFF COSTS	Total Medical & Dental Pay	937,295	812,550	124,745	12.60	921,274	723,941	197,332	12.60	959,148	1,051,025	-91,877	12.60
	Total Nursing & Midwife Pay	11,902,061	11,174,771	727,291	391.61	11,523,718	10,969,450	554,268	370.77	12,947,617	11,803,613	1,144,004	392.41
	Total Social Services Pay	908,301	966,220	-57,919	25.21	910,074	1,064,797	-154,723	25.21	922,764	1,166,725	-243,961	25.21
	Total P&T Pay	54,341	30,394	23,947	2.51	54,877	45,916	8,961	2.51	56,518	49,425	7,093	2.51
	Total Support Services Pay	0	0	0	0.00	0	34,873	-34,873	0.00	0	22,831	-22,831	0.00
	Total Administration Pay	678,471	721,120	-42,649	26.05	680,406	746,539	-66,132	26.05	664,982	752,707	-87,725	22.18
	Total Management Pay	104,628	104,628	0	2.00	105,084	90,830	14,254	2.00	98,221	48,756	49,465	2.00
	Sub total	**14,585,097**	**13,809,682**	**775,415**	**459.98**	**14,195,433**	**13,676,346**	**519,087**	**439.14**	**15,649,249**	**14,895,083**	**754,167**	**456.91**
STAFF COSTS PCSS	Total Nursing & Midwife Pay	0	0	0		0	0	0		0	31	-31	
	Total Social Services Pay	0	0	0		0	264	-264		0	0	0	
	Total Support Services Pay	1,676,238	1,474,481	201,757	76.64	1,651,178	1,389,591	261,587	74.64	1,729,320	1,429,112	300,208	74.78
	Total Administration Pay	0	52,197	-52,197	0.00	44,700	97,835	-53,135	1.00	45,774	94,949	-49,175	1.00
	Sub total	**1,676,238**	**1,526,677**	**149,561**	**76.64**	**1,695,878**	**1,487,690**	**208,188**	**75.64**	**1,775,094**	**1,524,092**	**251,002**	**75.78**
GOODS AND SERVICES	Goods and Services Muckamore Abbey Hospital	559,997	912,013	-352,016		599,467	513,968	85,499		599,285	758,342	-159,057	
	Goods and Services PCSS	426,140	308,793	117,347		392,080	273,523	118,557		388,458	267,681	120,777	
		986,137	**1,220,806**	**-234,669**		**991,547**	**787,491**	**204,056**		**987,743**	**1,026,022**	**-38,279**	
RATES	Rates	415,110	340,427	74,683		415,110	374,065	41,045		415,110	381,376	33,734	
	Sub total	**415,110**	**340,427**	**74,683**		**415,110**	**374,065**	**41,045**		**415,110**	**381,376**	**33,734**	
SERVICES AND MAINTENANCE	Building And Engineering	48,719	116,036	-67,317		29,877	-32,209	62,086		29,877	177,624	-147,747	
	Heat Light And Power	759,214	357,458	401,756		344,358	474,895	-130,537		349,240	411,837	-62,597	
	M&S Repairs & Maintenance	1,392	0	1,392		1,392	1,350	42		1,656	522	1,134	
	Sub total	**809,325**	**473,494**	**335,831**		**375,627**	**444,035**	**-68,408**		**380,773**	**589,984**	**-209,211**	
INCOME FROM ACTIVITIES	Non Hsc Patients - Other	0	0	0		0	-426	426		0	-1	1	
OTHER OPERATING INCOME	Inc From Non Patient Services	-5,162	-11,724	6,562		-29,723	-33,711	3,988		-5,343	-5,169	-174	
	Income from Seconded staff	0	0	0		0	0	0		-10,762	-10,762	0	
	Sub total	**-5,162**	**-11,724**	**6,562**		**-29,723**	**-34,137**	**4,414**		**-16,105**	**-15,932**	**-173**	
	TOTAL BEFORE DEPRECIATION & SUSPENSE	**18,466,745**	**17,359,362**	**1,107,384**	**536.62**	**17,643,872**	**16,735,491**	**908,381**	**514.78**	**19,191,864**	**18,400,625**	**791,239**	**532.69**
DEPRECIATION	Depreciation	1,109,098	1,109,098	0		1,151,836	1,151,836	0		1,226,584	1,226,584	0	
CAPITAL PAYMENTS SUSPENSE	Capital Payments Suspense	0	12,639	-12,639		0	0	0		0	0	0	
	TOTAL INCLUDING DEPRECIATION & SUSPENSE	**19,575,843**	**18,481,099**	**1,094,745**	**536.62**	**18,795,708**	**17,887,327**	**908,381**	**514.78**	**20,418,448**	**19,627,209**	**791,239**	**532.69**
	CONTROL TOTAL	**19,575,843**	**18,481,099**			**18,795,708**	**17,887,327**			**20,418,448**	**19,627,209**		

NOTES:

The 2018/19 total budget figure has been reconciled back to to the Strategic Resource Framework (SRF) report (coming to within £52.8k).
The SRF report shows planned recurrent investment in services by programme of care at the start of the year, however the budget figures above include non-recurrent funding.
In 2018/19, the non-recurrent element of funding was £2.802m.

An amount of £224,925 was transferred from BHSCT to NHSCT in 2019/20 in respect of a transfer of a Learning Disability Consultant service from BHSCT to NHSCT. This transfer is not yet reflected in the 2018/19 figures above.

The budget and cost figures exclude the 'Iveagh' ward (children's).
The budget and cost figures include 'Daycare' which is likely to be required for any revised model of care in the future.
The budget and cost figures include the swimming pool which is likely to be required for any revised model of care in the future.
The budget and cost figures include the Forensics unit at Sixmile which is likely to be required for any revised model of care in the future.

The budget and cost figures above **exclude** corporate overheads such as Finance, Human Resources, Estates, ICT etc.

There are a number of non-retractable elements within this costing which will be required in the community if the model of care changes.
The Administration team within Muckamore Abbey Hospital performs a large number of corporate functions which would not cease if Muckamore Abbey Hospital were to close (eg PQs / AQs / FoIs / SARs / litigation Amin) and hence the resourcing of this would need to be considered if the model of care changes.

The staff costs underspend in Nursing and Midwifery is as a direct result of the significant recruitment issues that are faced in MAH.
This is why decision has been made to pay the 15% recruitment and retention allowance to staff in an effort to retain those currently in post but also attract additional staff into the site.
In 18/19 the full impact of the high agency spend had not yet been felt. Agency spend in 17/18 was, £166k , in 18/19 was £2.1m and in 19/20 was £6m.
At current rates BHSCT expect to see a full year cost of agency for MAH of some £9m for 20/21 given the position by period 2 has been an average spend of just over £750k per month.
The agency expenditure has ramped up significantly due to the high volumes of agency numbers needed to cover vacancies, high sickness absences , suspensions but also the premium which is required to be paid to those staff due to the Trust having to utilise off-contract agencies.

The additional funding received to meet the MAH pressures was posted to the Nursing and Midwifery Staff Costs budgets.

In 2018/19 Trust Management accounts, MAH was £152k overspent at the end of 2018/19 which formed part of the overall overspend for LD Division.
Trust Management accounts for MAH include just direct staff salaries and goods and services costs of MAH. They exclude all PCSS, Estates, and other centralised account codes as these are reported within different parts of theTrust's management accounts.
The management accounts for MAH also exclude all of the managerial staff costs, most of which sit in a centralised cost centre in AS&PC.
A reconciliation of the £152k overspend in 2018/9 Trust management accounts for Muckamore, to the 2018/19 variance figures above is included in the next spreadsheet.

It is worth flagging that the £2.1m referenced in the oral question included care management as well as all other parts of LD Division.
There is a risk that comparisons may be drawn between figures that are not related and therefore not directly comparable. This can be misleading to the public and other interested parties.

Depreciation is non cash expenditure which is funded as part of the Trust's Non Cash Revenue Resource Limit. Depreciation is neutrality funded – ie the expenditure is matched by the non cash RRL
Depreciation is also referred to as capital charges. As this costing exercise has been taken as a direct lift from the General Ledger this should also be included in the Trust Financial Return by costing staff as they are working from the same source.

The Trust is preparing actual spend figures against budget for 2019/20

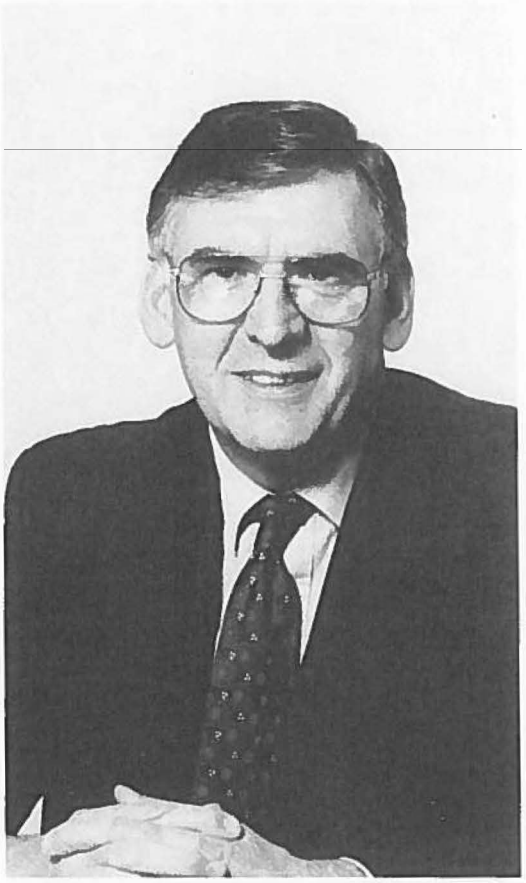
Fit for the future

A consultation document on the Government's proposals for the future of the Health and Personal Social Services in Northern Ireland

DHSS

Fit for the future

CONTENTS



FOREWORD

This year marks the 50th anniversary of the National Health Service (NHS) and the 25th anniversary of integrated Health and Personal Social Services (HPSS) in Northern Ireland. Over that period the people working in the HPSS have served with dedication, professionalism and fairness, often through very difficult times, and are rightly held in the highest regard and affection by the people of Northern Ireland.

This Government is committed to building on that proud tradition and to maintaining and supporting strong, flourishing health and social services. We need to return to the founding principles of providing the very best care and treatment, available to everyone on the basis of need - a seamless web of care.

The internal market introduced by the previous Government did not improve services. It was supposed to promote efficiency, effectiveness and quality. Instead it brought damaging fragmentation, unfairness and increased bureaucracy. Worse still, it distracted staff from the real challenge of providing better services. That is why this Government is abolishing the internal market and replacing it with new arrangements based on co-operation, not competition.

The Government has published White Papers in England, Scotland and Wales setting out its vision for a new NHS and the changes which will be introduced in Great Britain to achieve that vision. This consultation document

reflects many of those changes. It establishes some firm policy principles around which the HPSS will continue to develop.

In setting those principles, I believe the time is right also to examine whether we have the right organisational structures in Northern Ireland to permit the HPSS to meet their fundamental objective of improving the health and well-being of the people of Northern Ireland. I know that organisational change can be complex and is potentially controversial. That is why I have decided to issue a consultation paper at this stage. It is very important that all those who may be affected by any changes - those who work in the services as well as those who use them - have an opportunity to express their views on how the HPSS should be organised. To be successful, any change process needs the participation and support of all those who will be affected.

My aim is to ensure that Northern Ireland has modern and effective health and social services which deliver high quality care and treatment to everyone on the basis of need. Services designed to meet the fresh challenges and opportunities of a new millennium. In publishing this consultation paper, I am inviting everyone in Northern Ireland to let their views be known to help shape the way ahead. I look forward to the responses.

TONY WORTHINGTON
MINISTER FOR HEALTH AND SOCIAL SERVICES

1. INTRODUCTION

1.1. In December 1997 the Government set out its vision for improving the health and well-being of the people of Northern Ireland in 'Well into 2000 - A Positive Agenda for Health and Well-Being'. That document recognised the key role which the health and personal social services (HPSS) will play in realising the vision, and the need to renew and modernise the HPSS to make them fit for the future. It set the Government a new goal in relation to the HPSS:

'To provide and maintain a structure for the organisation of the health and personal social services which promotes health and well-being and delivers the best possible services when and where they are needed.'

To achieve that goal, the Government will abolish the internal market for health and social care, including the GP Fundholding Scheme, and replace it with new, more effective arrangements for delivering health and social services.

1.2. 'Well into 2000' committed the Government to publishing a consultation paper inviting views on proposals for change. This document fulfils that commitment. It marks the beginning of a process of developing and implementing new arrangements for the organisation, planning, management and delivery of health and social services in Northern Ireland.

1.3. The broad policy principles in this paper are similar to those in the recently published White Paper The 'New NHS - Modern and Dependable' (Cm 3807)[1], which sets out the Government's vision for the National Health Service (NHS) in England. However, these principles have been tailored to take account of the integrated system of health and social services in Northern Ireland.

1.4. This paper aims to:

- set out the Government's overall vision for the HPSS;
- identify the key changes needed to achieve that vision;
- identify the key issues to be resolved; and
- invite views on the issues raised and the way forward.

[1] The White Paper 'The New NHS, Modern and Dependable' (Cm 3807) is available from Government bookshops, priced at £12.50 (ISBN 0-10-138072-0). The White Paper 'Putting Patients First' (Cm 3841) describes similar new arrangements for Wales. It is also available from Government bookshops priced at £9.75 (ISBN 0-10-138412-2). The White Paper 'Designed to Care' (Cm 3811) describes new arrangements for Scotland. It is also available from Government bookshops priced at £6.80 (ISBN 0-10-138112-3).

1.5. Any new arrangements must be shaped by the people most closely involved with health and social services - the staff on whose skills and dedication the services are built - and, just as importantly, the people who use them. Therefore, before deciding on the way forward, the Government wishes to invite views on the issues raised in this paper.

1.6. This paper is being sent for comment to Health and Social Services Boards, Trusts, Agencies and HSS Councils; GPs and other family health service practitioners; the Queen's University of Belfast and the University of Ulster; trades unions, health and social services training organisations and professional bodies; Northern Ireland political parties; MPs, MEPs and District Councils; and voluntary, community and private sector organisations. It is also being made available direct to the public on request and through libraries, health and social services premises, and via the Internet and HPSS Intranet. Throughout the document attention is drawn to questions and issues on which the Government would particularly welcome views. However, comments on any of the issues raised in the paper will be welcome. The address to which comments should be sent is shown at the end of the paper, along with telephone numbers for enquiries about the paper.

1.7. The period of consultation will extend until 31 August 1998. The views expressed will help the Government's decisions on the way ahead for the HPSS, which will be published in the autumn this year. The range of issues to be addressed will present a formidable agenda for action. For example, the drive to improve quality, effectiveness and efficiency will require a long-term commitment to a process of continuous improvement over many years; it will not be completed overnight. Any decisions to change organisations and structures will undoubtedly be of particular and immediate interest to those who work in the HPSS. Pending the outcome of this consultation, the Government will wish to move ahead quickly with any changes, starting in 1999. An implementation plan for giving effect to changes will be drawn up in close collaboration with the HPSS.

2. THE GOVERNMENT'S VISION - THE NEW HPSS

2.1. The HPSS in Northern Ireland have a proud record of achievement. They are staffed by dedicated and skilled professionals across many disciplines, all committed to providing the best possible care and treatment to the hundreds of thousands of people who use the services each year. But there are some areas where improvements are needed. For example: it can sometimes take too long for patients and clients to get the care or treatment they need; the quality of the services can vary; the internal market makes it harder for HPSS organisations to work in partnership; and many HPSS staff feel that too much of their time and effort are spent on paperwork rather than on providing health and social care. This paper sets out the Government's proposals for renewing the HPSS, building on the things which work well, and discarding those which do not.

2.2. The new HPSS will be built on seven principles, which will underpin any proposals for change and everything the HPSS do.

- ***Equity***
  The new HPSS must provide a consistent standard of service for the whole of Northern Ireland, with equal access for equal need.

- ***Promoting health and well-being***
  The new HPSS must not only treat people who are ill or in need of care: they must also improve overall health and well-being, and reduce inequalities in health and well-being.

- ***Quality***
  Quality of care must be the driving force for decision making.

- ***A local focus***
  The new HPSS must be shaped by family doctors, nurses, therapists, social workers and other primary care professionals who know what patients and clients need.

- ***Partnership***
  There must be partnership between HPSS organisations as well as with other organisations which can play a part in improving health and well-being.

- ***Efficiency***
  Efficiency must be increased through proper performance management, and by cutting unnecessary bureaucracy.

- ***Openness and accountability***
  The new HPSS must be open and accountable to patients and clients, and must be shaped by their views.

2.3. The new HPSS must be prepared to change, to take account of developments in technology, professional practice and information technology. They will be built around the needs of people, not of institutions, and will provide prompt, reliable care and treatment. They will learn from those at the leading edge of good practice, and will make the best available to all.

2.4. Achieving this vision means changing the way the HPSS are run. The internal market has prevented the HPSS from focusing properly on the needs of patients and clients, and wasted resources on promoting competition between service providers.
This paper proposes how the internal market will be replaced by new arrangements based on co-operation rather than competition, and driven by quality and performance.

2.5. To demonstrate the Government's determination to improve the HPSS, the following targets for the improvement of services are being set now.

- Access to specialist cancer services will be improved so that anyone with suspected cancer will be able to see a specialist within two weeks of his/her GP deciding that he/she needs to be seen urgently and requesting an appointment. These arrangements will be guaranteed, by April 1999, for everyone with suspected breast cancer, and for all other cases of suspected cancer by 2000.

- Hospital waiting lists will be reduced. Additional funding of £13 million has been allocated for 1998/99, which will enable an additional 25,000 operations to take place. The Government has set a target of bringing waiting lists down to 39,000 by 31 March 1999, which will be a reduction of 7,000 since the Government assumed office.

- Patients and clients will benefit from improvements in information and information technology, for example: comprehensive use of a unique patient and client identifier by all of the HPSS (based on the existing Central Health Index Number) is to be achieved within the next three years; extending and upgrading the secure HPSS telecommunications network to include linking every GP surgery within the next three years; speeding up the transfer of information and records together with the transmission of test results and access to the appointments process across the whole of the HPSS; facilitating greater use of telemedicine to enable consultations with hospital specialists to take place in GPs' surgeries; piloting the concept of the electronic patient record including patient-held records

for chronic care; increasing integration of information in order to facilitate person-centred care delivered by multi-disciplinary professional teams.

2.6. These developments will chart progress to quicker and more responsive HPSS. They will demonstrate that services to patients and clients are getting better year by year.

Summary - the new HPSS

The new HPSS will keep the things which work, and discard those which do not. They will be built on seven key principles.

- ***Equity*** - a consistent standard of service for the whole of Northern Ireland, with equal access for equal need.
- ***Promoting health and well-being*** - including tackling inequalities.
- ***Quality*** - quality of care will be the driving force for decision making.
- ***A local focus*** - services will be shaped by primary care professionals who know what patients and clients need.
- ***Partnership*** - the HPSS will work together with other organisations to improve health and well-being.
- ***Efficiency*** - through performance management, and a drive to cut unnecessary bureaucracy.
- ***Openness and accountability*** - to local communities.

Achieving this vision means changing the way the HPSS are run.
The internal market will be replaced by new arrangements based on co-operation rather than competition, and driven by quality and performance.

The Government has set the following targets for improving the HPSS:

- better and faster access to specialist cancer services;
- hospital waiting lists will be reduced by the end of the current Parliament;
- better use of information and information technology.

3. THE NEED FOR CHANGE

3.1. To improve the HPSS, the internal market and the GP Fundholding Scheme must be abolished, and significant changes must be made to the complex, fragmented and bureaucratic structures which were created to support the internal market. There will also need to be a greater emphasis on improving quality, involving patients and clients and developing a primary care-centred service.

3.2. The internal market has been an obstacle to the necessary modernisation of the HPSS. It has created more problems than it solved, for example:

- the market led to fragmentation in planning and decision-making throughout the HPSS;
- the market was built around a false concept of the HPSS as a 'business' that simply did not reflect reality - staff, patients and clients are interested in improving local services, rather than in 'trading' for health and social care elsewhere;
- the market focused on 'business transactions' rather than the things that count most - improvements in quality and in health and well-being;
- there are too many separate organisations tying up resources in bureaucracy which could be better spent on services;
- whilst the GP Fundholding Scheme has some positive features, it has proved to be divisive, bureaucratic and expensive.

3.3. The main changes needed include the following:

- Better use could be made of research findings. The HPSS must have arrangements to ensure the rigorous assessment of the clinical and cost effectiveness of treatments and ensure that good practice is adopted locally.
- Decisions about how best to use resources should be taken by those who care for patients and clients. New primary care-centred local commissioning arrangements will give all professionals who make prescribing and referral decisions the opportunity to make financial decisions in the best interests of their patients and clients.
- The HPSS need to make better use of their resources. The internal market has driven up administrative costs. In England, changes to the NHS will save a billion pounds over the lifetime of the current Parliament. An equivalent target for Northern Ireland - adjusted to take account of our smaller size - would be a saving of £25 million. Therefore, as a minimum, the new HPSS must reduce administrative costs by

this amount over the lifetime of the current Parliament, releasing these resources for better services for patients and clients.

3.4. Change must come about through a carefully considered, collaborative process in which the HPSS play a full role, contributing their considerable energy and drawing on their experience and expertise to ensure the quality of the outcome. This partnership is essential to developing sound new arrangements, and creating that sense of common ownership which has traditionally been the hallmark of the HPSS.

3.5. No one doubts that significant change will be challenging. By taking time and getting the new arrangements right, the HPSS can look forward to a period of stability which will allow them to concentrate their efforts on the significant challenges which lie ahead.

What will change

3.6. Changes are required right across the HPSS. There needs to be a thorough examination of structures, roles, responsibilities and relationships throughout the HPSS. No organisations are to be excluded. However, there will not be change for the sake of change - potential changes will be carefully considered in terms of the net benefit to patients and clients, and the effect on staff, who are the mainstay of the HPSS and their most valuable resource.

3.7. The Government has a number of specific objectives for change.

- ***More co-operation***
  The market forced HPSS organisations to compete against each other even where it would have made better sense to co-operate. In future the relationships between organisations must be based on co-operation, not competition.

- ***Ending unfairness***
  The internal market resulted in an unfair system, with the patients of GP fundholders sometimes having better access to services than patients of non-fundholders with similar or greater clinical need. The GP Fundholding Scheme will end and be replaced with new arrangements which will allow all GPs to obtain fair access to services for their patients. This issue is addressed in chapter 5.

- ***Ending fragmentation***
  The present configuration of an HSS Executive operating within the Department of Health and Social Services (DHSS), 4 Health and Social Services Boards, 19 Trusts, 5 Agencies and 4 Health and Social Services Councils is fragmented, making planning and strategic change difficult to achieve. The streamlining of HPSS structures is addressed in chapters 5 to 8.

- ***More local commissioning***
  The arrangements for commissioning the majority of services should be locally based, involving all GPs and other primary care professionals, including social workers.

- ***Ending inefficiency***
  The new HPSS will be assessed against the things which count most for patients and clients, including the outcomes of care and treatment - not just their cost. Reference costs will allow commissioners to benchmark the performance of providers. Unified budgets will be established for: elective and emergency hospital services; community health and social services; prescribing costs; and GP practice staff, premises and equipment. This will enable resources to be matched locally against the needs of patients and clients, ensuring more efficient and appropriate care.

- ***Ending instability***
  The internal market forced Trusts to compete for contracts that at best lasted a year, and at worst were agreed on a day-to-day basis. Such short-term instability placed a constant focus on maintaining the status quo rather than creating the space to plan and implement major improvement. In the new HPSS, annual contracts will be replaced by longer-term funding agreements, typically three years, although longer terms may be appropriate in some circumstances.

- ***Ending secrecy***
  The fact that HPSS organisations held few public meetings made it difficult for local people to find out what local providers were planning, and how they were performing. GP fundholders could make purchasing decisions without reference to the local community. This is already changing, as Boards and Trusts are now meeting in public. In the new HPSS, organisations will normally be required to hold their meetings in public. Comparative information on performance will be published. Openness and public involvement will be key features of all parts of the new HPSS. However, information about individual patients and clients will, of course, continue to be confidential.

- ***Reducing bureaucracy***
  The Government wants to see as much as possible of the resources available to the HPSS being spent on services for patients and clients. This means that the proportion spent on administration must be reduced.

What will not change

3.8. Not everything will change. The positive aspects of the existing arrangements will be retained, such as:

- ***Separate commissioning and provision functions***
  The development of the commissioning and provision of services as separate and distinct functions is one of the positive features of the internal market. It allows commissioners to focus on the assessment of need and strategic planning, and providers to focus on maximising the quality, efficiency and effectiveness of the services they provide.

- ***Allocating resources on the basis of need***
  Currently, commissioners are funded on the basis of population size and need, and providers are funded on the basis of the services they provide, rather than on the basis of the facilities which they operate. Both of these features of the current arrangements will be retained, as they help to ensure that the HPSS put the needs of patients and clients before the needs of institutions.

- ***Value for money***
  The new HPSS will be driven by quality. However, getting value for money will still be important. This means that HPSS organisations need information about:
  - the costs and effectiveness of particular services, as well as their quality; and
  - how providers' costs compare with each other.

  Much progress has been made in recent years in gaining a better understanding of the costs and value for money of services, and this work will continue.

- ***Greater influence of primary care***
  The Government is ending the GP Fundholding Scheme. New arrangements will be put in its place to reflect the pivotal role that primary care can play in the commissioning of services. Unlike fundholding, however, the Government wishes to see **all** primary care professionals involved in the commissioning of services. The new arrangements will seek to build on the experience of all GPs - both fundholding and non-fundholding - who have been involved in the commissioning of services, and encourage and promote primary care-centred commissioning as a cornerstone of future arrangements. This issue is addressed in chapter 5.

- ***Integrated health and social services***
  The unique integration of health and social services in Northern Ireland has proved to be very beneficial to patients and clients, and is a model which has aroused the interest of other parts of the United Kingdom. The new HPSS will continue to deliver integrated health and social services, but will need to develop them further to ensure that care in hospital, community and primary care settings is truly seamless.

- ***Inter-sectoral co-operation***
  It has been recognised in successive Regional Strategies and in 'Well into 2000' that influences over the health and well-being of the population are exercised far beyond the boundaries of the health and social services. Over recent years many HPSS bodies have been energetic and imaginative in building successful alliances with a wide range of organisations outside the HPSS - in the voluntary, community, private and public sectors - with the aim of working in partnership to improve the health and well-being of the population. This emphasis on inter-sectoral co-operation will be maintained.

Fit for the future

Summary

Things which will change include:

- ***More co-operation*** - the relationships between organisations must be based on co-operation, not competition.
- ***Ending unfairness*** - all GPs will be able to obtain fair access to services for their patients.
- ***Ending fragmentation*** - the new HPSS must be less fragmented to allow better strategic planning.
- ***Local commissioning*** - the arrangements for commissioning services should be locally based, involving all GPs and other primary care professionals, including social workers.
- ***Ending inefficiency*** - the new HPSS will be assessed against the things which count most for patients and clients, including the outcomes of care and treatment as well as their cost.
- ***Ending instability*** - annual contracts will be replaced by longer-term funding agreements, typically lasting 3 years.
- ***Ending secrecy*** - openness and public involvement will be key features of all parts of the new HPSS.
- ***Reducing bureaucracy*** - the proportion of HPSS resources spent on administration must be reduced.

Things which will not change include:

- ***Separate commissioning and provision functions*** - this allows commissioners to focus on the assessment of need and strategic planning, whilst providers focus on maximising the efficiency, effectiveness and quality of the services they provide.
- ***Allocating resources on the basis of need*** - commissioners will be funded according to population size and need, providers will be funded according to the services they provide to meet need.
- ***Value for money*** - the new HPSS will be driven by quality, but value for money and sound financial management will continue to be important.
- ***Greater influence of primary care*** - the Government wishes to see all primary care professionals involved in the commissioning of services, building on the achievements already evident.
- ***Integrated health and social services*** - the new HPSS will continue to deliver integrated health and social services, but will need to develop and cement that integration.
- ***Inter-sectoral co-operation*** - the emphasis on building alliances with a wide range of organisations outside the HPSS will be maintained.

4. IMPROVING QUALITY

Putting quality first

4.1. In the internal market, the measurement of HPSS performance tended to concentrate on activity levels and processes rather than quality and outcomes. This meant that the management focus was on accounts and 'business transactions' rather than the real measures of success - the contribution that was being made to improving the health and well-being of individuals.

4.2. Promoting efficient financial management and ensuring value for money will continue to be important, and the progress made in these areas must not be lost. However, alongside these, the HPSS need to refocus on all aspects of performance.

4.3. There needs to be a shared understanding of the aspects of performance that count. Effective measurement of performance must underpin policy making, strategic planning, the commissioning and delivery of services and the monitoring of outcomes.

Defining and measuring quality - a new framework

4.4. The HPSS need to adopt a new approach to defining and measuring quality which reflects all those aspects of performance which count. The English White Paper announced that the Government would consult on a new framework for measuring quality, containing the following 6 key themes[2].

- ***Health improvement***
  The measurement of quality must reflect the overall aim of improving the general health of the population, which is influenced by a range of factors, including those reaching well beyond the NHS.

- ***Fair access***
  The NHS contribution must begin by offering fair access to health services in relation to people's needs.

- ***Effective delivery of appropriate health care***
  Fair access must be to health care that is effective, appropriate and timely, and which complies with agreed standards.

- ***Efficiency***
  The measurement of quality will include the way the NHS uses its resources to achieve value for money.

- ***Patient/carer experience***
  The measurement of quality will include the way in which

[2] The consultation paper, entitled 'The new NHS Modern and Dependable: A National Framework for Assessing Performance' is available from the Department of Health Stores, PO Box 410, Weatherby, West Yorkshire, LS23 7LN.

patients and carers view the quality of the treatment and care that they receive.

- ***Health outcomes of NHS care*** The direct contribution of NHS care to improvements in overall health will be measured.

4.5. **The DHSS will consult separately on the development and application of a similar quality framework for the HPSS, which will cover health and social services.**

Ensuring quality

4.6. The White Paper for England 'The New NHS, Modern and Dependable' (Cm 3807) announced a number of specific measures aimed at ensuring quality in all parts of the NHS. These include:

- new evidence-based Service Frameworks to help ensure consistent access to services and quality of care across the country;
- a new National Institute for Clinical Excellence to give a strong lead on clinical and cost effectiveness, drawing up new guidelines and ensuring they reach all parts of the health service;
- a new Commission for Health Improvement which will support and oversee the quality of clinical services at local level, tackle shortcomings and intervene where necessary;
- a new statutory duty for NHS Trusts to ensure quality of care through sound clinical governance arrangements;
- clear incentives to improve performance and efficiency - Health Authorities which perform well will be eligible for extra resources, and NHS Trusts and Primary Care Groups (see glossary) will be able to use savings from longer term agreements to improve services for patients; and
- clear sanctions where performance and efficiency are not up to standard - Health Authorities will be able to withdraw freedoms from Primary Care Groups, commissioners will be able to change provider if, over time, service does not meet required standards, and the NHS Executive will be able to intervene to rectify poor performance in any part of the NHS.

4.7. **The DHSS will consider how these or similar measures can best be applied to the HPSS.**

4.8. In addition, the Government will shortly publish a White Paper setting out a number of measures which will be taken in England to ensure the quality of social care. The Government's proposals will cover:

- the regulation of the social care workforce and training through the establishment of a General Social Care Council;
- arrangements for developing and maintaining the competence of the workforce; and
- the registration and inspection of day and domiciliary care.

4.9. **The DHSS will consider the need for similar arrangements in Northern Ireland, and will set out proposals in a separate publication later this year.**

Other key changes

- ***Information requirements and systems***
  A full review of the information and information system implications of any new arrangements will be carried out. The objective will be to develop the necessary measures and systems to support new arrangements whilst minimizing bureaucracy.
- ***Quality standards***
  Research, policy reviews and inspections will guide the development of care standards. There will be clear accountability for the achievement of these standards, measured through audit and inspection, with action taken when these standards are not met.
- ***The Charter for Patients and Clients***
  The Northern Ireland Charter for Patients and Clients will be reviewed in conjunction with a similar review in Great Britain. Charter marks will be symbols of co-operation and collaboration. Charters will concentrate on issues which users identify as important. They will identify the standards users of the service can, of right, expect and the responsibilities they share with service providers.

Summary

Quality will be at the heart of the new HPSS.

The DHSS will consult separately on the development of a new quality framework which will be used to measure quality and performance throughout the HPSS.

The DHSS will consider how new quality improvement measures to be introduced in the NHS in England should be applied in Northern Ireland, including:

- evidence-based Service Frameworks;
- the National Institute for Clinical Excellence;
- the Commission for Health Improvement; and
- a statutory duty for NHS Trusts to ensure quality of care through sound clinical governance arrangements.

A forthcoming White Paper will set out a number of measures to be taken in England to ensure the quality of social care, including:

- the regulation of the social care workforce and training through the establishment of a General Social Care Council;
- arrangements for developing and maintaining the competence of the workforce; and
- the registration and inspection of day and domiciliary care.

The DHSS will consider the need for similar arrangements in Northern Ireland, and will develop proposals.

The Northern Ireland Charter for Patients and Clients will be reviewed in conjunction with a similar review in Great Britain.

5. NEW ARRANGEMENTS - AN OVERVIEW

5.1. To ensure that the services needed by patients and clients are available in the right balance, in the right place and at the right time, there must be effective arrangements for planning, commissioning and providing those services. This chapter gives an overview of the main objectives which the Government has for those arrangements, whilst chapters 6 and 7 give two examples of possible options. Alongside effectiveness, efficiency must remain an important consideration in ensuring value for the taxpayer's money. Therefore, the costs and benefits of any proposals for change will be carefully evaluated in terms of their transitional and ongoing running costs, and also in terms of their effect on staff, services, patients and clients. Final decisions on any new arrangements, and the timetable for their implementation, will be taken in the light of these costs and benefits and the available resources.

Strategic planning

5.2. At present, the strategic planning of health and social services at regional level is the responsibility of the HSS Executive and the Health and Social Services Boards. These arrangements, in which the strategic planning function is split between five separate organisations, can militate against securing strategic change, particularly for services which need to be planned on a Northern Ireland-wide basis, for example, specialised acute hospital services. **Therefore, the Government wishes any new arrangements to have a much stronger strategic planning focus, so that the strategic changes signalled in 'Well into 2000' can be delivered effectively.**

Commissioning - the present arrangements

5.3. At present, the lead responsibility for commissioning [3] rests with the four Health and Social Services Boards. GP fundholders also commission a range of services for their patients. There are 178 fundholding units involving 212 practices. Approximately 70% of the population of Northern Ireland are registered with fundholding GPs. HSS Trusts and Agencies, non-fundholding GPs and other primary care professionals, voluntary, community and private sector organisations also play a part in the commissioning process.

[3] This term is more fully explained in the Glossary of Terms

Primary care-centred local commissioning

5.4. It is the Government's policy that most commissioning decisions should be taken as close as possible to patients and clients. Services will be most responsive to individual and community need if they are commissioned by local primary care professionals. **Therefore, the Government wishes to see a fundamental change, with the main responsibility for commissioning moving from HSS Boards to a more local level, based on smaller populations than those served by Boards, and centred on primary care professionals.**

5.5. Whenever people need help from the HPSS, they will naturally turn first to a primary care professional - a family doctor, community nurse, therapist, pharmacist, dentist or social worker. These primary care professionals are best placed to understand their patients' and clients' needs and either meet them directly or assist them to access services elsewhere. Family doctors who have been involved in commissioning services have welcomed the chance to act as advocates for their patients to improve services. The Government believes that commissioning arrangements should build on this experience. In contrast with the present arrangements, which only involve some GPs, all GPs and other primary care professionals need to be given the opportunity to play their part in new arrangements. None of the new commissioning arrangements to be considered will affect the independent contractor status of general medical practitioners or other family practitioners.

Features of new local commissioning arrangements

5.6. The Government recognises that a number of different approaches could be taken to local commissioning, and would welcome views before taking a decision on the way forward. There are, however, a number of key features which the Government believes must be part of any new arrangements.

- ***They should involve all Primary Care practitioners***
  All primary care practitioners should have the opportunity to be involved in local commissioning, so that all patients and clients, rather than just some, can benefit. This includes: general medical and general dental practitioners; community nurses, health visitors and midwives; social workers; pharmacists; opticians; and the professions allied to medicine.

- ***They should be comprehensive***
  An important criticism of the GP Fundholding Scheme was that it only covered a narrow range of services,

thus encouraging fragmentation in local planning. For example, fundholding covered planned hospital treatment but not emergency hospital treatment. New arrangements for local commissioning must ensure that primary care professionals can take a wider view of the health and social care needs of communities and individuals. This means that local commissioning must cover a broad range of health and social services including some public health functions such as:

- developing and implementing health promotion and disease prevention strategies;
- quality assurance and screening programmes;
- professional input into health protection strategies; and
- activities related to communicable disease control.

- ***They should have a local focus***
  Any new arrangements must be based on areas or populations which are small enough to be local, but large enough for efficient, effective commissioning.

- ***They should not add to bureaucracy***
  The number of commissioning organisations is important - having large numbers of local commissioners could lead to an unacceptable increase in bureaucracy, and could result in the staff with key commissioning skills being spread too thinly.

- ***There should be a single budget for all types of care and treatment***
  Local commissioners must be able to select the right type of care or treatment for their patients and clients without any artificial barriers. At present this can be difficult because there are separate budgets for different types of care - such as prescriptions, hospital treatment and community care. This can sometimes mean that people do not get the right care or treatment because the money is in the 'wrong' budget. To avoid this, local commissioners will work within a single cash-limited budget to cover: elective and emergency hospital services; community health and social services; prescribing costs; and GP practice staff, premises and equipment. This reflects the care and treatment options available for patients, which includes the prescribing of drugs alongside other forms of care and treatment in hospital, in the community, or in GP practices. Unified budgets should help to ensure that people are not forced to remain in hospital because the community care they need is not available.

- ***There should be partnership with other organisations***
  To be effective, commissioning arrangements must involve partnership with other organizations whose work impacts on health and well-being, for example: district councils; education authorities; the Northern Ireland Housing Executive; the police; community, voluntary and private sector organisations.

5.7. Within this new funding framework, the HPSS will continue to give priority to ensuring that all patients have access to the medicines they need. The new arrangements will create flexibility within the total sum to fund care and treatment patterns that best meet patient and client need, without the current artificial constraints and barriers.

Replacing the GP Fundholding Scheme

5.8. The Government has decided that new local commissioning arrangements will replace the GP Fundholding Scheme. There will be no further admissions to the Scheme. There are negative aspects to fundholding. It allowed development of services to take place in a fragmented way outside a coherent strategic plan. It has artificially separated responsibility for emergency and planned care, and meant that some patients have benefited from better care than others.

5.9. However, the Government recognises that many innovative GPs have used fundholding to improve services for their patients. It wishes to build on those achievements, to retain the knowledge and skills of fundholding GPs and others in their primary care teams and to find ways of ensuring that the new local commissioning arrangements draw on their experience and motivation. Fundholders and other key interested parties will be involved in the development and implementation of the new arrangements, including any necessary transitional arrangements.

5.10. In Great Britain the Fundholding Scheme will end on 1 April 1999. On the same date GP fundholders will migrate into the new local commissioning arrangements which have already been announced. However, in Northern Ireland, strategic and policy decisions on structures, roles and relationships as well as on new primary care-centred commissioning arrangements will not be taken and embodied in a policy paper until later this year. Implementation of those policy decisions may be subject to primary legislation and there could therefore be a fairly long transitional period, certainly stretching well beyond 1 April 1999. If the GP Fundholding Scheme were to end in Northern Ireland on the same date as in Great Britain,

it would not be possible to secure an orderly transition from fundholding into the new primary care-centred commissioning arrangements, building on the important commissioning experience of fundholders and their primary care colleagues. In view of this the Government has decided that the Fundholding Scheme in Northern Ireland will end on 1 April 2000, one year later than in Great Britain. As in Great Britain it will be the Government's objective in Northern Ireland to ensure migration from existing successful forms of commissioning to an all embracing, more holistic form, using an approach which will be bottom-up and developmental, fully involving primary care professionals themselves.

Transition to new commissioning arrangements

5.11. The Government recognises that HSS organisations and primary care professionals are keen to make early progress towards new primary care-centred local commissioning arrangements. However, given the possibility of changes to HSS organisations, it is important not to go off in the wrong direction at this stage and create primary care groupings which might subsequently have to be dismantled. Decisions first have to be taken about the new organisational arrangements, about functions and about roles and responsibilities. These decisions will only be taken and announced following consultation on this paper. At that point the Government will expect HSS organisations and primary care professionals to begin work on the process of transition towards new commissioning arrangements in accordance with guidance, including criteria for entry into primary care groupings, which will be issued by the DHSS. Until then, interested parties will undoubtedly want to think about how they would see the future and the type of primary care groupings which might work, but they should not seek to put any new local commissioning arrangements in place, even in shadow form.

5.12. The factors which will determine the timing of the introduction of new commissioning arrangements will also apply to the introduction of unified budgets. Therefore, unified budgets will not be introduced until after 1 April 2000.

Summary -

Primary care-centred local commissioning

The lead role in commissioning will move from Health and Social Services Boards to new, local, primary care-centred commissioning arrangements.

Features of new local commissioning arrangements

New local commissioning arrangements should:

- offer all GPs and other primary care professionals an opportunity to participate;
- cover all health and social services;
- be based on areas or populations which are small enough to be 'local' but large enough for efficient and effective commissioning;
- not add to bureaucracy;
- be based on a single budget covering all types of care and treatment; and
- involve partnership with other organisations whose work impacts on health and well-being.

Summary -

Replacing the GP Fundholding Scheme

The new local commissioning arrangements will replace the GP Fundholding Scheme. There will be no further admissions to the Fundholding Scheme. However, the Government values the experience and motivation of fundholders, and wants the new arrangements to retain and build on the knowledge and skills of fundholders and their primary care colleagues. Fundholders and other key interested parties will be involved in the development and implementation of new local commissioning arrangements, including any necessary transitional arrangements.

The Fundholding Scheme will end on 1 April 2000, one year later than in Great Britain. This is to secure an orderly transition from fundholding into the new primary care-centred commissioning arrangements.

HPSS organisations and primary care professionals should not seek to put new local commissioning arrangements in place until decisions have been announced on organisational arrangements, roles and responsibilities.

The provision of services

5.13. At present there are 19 Health and Social Services Trusts and 5 Health and Social Services Agencies in Northern Ireland. Of the Trusts, one provides ambulance services, seven provide hospital services only, five provide community health and social services (4 of these include continuing care hospital services), and six provide the full range of health and social services.

5.14. The Government considers that this configuration - which was established in response to the internal market - should be re-examined for a number of reasons:

- it is complex and fragmented;
- fragmentation makes the planning of services and the implementation of strategic change difficult;
- the present configuration does not always reflect natural population catchment areas, communities, or the boundaries of key partner organisations such as District Councils, Education and Library Boards, etc; and
- the present configuration is too bureaucratic - there are too many separate organisations tying up too great a proportion of the available resources in administration.

5.15. **Therefore, the Government intends to re-examine the number and configuration of provider organisations with the aim of producing a more effective and efficient configuration.**

6. OPTIONS FOR NEW ARRANGEMENTS - MODEL A

Introduction

6.1. The Government has set out a number of key principles on which the future NHS (and the HPSS in Northern Ireland) will be built. Within this overarching framework, there is scope for developing separate organisational arrangements for different parts of the United Kingdom which reflect local circumstances and needs. The recent White Papers published in England, Scotland and Wales[4] have sought to define the most appropriate arrangements for those parts of the United Kingdom. Clearly, it is also important to develop appropriate arrangements for the circumstances which obtain in Northern Ireland, and which have the scope to meet the needs of any new political structures which may emerge.

6.2. Many different models may be defined, and the Government is keen to hear the views of the people of Northern Ireland on the arrangements which they wish to see for the administration and delivery of the HPSS in Northern Ireland. Two possible models are set out in this chapter and chapter 7 to exemplify the approaches which may be taken, and to help stimulate and focus the debate. There are, of course, other possible options.

Model A

6.3. Drawing heavily upon the key features of the arrangements described in the three White Papers already published in Great Britain, it would be possible to define a model for Northern Ireland which required relatively little change to existing HPSS organisations and structures, but which redefined their roles and responsibilities in line with the requirements of the Government's new policy framework. The main components of such a model would be Health and Social Services Boards, Health and Social Services Trusts and new primary care-centred local commissioning bodies. The main roles and responsibilities of each are described below.

Health and Social Services Boards

6.4. Health and Social Services Boards would be responsible for:

- assessing the overall health and well-being needs of their residents, drawing on the knowledge of other organisations
- drawing up strategies to meet those needs;

[4] See bibliography.

- deciding on the range and location of health and social services for their residents; and
- determining local standards and targets to drive up quality and efficiency in the light of national priorities and guidance, and ensuring their delivery.

6.5. Health and Social Services Boards would have a more strategic role than at present. They would have the lead responsibility for improving overall health and well-being and reducing inequalities, acting in partnership with district councils and other organisations which have an impact on health and well-being. Over time, Health and Social Services Boards would devolve the lead role in commissioning to new local commissioning bodies. As the role of local commissioning bodies developed, the number and configuration of Boards would be kept under review with the aims of: providing a stronger strategic planning focus; increasing efficiency and effectiveness; and reducing bureaucracy.

Local commissioning arrangements

6.6. Local commissioning would be carried out by Primary Care Groups in which the full range of primary care professionals could be involved, including: general medical and general dental practitioners; community nurses, health visitors and midwives; social workers; pharmacists; opticians; and the professions allied to medicine.

Primary Care Groups could serve populations of typically between 50,000 and 100,000. The main functions of Primary Care Groups would be:

- to contribute to local strategies for health and well-being, helping to ensure that this reflects the perspective of the local community and the experience of patients and clients;
- to promote the health and well-being of the local population, working in partnership with other agencies;
- to commission health and social services for their populations;
- to monitor performance against service agreements; and
- to develop primary care.

6.7. Each Primary Care Group would have its population's share of the available resources for hospital and community health services, social services, prescribing and general practice infrastructure. These resources would allow the Group to commission and provide services. Within this single cash-limited envelope, the Group would be able to deploy resources and savings to strengthen local services and ensure that patterns of care best reflect the needs of patients.

6.8. Primary Care Groups, rather than individual practices, would reach service agreements with providers. All general medical practices within

each Group would have a budget for prescribing. Over time, the Groups could extend indicative budgets to individual practices for the full range of services, but no individual element would be artificially capped.

6.9. Primary Care Groups could develop to become free-standing Primary Care Trusts, which could combine with all or part of an existing community Trust. Primary Care Trusts would be accountable to Health and Social Services Boards. They would be managed by a Board of primary care professionals and lay members. They would not be expected to take responsibility for specialised mental health or learning disability services. Primary Care Groups/Trusts would commission hospital services from acute hospital Trusts which would remain as separate organisations accountable to Health and Social Services Boards and Primary Care Groups/Trusts for the services they deliver, and to the HSS Executive for their statutory duties.

6.10. There are various options for the form that Primary Care Groups could take. They could:

I. as a minimum, support Health and Social Services Boards in commissioning care for their populations, acting in an advisory capacity; or

II. take devolved responsibility for managing the budgets for health and social care in their areas, formally as part of a Health and Social Services Board; or

III. become established as free-standing Primary Care Trusts with real devolved budgets but accountable to Health and Social Services Boards for commissioning care and the use of public funds; or

IV. become established as free-standing Primary Care Trusts accountable to Health and Social Services Boards for commissioning care, and with the added responsibility for the provision of community health and social services for their populations. This would involve combining with community Trusts.

Health and Social Services Trusts

6.11. There would be a number of changes to the role of Trusts:

- in place of competition, Trusts would as a matter of right participate in local planning and strategy development;
- there would be explicit new standards for quality and efficiency in agreements between Health and Social Services Boards, Primary Care Groups and Trusts;
- doctors, nurses and other senior professionals would be much more closely involved in designing service agreements with commissioners, and in

aligning Trust financial priorities with clinical priorities;

- clinical governance arrangements would be developed in every Trust to guarantee an emphasis on quality;
- Trusts would be able to share and re-invest efficiency gains to improve services in a way consistent with local strategies; and
- public confidence would be rebuilt through openness, improved governance and public commitment to the values of the HPSS.

6.12. The number and configuration of Trusts would be reviewed with the aim of producing a more effective configuration to meet the service needs of the population.

6.13. **The Government would welcome views on this model generally, and on the following issues in particular.**

Size of Primary Care Group

6.14. **The Government would welcome views on the appropriate population size for Primary Care Groups in Northern Ireland.**

Form of Primary Care Groups

6.15. **The Government would welcome views on what form Primary Care Groups might take and whether they should be expected to progress along the continuum of options described at paragraph 6.10.**

Local Care Agency would need to reflect the range of public and professional interest in its functions. This point is developed further in paragraphs 7.11 and 7.12 below. **The Government would welcome views on the appropriate population coverage of Local Care Agencies.**

Primary Care Partnerships

7.6 Primary Care Partnerships would serve populations of between 25,000 - 50,000. This size of grouping takes account of the experience gained in Total Purchasing Pilots, within which populations of this size facilitate effective primary care-centred commissioning. **The Government would welcome views on the appropriate population coverage of Primary Care Partnerships.**

7.7. The development of Primary Care Partnerships would be locally - driven, within an overall development scheme which would be drawn up by the Department of Health and Social Services. The scheme would specify qualifying criteria which prospective Primary Care Partnerships would have to meet, and their roles, responsibilities and accountability arrangements. The Government would expect Primary Care Partnerships to develop from geographical groupings of GPs and other primary care professionals.

7.8. During the initial development of Primary Care Partnerships, some services would need to be commissioned on their behalf by the parent Local Care Agencies. Over time, Primary Care Partnerships should evolve to the stage where they are commissioning most health and social care with unified, delegated budgets. However, it may be more efficient and effective for the commissioning of some services to remain with Local Care Agencies. **The Government would welcome views on which services should be commissioned by Local Care Agencies rather than Primary Care Partnerships, for example, should services associated with statutory child care and mental health functions be included?** Over time, the Partnerships could also extend indicative budgets to individual practices for the full range of services.

Provision of services

7.9. The creation of Local Care Agencies, with responsibility both for commissioning and for providing, would provide an opportunity to streamline the current configuration of 19 Trusts. There are a number of different ways this could be done. The following paragraphs explore three possibilities.

- ***Fully integrated providers*** This would involve bringing together the existing community and hospital Trusts to create one integrated provider body for

each Local Care Agency. This would mean between 6 and 8 bodies, and it would end the current existence in some parts of Northern Ireland of community-only and hospital-only Trusts. This approach would serve to strengthen the integration of services at delivery level. However, it also carries the risk that strong hospital providers, spending a large proportion of funds and employing large numbers of staff, could dominate smaller community providers. This risk could, of course, be reduced by the influence of determined Primary Care Partnerships able to use their commissioning power to ensure a proper balance.

- ***Separate acute and community providers***
  A second possible approach would be to maintain hospital providers as separate acute Trusts, either within or outside Local Care Agencies. In this scenario, it would be feasible to bring together hospital providers into a small number of coherent groups of acute Trusts. Community providers would be brought together as provider bodies of the Local Care Agencies, with probably one body for each Agency. In this model the Local Care Agencies would be responsible for all primary health and social care, including community hospitals. One effect of this approach would be to separate the hospital and community functions of the current five integrated Trusts. Again, strong Primary Care Partnerships could ensure continuity of care for patients across the hospital/ community boundary through their commissioning power.

- ***A mixture of separate and integrated providers***
  A third possibility would be to develop a 'mixed economy' of community-only, hospital-only and integrated providers, recognising and building upon the successes of these different provider types. As in the example above, some providers, for example, hospitals providing regional services, could remain separate from Local Care Agencies. While this approach would offer greater flexibility, it would also be likely to lead to the continuation of a significant number of separate providers, either as discrete entities within a Local Care Agency, or as separate Trusts, with the associated management overheads.

7.10. **The Government would welcome views on which of these options - or any others - would be appropriate for the provision of services.**

Constitution of Local Care Agencies

7.11. The membership of the Board of a Local Care Agency would need to reflect a wide spectrum of interests: commissioners; providers; professionals; and the voice of the public, as expressed through community and voluntary organisations Equally, its membership must not become so large as to be unwieldy, and it must be able to strike a proper balance between its commissioning and providing functions.

7.12. Each Local Care Agency would have a Board consisting of: a Chairman; a number of executive Directors (including a significant proportion representing Primary Care Partnerships); and a number of non-executive Directors appointed in accordance with the guidelines of the Commissioner for Public Appointments.
Views are invited on the possible constitution of the Boards of Local Care Agencies.

Relationships within Local Care Agencies

7.13. The Government would particularly welcome views on the nature of the relationships within Local Care Agencies. Local Care Agencies would be statutory bodies established by legislation, with overall responsibility for the commissioning and provision of services. These responsibilities would be discharged by Primary Care Partnerships and provider bodies. As already stated, Primary Care Partnerships and most providers[5] would not be separate organisations in their own right, but would be part of a Local Care Agency, and accountable to it. Although the Local Care Agency would be the employer of those staff who are salaried, general medical practitioners, general dental practitioners, community pharmacists and optometrists would retain their independent contractor status, unless they choose to enter into other contractual arrangements permitted under legislation.

7.14. Primary Care Partnerships would have a strong voice in the running of Local Care Agencies and, in particular, in drawing up the Local Care Agencies' strategies. This would be achieved through membership of the Boards of Local Care Agencies. It would also be essential to ensure that the Primary Care Partnerships are in a position to lead the commissioning process. It is proposed that Local Care Agencies would be responsible for providing support to Primary Care Partnerships in their commissioning role.

[5] Other than some Trusts which might remain separate from Local Care Agencies as in the examples described in paragraph 7.9.

The Government would welcome views on how the relationship and accountability framework between Local Care Agencies and Primary Care Partnerships might work.

7.15. **The Government would particularly welcome views on the relationships between Local Care Agencies and providers.** On the one hand, providers must have sufficient day-to-day managerial autonomy to allow them to maximize quality, efficiency and effectiveness - the Government does not wish to see a return to the old top-down command and control arrangements. On the other hand, having separate administrative structures for each provider - such as finance and personnel departments - could lead to an unacceptable increase in bureaucracy.

Fit for the future

Summary - model B

The main elements would be Local Care Agencies, consisting of Primary Care Partnerships and providers.

Commissioning

Local Care Agencies would replace Health and Social Services Boards and some or all Health and Social Services Trusts. They would have two operational elements - Primary Care Partnerships and provider bodies, which would be part of - and accountable to - the Local Care Agency. Local Care Agencies would:

- draw up local strategic frameworks; and
- allocate budgets to Primary Care Partnerships.

There would be 6 to 8 Local Care Agencies with populations of 200,000 to 300,000. The membership of Local Care Agencies would need to reflect a wide spectrum of local interests.

Primary Care Partnerships would be set up and operate within an overall development scheme drawn up by the DHSS. This would contain:

- specific qualifying criteria for prospective Primary Care Partnerships; and
- the roles, responsibilities and accountability arrangements for Primary Care Partnerships.

Primary Care Partnerships would serve populations of 25,000 to 50,000. They should eventually evolve to the stage where they are commissioning most health and social services. Indicative budgets could be devolved to individual practices.

Provision of services

The configuration of providers could be streamlined, for example:

- one integrated provider for each Local Care Agency;
- one community provider for each Local Care Agency with a small number of separate acute hospital providers;
- a mixture of integrated providers, community-only providers, and hospital-only providers, some of which could remain separate from Local Care Agencies.

The Government would welcome views on model B, and in particular on:

- the appropriate population coverage of Local Care Agencies and Primary Care Partnerships;
- the possible configuration of provider bodies; and
- relationships between Local Care Agencies and their constituent Primary Care Partnerships and provider bodies.

Model B - new arrangements at regional level

7.16. Under model B, certain functions would not sit easily within Local Care Agencies, and would need to be carried out under new arrangements at a regional level. Examples include:

- regional strategic planning and accountability for the strategic direction of Local Care Agencies;
- the commissioning of specialized regional services;
- the provision of specialist expertise and support to the local commissioning and provision of services;
- some public health functions;
- standard-setting and regional quality assurance;
- commissioning education and training for professional staff; and
- the regulation and inspection of services.

Strategic planning

7.17. There must be a strong strategic planning focus in order to meet the challenges of changing need and demand for services, and changing types of care and treatment. Strategic plans must set a regional framework for commissioning and provide the basis for performance measurement and accountability of local commissioners. As part of this process the regional arrangements must drive forward the quality agenda.

Specialist commissioning

7.18. The introduction of local commissioning will bring the commissioning process much closer to patients and clients. However, there may be some services which would need to be commissioned regionally, because they are very specialised or because it would be more efficient or effective to commission them on the basis of larger populations. Views would be welcome on the services which should be commissioned regionally.

Public Health

7.19. Some public health functions currently carried out by Health and Social Services Boards could be devolved to Local Care Agencies. However, a strong public health focus at regional level would be essential in order to:

- provide an overview of the population's health status;
- provide a co-ordinated input into policy development and strategy implementation;
- co-ordinate public health activities;
- allow input from and provide advice to practitioners;
- allow communication between different agencies; and
- provide public health leadership.

7.20. In addition to the general responsibilities that need to exist regionally, there are some specific public health functions which could only be performed successfully at a regional level. They include:

- supporting the development of policy and taking forward legislation;
- developing health strategies;
- maintaining an appropriate range of regional services; and
- workforce planning.

Other regional functions

7.21. A number of other functions could not be carried out effectively at the level of Local Care Agencies, such as: regional emergency planning; reviewing the performance of Local Care Agencies and providers; and the wider assessment of need (local assessment would fall to Local Care Agencies). Consideration would also have to be given to the future location of functions such as: quality assurance/inspection; commissioning of professional education; and some statutory functions and duties such as midwifery supervision, responsibilities for children's services and registration and inspection arrangements.

HSS Agencies

7.22. The five HSS Agencies[6] provide a range of regional services to the Boards and Trusts. The Northern Ireland Ambulance Service Trust also provides services on a regional basis. The establishment of new regional arrangements could open the way to establishing new ways of commissioning and providing these services.

Features of new regional arrangements under model B

7.23. Many of the functions listed above might best be carried out on the basis of larger areas or populations than those of Local Care Agencies or Health and Social Services Boards. To keep resources focused on patients and clients, bureaucracy must be kept to a minimum and organisational roles must be clear and transparent. Regional arrangements must also be responsive to Government policy and strategy. **Therefore, it is suggested that, under model B, the functions described above would best be discharged by a single regional organisation focusing on the needs of the entire population.** Other solutions divide responsibilities for functions which are not naturally divisible, and risk

[6] See Appendix.

re-creating some of the functional fragmentation which has dogged internal market arrangements.

7.24. **Views would be welcome on the role and functions of a regional body, its focus and functions, and its relationship with Local Care Agencies and other key interests.**

The HSS Executive under model B

7.25. At present the Health and Social Services Executive - which is within DHSS - undertakes a key public accountability role, supports the Minister and Parliament, and discharges a number of functions relating to the HPSS, including:

- policy and legislation;
- providing leadership, direction and support;
- planning;
- resource allocation;
- human resources matters;
- performance management.

7.26. The possible creation of a regional organisation with a more strategic focus would raise the question of how it should relate to the HSS Executive.[7] If the two were to remain separate, there would be two regional organisations carrying out a range of functions on a Northern Ireland-wide basis. This would not be in keeping with the Government's objective of having streamlined arrangements which minimize bureaucracy and which are easily understood.
Therefore, there would be a strong case for any new regional organisation to be combined with the HSS Executive to form a single organisation.

7.27. Whilst some of the functions of such an organisation could be carried out by a free-standing body, other functions, such as making policy and legislation and providing support to Ministers and Parliament, could not easily be discharged outside Government.
On balance, therefore, the Government considers that any new regional organisation should operate within the DHSS.

Relationships between a regional organisation and Local Care Agencies

7.28. Local Care Agencies would be responsible for commissioning health and social care for their resident populations in order to meet the objectives and targets for improving health and well-being contained in a new, tightly-focused, five-year HPSS strategy which would be drawn up at regional

[7] The position of Health Estates - a Government agency within DHSS which provides a service to both the HSS Executive and the HPSS - must also be carefully considered.

level. Local Care Agencies would be formally involved in the preparation of this HPSS strategy and be directly accountable to the regional organisation for delivering its strategic objectives.

7.29. **The Government would welcome views on the nature, role, functions and configuration of future regional arrangements for the HPSS under model B. In particular, it would welcome views on the establishment of a single regional organisation which would operate within the DHSS.**

Summary

Under model B, certain functions would best be carried out at a regional level, including:

- regional strategic planning;
- specialist commissioning;
- functions which need to be carried out independently of local commissioning;
- promoting regional quality standards and bench-marking, including registration and inspection; and
- holding Local Care Agencies and providers to account for their performance.

It is suggested that these functions would best be discharged by a single regional organisation. There would be a strong case for such an organisation to be combined with the HSS Executive to form a single organisation, operating within the DHSS.

The Government would welcome views on the nature, role, functions and configuration of future regional arrangements for the HPSS under model B. In particular, it would welcome views on the establishment of a single regional organisation which would operate within the DHSS, and the services which should be commissioned regionally.

8. ACCOUNTABILITY

8.1. The new HPSS need to have clear and effective lines of accountability, greater participation and involvement by, for example: the public; elected representatives; the community and voluntary sectors; and patients, clients and carers. There are four main dimensions to ensuring local accountability. Firstly, there is a need to ensure that all HPSS organisations are truly representative of the communities they serve, and operate in an open way. Secondly, there is a need for independent organisations to oversee the activities of the HPSS. Thirdly, there is a need to involve the public in the running of the HPSS; and, fourthly, there is a need to involve individual HPSS users.

Local Representation

8.2. The new HPSS must reflect developments on the broader political front in Northern Ireland. **The Government will, therefore, take account of the outcome of the current political talks process in determining any new arrangements for the HPSS.** The configuration, roles, responsibilities and accountability arrangements of HPSS organisations will be compatible with any new democratic structures which are put in place.

8.3. **The Government would also welcome views on how[8] the membership of HPSS organisations can be made more representative of local communities, for example, by including elected representatives and representatives of community organisations.**

Independent oversight

8.4. At present, Health and Social Services Councils (HSSCs) play an important role in representing the interests of consumers in the commissioning process, and providing an independent oversight.

8.5. **The Government would welcome views on the type of arrangements needed to ensure independent oversight of the new HPSS. It will be important for the new arrangements to be able to focus on all parts of the new HPSS, including the new regional arrangements, local commissioners and providers. The Government would welcome views on the type of organisations required, their membership, configuration, role, responsibilities and accountability arrangements.**

[8] The appointment of members of HPSS organisations will continue to be subject to regulations and guidance issued by the Commissioner for Public Appointments.

Involving the public

8.6. Many people wish to have a strong input to, and a stake in, those decisions which are made on their behalf. To do this effectively, commissioners and providers must provide sufficient information to help people to take a more informed view. Health and Social Services Boards, Trusts and GPs have been working towards giving people a greater voice and providing more information about services, but there is still considerable scope for improvement.

8.7. It is important that commissioners and providers of services work effectively with communities and groups representing particular interests, for example, women's issues, ethnic minorities, or travelling people. Recent developments in Northern Ireland such as the establishment of patient participation groups, special focus groups and more regular engagement with district councils are examples of practical ways of involving users and the public more effectively.

Involving the user

8.8. HPSS commissioners and providers should involve the public and users in decision-making at all levels. Through such user involvement services can be better targeted and refined, so maintaining the highest possible quality of care, and increasing user choice and independence. For the new HPSS to gain the full confidence of the people they serve, they must be given an effective voice in shaping the services that are provided. Services must become more transparent and planning and service delivery more open. This is a necessary part of re-building public trust and confidence. The outcome will be better and more appropriate services.

The Government wishes to receive views on how:

- **the public can be empowered to engage effectively with commissioners and providers in the planning, delivery and evaluation of services; and**
- **the perspective of patients and clients can be harnessed to influence policy and service development positively in the future.**

8.9. In England, the Government will introduce a new national survey of patient and user experience. It will be carried out annually, and the results will be published both locally and nationally. These surveys will give patients and their carers a voice in shaping the NHS.

The Government would welcome views on the scope and frequency of similar surveys in Northern Ireland.

Summary

The new HPSS need to have clear and effective lines of accountability, greater participation and involvement by, for example: the public; elected representatives; the community and voluntary sectors; and patients, clients and carers.

The Government will take account of the outcome of the current political talks process before finalising the new arrangements for the HPSS.

Every opportunity must be taken to encourage individuals and communities to participate at all levels within health and social services. Services must be built from a firm foundation of user, community and public involvement.

The Government would welcome views on:

- **how the membership of the boards of HPSS organisations can be made more representative of local communities, for example, by including elected representatives and representatives of community organisations;**
- **the type of arrangements needed to ensure independent oversight of the new HPSS;**
- **how the public can be empowered to engage effectively with commissioners and providers in the planning, delivery and evaluation of services;**
- **how the perspective of patients and clients can be harnessed to influence policy and service development positively in the future;**
- **the scope and frequency of surveys of patient, client and carer experiences to give them a voice in shaping the HPSS.**

9. THE MANAGEMENT OF CHANGE

9.1. The Government believes that significant changes may be required in order to make the vision of the new HPSS a reality. This does not mean change for the sake of change, or change which is driven by dogma. It means change for the better, keeping the things that work, and discarding the things which have failed.

9.2. Change inevitably brings challenges. It can also give rise to concern amongst staff and patients and clients. The process of change must be properly managed in order to address those concerns and meet the challenges. This means:

- involving staff from across the HPSS in a genuinely inclusive manner throughout the process;
- fostering an atmosphere of openness and honesty;
- communicating clearly with staff throughout the process, making information freely available to individual staff members, trades unions and professional bodies and patients, clients and carers and the organisations which represent them, and listening to their ideas and concerns;
- evaluating the costs and benefits of proposed changes, not only in financial terms, but in terms of their effect on patients and clients and staff; and
- piloting change where feasible or phasing its implementation so that lessons can be learned and mistakes avoided.

9.3. Staff throughout the HPSS will want to know what this means for them and for the services they provide. Until the outcome of the consultation process is known the Government cannot say for certain what changes will take place or which staff will be affected. However, the aim of Government is to provide and enhance the quality, care and treatment provided to the people of Northern Ireland and, therefore, the demand for the skills, knowledge and experience of front-line staff will continue.
It is possible that the content of some of these jobs could change, but they will not necessarily disappear. For other staff, a reduction in the number of HPSS organisations may result in significant change but again for many little will change. Sound administration and effective management will continue to be of the utmost importance. In considering the way ahead for the HPSS it is important that bureaucracy is not confused with management.
An organisation as large and as complex as the HPSS, which consumes resources in excess of £1.7 billion and provides a vast array of services to many hundreds of thousands of people each year, requires managers of the highest

capability if it is to deliver high quality and effective services in a way which achieves value for money. Whatever the outcome, it will be particularly important that all staff have the opportunity to play a full and meaningful role in contributing to the new HPSS and enabling the Government to achieve its primary objective of improving the health and well-being of the people of Northern Ireland.

A human resources strategy

9.4. The human resource implications of change require effective and sensitive management. A strategy must be developed to support the change process which ensures a service-wide clear and consistent approach. Guiding principles which will apply in taking forward the human resources agenda should include:

- equality and equity;
- partnership and collaboration with staff, trade unions and professional organisations;
- effective two way communications; and
- established good practice.

9.5. The following are some of the key issues which will need to be addressed.

Slotting in arrangements

9.6. To minimise disruption in the introduction of any revised management arrangements, there needs to be a procedure for slotting in of existing staff where posts in the new structure remain broadly similar.

Competition for senior posts

9.7. There must be a fair and consistent approach to the filling of senior posts throughout the HPSS which ensures that the most able candidates are selected. Where possible, these should be on the basis of competitions internal to the HPSS to ensure that valuable skills and experience are not lost, and also that the change represents value for money for the taxpayer.

Redeployment within the organisation / within the HPSS

9.8. Procedures will be required to enable the organisation to match any surplus staff to potentially vacant posts within their own organisation/throughout the HPSS.

Protection of pay and terms and conditions of service

9.9. Consideration needs to be given to the level of protection which will be afforded to staff who, as a consequence of change, are required to move by transfer, or in competition, to a new post.

Redundancy arrangements

9.10. Whilst every effort will be made to minimise any redundancies both in terms of the implications for staff involved and the cost to the HPSS overall, it will be necessary to have a policy for the handling of

redundancies covering matters such as the selection process and other arrangements.

Appeals

9.11. Matters may arise from the change process for which there is presently no appeals mechanism if staff feel dissatisfied. Issues which are appealable will have to be identified and a procedure put in place which ensures that they are dealt with fairly and within a specified time.

Termination payments for senior managers

9.12. Guidance should be provided on the principles to be taken into account when considering termination payments on the early termination of contracts.

Mergers - variations in terms and conditions

9.13. Some staff, particularly at manager level, are employed on Trust contracts and there may be some variations in terms and conditions between Trusts. It will be necessary to decide how any such variations are managed when organisations are merged.

Policy Appraisal and Fair Treatment (PAFT) implications

9.14. Every effort must be made to ensure that procedures / policies are fair and do not disadvantage particular groups of staff. PAFT must be kept in mind from the outset.

Staff participation

9.15. The Government will expect HPSS organisations to engage in open communication and collaboration with staff in planning and implementing change and service development as the best way for the HPSS to improve the care and treatment of patients and clients. Open communication - including early discussion of any changes - is an integral part of good management, and all staff should have the maximum opportunity to contribute their ideas for managing change which will lead to service improvement. All HPSS organisations will be required to work in partnership through staff consultative committees and other local arrangements to improve dialogue about decisions affecting staff and the delivery of services.

Interested parties

9.16. The management of change in the HPSS can be only addressed effectively if all key parties work together to develop a consistent, service-wide approach. The Government will involve all key interests in drawing up a strategy which will address the human resource implications of the changes which will emerge.

9.17. **The Government would welcome views on the management of the process of implementing new arrangements, including a human resources strategy.**

Summary - the management of change

The process of change must be properly managed. This means:

- involving staff from across the HPSS;
- fostering an atmosphere of openness and honesty;
- communicating clearly with staff throughout the process;
- evaluating the costs and benefits of proposed changes, not only in financial terms, but in terms of their effect on patients and clients and staff;
- piloting change where feasible or phasing its implementation.

A human resources strategy must be developed to support the change process, covering:

- slotting in arrangements;
- competition for senior posts;
- redeployment within the organisation/within the HPSS;
- protection of pay and terms and conditions of service;
- redundancy arrangements;
- appeals;
- mergers - variations in terms and conditions; and
- PAFT implications.

The Government would welcome views on the management of the process of implementing new arrangements, including a human resources strategy.

10. CONCLUSION AND NEXT STEPS

Conclusion

10.1. This paper sets out the Government's vision for the new HPSS. It details the Government's commitment to refocus the HPSS on its primary purpose of improving health and well-being. Commissioners and providers of services must unite and co-operate to deliver the best health and social care for all. Future services must be centred on the needs of their users and those who care for them. They must be focused on quality, and their performance must be measured against the things which really matter.

10.2. This paper sets out the key principles which will underpin the new HPSS, and the changes the Government wishes to see:

- equity;
- promoting health and well-being ;
- quality;
- a local focus;
- partnership;
- efficiency; and
- openness and accountability.

10.3. The Government has underlined its commitment to a collaborative process of change, in which key interested parties play a major part in shaping the new HPSS. There are many difficult issues to be resolved, and a number of different ways of meeting our objectives. The Government is not wedded to any particular solution. **Whilst this paper sets out a number of policy principles with which any new arrangements should comply, no decisions have been made on the form those arrangements will take, nor will they be made until a broad range of views have been considered. Respondents may, therefore, wish to challenge the suggestions in this paper, or to suggest modifications or alternatives.**

Next steps

10.4. The replacement of the internal market will be a major strategic change, and new arrangements will take some time to develop and implement. The next step is for the Government to consider carefully all the responses to this consultation paper and to take decisions on the broad framework of new structures. Following that, a considerable amount of detailed work will need to be undertaken in collaboration with HPSS organisations and other key interested parties to develop and implement these decisions. Depending on the degree of change required and the availability of resources, this process could take a number of years to complete.

10.5. The Government hopes that as many people as possible will respond to this consultation paper. The HPSS belong to everyone in Northern Ireland. They have served us all well during their first 50 years. Together we can ensure their future into the next millennium.

Your responses

10.6. Written responses to this paper should be sent to the following address by 31 August 1998.

The New Approaches Unit
Department of Health and Social Services
Room 121a
Dundonald House
Upper Newtownards Road
Belfast BT4 3SF

10.7. Alternatively, you may wish to respond by electronic mail. The address is:
new.approaches@dhssni.gov.uk

10.8. Copies of this paper or a separate executive summary, including versions for people with a visual impairment, may be obtained by telephoning 0845 3063030 (calls will be charged at local rates). Electronic versions are available on the Northern Ireland Civil Service (NICS) website at:
http://www.dhssni.gov.uk;
or on the HPSS intranet at:
http://hpssweb.n-i.nhs.uk
A Chinese version of the executive summary may also be ordered from the above telephone number.

10.9. If you have a query about any of the issues raised in this paper, you may telephone 01232 524752, or write to the address shown to the left.

10.10. **In keeping with the Government's policy on openness, responses to this paper may be made available to the public on request. If you do not wish your response to be used in this way, or if you would prefer it to be used anonymously, please let us know when responding.**

GLOSSARY

Accreditation - the official recognition of a facility or service which has voluntarily sought to be measured against prescribed standards and is found to meet those standards.

Acute services - health care and treatment provided mainly in hospitals.

Acute Trusts - Health and Social Services Trusts which provide acute hospital care only.

Benchmarking - a process whereby organisations identify the best performers in particular areas and measure themselves against the best, with a view to securing improvements in their own performance.

Cash limit - the amount of money the Government proposes to spend or authorise on certain services or groups of services.

Central Health Index - a list of all patients registered with a GP in Northern Ireland.

Clinical effectiveness - a measure of whether a particular type of care or treatment works.

Clinical governance - the organisation of services in line with set standards together with the minimisation and appropriate handling of adverse events.

Commission for Health Improvement - a new body proposed by the Government to oversee the quality of clinical governance and of clinical services.

Commissioner for Public Appointments - appointed by - though independent of - Government to monitor, regulate and provide advice on Government Departments' procedures for appointments to public bodies. The Commissioner also has the right to investigate and deal with complaints.

Commissioning - the process of identifying local health and social care needs, drawing up plans to meet those needs, making agreements with service providers to deliver services, and monitoring outcomes.

Community care - health or social care provided outside hospital.

Community nurses - nurses who work in GP practices, district nurses, health visitors and school nurses.

Community Trusts - Trusts which provide community health and social services, but not acute hospital services.

Contract - an agreement between a purchaser and a provider specifying the type and amount of services to be provided, their costs, and the required quality standards.

Cost effectiveness - a measure of the effectiveness of a particular type of care or treatment compared with its cost.

Department of Health and Social Services (DHSS) - the Government Department responsible for health and social services in Northern Ireland.

Elective hospital treatment - non-emergency treatment in hospital which is planned in advance.

Family Health Services - services provided by family doctors, dentists, pharmacists, opticians, community nurses, midwives, health visitors and professions allied to medicine.

General Medical Services - services provided by family doctors (GPs) and their staff.

GP Fundholding Scheme - a scheme which allows some GPs to manage budgets for certain services.

Health and Personal Social Services (HPSS) - includes hospital services, community health services, personal social services and general medical services.

Health and Social Services Agencies - organisations which provide a range of specialized services. There are 5 such agencies:

- the Central Services Agency;
- the Health Promotion Agency;
- the Regional Medical Physics Agency;
- the Blood Transfusion Agency; and
- the Guardian ad Litem Agency.

Health and Social Services Boards - organisations responsible for commissioning health and social services for their resident populations. There are 4 Health and Social Services Boards (see Appendix).

Health and Social Services Councils - organisations responsible for representing the views of health and social services users, and for providing an independent oversight of the activities of Health and Social Services Boards. There are 4 Health and Social Services Councils, one for each Health and Social Services Board area.

Health and Social Services Trusts - organisations responsible for providing health and social services, and for exercising certain statutory functions on behalf of Health and Social Services Boards. There are 19 Trusts (see Appendix).

Health Authorities - the organisations in England and Wales which are responsible for commissioning health care. They are not responsible for social care.

HPSS Intranet - the means by which HPSS organisations can exchange information via computer.

HSS Executive - the part of the DHSS which is responsible for policy and legislation covering health and social services matters, and for managing the HPSS.

Integrated health and social services - health and social services which are commissioned or delivered together by one organisation.

Integrated Trusts - Trusts which provide both health and social services.

Internal market - the arrangements under which commissioners purchase services from providers in a competitive environment.

Local Care Agency - a possible new type of HPSS organisation which would bring together both commissioning and provision (see chapter 7).

MEP - Member of the European Parliament.

MP - Member of Parliament.

National Institute for Clinical Effectiveness - a new Institute which will be set up to promote clinical and cost-effectiveness and the production and dissemination of clinical guidelines.

National Schedule of Reference Costs - a national schedule in which providers will be required to publish their costs on a consistent basis.

NHS Executive - the part of the Department of Health (London) which is responsible for policy and legislation for the NHS, and for managing the NHS in England.

Northern Ireland Charter for Patients and Clients - the document which sets out the rights of patients and clients in relation to the HPSS, and certain standards which the HPSS must meet.

Personal social services - personal care services for vulnerable people, including those with special needs because of old age or physical or mental disability, and children in need of care and protection.

Policy Appraisal and Fair Treatment (PAFT) - a requirement to test new policies or initiatives to ensure that they do not disadvantage or unfairly discriminate against individuals or groups on the basis of religion, gender, political affiliation, marital status, number of dependants, ethnicity, disability or sexual orientation.

Primary care - includes family health services (see above) and major components of social care.

Primary Care Groups - new local commissioning organisations which would bring together groups of GPs and other primary care professionals to commission care for their resident populations (see chapter 6).

Primary Care Partnership - part of a Local Care Agency (see above and chapter 7). Primary Care Partnerships would bring together groups of GPs and other primary care professionals to commission care for their resident populations.

Providers - organisations which provide health and/or social services.

Public health - how society is organised to prevent disease, prolong life and promote health.

Secondary care - specialist care, typically provided in a hospital setting or following referral from a primary or community health professional.

Service framework - a means of bringing together the best evidence of clinical and cost effectiveness with the views of service users to determine the best ways of providing particular services.

Social Services - see personal social services.

Tertiary care - that type of care which, because of the rarity or complexity of the conditions involved, can only be provided from a limited number of centres. In Northern Ireland, this will usually be a single centre.

Total purchasing pilots - groups of GPs who purchase hospital and community care services not covered by the Fundholding Scheme on behalf of their patients and clients. Legal responsibility for these services remains with the relevant Health and Social Services Board.

fit for the future

APPENDIX - THE HPSS - SOME FACTS AND FIGURES

TABLE 1 HSS EXECUTIVE

NUMBER OF STAFF (1996/97)	DEPARTMENTAL RUNNING COSTS[9] (1996/97)
326	£9,183,606

TABLE 2 HEALTH AND SOCIAL SERVICES BOARDS

HEALTH AND SOCIAL SERVICES BOARD	POPULATION[10]	NUMBER OF STAFF[11]	REVENUE ALLOCATION[12] (1996/97)	COMMISSIONING EXPENDITURE[12] (1996/97)
NORTHERN	411,200	157	£331,077,000	£5,794,000
SOUTHERN	298,800	154	£254,867,000	£4,977,000
EASTERN	667,500	262	£599,105,000	£8,835,000
WESTERN	271,400	83	£233,296,000	£3,759,000
TOTAL	**1,648,900**	**656**	**£1,418,345,000**	**£23,365,000**

[9] Includes staff costs and general administrative expenditure such as travelling and subsistence costs, training etc.

[10] Source - estimates compiled by the General Registry Office, June 1995.

[11] Number of staff employed at 31 March 1997. Source - HSSB annual accounts.

[12] Source - HSSB annual accounts.

APPENDIX - THE HPSS - SOME FACTS AND FIGURES

TABLE 3 HEALTH AND SOCIAL SERVICES TRUSTS

TRUST	TYPE[13]	NO OF STAFF[14]	TURNOVER[15] (£000)	MANAGEMENT COSTS[14] (M2) (£000)	M2 AS % OF TURNOVER
CAUSEWAY	INTEGRATED	1837	£51,102	£2,927	5.73%
HOMEFIRST	COMMUNITY	3316	£95,913	£5,128	5.35%
UNITED HOSPITALS	ACUTE	2778	£77,985	£3,882	4.98%
CRAIGAVON AREA HOSPITALS	ACUTE	1454	£45,598	£2,553	5.60%
C'AVON BANBRIDGE COMMUNITY	COMMUNITY	1025	£32,534	£1,996	6.14%
ARMAGH/D'GANNON	INTEGRATED	1979	£57,790	£2,672	4.62%
NEWRY & MOURNE	INTEGRATED	1524	£43,392	£1,931	4.45%
N&W BELFAST	COMMUNITY	2584	£84,727	£4,748	5.60%
S&E BELFAST	COMMUNITY	2607	£92,772	£4,637	5.00%
NORTH DOWN & ARDS[16]	COMMUNITY	1092	£45,262	£2,351	5.19%
DOWN/LISBURN	INTEGRATED	2310	£83,174	£4,426	5.32%
ROYAL GROUP OF HOSPITALS	ACUTE	4376	£135,709	£5,198	3.83%
BELFAST CITY HOSPITAL	ACUTE	2963	£90,476	£4,248	4.70%
MATER INFIRMORUM	ACUTE	705	£19,404	£1,143	5.89%
GREEN PARK	ACUTE	1417	£49,778	£2,626	5.28%
ULSTER, N. DOWN & ARDS HOSPITALS	ACUTE	2210	£57,781	£2,700	4.67%
ALTNAGELVIN	ACUTE	1306	£46,838	£2,382	5.09%
SPERRIN/LAKELAND	INTEGRATED	3528	£77,776	£4,000	5.14%
FOYLE	COMMUNITY	2152	£67,760	£3,083	4.55%
N.I. AMBULANCE SERVICE	AMBULANCE	680	£18,591	£850	4.57%

[13] See glossary of Terms for definitions of Trust types.
[14] Average number employed in 1996/97. Source - Trust annual accounts.
[15] Source - Trust annual accounts.
[16] Merged with Ulster, North Down & Ards Hospital Trust from 1 April 1998.

Fit for the future

APPENDIX - THE HPSS - SOME FACTS AND FIGURES

TABLE 4 HEALTH AND SOCIAL SERVICES AGENCIES

AGENCY	NO OF STAFF[17]	REVENUE[18]	TOTAL STAFF COSTS[17]
CENTRAL SERVICES AGENCY	551	£30,215,076	£7,489,975
HEALTH PROMOTION AGENCY	28	£1,738,289	£674,057
REGIONAL MED. PHYSICS AGENCY	65	£2,450,870	£1,476,328
BLOOD TRANSFUSION AGENCY	169	£9,038,484	£2,805,556
GUARDIAN AD LITEM AGENCY	17	£300,000	£180,391

[17] Number employed in 1996/97. Source - Agency annual accounts.
[18] Source - Agency annual accounts.

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