TOWARDS BETTER HEALTH CARE:

MANAGEMENT IN THE HEALTH BOARDS

THE DEPARTMENT OF HEALTH

INTRODUCTION

At several stages in Volume I of this report, we raised certain matters that needed either clarification or amplification. These matters are discussed in the following appendices:

A. Our Terms of Reference and Approach, in which we amplify the brief discussion of this subject in the letter of submittal

B. Functions of the Statutory Authorities, in which we describe what we currently understand to be the intended roles and interrelationships of the Department, the Comhairle na nOspidéal, the Regional Hospital Boards, the Health Boards and the local committees in managing the delivery of health care

C. Functions of the Board and the CEO, in which we take some specific examples of significant decisions related to the management of health services and illustrate the part we believe the Board and the CEO should play in reaching them

D. Job Descriptions, in which we identify the major duties responsibilities and reporting relationships of the CEO, programme managers and functional officers

E. Terms of Reference for Hospital Executive Committees, in which we propose some guidelines for the membership, working relationships and principal duties and responsibilities of hospital executive committees

F. Organizing the Visiting Committees, in which we suggest ways of organizing the visiting committees' major activities - i.e., making the actual visits, holding meetings to discuss findings, making recommendations, and ensuring that recommendations are implemented satisfactorily

G. Training of the Health Boards' Officers, in which we suggest ways of taking advantage of the unique opportunity to prepare senior officers for the tasks involved in managing the health services.

Although we have made these appendices into a separate volume, they must be read in conjunction with the main body of the report - Volume I - if they are to be fully appreciated.

APPENDIX A

OUR TERMS OF REFERENCE AND APPROACH

In this appendix we describe the terms of reference that we were given for our assignment, i.e., the questions that the Department wanted us to answer. We then outline the approach we used in trying to find the answers and develop recommendations.

TERMS OF REFERENCE

The Department asked us to recommend answers to four main groups of questions that related to the setting up of the new Health Boards. These questions were:

1. How should the Boards themselves conduct their affairs?
   - What decisions should they make and what decisions should they delegate to their officers?
   - What committees should they have, in addition to the local committees set up under statute?

The Department did not ask us to make recommendations on the other new statutory bodies (the Comhairle na nOspidéal, the Regional Hospital Boards and the local committees), but it was understood that we would have to consider the Boards' relationships with these bodies, so that we could define the Boards' own role clearly.

2. What guidelines should be given concerning officers of the Boards?
   - What should be the CEOs' terms of reference?
   - What other senior officers should the Boards have, and should their numbers and functions vary among large and small Boards?
   - What criteria should be used for recruiting and selecting these officers?

3. What local offices would be needed?
   - Should existing local offices (e.g., at county level) be kept open?
   - If so, what functions should these offices have?

4. What further steps would be required after November 1? Since the deadline for the first report was very tight (only 2 months after the full-time start of the study), the Department recognized that much would have to be done after November 1 to make the new organization effective. This task would involve two main areas, namely:

- What would have to be done to implement the organizational recommendations before April 1?
- How could a practical management information and budgeting system be developed and introduced to meet the Boards' decision-making requirements?

These four groups of questions, then, are the ones we set out to investigate and on which we promised to advise the Department. We also agreed that the approach taken to the assignment should be broad rather than narrow, and should take into account the particular needs and opportunities of the health services in Ireland.

APPROACH

In attempting to answer the Department's questions we took three steps:

1. We set out to understand the main ways in which Ireland wishes to improve the delivery of health care during the 1970s. For this purpose, we

- Analysed trends in the service compared with England and Wales, and other countries
- Read the major commission reports published over the last 10 years relating to health care in Ireland
- Talked to many people in the Department, the local authorities, the institutions and the health service professions.

2. We studied how the Health Boards would interrelate with other statutory bodies. Without an understanding of these bodies - i.e., the Department, the Comhairle, the Regional Hospital Boards and the local committees - we could not hope to understand the tasks of the Health Boards. To gain this understanding we

- Read with care the Health Act, 1970, its accompanying documentation and the debates in the Dáil and Seanad
- Discussed the matter with many senior officers of the Department

- Attended the meetings in Dublin and Cork at which the roles of the Regional Hospital Boards and the Comhairle were explained to the voluntary hospitals by the Minister and his officers
- Defined our understanding of the role of each of the principal statutory bodies (see Appendix B).

3. We formulated recommendations concerning each of the main groups of questions outlined in the previous section. In doing so we

- Focused our analysis and resulting recommendations on the particular role that the Boards might play in improving health care, and how their role would interrelate with those of the other statutory bodies concerned
- Studied the existing arrangements of the Joint Health Authorities in Dublin and Cork, and to a lesser extent in Waterford and Limerick, examining the ways in which the Boards and their committees work, their officer organization and their management processes (the management order system, the present budgeting system and the information available)
- Studied the existing County Management System and the implications of such commissions as the Devlin Review Group in Ireland and the Maud Commission in the United Kingdom
- Discussed the possible alternatives with a wide range of people in most parts of Ireland, including the seven Chief Executive Officers so far selected for the new Health Boards.

* * *

The recommendations that resulted from our study appear in the main body of the report.

APPENDIX B

FUNCTIONS OF THE STATUTORY AUTHORITIES

In the attached charts we explain what we currently understand to be the intended role of each statutory authority in running the health services of the future. Included among the authorities are those established by the Health Act, 1970 - i.e., the local committees, the Health Boards, the Regional Hospital Boards and the Comhairle na nOspidéal.

We were not asked to define the roles of all these authorities but we could not hope to recommend feasible ways for the Health Boards to manage their affairs without at least understanding the functions of the other authorities and their likely relationship with the Health Boards. To gain this understanding we studied closely the Health Act, 1970, and the text of debates in the Dáil and the Seanad, and we talked with many people inside and outside the medical profession both in the Department and in the field.

Under the Act, the Minister clearly has several alternatives available to him in deciding where to assign functions. The regulations in which he prescribes the functions of the authorities, therefore, may well differ from our charts. Our charts specify the broad assumptions on which our recommendations are based but we stress that they are for general guidance only. If any of the authorities turn out to have significantly different functions from those we have assumed, we shall probably need to alter some of our recommendations.

The charts explain the role that we believe each authority should play in reaching a series of decisions. These decision areas are summarized as follows:

1. Develop and implement service programmes

2. Determine annual revenue budget and control expenditure

3. Plan and execute capital projects

4. Determine staffing levels

5. Appoint staff and determine rates of pay.

Under Health Boards, we have not distinguished in this appendix between tasks performed by the Boards themselves, and those performed by the Boards' CEOs and officers. However, Appendix C does make this more detailed distinction.

FUNCTIONS OF THE STATUTORY AUTHORITIES (Continued)

Main Decision Areas	Minister for Health And Department	Comhairle Na nOspidéal	Regional Hospital Boards	Health Boards	Local Committees	Statutory Reference, Where Appropriate, And Other Comments	
						Statutory Reference or Precedent	Other Comme
1. Develop and Implement Service Programmes							
1.1 Set objectives and strategy for developing the services	1.11 Appoint advisory bodies, etc., to recommend ways of developing services	1.11 Set objectives and strategy for developing specialties in individual hospitals (in line with national objectives and strategy, and after consultation with RHB)	1.11 Propose to Department, Comhairle and Health Boards changes in the services that will affect both voluntary and Health Board hospitals	1.11 Propose changes to Department and RHB	1.11 Propose changes to Health Board	Senate debate Col. 817-824 14.1.70 Dáil debates Col. 2186 27.11.69 Col. 2026 27.11.69 Health Act, '70 Section 6, 7, 41	
	1.12 Set national objectives and strategy		1.12 Set objectives and strategies for developing regional hospital services (in line with national)	1.12 Set local objectives and strategies (in line with national and RHB)	1.12 Comment to Comhairle and RHB on proposals concerning functioning of hospitals in local area		
1.2 Implement strategy by means of service programmes	1.21 Recommend or require Health Boards and voluntary hospitals to make specific changes	1.21 Implement strategy by determining consultant and senior registrar establishment in hospitals	1.21 Implement strategy by providing management advisory services and by organizing common services	1.21 Implement strategy at Health Board level*		Dáil debate Col. 2066 27.11.69 Senate debate Col. 817-824 14.1.70 Health Act, '70 Section 6, 41	Strategy is implemente Department Boards, and Regional H Boards by m budget allo
1.3 Review programme effectiveness and take corrective action	1.31 Review programme effectiveness and, when necessary, recommend or require Health Boards and voluntary hospitals to take corrective action (after consultation with them, and with RHBs when appropriate)	1.31 Review progress and change strategy when necessary	1.31 Review programme effectiveness in voluntary and Health Board hospitals and recommend improvements to them, the Comhairle and the Department (after consultation with boards and hospitals concerned)	1.31 Review programme effectiveness at local level and take corrective action	1.31 Review programme effectiveness at local level and advise Health Boards of necessary changes	Health Act, '70 Section 6	Review will ¶ Use of pe mance in ¶ Quarterly uation of programm ¶ Annual re all progra leading t plans and decisions

* – Excludes voluntary hospitals

FUNCTIONS OF THE STATUTORY AUTHORITIES (Continued)

Main Decision Areas	Minister for Health And Department	Comhairle Na nOspidéal	Regional Hospital Boards	Health Boards	Local Committees	Statutory Reference, Where Appropriate, And Other Comments	
						Statutory Reference or Precedent	Other Comments
2. Determine Revenue Budget and Control Expenditure							
2.1 Set guidelines	2.11 Set overall multi-annual figure for budget planning to be used by Health Boards and by Regional Hospital Boards (in the case of voluntary hospitals) 2.12 Direct or recommend priorities for allocation	2.11 Advise Department on priorities for developing specialties and on the associated costs (in consultation with RHB)	2.11 Advise Department on overall guidelines and priorities (for Health Board and voluntary hospitals) 2.12 Set overall multi-annual figure for budget planning in all hospitals (in line with priorities set by Department)	2.11 Advise RHB of priorities for area hospital development* 2.12 Advise Department of other area priorities	2.11 Advise Health Boards of unmet local needs	Department Letter to Voluntary Hospitals: 27.8.70 Dáil debate Col. 2066 27.11.69	Budget guidelines will include an allowance for maintenance but maintenance items will be dealt with as minor capital works under 3-2 and 3-4 below
2.2 Prepare budget	2.21 Set standard programme structure and indicators for use by all Health Boards 2.22 Set standard procedures and formats for all Health Board accounting and budgeting			2.21 Prepare programme budgets within overall figure, taking account of directed/recommended priorities 2.32 Propose total budget to Department, sending copy of hospitals section to RHB		Health Act, '70 Section 27	Public Bodies Orde 1946, regulating accounting proce- dures and format fo local authorities does not apply to Health Boards
2.3 Review/approve budget	2.31 Review all budgets 2.32 Approve/revise all budgets (subject to Department of Finance and Dáil)		2.31 Review all hospital budgets - Advise Department of recommended changes in Health Boards' budgets - Advise Department and voluntary hospitals of recommended changes in voluntary hospitals' budgets	2.31 Review all programme budgets for Health Board 2.32 Approve/revise all programme budgets for Health Board (subject to Department guidelines and directions)	2.31 Propose budget changes in light of unmet local needs	Department Letter to Voluntary Hospitals: 27.8.70 Dáil debate Col. 2066 27.11.69	Comhairle will be informed of appro- ved budget for eac hospital and will develop specialtie within the con- straints imposed by this

* - Excludes voluntary hospitals

FUNCTIONS OF THE STATUTORY AUTHORITIES (Continued)

Main Decision Areas	Minister for Health And Department	Comhairle Na nOspidéal	Regional Hospital Boards	Health Boards	Local Committees	Statutory Reference, Where Appropriate, And Other Comments	
						Statutory Reference or Precedent	Other Comments
2.4 Control expenditure within budget	2.41 Review all monthly health expenditure (in aggregate for each Health Board and RHB) 2.42 Challenge major variances from budget - For voluntary hospitals, with RHB - For all others, with Health Boards 2.43 Authorize variances arising from wage awards, and other departures from constant price budgeting base 2.44 Control all health expenditure within total budget 2.45 Publish up-to-date comparative performance and cost reports		2.41 Review monthly expenditures on hospitals compared with budget 2.42 Challenge major variances to ensure total hospital expenditure is kept within budget - For Health Board hospitals by advising boards and, when necessary, Department - For voluntaries by advising hospital concerned and by initiating corrective action when necessary	2.41 Control expenditure within budget		Health Act, '70 Section 30, 31 Department Letter to Voluntary Hospitals: 27. 8. 70 Senate debate Col. 822 14. 1. 70	
3. Plan and Execute Capital Projects 3.1 Formulate national plan for major capital works (total commitment over £75,000)	3.11 Formulate national plan by - Defining main needs, priorities and long-term objectives - Outlining plan to meet needs for 5 years ahead - Selecting new schemes for coming year - Negotiating finance with Department of Finance	3.11 (Addition of consultant posts - see 4 below - must be integrated with national plan for capital works)	3.11 Propose major hospital projects, including priorities, in region to Department	3.11 Propose major hospital projects in Health Board area to RHB, and major non-hospital projects to Department (copy to RHB)	3.11 Propose developments in locality based on unmet needs	Department Letter to Voluntary Hospitals: 27. 8. 70 Health Act, '70 Section 41	Regional Hospital Boards must take account of Health Board non-hospital projects that may reduce needs for hospital facilities (e.g., welfare homes projects)
3.2 Determine capital budget for minor capital works (total commitment less than £75,000)	3.21 Set overall multi-annual figure for budget planning to be used by Health Boards for all projects, and by RHBs for hospital projects	3.21 (As in 3.11 above)	3.21 Review once a year needs for building maintenance and equipment replacement in all institutions, in light of national plan for hospital development in region	3.21 Propose to RHB (copy to Department) overall hospital needs specifying priorities and - All individual schemes where total commitment will exceed £5,000 - 'Basic capital' required for minor capital schemes and routine maintenance	3.21 Propose developments in locality based on unmet needs	Department Letter to Voluntary Hospitals: 27. 8. 70	Regional Hospital Boards' allocations must take account of Health Board non-hospital projects (as outlined above)

FUNCTIONS OF THE STATUTORY AUTHORITIES (Continued)

Main Decision Areas	Minister for Health And Department	Comhairle Na nOspidéal	Regional Hospital Boards	Health Boards	Local Committees	Statutory Reference, Where Appropriate, And Other Comments	
						Statutory Reference or Precedent	Other Comments
	3.22 Set guidelines for planned maintenance 3.23 Set budget for specific projects costing more than £5,000 and notify Health Boards and voluntary hospitals concerned (copy to RHB) 3.24 Set basic capital budget for minor capital and routine maintenance - To RHB for all hospital works - To Health Boards for all other works 3.25 Review/approve use of basic capital for non-hospital work by Health Boards		3.22 Set multi-annual figure for budget planning for all hospitals in each Health Board area to be used by the Board, and individual voluntary hospitals in region 3.23 Review Health Board and voluntary hospital proposals and recommend overall hospital budget for region to Department, specifying - All schemes with total commitment exceeding £5,000 - Basic capital allocation required 3.24 Allocate basic capital to Health Boards for hospital use and to individual voluntary hospitals 3.25 Review/approve use of basic capital for hospitals by Health Boards	3.22 Propose non-hospital needs to Department (in same detail as above) 3.23 Allocate 'basic capital' for hospitals (subject to review by RHB) and for non-hospital work (subject to review by Department)			Department approval must be obtained for all individual schemes costing more than £5,000 (i.e., schemes where the structure of a building, or its major equipment, will be affected). In approving a specific scheme the Department will ensure that revenue effects have been fully budgeted and that the scheme fits in with the national plan for major works
3.3 Execute major capital works (over £75,000)	3.31 Provide specialist advisory services - Design philosophy, standards and research - Planning procedures - Cost analysis of building projects - Conditions of contracts and of engagement of architects, quantity surveyors and engineers - Members of project teams - Standard designs and costs 3.32 Approve siting, outline schemes and budget cost	3.31 Recommend choice of major medical equipment to Department	3.31 Monitor progress of all hospital projects in developing plans for hospital services in the region	3.31 Develop, with Department, outline schedule of accommodation, functions, operational policies, siting and budget cost for approved schemes as brief for professional advisers (i.e., architects, etc.) 3.32 Engage architects, consulting engineers and quantity surveyors (subject to Department approval)		Department Letter to Voluntary Hospitals: 27.8.70	Department controls may be relaxed where standard designs have been agreed (e.g., welfare homes)

FUNCTIONS OF THE STATUTORY AUTHORITIES (Continued)

Main Decision Areas	Minister for Health And Department	Comhairle Na nOspidéal	Regional Hospital Boards	Health Boards	Local Committees	Statutory Reference, Where Appropriate, And Other Comments	
						Statutory Reference or Precedent	Other Comments
	3.33 Approve - Choice of professional advisors - Operational policies - Detailed schedule of accommodation - Development control plan - Cost planning controls (including overall maximum price before tender) - Preliminary diagrammatic schemes and ancillary planning documents - Sketch plans and ancillary planning documents - Specifications and significant variations from approved sketch plans - Invitation and acceptance of tender			3.33 Develop with professional advisers and obtain Department approval for - Operational policies - Detailed schedule of accommodation - Development control plan - Cost planning controls (including overall maximum price before tender) - Preliminary diagrammatic schemes and ancillary planning documents - Sketch plans and ancillary planning documents - Specifications			Execution of projects in voluntary hospitals will be undertaken by the hospital concerned (subject to the same controls by the Department as are applied to Health Boards)
	3.34 Set guidelines for extras and variations, and set equipment budget			3.34 Develop with professional advisers - Working drawings - Bills of quantity			Health Boards develop working drawings and bills of quantity within design cost limits and obtain Department approval for significant variations from approved sketch plans and budget costs
	3.35 Approve - Extras and variations (within guidelines) - Choice of major equipment - Final accounts			3.35 Invite tenders (after obtaining Department authorization)			
	3.36 Review progress of hospital projects with RHB and of non-hospital projects with Health Board challenging major adverse variances			3.36 Let contracts (after approval of acceptance of tender by Department)			Department will authorize invitation of tenders on the basis of current availability of capital funds
				3.37 Control progress of contractors (through professional advisers) including - Timing - Quality - Cost			

FUNCTIONS OF THE STATUTORY AUTHORITIES (Continued)

Main Decision Areas	Minister for Health And Department	Comhairle Na nOspidéal	Regional Hospital Boards	Health Boards	Local Committees	Statutory Reference, Where Appropriate, And Other Comments	
						Statutory Reference or Precedent	Other Comments
	3.37 Study use of new buildings and equipment after commissioning, and review user criticisms			3.37 Obtain Department approval (within guidelines) for - Extras and variations - Choice of major equipment - Final accounts 3.38 Study use of new buildings and equipment after commissioning, and review user criticisms			
3.4 Execute minor capital works (below £75,000)	3.41 Provide specialist advisory services (as 3.31 above) 3.42 As 3.32 above 3.43 Approve - Choice of professional advisers - Operational policies - Detailed schedule of accommodation - Development control plan - Cost planning controls - Preliminary diagrammatic schemes - Acceptance of tender 3.44 Set equipment budget 3.45 Approve - Extras and variations where cumulative cost exceeds 5 per cent of total - Choice of major equipment - Final accounts (if more than 5 per cent in excess of budget figure)		(For hospital projects from £5,000 to £75,000) As for major capital works under 3.3 above	(For projects from £5,000 to £75,000) As for major capital works under 3.3 above, but Health Board need not obtain Department approval for sketch plans and specifications; it can also make minor variations and settle final accounts provided action does not involve expenditure in excess of guidelines set by Department (For projects below £5,000) Execute project so long as total for all such projects is within budget allocation		Department Letter to Voluntary Hospitals: 27.8.70	Department controls will generally be relaxed where standard designs have been agreed or the total cost will be below £20,000

FUNCTIONS OF THE STATUTORY AUTHORITIES (Continued)

Main Decision Areas	Minister for Health And Department	Comhairle Na nOspidéal	Regional Hospital Boards	Health Boards	Local Committees	Statutory Reference, Where Appropriate, And Other Comments	
						Statutory Reference or Precedent	Other Comments
4. Determine Staffing Levels							
4.1 Determine consultant and other senior medical staff establishments in hospitals	4.11 Inform Comhairle of national objectives, strategy, and finance available	4.11 Decide number of hospital consultants and senior medical posts - By specialty - By region - By hospital (in light of proposals from RHBs and guidelines from Department specifying national objectives, strategy, and finance available)	4.11 Propose changes in hospital consultant and senior medical staff establishment to Comhairle	4.11 Propose changes in hospital consultant and senior medical staff establishment to Regional Hospital Board	4.11 Propose changes locally, based on unmet needs	Department Letter to Voluntary Hospitals: 27.8.70 Health Act, '70 Section 41-(1)b Senate debate Col. 817-824 14.1.70 Dáil debate Col. 928-929 20.12.69	
	4.12 Advise Department of Education of medical manpower needs	4.12 Decide qualifications required for all consultant and senior medical posts (subject to any general requirements set by the Department)					
4.2 Determine number of general practitioners required	4.21 Set standards (in relation to eligible population)			4.21 Arrange contracts with general practitioners		Health Act, '70 Section 14-(1)	These arrangen for provision of general medica services will no apply until cho of doctor schen is introduced
	4.22 Advise Department of Education on medical manpower needs						
4.3 Determine establishment for other professionally qualified personnel (e.g., junior medical, dental, nursing, social work, officer grade, administrative, etc.)	4.31 Set guidelines (e.g., 1 public health nurse per 4,000 population)		4.31 Recommend guidelines for hospital personnel to Department	4.31 Determine establishment within budget and in accordance with Department guidelines and rulings on qualifications	4.31 Propose changes locally, based on unmet needs	Health Act, '70 Section 14-(1) Department Letter to Voluntary Hospitals, 27.8.70	Department wi ensure training capacity balan manpower need cooperation wi professional bo universities, colleges, etc.
	4.32 Determine qualifications		4.32 Advise on training and development, and run courses for hospital personnel	4.32 Train and develop people in the service for more highly qualified posts			
	4.33 Ensure that training capacity balances manpower needs						

FUNCTIONS OF THE STATUTORY AUTHORITIES (Continued)

Main Decision Areas	Minister for Health And Department	Comhairle Na nOspidéal	Regional Hospital Boards	Health Boards	Local Committees	Statutory Reference Where Appropriate And Other Comments: Statutory Reference or Precedent	Statutory Reference Where Appropriate And Other Comments: Other Comments
4.4 Determine establishment for all other personnel	4.41 Set guidelines if Department considers this desirable		4.41 Recommend guidelines if Regional Hospital Board considers this desirable 4.42 Same as 4.32	4.41 Determine establishment within budget and in accordance with Department guidelines 4.42 Same as 4.32		Health Act, '70 Section 14-(1) Department Letter to Voluntary Hospitals: 27.8.70	
5. Appoint Staff and Determine Rates of Pay 5.1 Appoint hospital consultants and senior medical staff	5.11 Set common selection and appointment procedures for Health Board hospitals and encourage development of an agreed system that will eventually apply generally 5.12 Prescribe general qualifications for appointments in all hospitals	5.11 Undertake studies to work out and recommend broadly agreed selection and appointment procedures for all hospitals 5.12 Assist in selecting and appointing for all hospitals (when common selection procedures have been agreed and legislated) 5.13 Specify qualifications for all hospital appointments				Department Letter to Voluntary Hospitals: 27.8.70 Explanatory memorandum to Health Act, '70, Page 11, Health Act, '70 Section 41 Senate debate Col. 821-822 14.1.70	Existing procedures will continue to apply until common selection procedures have been agreed and legislated by both Houses of the Oireachtas
5.2 Appoint all other staff	5.21 Specify appointments for which Health Boards should use Local Appointments Commission procedures 5.22 Set appointments procedures for all other Health Board staff			5.2 Select and appoint all Health Board staff (using procedures specified by Department)		Department Letter to Voluntary Hospitals: 27.8.70 Health Act, '70 Section 14-(2) Section 14-(5) Section 15-(1)	
5.3 Set terms of employment and rates of pay for all staff	5.31 Approve all adjustments to pay rates and conditions of service that are proposed as a result of conciliation and arbitration procedures		5.31 Ensure that pay rates and conditions for all voluntary and Health Board hospitals' staff are harmonized	5.31 Negotiate and set pay rates and conditions of service for all Health Board staff (subject to Department approval)		Health Act, '70 Section 14-(4) Department Letter to Voluntary Hospitals: 27.8.70	
5.4 Set GP and pharmacist scale fees	5.41 Negotiate and set scale fees for GPs 5.42 Negotiate and set scale fees for pharmacists						

TOWARDS BETTER HEALTH CARE:

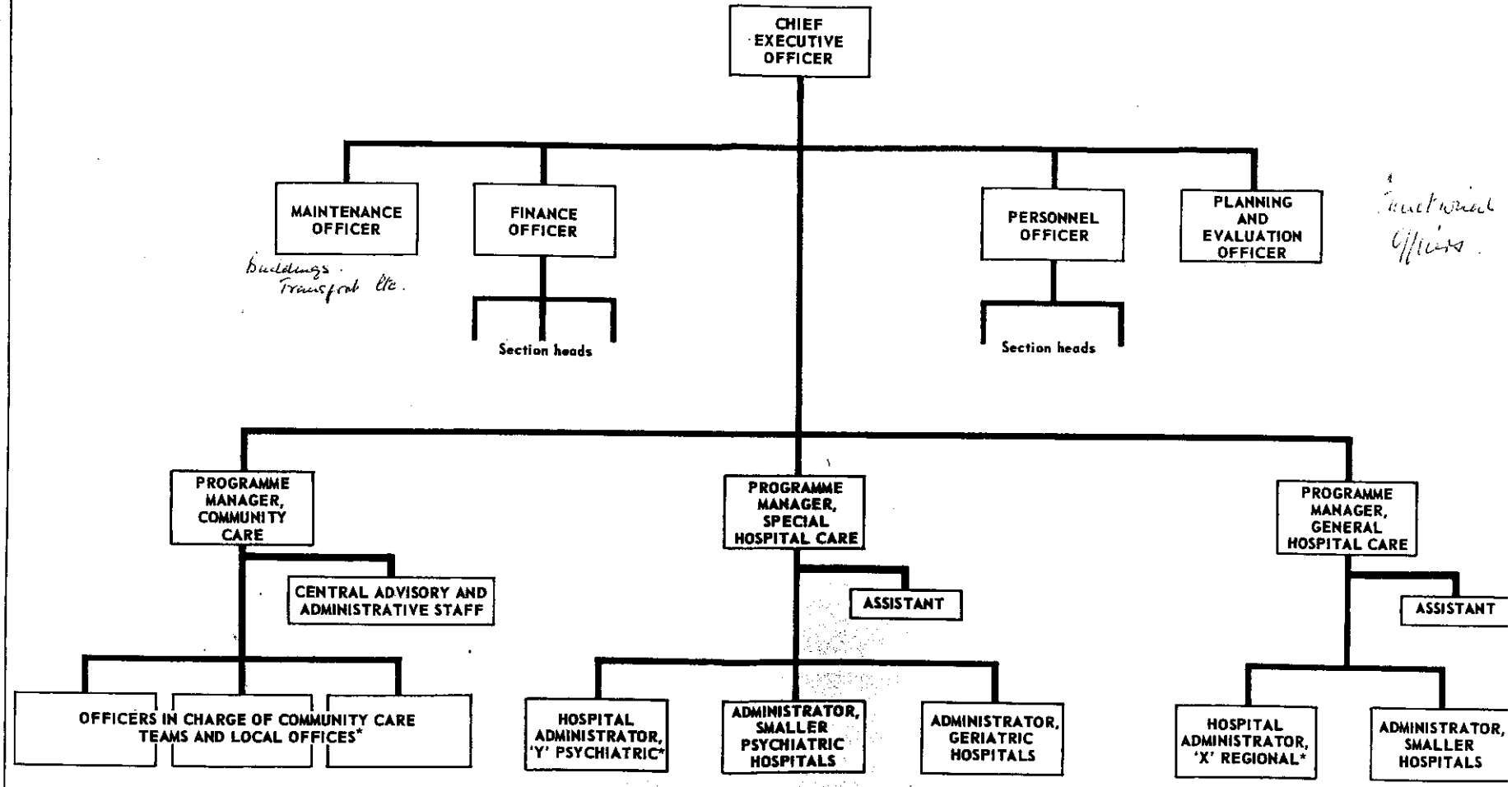
MANAGEMENT IN THE HEALTH BOARDS

THE DEPARTMENT OF HEALTH

TABLE OF CONTENTS

TABLE 8

HYPOTHETICAL ORGANIZATION FOR A RELATIVELY LARGE HEALTH BOARD



* - *Stationed in community or hospital (not at Health Board)*

FUNCTIONS OF THE BOARD AND THE CEO

Although each Health Board is responsible for ensuring that its affairs are well managed, it should delegate this responsibility and not itself try to manage its affairs in detail. In the series of charts that follows, we recommend the way in which the Board should delegate day-to-day management to the CEO while retaining overall responsibility for the management of its affairs and for setting the major objectives and strategy for the area. The charts use a series of example decisions to show how the role of the Board differs from that of the CEO. Decisions are grouped under the same headings as in Appendix B - i.e.,

1. Develop and implement service programmes
2. Determine annual revenue budget and control expenditure
3. Plan and execute capital projects
4. Determine staffing levels
5. Appoint staff and determine rates of pay.

The decision-making process is, however, complex, frequently involving not only Board and CEO but also one or other of the authorities listed in Appendix B. Frequently, neither Board nor CEO has ultimate authority in reaching a particular decision. These charts merely show how the Board and the CEO work together to complete their part of the process.

FUNCTIONS OF THE BOARD AN

Management Decisions				Other Comments
Type	Specific Examples*	Board		
1. Develop and Implement Service Programmes				An officer of the Board or, when necessary, the CEO will attend all local committee meetings; we recommend that the same apply to meetings of advisory groups. Advisory groups will be formed on an ad hoc basis and will disband when members judge that their tasks are complete. Programme managers will participate as members of groups studying services in their programme areas; otherwise composition of groups will be at the discretion of the Board (advised by the CEO).
1.1 Set objectives and strategy	Agree to implement the Department's report on the Child Health Services by - Providing all children with scheduled medical examinations at 6 months, 1 year and 2 years of age, which would mean . Employing one extra ACMO and conducting child health clinics in all towns with more than 5,000 population . Contracting with six GPs to conduct clinics in small towns and rural areas . Recording all children born in area (or moving into it) and following up any who are not examined within 3 months of scheduled age - Etc.	1.11 Establish advisory groups (when judged appropriate) to study specific services and recommend objectives and strategy, e.g. - A group might be formed to recommend the specific steps the Board should take to achieve the service objectives set in the Child Health Services report 1.12 Set local objectives and strategy (in line with national objectives and strategy and taking account of proposals made by CEO, RHB and advisory groups) 1.13 Propose changes in national objectives and strategy (to RHB and Comhairle for hospitals and to Department for all other services)		
1.2 Implement strategy by means of service programmes	Phase implementation of the Child Health Services report over the next 3 years, giving first priority to pre-school medical examinations	1.21 Review and approve/revise annual programme plans (for example, the Board might direct the CEO to accelerate the implementation of a programme for new services)		Board also implements strategy through budget allocations; CEO ensures that programme managers develop plans within these allocations and together they agree plans before submitting them to Board. Once the Board has approved the plans, the CEO and his officers take all routine decisions required for their implementation. (For example, the Board should rarely involve itself in a decision to locate a clinic in a particular building and never be involved in a decision to rent computer time for child health records; similarly the CEO should rarely be involved in an individual eligibility decision as he should delegate this function to appropriate officers.)
1.3 Review programme effectiveness and take corrective action	Employ another ACMO and extend child health clinics to additional towns	1.31 Review performance in each programme area once every quarter; query major variances from planned performance and, if necessary, direct CEO to take corrective action	1.31 [illegible] programmes once each [illegible] variances and [illegible] necessary 1.32 [illegible] reports to [illegible] Board on [illegible] solutions and take corrective action (including any actions directed by Board) [illegible]	CEO queries variances with the appropriate programme managers and initiates corrective action through them. CEO normally submits a formal performance report on one programme a month, so that all programmes are reviewed in depth by the Board once a quarter.

* - These examples are ILLUSTRATIVE ONLY. In particular, the number of examples relating to the Child Health Service is for convenience and should not be taken as representative.

FUNCTIONS OF THE BOARD AND THE CEO (Continued)

Management Decisions		Functions		
Type	Specific Examples*	Board	CEO	Other Comments
2. Determine Annual Revenue Budget and Control Expenditure				
2.1 Set guidelines	Restrict increase in cost of General Hospital Care to 1 per cent, so that share of the coming year's total budget falls from 70 per cent to 68 per cent; increase spending on Community Care by 20 per cent to cover cost of new Child Health Services, so that share of the coming year's total budget increases from 15 per cent to 17 per cent	2.11 Review CEO's proposals for total requirements and priorities for allocation 2.12 Propose total requirement and priorities for allocation, for use by Department in setting guidelines - To RHB (for hospitals - copy to Department) - To Department (for all other services) 2.13 Set annual programme allocations, in line with directed/recommended priorities, on receipt from Department of overall multi-annual figure for budget planning	2.1 [illegible] cost implications of local strategy set by Board [illegible] revenue balance available for to initiate service improve- [illegible] and total requirement and cation (including adjust-for increase allocations for	Budget guidelines will include an allowance for maintenance works but these will be dealt with as minor capital works under 3.2 and 3.4 below. CEO will take the coming year's budget planning figure, as set by Department on a constant price base in previous year; he will subtract full year's cost of existing services, add back income expected from patients, and thus assess revenue balance available for new or improved services in coming year. He will also suggest any adjustments that could be made to existing services to release funds for improvements. Cost of wage awards and other departures from this constant price base will be authorized separately by Department.
2.2 Prepare budget	a. Allocate £14,000 to Community Care Personal Health sub-programme to cover cost of new Child Health Services - Clinics (£10,000) - GPs (£2,000) - Records (£2,000) - Etc. b. Prevent £20,000 increase in costs of General Hospital Care by - Deferring planned improvement in dietary scales - Etc.		2.21 [illegible] planning allocations for individual [illegible] managers (in line with alloca-[illegible] by Board) 2.22 Revise programme budgets and direct programme managers to revise them (when necessary)	
2.3 Review/approve budget	Spend on Special Hospital Care £10,000 more than originally allocated, because services cannot be maintained within original allocation and funds can be made available from Community Care	2.31 Review all annual programme budgets and either approve them or direct CEO to revise them (subject to Department directions or guidelines) 2.32 Delegate to CEO responsibility for authorizing payments up to total budget amount for year	2.31 Propose annual programme budgets to Board 2.32 Revise programme budgets (including revisions directed by Board/Department)	CEO will normally delegate authorization of payments to appropriate officers within his organization (subject to appropriate controls).
2.4 Control expenditure within budget	a. Defer planned commissioning of new maternity wing for a general hospital, saving £10,000 additional costs in current year b. Continue planned introduction of expanded Child Health Services even though expected current year costs will be £10,000 above original annual budget	2.41 Review net quarterly and cumulative expenditures in each programme during quarterly programme performance review	2.41 Review net monthly and cumulative expenditure in each programme	Corrective action initiated by CEO may include proposals to reallocate funds among programmes to ensure that priority objectives are achieved. Fixed levels of annual expenditure originally authorized by Department will be varied periodically to allow for approved departures from constant price base (e.g., wage awards).

* - These examples are ILLUSTRATIVE ONLY. In particular, the number of examples relating to the Child Health Service is for convenience and should not be taken as representative.

FUNCTIONS OF THE BOARD AND [illegible]

Management Decisions		Fun[illegible]		Other Comments
Type	Specific Examples*	Board	[illegible]	
2.4 Control expenditure within budget (Continued)		2.42 Query major variances from budget and, where necessary, direct CEO to take corrective action (e.g., Board might advi[illegible] or direct the CEO to defer opening new maternity wing because in its view Child Health Services are more important, even though costs are above budget) 2.43 Ensure that total net expenditure for any service or purpose does not exceed annual budget authorized by Department	[illegible]nd, when [illegible]ction by [illegible]ed [illegible] follow [illegible]re for any [illegible]ed annual [illegible]	
3. Plan and Execute Capital Projects 3.1 Formulate national plan for major capital works (total commitment over £75,000)	Determine that £700,000 will be spent in the area over the next 3 years to build - Paediatric unit (£300,000) - 75-bed convalescent unit (£100,000) - 3 welfare homes (£170,000) - 2 health centres (£130,000)	3.11 Set up each year an advisory group to study local needs and priorities and to recommend major projects for the next 5 years 3.12 Consider advisory group recommendations and CEO's proposals, and propose total programme that lists projects (in priority) for area for next 5 years	[illegible] to support [illegible] [illegible] projects for next [illegible] proposals originat- [illegible] group, or local	Advisory group recommendations and CEO proposals will include assessed costs and priorities for all projects. Group will normally disband after submitting recommendations. Every year the Board will draw up a 5-year programme, submitting proposals for major hospital projects to RHB and the remainder to the Department (with copy to RHB).
3.2 Determine capital budget for minor capital works (total commitment less than £75,000)	Determine that £130,000 will be spent in area next year on - New X-ray equipment in general hospital (£30,000) - New toilet facilities in long-stay mental institution (£45,000) - Replacement boiler (£15,000) - Structural alterations in a county home (£11,000) - Basic capital (£29,000)	3.21 Set up advisory group each year (when judged appropriate) to study proposals from CEO and Board members 3.22 Propose overall hospital needs to RHB, with copy to Department, specifying - 3-year programme for projects of more than £5,000 (in order of priority) - Basic capital required 3.23 Propose other service needs to Department (in same detail as 3.22) 3.24 Allocate funds for specific projects of more than £5,000 and for basic capital (in line with Department directions and guidelines and within total authorization)	3.21 [illegible] each year (taking account [illegible] from local committees) [illegible] programme for projects where [illegible] commitment will exceed £5,000 (in order of priority) - Allocation of basic capital required in the coming year for minor works and routine maintenance 3.22 Allocate basic capital for specific minor works/routine maintenance (subject to review by Board)	Each year the Board should propose in order of priority a 3-year programme of projects each costing from £5,000-75,000. The Department should vet this list for budgetary purposes and set the budget for specific projects for the coming year and, for planning purposes, for the following 2 years; in setting the budget for the coming year the Department should identify those projects that have been approved and that require no further details provided that costs are kept within budget allocation. (In general all projects costing less than £20,000 should be freed of detailed departmental controls once the type and location of each project has been approved.)

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FUNCTIONS OF THE BOARD AND

Management Decisions					Other Comments
Type	Specific Examples*	Board			
3.3 Execute major capital works (over £75,000)	a. Determine the layout and equipment for a new paediatric unit b. Choose a particular firm of contractors to execute the project	3.31 Authorize CEO to borrow funds required … and approve loan terms negotiated by hi… 3.32 Set up advisory group (when judged appro… riate) to monitor progress and recommend … to CEO desirable extras and variations 3.33 Use visiting committee to advise CEO o… any adverse user criticism (after commis… sioning)			CEO may be able to submit proposals in less detail where standard designs have been agreed (e.g., welfare homes). Board will make regulations governing procedure for seeking, receiving and examining tenders, which will apply to both construction and routine supply contracts. Board will authorize loans up to the total amount required to finance the Health Board's share of the authorized capital budget for the year. Department guidelines will normally allow the CEO to spend a small amount in excess of budget to cover small extras and variations, without reference to the Department.

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FUNCTIONS OF THE BOARD AND THE CEO (Continued)

Management Decisions		Functions		
Type	Specific Examples*	Board	CEO	Other Comments
3.4 Execute minor capital works (below £75,000)	a. Select a particular type of replacement boiler and choose the contractor to install it b. Choose contractors to redecorate a nurses' home, and decide on the colour schemes	For projects from £5,000 to 75,000 - As for major capital works under 3.3 above, but Board would not normally establish an advisory group For basic capital - Ensure that CEO does not incur expenditure in excess of budget allocation	For projects from £5,000 to 75,000 - As for major capital works under 3.3 above, but Health Department approval [illegible] specifications; moreover, [illegible] variations and settle final [illegible] that action does not involve [illegible] of guidelines set by [illegible] For basic capital - Proceed as long as total expenditure [illegible] allocation	Controls will usually be relaxed on all projects where - Standard designs have been agreed, or - Cost does not exceed £20,000 (see comments against 3.2 above). CEO will delegate execution of basic capital schemes to appropriate officers.
4. Determine Staffing Levels 4.1 Determine consultant and senior medical staff establishment in hospitals	Establish an additional consultant geriatrician in a general hospital	4.11 Review proposals by CEO (or members) and submit documented recommendations to RHB	4.11 [illegible] with senior medical staff in Health Board hospitals, develop a rational case for increasing establishment, taking account of voluntary hospitals' staffing in area and of other priorities, and propose changes to Board	
4.2 Determine number of General Practitioners required	Increase the number of GPs authorized to provide services for eligible persons in Cork from 50 to 55	4.21 Not involved - except that individual members may suggest changes to CEO based on needs in particular areas	4.21 Review need for additional GPs each year on basis of - Standard number of eligible patients per GP recommended by Department - Proposals from local committees and members of Board 4.22 Enter into contracts with the additional GPs required	Any change in numbers of GPs will be approved by the Board when the Community Care programme budget is finalized. Contracts with GPs will be on standard terms set as a result of national negotiations between the Department and the medical profession.
4.3 Determine establishment for other professionally qualified personnel (e.g., medical, dental, nursing, social work, officer grade, administrative, etc.)	Increase the establishment of public health nurses from 10 to 15 as part of a programme to reduce by 20 per cent the number of geriatric patients in special hospitals	4.31 Monitor establishment in all programme areas during annual programme performance and budget review and, when necessary, direct CEO to make changes (in accordance with Department guidelines and rulings)	4.31 Determine establishment within budget, in accordance with Department guidelines and rulings on qualifications, and in light of proposals by local committees 4.32 Train/develop people in the service for more highly qualified posts	CEO will ensure that Personnel Manager develops effective and appropriate training programmes.
4.4 Determine establishment for all other personnel	Reduce kitchen staff in a general hospital from 30 to 28 as part of the programme to hold the cost increase in General Hospital Care down to 1 per cent	4.41 Not involved - except to ensure that total staff costs are held within budget	4.41 Determine establishment within budget and in accordance with Department guidelines 4.42 Same as 4.32	CEO would normally delegate this decision (within overall budget limits).
5. Appoint Staff and Determine Rates of Pay 5.1 Appoint hospital consultants and senior medical staff	Appoint Dr. O'Reilly as consultant geriatrician in a general hospital with sessional deployment to a county home two afternoons a week	5.11 Not involved	5.11 Not involved in selection or appointment (if Regional Hospital Board is the employing authority) 5.12 Arrange for sessional deployment	

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FUNCTIONS OF THE BOARD AND THE [illegible] (continued)

Management Decisions		Functions		
Type	Specific Examples*	Board	[illegible]	Other Comments
5.2 Appoint all other staff	Appoint the Programme Manager for General Hospital Care	5.21 Not involved	5.[illegible] procedures specified [illegible] appoint all staff [illegible] result of these procedures 5.[illegible] structure and dele- [illegible] (within overall [illegible] set by Department)	CEO's reserved functions of determining appointments and remuneration will be discharged within closely defined national procedures and guidelines. CEO will normally delegate reserved functions to appropriate members of his staff, but will participate in selection of senior staff of programme and functional manager level.
5.3 Set terms of employment and rates of pay for all staff	Determine the terms of employment and rate of pay for the chief officer in a general hospital		5.[illegible] [illegible] negotiations to set [illegible] conditions of service for all [illegible] (subject to Department [illegible] 5.[illegible] awards for individual senior [illegible] on performance (if and when [illegible] scheme is introduced)	

* - These examples are ILLUSTRATIVE ONLY. In particular, the number of examples relating to the Child Health Service is for convenience and should not be taken as representative.

JOB DESCRIPTIONS

A job description outlines in some detail the scope of a job and its relationship to other positions in the organization. The appendix contains draft job descriptions for the Chief Executive Officers, the programme managers and functional officers of the Health Boards. We describe below the uses and limitations of job descriptions, the draft job descriptions themselves and the procedure for writing them.

USES AND LIMITATIONS

Job descriptions can be very useful in clarifying the manager's view of his organization. They can

1. Establish the scope and responsibilities of each job

2. Determine (with the agreement of the officer concerned) the major immediate tasks that need to be accomplished, and how performance in the job will be measured

3. Ensure that the interrelationship between jobs is thought through clearly

4. Establish career development policies (salaries, grading, training).

Job descriptions should be used mainly for senior positions, where specific responsibilities and major tasks are broad enough to allow for flexibility and freedom of action. If they are used for junior positions they can become too restrictive since the person holding the job may resist undertaking tasks not specifically mentioned in his job description.

To be used properly, job descriptions should be revised at least once every 12 months in the light of experience and new situations. These revisions will enable job descriptions to fulfil one of their prime purposes, that is, to act as a programme for the person concerned.

DRAFT JOB DESCRIPTIONS

The draft job descriptions in the appendix are organized under several headings: purpose of the job, reporting and working relationships, principal duties and responsibilities, limits of authority, measures of performance, major tasks for the coming year, and gradings and promotion. Examples that illustrate each part of the job of the Programme Manager, Community Care, have been developed; a similar development can be undertaken for the other job descriptions.

Limits of authority have been prescribed for the functional officers so that they do not interfere with the line authority that must exist between the programme managers and the CEO.

Major tasks for the coming year have been suggested for programme managers. Once these are confirmed, it will be useful to set supporting major tasks for the functional officers.

WRITING PROCEDURES

Each CEO will wish to develop the draft job descriptions and perhaps produce descriptions for other staff positions. Job descriptions should be concerned with the job to be performed and not with the person performing it. However, the person whose job is to be described should take an active part in preparing his job description so that it will be comprehensive, accepted and used.

The following procedure for writing job descriptions is recommended:

1. After reading his draft job description, the person involved prepares a revised draft using the same format and fitting it to his own specific situation, particularly as regards major tasks and measures of performance.

2. The person to whom he reports reviews and revises the draft.

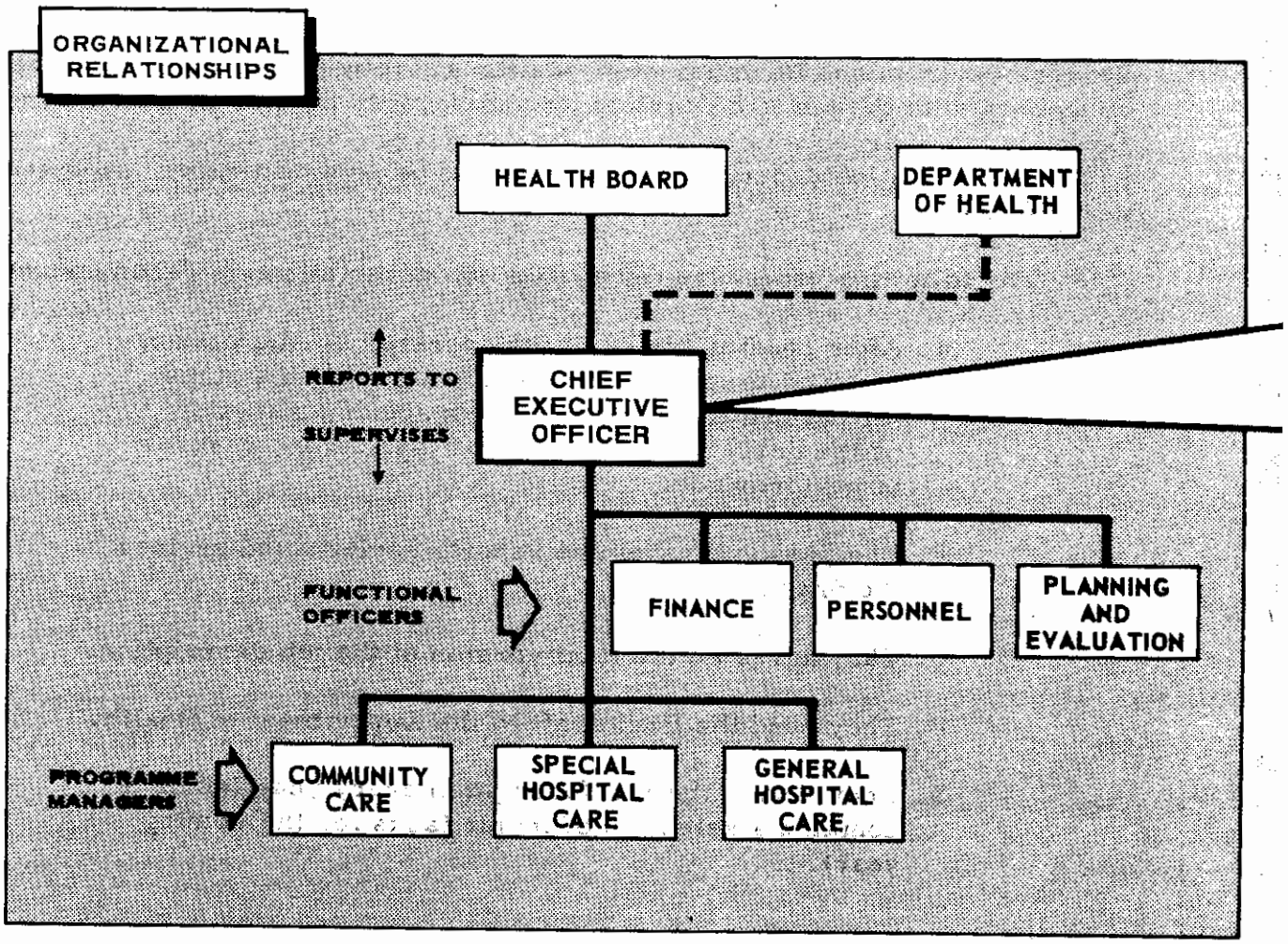
3. They agree on the final version of the job description.

4. They send the final draft to the Department of Health.

5. They revise the job description every year (since it contains a selection of major tasks for the coming year).

TABLE D - 1

CHIEF EXECUTIVE OFFICER, 'X' HEALTH BOARD (LARGE BOARD)



JOB DESCRIPTION

CHIEF EXECUTIVE OFFICER

'X' HEALTH BOARD

PURPOSE OF JOB

The Chief Executive Officer is responsible to the Health Board for the provision of comprehensive health care to the people of Area 'X', particularly to those eligible to receive free services, and for the management of services operated by the Health Board. He has four main areas of responsibility:

1. To ensure the development of plans and budgets to meet objectives and targets for health care within guidelines set by the Department of Health, Regional Hospital Board and Health Board as appropriate

2. To ensure the execution of plans once they are approved by the Health Board and (in so far as their approval is required) by other bodies

3. To develop and maintain a high level of efficiency throughout the services provided by the Health Board in Area 'X'

4. To discharge functions specified in the Health Act, 1970, and other tasks specified by the Minister or the Board.

In discharging these responsibilities he will make himself personally available (at his discretion) to the public and members of all the health service professions to discuss proposals, ideas and concerns. However he will normally act on such discussions with and through the members of his management team.

REPORTING RELATIONSHIPS

1. Reports to:

The Health Board for most matters affecting health services in Area 'X'
The Department of Health for discharge of functions relating to eligibility and employment of Health Board staff as required in the Health Act, 1970

2. Supervises:

Programme managers
Functional officers.

WORKING RELATIONSHIPS

1. Works with the Health Board

   1.1 To determine level and quality of services to be provided

   1.2 To allocate budgets to health services

   1.3 To determine grants required from Department of Health and local authorities

   1.4 To authorize major changes in provision of services and budget allocations.

2. Works with programme managers

   2.1 To provide guidelines for developing health service targets, budgets and alternative plans to achieve targets

   2.2 To coordinate the development of targets, budgets and plans (for each programme) to avoid overlap, conflict and unnecessary buildup of services and personnel

   2.3 To monitor the development and execution of plans to achieve targets, within budgetary and other constraints.

3. Works with functional officers to provide guidelines for developing their plans for functional areas.

4. Works with the management team to develop and execute plans for health services in the area.

4. Works with the Department of Health

   5.1 To develop plans and budgets for health services in the area

   5.2 To report expenditure against budget and progress against plan

   5.3 To apply national policies for recruitment, appointment, remuneration and conditions of service.

5. Works with the Regional Hospital Board

   6.1 To present plans and budget estimates for health services provided in Health Board hospitals

   6.2 To present capital budget proposals for the development and maintenance of Health Board hospitals

   6.3 To propose changes in the role of particular Health Board hospitals (e.g., development or reduction of specific specialties) where he is satisfied that such changes are in the patients' interests and have been fully considered by the professional staff concerned.

7. Works with medical, nursing and other professional staffs to obtain their participation and support in developing and executing programmes of health service care.

8. Works with voluntary and other local organizations to encourage them to participate in providing parts of the area health service.

9. Works with other CEOs to ensure that health services provided are reasonably consistent across the country and that the best available management practices are adopted.

PRINCIPAL DUTIES
AND RESPONSIBILITIES

1. To ensure the development of plans and budgets to meet objectives and targets for health care by

   1.1 Developing tentative programme objectives, targets and budgets for all health services based upon Department of Health guidance, Regional Hospital Board plans for hospitals and policies approved by the Health Board

1.2 Providing each programme manager and functional officer with tentative programme objectives, targets and budgets, and requiring them to develop alternative plans that define how targets will be achieved and project budget requirements

1.3 Reviewing alternative plans with individual managers and with the management team to select plans that achieve targets most effectively and economically

1.4 Supervising the integration and revision of separate programme plans to provide a comprehensive health service plan for all programmes for succeeding years; as the system develops, the plan may cover the next 5 years

1.5 Obtaining Health Board approval for proposed plans and budgets and for the level of grant requested from Department of Health and local rating authorities

1.6 Obtaining Department of Health approval for plans and payment of grants; the Regional Hospital Board reviews and advises the Department on proposed hospital plans and budgets

1.7 Demanding grant from local rating authorities.

2. To ensure the execution of plans by

2.1 Requiring each programme manager and functional officer to develop and seek his approval for a series of action plans intended to work towards approved programme objectives and meet agreed targets within approved budget levels; each action plan defines targets, key events and dates, individual responsibility and allocation of staff and money

2.2 Monitoring progress made against key events and dates in each action plan, approving significant plan changes designed to recover lost time or to meet changed programme targets

2.3 Reporting regularly to the Health Board on progress towards programme targets, and on expenditure against budget for each programme element, seeking covering approval for significant variations from budget

2.4 Reporting regularly to the Department of Health on progress towards targets, and expenditure against budget by programme and programme element

2.5 Obtaining covering Department of Health approval for major variations in plans and budgets approved by the Health Board

2.6 Seeking medical, nursing and professional staffs' full participation in and commitment to the execution of approved action plans.

3. To develop and maintain a high level of efficiency throughout the health services provided by the Health Board in Area 'X' by

3.1 Preparing and executing directives that define the extent of functions, duties and responsibilities of each manager including the delegation of powers vested personally in the CEO

3.2 Encouraging programme managers and functional officers to compare their programmes with others in Area 'X' and with programmes of other Health Boards, and to develop proposals for improving policies, practices and services

3.3 Encouraging programme managers and functional officers to make and implement personal career development plans, particularly to acquire new skills and experience intended to improve their performance

3.4 Consulting with other Health Board CEOs and the Department of Health to improve management, organizational and administrative practices

3.5 Commissioning research and survey studies into particular aspects and needs of health services in the area as a basis for developing these services further, and ensuring that account is taken of research undertaken by others.

4. To discharge functions specified in the Health Act, 1970, and other functions specified by the Minister or the Board, by

4.1 Delegating certain functions to officers of the Board

4.2 Reviewing eligibility decisions in respect of health services and the payment of health service grants and allowances

4.3 Reviewing decisions for making or recovering charges for health services in individual cases

4.4 Applying policies and practices relating to the appointment, control, supervision, service, remuneration, privileges and superannuation of certain officers and staffs of the Board

4.5 Advertising and placing contracts in accordance with guidelines laid down by the Minister and the Board.

PERFORMANCE MEASURES

1. Achievement of targets set for each health service programme

2. Success in keeping expenditure within the approved budget

3. Response to changing health service needs with revised targets and plans to achieve them

4. Development and execution of plans for the career development of existing and potential managers and senior officers of the Board.

MAJOR TASKS FOR 1971 (Illustrative only)

1. Establish Health Board organization in Area 'X' by

1.1 Completing appointment of programme managers and top functional officers by April 1, 1971

1.2 Approving all job descriptions for these six (four) officers by May 1, 1971

1.3 Approving and putting into operation initial management process guides and instructions by July 1, 1971.

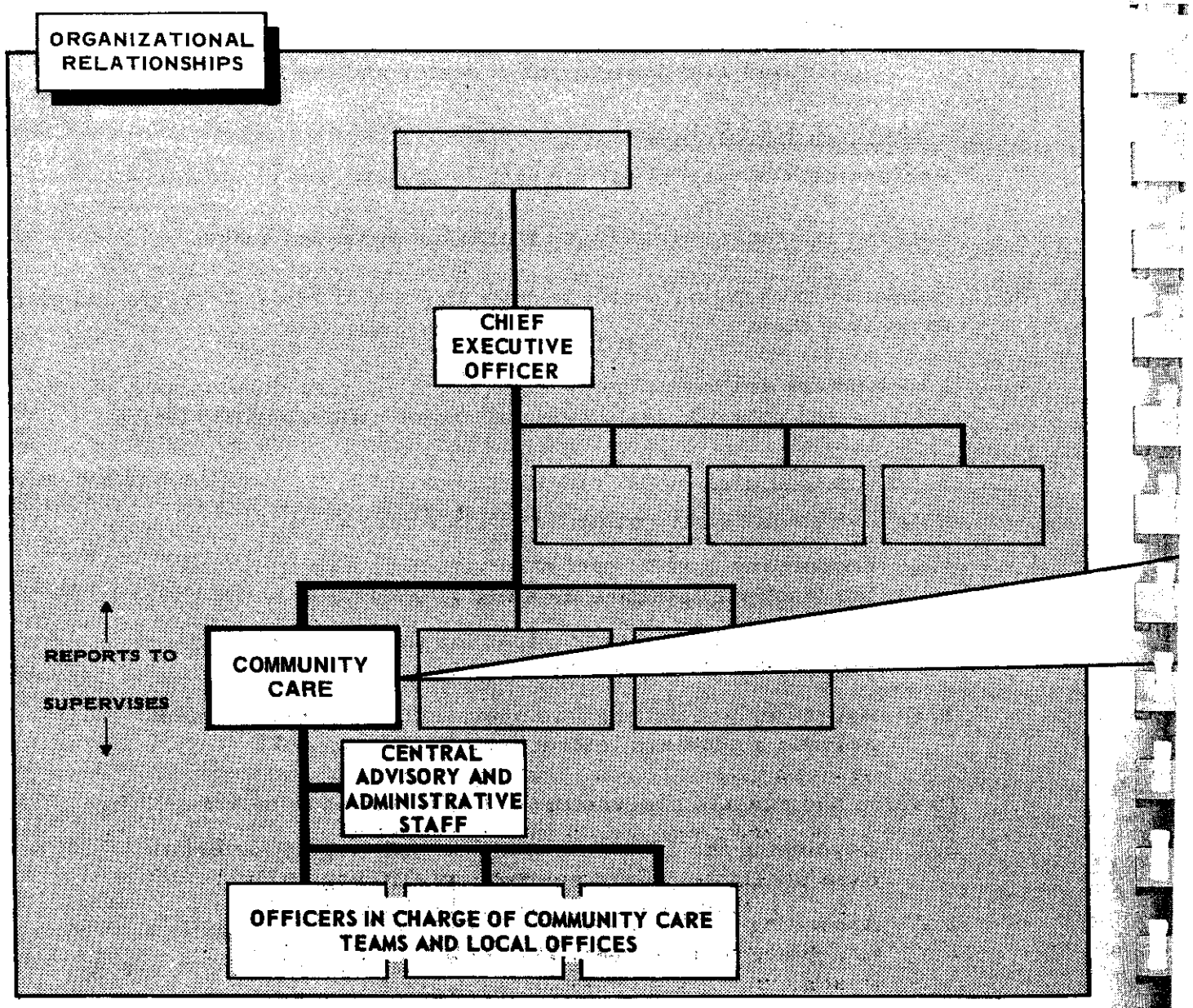
2. Develop and execute programme of health services in Area 'X' by

2.1 Developing the 1972-73 objectives and targets for health care for Health Board approval by October 1971

2.2 Approving by December 1971 action plans and budgets to achieve these targets for 1972-73.

TABLE D - 2

PROGRAMME MANAGER,
COMMUNITY CARE
'X' HEALTH BOARD



JOB DESCRIPTION

JOB DESCRIPTION

PROGRAMME MANAGER, COMMUNITY CARE*

'X' HEALTH BOARD

PURPOSE OF JOB

The Programme Manager, Community Care, is accountable for the overall direction of the programme. He has six main areas of responsibility:

1. To identify the major priorities in the programme
2. To develop and cost plans for the services within his programme
3. To ensure that the plans are put into operation appropriately
4. To take action and reallocate resources in response to changes inside and outside the programme
5. To establish a high level of efficiency in the services provided in the programme consistent with his objectives for developing professional and administrative staff
6. To enhance the effectiveness of his officers and their staff.

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* - Community care includes personal health care (the GP and public health nurse services) environmental protection, preventive care (the collective and individual prevention of disease by immunization, health education and early diagnosis) and welfare services.

ILLUSTRATIVE ONLY

The job description of Programme Manager, Community Care, outlines the activities and responsibilities of this particular position in a concentrated form. To illustrate the meaning of some of these summarized activities, examples are provided. These examples relate specifically to the programme manager's activities in promoting community care of the aged - one aspect of his responsibilities for community care. They should be seen as illustrations of what the programme manager, responsible for the tasks presented in the job description, might be doing.

WORKING RELATIONSHIPS

1. He is working closely with the Programme Manager, Special Hospital Care, in the reclassification of 200 aged patients in county homes and 400 geriatric patients in 2 large mental hospitals; he aims to return 200 patients to the community by April 1972.

2. He is deciding how to meet the assistance officers' need for training in the field of social work.

   2.1 -

   2.2 -

   2.3 -

   2.4 -

   2.5 -

3. The Finance Officer is costing proposals

   - To increase the number of home helps by 20 and to employ 4 more public health nurses
   - To open 2 more day centres for the aged.

   He is also analysing unit costs of meals on wheels to estimate the increase in this item in next year's budget if meals increased by 25 per cent.

4. He has developed with the Planning and Evaluation Officer the following objectives for community care of the aged (see Table D - 3) and has set targets for 1971/72 (see 'Major Tasks for 1971/72'). They both agree on the need to draw up a register of aged people at risk in the community.

   4.1 -

   4.2 -

   4.3 -

REPORTING RELATIONSHIPS

1. Reports to: The Chief Executive Officer

2. Supervises: Senior officers assisting him in the management of the programme
Officers in charge of administering community health services from local offices.

WORKING RELATIONSHIPS

1. Works with the Programme Manager, General Hospital Care, and Programme Manager, Special Hospital Care, to ensure that overall planned targets are achieved and that each programme provides adequate support for the others.

2. Works with the Personnel Officer

2.1 To devise and implement training and development programmes in coordination with other Health Boards and national organizations

2.2 To develop career plans for those officers under his supervision, proposed salary scales, and specifications of new posts to be created

2.3 To discuss current problems in labour relations in the programme

2.4 To facilitate the interchange of members of staff among jobs inside and outside his administration for development purposes

2.5 To appraise performance of all staff in his programme to assist the CEO in staffing senior posts.

3. Works with the Finance Officer to develop estimates and budgets for the Community Care Programme, to interpret indicators of programme performance and to achieve control over programme expenditure.

4. Works with the Planning and Evaluation Officer

4.1 To use the information currently available to develop objectives for the Community Care Programme

4.2 To decide what additional information is necessary

4.3 To develop a planning process in the Community Care Programme to assess the situation, set objectives, draw up plans and measure performance.

He is primarily concerned with the contribution of voluntary agencies to

- Day centres
- Community social service councils
- Social workers and home helps
- Meals on wheels.

He has discussed his targets for each of these with the heads of each voluntary agency.

5.1 -

5.2 -

NCIPAL DUTIES
) RESPONSIBILITIES

1.1 See 'Working Relationships'.

1.2 He has agreed with the Planning and Evaluation Officer some of the critical indicators for evaluating the services provided for the aged in the community (e.g., life expectancy per community; number of medical and social services available in the community; number of outpatient services available and actually used; number of aged patients in hospitals and homes; number of aged admitted to and discharged from hospitals and homes). He has also developed with the Planning and Evaluation Officer some lower level indicators for his target of discharging 200 aged patients from institutions into the community by April 1972 (see Table D - 4) and is working with the Finance Officer on those costs that are at present not available.

1.3 -

1.4 -

1.5 He has agreed with his senior officers the following order of priority for upgrading these services in 1971/72

- Day care centres
- Housing for the aged
- Social workers
- Home helps
- Meals on wheels.

5. Works with the heads of voluntary agencies providing welfare services

   5.1 To communicate the nature of the targets for the Community Care Programme and to agree on the funds they are to receive

   5.2 To ensure that there is agreement among the voluntary agencies as to the specific contributions they will make to reach these targets and to encourage the effective operation and coordination of these organizations.

PRINCIPAL DUTIES
AND RESPONSIBILITIES

1. To identify the major priorities in the Community Care Programme by

   1.1 Defining the objectives of the programme within the guidelines laid down by the CEO

   1.2 Developing methods for measuring the need, output and impact of each element in the programme

   1.3 Assessing the present and future needs for community care in the area by regular fact-finding, using local, national and international information sources

   1.4 Relating the area need to the services currently available for providing community care, and assessing the need for services that are not currently available

   1.5 Identifying gaps in or over-provision of each element of the service, and deciding on priorities for correcting them.

2. To develop and cost plans for the services within the Community Care Programme by

   2.1 Analysing the major targets to be achieved in the Community Care Programme, and the resources required to supply the services involved

   2.2 Determining the feasibility of the alternative ways in which the major targets can be achieved

   2.3 Drawing up, costing and selecting action plans with his senior administrative and professional officers to achieve the major targets in the programme

   2.4 Specifying the people responsible for each stage of the plan, the dates by which each stage should be accomplished and how performance will be measured

2.1 -

2.2 -

2.3 -

2.4 -

2.5 With his senior officers, he has developed a set of targets for the programme in 1971/72, 1972/73, 1973/74. An example of these for part of the welfare services sub-programme appears in Table D - 5.

An example of the kind of action plans that he formulates with his officers appears in Table D - 6.

3.1 -

3.2 -

3.3 Three voluntary agencies have agreed to increase their number of home helps. Two other agencies will contribute the services of three people to assist in expanding the meals-on-wheels service

3.4 He reviews all complaints about service received in the Community Care Programme and seeks to determine whether it is the level or the quality of the service that is the cause for complaint.

3.5 He is currently having a leaflet prepared outlining community care services for the aged, to be inserted in every old-age pension book.

.1 -

.2 -

.3 -

.4 -

5 -

6 -

2.5 Drawing up an overall plan for the programme and presenting this plan and the action plans to the CEO for discussion, modification and approval.

3. To ensure that the plans for the Community Care Programme are put into operation appropriately by

3.1 Discussing each stage of each action plan with the people involved, so that they understand clearly their responsibilities, the targets to which they are directed, the methods and dates by which these should be achieved and the resources available

3.2 Reviewing, on a regular basis and with the people involved, the progress of each stage of each plan

3.3 Agreeing on targets and the means of reaching them for voluntary agencies and offering advice, encouragement and professional services where appropriate

3.4 Ensuring that the work of providing for the disadvantaged is carried out as sensitively as possible

3.5 Publicizing community care services to those for whom the services are made available.

4. To take action and reallocate resources in response to changes inside and outside the Community Care Programme by

4.1 Determining on a regular basis the major targets that are not being met, as well as any related problems and opportunities

4.2 Agreeing with the officers the major causes for the targets not being met and the significance of related problems and opportunities

4.3 Consulting with the CEO and other officers as to whether reallocation of resources is necessary to achieve targets, to cope with related problems and to exploit opportunities

4.4 Agreeing with the CEO what changes, if any, should be initiated

4.5 Amending the action plans and discussing each change with the people involved

4.6 Reviewing regularly the performance of the services in which these changes have been made.

5.1 He has agreed with his Chief Executive Officer to provide him with an annual report of the Community Care Programme, with detailed indicators of performance, and to present a quarterly report to the Board. They also have informal monthly meetings to discuss progress to date.

5.2 He has agreed with the CEO to set up, in coordination with the Finance Officer, a project team to investigate a proposal to reform the welfare payments system, both by upgrading the amount of welfare paid per person to benefit level and by integrating all welfare payments so that each recipient receives one, and only one, cheque.

5.3 He is forwarding information to the Medico-Socio Research Board on the Community Care Programme in his area for a new study that they are considering on community care of the aged.

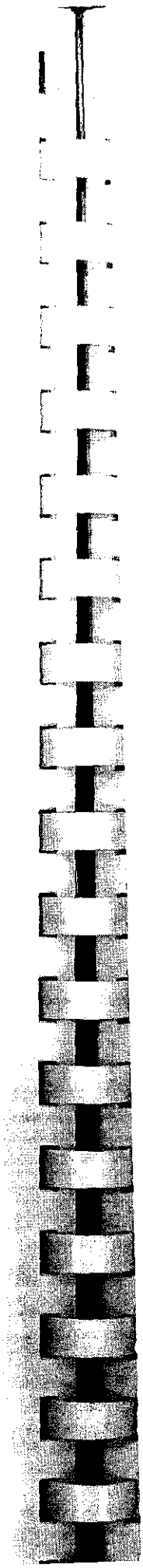
5.4 He has made suggestions to the heads of several voluntary agencies on case-load planning for social workers and route planning for meals-on-wheels services.

6.1 -

6.2 -

6.3 -

TS OF AUTHORITY



5. To establish a high level of efficiency in the services provided in the Community Care Programme by

   5.1 Preparing and submitting to the Chief Executive Officer regular reports on the performance, in output and financial terms, of the Community Care Programme

   5.2 Seeking constantly opportunities to improve performance and release resources, directing and supervising project teams set up to achieve these aims

   5.3 Cooperating with research projects aimed at improving the efficiency of community care nationally

   5.4 Advising heads of voluntary agencies on measures to improve efficiency of their services.

6. To enhance the effectiveness of his officers and their staff by

   6.1 Ensuring that each section and activity has a clear purpose, that tasks are balanced and performance in the Community Care Programme is reviewed periodically during the year

   6.2 Planning the needs of his administration for personnel, encouraging officers and staff to keep their knowledge and training up to date so as to ensure a supply of suitably qualified and trained people and to satisfy their career expectations whether within or outside his administration

   6.3 Ensuring, where appropriate, that field workers cooperate and plan their casework rationally to provide the most effective and economical service on a community basis.

LIMITS OF AUTHORITY

The programme manager is responsible for all matters in his programme area except those involving direct clinical responsibility. Thus, he does not control directly many of the activities in his programme area and must rely upon persuasion to obtain participation and support for the programme. In exceptional circumstances he would have recourse to the support of the CEO and of the Board to achieve the programme plan.

PERFORMANCE MEASURES

1. -

2. -

3. -

MAJOR TASKS FOR 1971

1. Continue to improve services for the care of the aged in the area by
   - 1.1 Opening 2 day centres
   - 1.2 Employing 5 social workers and 30 home helps
   - 1.3 Settling 100 aged people in new (or renovated) housing accommodation
   - 1.4 Developing a meals-on-wheels service that can provide 100 meals a day.

2. Continue to improve the child health services in the area by
   - 2.1 Opening 2 new clinics
   - 2.2 Employing 3 additional ACMOs and 4 nurses
   - 2.3 Developing school health teams for regular school medical examinations.

. Strengthen and expand services supplied within the community by
   - 3.1 Opening 3 more Community Social Service Councils
   - 3.2 Employing 2 community social service leaders
   - 3.3 Improving the centres of 2 existing Community Social Service Councils.

RADINGS AND PROMOTION

-

-

PERFORMANCE MEASURES

1. Achievement of the programme targets agreed with the CEO

2. Ability to keep expenditure within budget

3. Completion of action plans by the agreed dates

4. Success in reallocating resources in response to changes in the programme.

MAJOR TASKS FOR 1971

These will be agreed between the programme manager and the CEO. They should be in the form of targets specifying which areas of patient care need attention, and, within these areas, which services should be upgraded or modified. Care should be taken to restrict these major tasks to a reasonable number.

GRADINGS AND PROMOTION

1. The position is paid on a salary scale that goes from £_____ to £_____ with the actual salary influenced by experience, professional and administrative skills and whether the post is held on a full-time or part-time basis.

2. A successful holder of this position could expect to be a good contender in the future for a Chief Executive Officer post.

COMMUNITY CARE OF THE AGED

PURPOSE

To develop a comprehensive programme for the care of the aged that will consider both the present and future needs of the aged and the composition of this sector of the population

OBJECTIVES

1. To improve the standard of care and treatment available to the aged by expanding and improving the services in the community to cover the physical, medical, social, psychological and financial needs of the aged

2. To ensure that the aged receive care and treatment, where possible, as members of the community, rather than as residents of health or welfare institutions, by encouraging those currently in institutions (e.g., county homes) to return to the community, and by discouraging elderly patients from entering institutions

TABLE D - 4

ES OF INDICATORS

Y CARE PROGRAMME

Health Board 'X'
February 1972

SPECIFIC TARGET - Discharge 200 l
and 2 mental h
April 1972

Number of Staff Involved		Housing for A	
January	February	Used January	Avail Fe
Public health nurses		Accommodatio available	
10	11	12	1
Social workers			
4	5		
Home helps			
35	46		

mes

Number of Aged				
Discharged (January)	Discharged to Date	Waiting To Be Discharged	Awaiting Reclassification	Awaiting Social Assessment
Mental Hospital 'X'				
10	28	20	1	3
Mental Hospital 'Y'				
11	27	30	1	3
County Home 'X'				
9	20	10	2	5
County Home 'Y'				
3	15	35	1	4
33	90	95	5	15

ACTION PLAN FOR RETURNING AGED PEOPLE CURRENTLY IN HOSPITALS AND HOMES TO THE COMMUNITY IN 'X' HEALTH BOARD

TARGETS

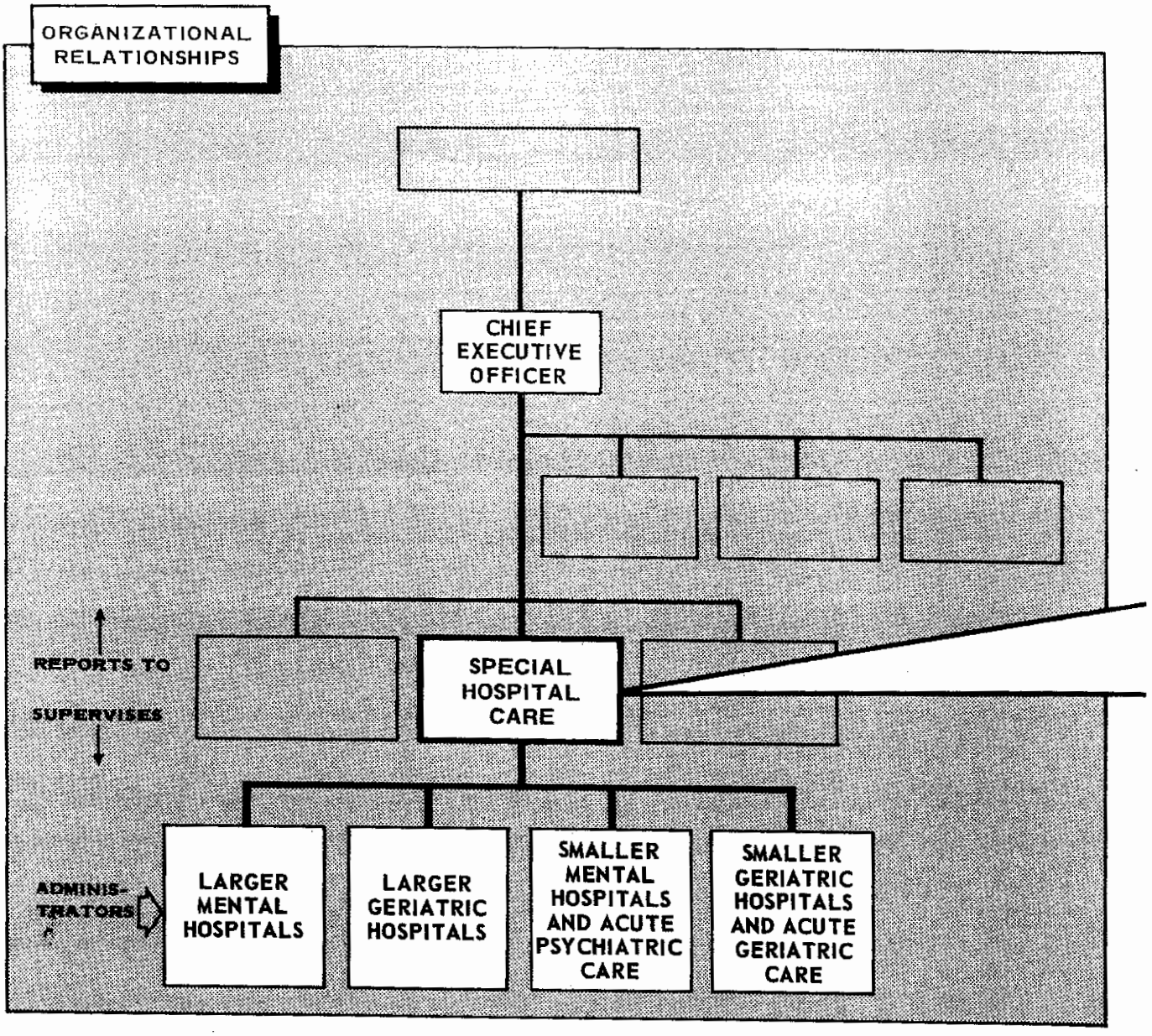
1. To discharge 200 long-stay aged patients from county homes and mental hospitals by April 1972
2. To provide adequate social and medical support services to facilitate their return to the community

Action Required	By	Dates	
		Start	Complete
Reclassify aged patients in two county homes and two mental hospitals	Hospital administrators and doctors	February 1971	July 1971
Select 200 aged patients suited to return to community	Hospital administrators and doctors	July 1971	August 1971
Assess social needs of patients to be discharged	Public health nurses	August 1971	September 197
Employ extra home helps to assist those patients to be discharged who are handicapped	CEO Programme Manager, Community Care	July 1971	September 197
Organize other social and medical support services	Programme manager Public health nurses	February 1971	September 197
Start to discharge patients	Hospital administrators and doctors	September 1971	April 1972
Hold monthly meetings to review progress	Programme manager Public health nurses Social workers GPs	September 1971	April 1972

Sub-Programme	Objectives	Elements	Present No.	Present Cost (£000)	Targets Set	Costs (£000) Capital Costs	Annual Running Costs 1971	1972	1973	Date To Be Achieved By
WELFARE SERVICES - Care of the Aged	- Keep aged in the community				- Document register of aged 'at risk' in community	–	0.8	0.8	0.8	October 1973
	- Improve community life for aged	Welfare homes	5	–	- Build three 40-bed welfare homes	300.0	16.0	48.0	48.0	April 1971 April 1972
		Sheltered housing	0	0.0	- Corporation to provide seven schemes of sheltered housing (25–30 beds)					
					- First scheme to be completed					March 1972
		Meals on wheels	–	–	- Set up a Health Board lunch service with a capacity of 100 meals per day	1.5	1.0	1.0	1.0	April 1971
		Home helps	153	23.0	- Increase number of home helps by 30 and employ 1 supervisor		3.0	3.0	3.0	August 1971
			33	5.5	- Increase by 100 home helps provided by voluntary group		15.0	15.0	15.0	August 1971
			2,781	13.0	- Increase number of meals on wheels served per week by 1,000	1.0	6.5	6.5	6.5	October 1971
					- Increase number of day centres by 6 to 20	6.0	1.6	1.6	1.6	October 1971
			1,235	10.0	- Increase number of meals at day centres by 25 per cent					
		Transport	0	0.0	- Provide transport to day centres for 60 persons 4 days per week		3.0	3.0	3.0	April 1971
WELFARE SERVICES - Child Care	- Keep children out of institutions	Social workers	7	7.0	- Increase number of children's social workers by six Introduce training scheme for children's social workers	–	8.0	8.0	8.0	October 1971

TABLE D - 7

PROGRAMME MANAGER,
SPECIAL HOSPITAL CARE
'X' HEALTH BOARD



JOB DESCRIPTION

PROGRAMME MANAGER, SPECIAL HOSPITAL CARE*

'X' HEALTH BOARD

PURPOSE OF JOB

The Programme Manager, Special Hospital Care, is accountable for the overall direction of this programme. His principal duties and responsibilities are:

1. To determine needs and propose targets for special hospital care
2. To prepare plans and estimates of resources required for special hospital care in light of these targets
3. To ensure that plans for special hospital care are put into effect and that expenditure is kept within budget
4. To initiate changes, as required, in plans for providing special hospital care
5. To develop a high level of efficiency in the Special Hospital Care Programme.

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* - Special Hospital Care Programme includes care of all patients in mental hospitals and in psychiatric units in general hospitals, geriatric patients in general, district and county hospitals and institutional care of the physically and mentally handicapped, including the same patient categories in voluntary homes and hospitals.

REPORTING RELATIONSHIPS

Reports to:	The Chief Executive Officer
Supervises:	Administrative officers in geriatric and mental hospitals and units Administrative officers accountable for direction of services provided in groups of smaller hospitals.

WORKING RELATIONSHIPS

1. Works with Programme Managers, General Hospital Care and Community Care

   1.1 To ensure that overall planned targets are achieved

   1.2 To ensure that the programmes support each other without overlaps or gaps.

2. Works with the Programme Manager, Community Care

   2.1 To ensure that welfare homes and other community services and facilities are available for patients discharged from special hospitals

   2.2 To arrange for the proper assessment, treatment and, where necessary, rehabilitation of patients referred from the community.

3. Works with the Personnel Officer

   3.1 To review career development and manpower plans for officers under his supervision and professional staffs employed by the Health Board in his programme

   3.2 To appraise performance and progress of staff reporting to him in order to set remuneration levels and to aid the CEO in staffing senior posts

   3.3 To develop labour relations with unions representing staff in his programme.

4. Works with the Finance Officer

   4.1 To develop budgets for special hospital care

   4.2 To control special hospital expenditure within budget

   4.3 To seek revised resource allocation to reflect changes in targets.

5. Works with the Planning and Evaluation Officer

   5.1 To develop programme structure, objectives and indicators of performance

   5.2 To set targets, assess alternative strategies and develop plans

   5.3 To report progress made against targets and indicators

   5.4 To develop revised plans with revised targets and resource allocations.

6. Works with hospital visiting committees, advisory committees and local committees

   6.1 To ensure they are provided with data and that visiting committees are briefed on the institutions they are to visit

   6.2 To take necessary actions on committees' findings

   6.3 To obtain community views on the extent to which the services meet local expectations.

7. Works with Regional Hospital Boards

   7.1 To provide an efficient service in hospitals delivering special hospital care

   7.2 To develop the services provided in hospitals delivering special hospital care.

PRINCIPAL DUTIES
AND RESPONSIBILITIES

1. To determine needs and propose targets for special hospital care by

   1.1 Assessing present and projected needs for special hospitals based upon regular fact finding, commissioned surveys and data obtained from local and national sources

   1.2 Comparing assessed area needs with special hospital services provided and planned by Health Board, Regional Hospital Board and voluntary organizations to identify gaps, overlaps and opportunities in each specialty

   1.3 Assessing priorities for the development of new services and for modifying the levels of existing services

   1.4 Proposing and reviewing objectives and targets in terms of level of service, in accordance with analyses of needs and guidelines developed by CEO.

2. To prepare plans and estimates of resources required for special hospital care in light of these targets by

   2.1 Considering the resources likely to be available to achieve each target set in 1.4 above

   2.2 Assessing the means by which each target might be achieved, including alternative strategies

   2.3 Developing action plans with each special hospital to achieve each major target in the programme, specifying collective/individual responsibility for each part of the plan, dates for completing each part of the plan, budgets allocated to individuals/hospitals/units and ways of measuring performance

   2.4 Drawing up overall plan - including action plan for all special hospitals in the programme - for consideration, modification and approval by the management team, CEO and ultimately the Board.

3. To ensure that plans for special hospital care are put into effect and that expenditure is kept within budget by

   3.1 Discussing each stage of each action plan with those responsible (e.g., hospital administrators, senior consultants, matron) so that they become committed to reaching targets and accept allocation of resources, dates for completion and methods used to measure performance

   3.2 Reviewing progress of each major stage of the action plan with key administrative and professional staffs at regular intervals

   3.3 Monitoring expenditure against budget, probing variances and ensuring that corrective action is taken when appropriate (including on occasion revision of budget with CEO's approval).

4. To initiate changes, as required, in plans for providing special hospital care by

   4.1 Conducting regular progress reviews to identify major hospital targets and performance indicators not being achieved, and seeking opportunities for plan improvements and resolution of problems

   4.2 Developing plans and revised targets

4.3 Consulting with CEO and management team to seek acceptance and approval for plan changes and reallocation of resources within the programme and among programmes

4.4 Amending action plans and discussing each change with key hospital administrative and professional staffs involved

4.5 Reviewing progress on revised action plans at regular intervals.

5. To develop a high level of efficiency in the Special Hospital Care Programme by

5.1 Submitting regular reports on performance of special hospitals to CEO and management team; these reports must include, for each hospital and unit, expenditure compared with budget, performance against key indicators and progress against plan, and comparisons with similar hospitals in the area and elsewhere

5.2 Reviewing objectives and performance of each hospital, seeking improvements and cost reduction in the services provided

5.3 Directing and supervising ad hoc project teams of administrative and professional staffs, set up to conduct special surveys and tasks aimed at improvement and cost reduction

5.4 Commissioning surveys of special hospital care services provided and taking part in surveys undertaken by regional, national and other bodies

5.5 Consulting with management of voluntary special hospitals on measures to improve efficiency and level of services provided

5.6 Developing manpower and career development plans for administrative staff under his control - specifically performance appraisal, job rotation, training, and plans for selection, recruitment and training of new staff

5.7 Encouraging the professional staff to acquire and develop skills to meet new service requirements or to fill gaps exposed in existing services.

LIMITS OF AUTHORITY

The Programme Manager is responsible from the Health Board point of view for all matters in his programme area except for those involving direct clinical responsibility. Thus he does not directly control many of the activities in his programme area and must rely upon persuasion to obtain participation and support for the programme. In exceptional circumstances he would have recourse to the support of the CEO and of the Board to achieve the programme plans.

PERFORMANCE MEASURES

1. Achievement of programme targets agreed with CEO

2. Ability to keep expenditure within programme budget

3. Completion of action plans by the agreed date

4. Revision of action plans in response to changing needs.

MAJOR TASKS FOR 1971 (Illustrative only)

1. Complete assessment and classification, and begin treatment of 400 geriatric patients.

   1.1 Open geriatric assessment unit and long-stay unit in area general hospital

   1.2 Open geriatric assessment unit in 'Y' county hospital

   1.3 Open two welfare homes.

2. Undertake assessment and classification of 400 patients in 'X' Area's largest mental hospital

   2.1 Open acute psychiatric unit in hospital

   2.2 Open two welfare homes.

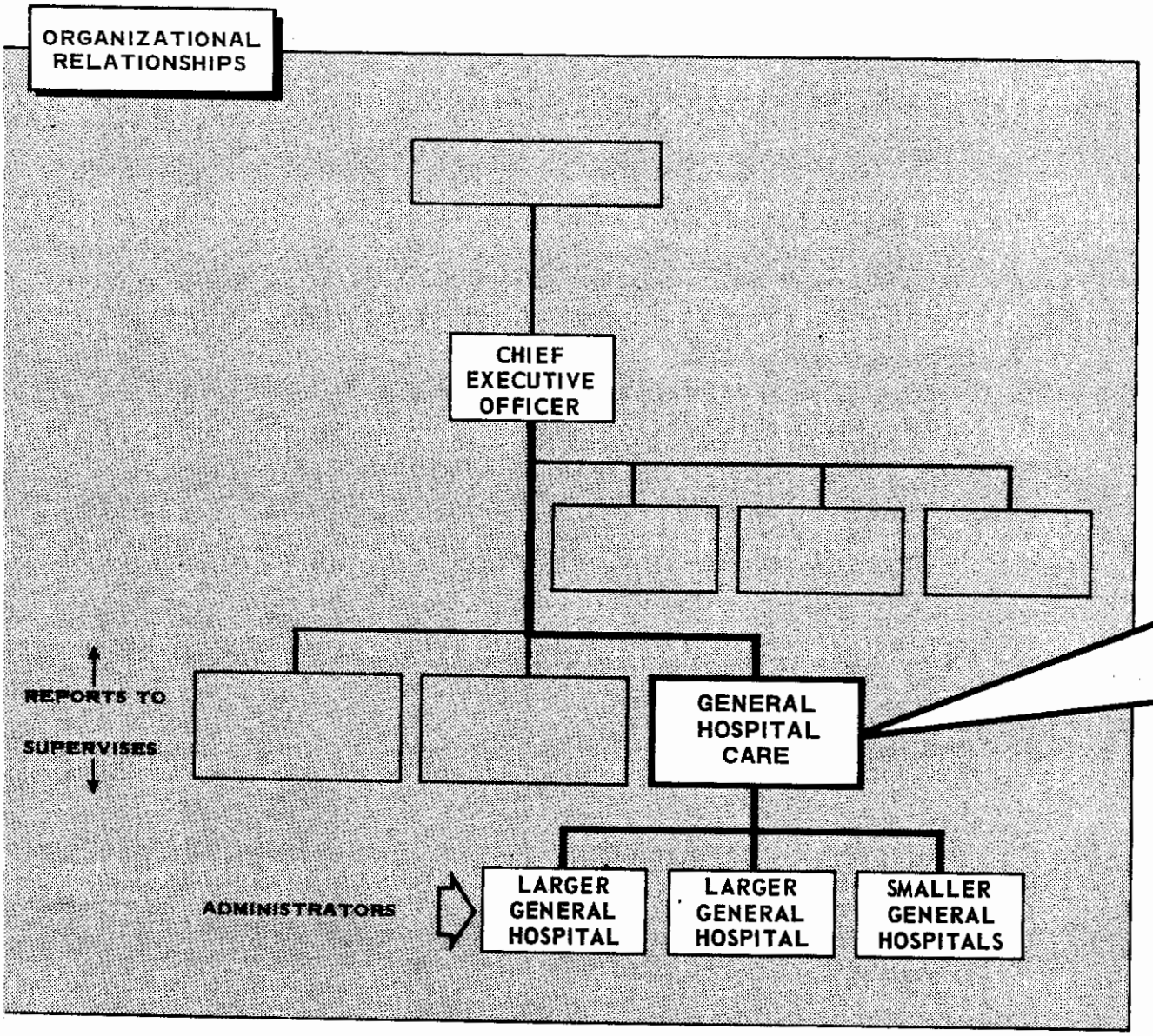
GRADINGS AND PROMOTION

1. The position is paid within the salary scale £_____ to £_____, with the actual salary influenced by experience, professional and administrative skills and whether the post is held on a full-time or a part-time basis.

2. A successful holder of this job could expect to be a strong contender for a Chief Executive Officer post in the future.

TABLE D - 8

PROGRAMME MANAGER, GENERAL HOSPITAL CARE 'X' HEALTH BOARD



JOB DESCRIPTION

PROGRAMME MANAGER, GENERAL HOSPITAL CARE*

'X' HEALTH BOARD

PURPOSE OF JOB

The Programme Manager, General Hospital Care, is accountable for the overall direction of the programme. His principal duties and responsibilities are:

1. To determine needs and propose targets for general hospital services

2. To prepare plans and estimates of resources required for services provided by general hospitals in the light of these targets

3. To ensure that the plans for providing services in general hospitals are put into effect and that expenditure is kept within budget

4. To initiate changes, as required, in plans for providing general hospital services

5. To develop a high level of efficiency in the General Hospital Care Programme.

* - General Hospital Care Programme includes the health care provided by general, district and county hospitals (excluding psychiatric and geriatric care) and the provision of ambulance services in the area.

REPORTING RELATIONSHIPS

1. Reports to: The Chief Executive Officer

2. Supervises: Administrative officers responsible for larger general hospitals
Administrative officers responsible for groups of smaller hospitals.

WORKING RELATIONSHIPS

1. Works with Programme Managers, Special Hospital Care and Community Care,

   1.1 To ensure that overall planned targets are achieved

   1.2 To ensure that the programmes support each other without overlaps or gaps.

2. Works with the Personnel Officer

   2.1 To review career development and manpower plans for officers under his supervision and for professional staffs employed by the Health Board in his programme

   2.2 To develop labour relations with unions representing staffs in his programme

   2.3 To appraise performance and progress of staff reporting to him as an aid to the CEO in staffing senior posts.

3. Works with the Finance Officer

   3.1 To develop budgets for General Hospital Care

   3.2 To control general hospital expenditure within budget

   3.3 To seek revised resource allocations to reflect changes in targets.

4. Works with the Planning and Evaluation Officer

   4.1 To develop programme structure, objectives and indicators of performance

   4.2 To set targets, assess alternative strategies and develop plans

   4.3 To report progress made against targets and indicators

   4.4 To develop revised plans with revised targets and resource allocations.

5. Works with the hospital executive committees in large general hospitals

   5.1 To prompt and seek support for plans defining objectives, targets and levels of services to be provided by the hospital

   5.2 To develop and gain acceptance for revenue and capital budget estimates.

6. Works with hospital visiting committees, advisory committees and local committees

   6.1 To ensure they are provided with data and that visiting committees are briefed on the institutions they are to visit

   6.2 To take necessary actions on committees' findings

   6.3 To obtain community views on the extent to which the services meet local expectations.

7. Works with Regional Hospital Boards

   7.1 To provide an efficient service in hospitals delivering general hospital care

   7.2 To develop the services provided by hospitals delivering general hospital care.

PRINCIPAL DUTIES
AND RESPONSIBILITIES

1. To determine needs and propose targets for general hospital services by

   1.1 Assessing present and projected needs for general hospital services (excluding psychiatric and geriatric) based upon regular fact finding, commissioned surveys and data from local and national sources

   1.2 Comparing assessed area needs with the hospital services provided and planned by Health Board, Regional Hospital Board and voluntary organizations to indentify gaps, over-provision of service and opportunities in each specialty

   1.3 Assessing priorities for developing new services, and for modifying level of existing general hospital services

   1.4 Proposing and reviewing objectives and targets in terms of level of service, in accordance with analyses of needs and guidelines developed by the CEO.

2. To prepare plans and estimates of resources required for the services provided by general hospitals in light of these targets by

   2.1 Considering the resources likely to be available to achieve each target set in 1.4 above

   2.2 Assessing the means by which each target might be achieved including alternative strategies

   2.3 Developing action plans with each general hospital to achieve each major target in the programme, specifying collective/individual responsibility for each part of the plan, dates for completion of each part of plan, budgets allocated to individuals/institutions and ways of measuring performance

   2.4 Drawing up overall plan - including action plans for all general hospitals in the programme - for discussion, modification and approval by the management team, the CEO and ultimately the Board.

3. To ensure that plans for providing services in general hospitals are put into effect and that expenditure is kept within budget by

   3.1 Discussing each stage of each action plan with those responsible (e.g., hospital administrators) and those principally affected, so that they become committed to reaching targets and accept allocation of resources, dates for completion and methods of measuring performance

   3.2 Reviewing progress of each major stage of action plans with key administrative and professional staffs at regular intervals

   3.3 Monitoring expenditure against budget, probing variances and ensuring that corrective action is taken when appropriate (including, on occasion, revision of budget with CEO's approval).

4. To initiate changes, as required, in plans for providing general hospital services by

   4.1 Determining on a regular basis those major targets not being met by the general hospitals, and identifying problems and opportunities for improving or varying plan

   4.2 Obtaining hospitals' acceptance of reasons why targets have been missed and their participation in developing plans to restore the position or to meet revised targets

4.3 Consulting with CEO and management team to seek acceptance of proposals for changing plans, and reallocating resources required within the programme and among programmes

4.4 Amending action plans and discussing changes with hospitals and administrative and professional people involved

4.5 Reviewing progress on revised action plans at regular intervals.

5. To develop a high level of efficiency in the General Hospital Care Programme by

5.1 Submitting regular reports on the performance of general hospital services to the CEO and to the management team; these reports must include, for each hospital, expenditure compared with budget, performance against key indicators and progress against plan, and comparisons with similar hospitals in the area and elsewhere

5.2 Reviewing objectives and performance of hospitals and seeking improvements and cost reduction in services provided

5.3 Directing and supervising ad hoc project teams of professional and administrative staffs charged with special surveys and tasks aimed at improvement and cost reduction

5.4 Commissioning surveys of services provided and taking part in surveys undertaken by regional and national bodies

5.5 Consulting management of voluntary hospitals on measures to improve efficiency and level of their services

5.6 Planning the manpower and career development needs of administrative staff under his control - specifically, performance appraisal, job rotation, training, and plans for selecting, recruiting and training new staff

5.7 Encouraging other professional staff to acquire and develop skills to meet new service requirements or to fill gaps exposed by analyses of needs.

LIMITS OF AUTHORITY

The Programme Manager is responsible from the Health Board point of view for all matters in his programme area except for those involving direct clinical responsibility. Thus, he does not directly control many of the activities in his programme area and must rely upon persuasion to obtain participation and support for the programme. In exceptional circumstances he would have recourse to the support of the CEO and of the Board to achieve the programme plans.

PERFORMANCE MEASURES

1. Achievement of programme targets agreed with CEO

2. Ability to keep expenditure within his programme budget

3. Completion of action plans by the agreed dates

4. Revision of action plans in response to changing needs.

MAJOR TASKS (Illustrative only)

1. Develop proposals and obtain approval for improving staffing and facilities in selected general hospitals, e.g.,

   - ¶ Outpatient care
   - ¶ Pathological laboratory services
   - ¶ X-ray services

2. Assess condition of and treatment required for long-stay patients in county homes and district hospitals.

GRADINGS AND PROMOTION

1. The job is paid within the salary scale £_____ to £_____, with the actual salary influenced by experience, professional and administrative skills and whether the post is held on a full-time or a part-time basis.

2. A successful holder of this position could expect to be a strong contender for a Chief Executive Officer post in the future.

JOB DESCRIPTION

PLANNING AND EVALUATION OFFICER

'X' HEALTH BOARD

PURPOSE OF JOB

The Planning and Evaluation Officer of the Health Board has three main functions:

1. To assist the CEO and programme managers in determining area health care needs and priorities, and in evaluating the results of the existing health care programmes designed to cater for them

2. To provide information required by programme managers in developing plans, and to support the CEO in developing a consolidated Health Board plan - particularly where the provision of care to meet specific needs involves action in more than one programme area

3. To help the CEO to monitor implementation of all health care programmes and to ensure that service objectives are achieved within budget.

REPORTING RELATIONSHIPS

1. Reports to: The Chief Executive Officer

2. Supervises: Staff assigned to the Board's Planning and Evaluation Unit.

WORKING RELATIONSHIPS

1. Works with the Chief Executive Officer

   1.1 To assist in allocating total current resources of the Board in accordance with identified health care needs and priorities*, ensuring that these resources are applied to cater for needs in the best possible way

   1.2 To help select capital projects for proposal to the Board, Regional Hospital Board (hospital projects only), and Department from the list suggested by programme managers and advisory committees of the Board

   1.3 To assist in ensuring service objectives are achieved within budget.

2. Works with the Board and the CEO, programme managers, and appropriate medical and nursing staff, to help identify area health care needs and priorities, providing support needed to develop plans and budgets, and to ensure that these plans support one another and are well coordinated.

3. Works with the Finance Officer

   3.1 To develop outline costs for possible capital projects

   3.2 To determine the cost of alternative schemes for meeting area health care needs

   3.3 To ensure that decisions by CEO and Board to allocate financial resources are made using accurate costings

   3.4 To help develop an integrated Health Board plan and budget

   3.5 To assist the CEO in ensuring that actual costs do not exceed budget.

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* - Allocations by CEO and Board will be in line with national objectives and priorities.

4. Works with the Personnel Officer

   4.1 To assist in determining personnel and training required to enable Health Board annual and longer term plans to be implemented effectively

   4.2 To appraise performance and progress of all planning and evaluation staff as an aid to the CEO in staffing senior posts.

5. Works with the Department, the Regional Hospital Board, programme managers, and appropriate medical staff

   5.1 To assist in developing standard health care indicators and in determining national and regional objectives and priorities

   5.2 To help ensure that Health Board plans are in line with these objectives and priorities.

6. Works with the planning and evaluation officers of other Health Boards to ensure that any ideas that are successful in other areas are rapidly tested by 'X' Health Board.

PRINCIPAL DUTIES
AND RESPONSIBILITIES

1. To assist the CEO and programme managers in determining area health care needs and priorities by

   1.1 Developing and installing systems to report health care needs and performance using the standard indicators laid down by the Department and the Board (e.g., the need for home help for the elderly might be indicated by the number of people in the area aged over 70, living alone and with an income of less than £8 per week; the Planning and Evaluation Officer will be involved with the Programme Manager, Community Care, in developing a system to report the number of such people)

   1.2 Assisting the CEO and programme managers to relate the needs for particular types of health services within the area to the services currently available by

   - Identifying gaps or over-provision in the present levels of service
   - Recommending to CEO and programme managers concerned priorities for action (both in terms of current services and capital projects)

1.3 Developing and installing systems to report the impact of services on the needs of the population within the area, using the standard indicators laid down by the Department and the Board (e.g., the impact of one part of the Child Health Services might be measured by the average age at which certain defects are discovered; the Planning and Evaluation Officer will arrange for samples or for routine reports to make this information available)

1.4 Comparing impact achieved with targets or with performance elsewhere in order to determine where the main opportunities and needs for improved services lie.

2. <u>To provide information required by programme managers in developing plans and to support the CEO in developing a consolidated Health Board plan</u> by

2.1 Agreeing on systems to measure need and impact with CEO and programme managers concerned

2.2 Leading special projects at the request of the programme managers, or as directed by the CEO and Board, to analyse problems and to recommend action plans for meeting known health care needs, particularly where a multi-programme approach is required (e.g., relieving severe over-crowding in a large mental hospital by returning 30 per cent of the patients to the community might involve coordinated action by psychiatric assessment units, GPs, and home-help and welfare/housing services, etc.)

2.3 Assisting in developing programme plans as a result of evaluating the need for and impact of existing programmes and of planned changes

2.4 Examining final programme plans and budgets as requested by the CEO

- To ensure that planning assumptions are soundly based and clearly stated
- To verify that cost and service targets are realistic
- To agree the measures and dates for assessing progress against plan

- To check that action planned in any one programme neither duplicates nor is harmful to action planned in another (e.g., a plan to cut back domestic nursing services might be harmful to a plan to remove long-stay patients from general hospital beds)
- To assist in consolidating individual programme and functional plans into an integrated Health Board plan and budget.

3. To help the CEO to monitor implementation of all health care programmes by

   3.1 Conducting monthly reviews to make certain that actions specified in programme and functional plans are implemented, and that service objectives (in terms of availability and impact) are achieved

   3.2 Examining monthly and cumulative costs in relation to services provided

   - Identifying major adverse variances either in total or in terms of cost per unit service
   - Challenging programme and functional managers concerned and suggesting corrective action to be taken by them

   3.3 Highlighting major adverse variances for the CEO; detailing corrective action already in hand; and, when necessary, recommending further measures.

LIMITS OF AUTHORITY

1. The Planning and Evaluation Officer has no authority over staff other than those assigned to the Board's Planning and Evaluation Unit (if any); he therefore has to develop cooperative working relationships with the programme managers and other functional officers and achieve the action he requires by presenting well-documented proposals and expounding these logically and persuasively. A successful Planning and Evaluation Officer will only rarely have to resort to the CEO to obtain the action he desires.

PERFORMANCE MEASURES

The performance of the Planning and Evaluation Officer will be measured by the extent to which he succeeds in

1. Providing accurate, timely and selective information to report health care needs and priorities

2. Analysing problems and recommending feasible action plans to the programme managers and the CEO

3. Assisting the CEO in developing an overall plan and budget for the Health Board

4. Highlighting major adverse performance and cost variances for the CEO and programme managers with a view to corrective action.

MAJOR TASKS FOR 1971

(Major tasks for the Planning and Evaluation Officer should be developed each year with the CEO and programme managers, and should list those major targets that the Planning and Evaluation Officer must achieve in order to support programme plans and enable Health Board objectives to be attained.)

GRADINGS AND PROMOTION

1. Salary scale for the Planning and Evaluation Officer varies from £____ to £____ among Health Boards and individuals depending on the size of the Board's budget and the past experience and present skills and performance of the holder.

2. A successful Planning and Evaluation Officer could expect to be a strong contender for future appointment as a programme manager.

JOB DESCRIPTION

FINANCE OFFICER

'X' HEALTH BOARD

PURPOSE OF JOB

The Finance Officer of the Health Board has six essential responsibilities:

1. To prepare budget estimates for the Board and for the CEO

2. To secure the income of the Board and to control expenditure within the budget limits approved by the Board and by the Department

3. To prepare the required statutory accounts and ensure that Health Board funds are properly applied to the services for which they were provided

4. To provide financial and accounting services for the CEO and the other managers of the Board

5. To develop and control effective central management services (e.g., O and M, Purchasing, and, in some large boards, Computer Services)

6. To ensure that the Board's assets are appropriately recorded and safeguarded.

REPORTING RELATIONSHIPS

1.	Reports to:	The Chief Executive Officer
2.	Supervises:	Central finance and accounting staff Heads of central management services (excluding Personnel, and Planning and Evaluation).

WORKING RELATIONSHIPS

1. Works with the CEO to ensure that the financial resources available to the Board are applied so that they may achieve the highest possible levels of service throughout the Health Board area.

2. Works with each programme manager

   2.1 To develop coordinated programme plans and budgets within the resources available to the Board

   2.2 To secure the income of the Board

   2.3 To control expenditure within budget.

3. Works with the Personnel Officer

   3.1 To ensure that full and accurate cost estimation of all staffs is included in budget

   3.2 To determine cost impact of wage awards and changes in conditions of service (i.e., staff cost increases that were not allowed for in the approved budget and for which additional funds must be obtained)

   3.3 To determine training needs and develop training programmes for all finance staff

   3.4 To appraise performance and progress of all finance and accounting staff as an aid to the CEO in staffing senior posts.

4. Works with the Planning and Evaluation Officer

   4.1 To assess the cost of alternative schemes for providing services so that the most efficient may be identified

   4.2 To ensure that final programme plans and budgets are costed realistically.

5. Works with the heads of central management services to ensure that services are well used, are of value, and do not duplicate work undertaken by the RHB.

6. Works with the Regional Hospital Board

   6.1 To develop effective management services for the Health Board

   6.2 To ensure management services available from the RHB are used by Health Board managers where desirable.

7. Works with the Department and contributing local authorities to determine approved budget and to ensure that funds are available when required.

8. Works with the Department and Local Government Auditor

   8.1 To assist in developing standard financial policies, practices, and procedures for all Health Boards

   8.2 To ensure that all Health Board funds are properly applied to the purposes for which they were provided

   8.3 To produce budget estimates and obtain authorized allocations on time.

PRINCIPAL DUTIES
AND RESPONSIBILITIES

1. To prepare budget estimates for the Board and the CEO by

   1.1 Analysing the budget planning guidelines and allocations advised by the Department for the coming year and the next 2 years; assessing the potential for increasing income and advising the CEO of probable true annual net revenue increases available

   1.2 Assisting programme managers to estimate costs of proposed new or extended services and taking the necessary steps to enable them to identify opportunities to save money on existing services (for example, the Finance Officer should draw their attention to significant cost differences between similar services)

   1.3 Developing a draft consolidated budget for the coming year and the next 2 years with the CEO, programme managers, functional officers and heads of central services, specifying targets and funds required for submission to the Board and (after agreement/revision by the Board) for submission to the Department and, in the case of the hospitals section, to the Regional Hospital Board

1.4 Examining and agreeing on annual plans developed by heads of central services (notably O and M and Purchasing and, in some large boards, Computer Services) ensuring that these set feasible objectives and strategies and that planned benefits are integrated into annual programme plans and budgets

1.5 Obtaining from CEO, Board and Department, approval for next year's budget and for the outline budget for the following 2 years (submitting a copy of the hospitals section of these budgets to the Regional Hospital Board).

2. To secure the income of the Board and to control expenditure within the approved budget limits by

2.1 Ensuring that charges to patients are based on a realistic assessment of their ability to pay (in line with national criteria)

2.2 Ensuring that procedures in local offices and institutions for collecting accounts receivable are sound, and that payments are collected when due (e.g., by making sure that final accounts are sent out on time)

2.3 Negotiating terms for Health Board borrowing and arranging loans after terms have been approved by Board

2.4 Obtaining additional budget allocations from the Department where justified by changes in costs or prices upon which estimates were based (e.g., to cover the cost of wage awards)

2.5 Developing monthly cash flow forecast for the coming year and obtaining funds from the Department, contributing local authorities, patients and any other sources to meet known commitments

2.6 Monitoring expenditure against budget in all programme and management service areas; challenging major variances, recommending corrective action, and, through CEO and managers concerned, ensuring that expenditure is held within budget limits.

3. To prepare the required statutory accounts by

3.1 Implementing standard accounting policies, practices and procedures set by Department covering

- Authorization of payments
- Cash handling and availability

- Internal controls and balances
- Personal expense allowances
- Bookkeeping format and detail
- Management accounts

3.2 Producing required accounts on time

3.3 Supervising appropriate systems of internal audit and check.

4. To provide financial and accounting services by

4.1 Analysing monthly accounts and highlighting significant trends and variances for CEO and managers concerned

4.2 Producing analyses and abstracts of cost data for CEO and managers when required

4.3 Recommending changes in standard management accounting procedures to improve the value of information produced.

5. To develop and control effective central management services by

5.1 Recommending to the CEO the central management services that should be provided (e.g., O and M, Purchasing and, in some large boards, Computer Services), the way in which they should be organized, and the funds that should be allocated to them

5.2 Ensuring that in each area of skill the highest possible standards are maintained

5.3 Ensuring by his involvement in the annual planning process that the work of central management services departments produces significant benefits in all health programmes that they serve.

6. To ensure that the Board's assets are appropriately recorded and safeguarded by

6.1 Maintaining an appropriate register of assets

6.2 Supervising the Board's insurance policies

6.3 Spotchecking assets and inventories.

LIMITS OF AUTHORITY

1. The Finance Officer has no line authority over programme managers and their staff; he will, therefore, keep expenditure within budget by bringing any excess expenditures to their attention and to the attention of the CEO, explaining why costs are excessive and recommending ways of keeping within budget. As a member of the management team he will thus control costs by presenting well-documented proposals and persuading programme managers to take action; a good Finance Officer should rarely have to request the CEO to issue formal directives to programme managers.

PERFORMANCE MEASURES

1. Control of costs within approved budget both in total and by service with minimum frustration to all concerned

2. Rapid collection of accounts receivable (performance might be measured by the average age of accounts receivable and the proportion that have eventually to be written off compared with other boards)

3. Accuracy, timeliness and usefulness of financial reports and analyses.

MAJOR TASKS FOR 1971

(Major tasks for the Finance Officer should be developed each year with the CEO and programme managers, and should list those major targets that the Finance Officer must achieve in the year in order to support programme plans and enable Health Board objectives to be attained.)

GRADINGS AND PROMOTION

1. Salary scale for the post of Finance Officer varies among Health Boards and individuals from £____ to £____ depending on the size of the Health Board's budget and the past experience and present professional skills and performance of the holder.

2. A successful Finance Officer could expect to be a good contender for future appointment as Chief Executive Officer.

JOB DESCRIPTION

PERSONNEL OFFICER

'X' HEALTH BOARD

PURPOSE OF JOB

The Personnel Officer of the Health Board has three main responsibilities:

1. To provide imaginative training programmes for all personnel so that they may discharge their present functions more effectively and may develop their full career potential in the health services

2. To determine and provide for future manpower needs

3. To ensure that cooperative working relationships are developed and maintained with all personnel.

REPORTING RELATIONSHIPS

Reports to:	The Chief Executive Officer
Supervises:	Health Board central personnel staff assigned to him.

WORKING RELATIONSHIPS

1. Works with the CEO to agree his annual and longer term plans for discharging each of his three main responsibilities, and to approve variations in these plans when necessary.

2. Works with the Department, the Regional Hospital Board, professional bodies (e.g., the Irish Nurses' Organization) and unions, programme managers and functional officers, and individuals concerned, to identify training needs and to ensure that programmes and plans specifying personnel requirements are integrated into the personnel plan and estimate manpower costs accurately.

3. Works with the Department, professional bodies, teaching institutes (e.g., the Institute of Public Administration), universities and their associated teaching hospitals, colleges, and individuals concerned

   3.1 To find out what instructional courses are available to meet particular training needs

   3.2 To assist in developing new or improved courses

   3.3 To programme Health Board staff to attend these courses

   3.4 To attract high-calibre personnel to the Health Board staff.

4. Works with the Finance Officer to determine cost of proposed training programmes.

5. Works with the Department, the unions, professional bodies, and the CEO to participate in determining standard rates of pay and conditions of service for all personnel, and in developing accepted common performance appraisal and selection procedures.

6. Works with programme managers and functional officers to appraise performance and progress of all staff as an aid to the CEO in staffing senior posts.

PRINCIPAL DUTIES
AND RESPONSIBILITIES

1. To provide imaginative training programmes for all personnel by

   1.1 Identifying professional, managerial, and technical training needs for all personnel (i.e., including medical and paramedical staffs)

   1.2 Finding out what instructional courses are available, or can be developed, to meet these needs (including planned job changes and secondment to other Health Boards as part of a career development programme)

   1.3 Programming personnel to attend appropriate courses as part of a comprehensive Health Board training plan and budget

   1.4 Obtaining approval for the personnel training plan and budget from programme managers and functional officers concerned, and the CEO and Board*

   1.5 Implementing the training plan with external training institutions and individuals concerned, ensuring that costs are kept within budget.

2. To determine and provide for future manpower needs by

   2.1 Assessing current and longer term needs for personnel, in terms of grades, skills and qualifications on the basis of the plans prepared by each programme manager and functional officer and in line with establishment guidelines set by the Department

   2.2 Developing and maintaining current and projected job descriptions for all key positions, in conjunction with managers and personnel concerned, identifying the skills and prior experience required for each post, and ensuring that major tasks are agreed each year

   2.3 Participating in negotiations to agree common performance appraisal procedures and providing programme managers with appropriate report forms

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* - Funds for training programmes will be provided within Department guidelines.

2.4 Using performance appraisals to build up an inventory of available skills and to guide the CEO in judging how well programme managers are able to appraise and develop staff (i.e., programme managers should be able to agree what their subordinates' weaknesses are with the individuals concerned, and to agree with them the steps required to improve performance)

2.5 Developing a management succession programme for all key positions, equating skills to job descriptions and identifying gaps that need to be filled either by

- Providing training for present staff
- Recruiting individuals with specific skills and experience (using procedures laid down by the Department - e.g., the Local Appointments Commission will be used for some posts)

2.6 Obtaining CEO's approval of management succession programme; ensuring training needs for present staff are provided for in the Health Board training plan, and assisting CEO to use approved procedures to recruit externally and/or promote internally as and when required

2.7 Drawing up and implementing recruitment and training plan for staff for all other posts (including training and planned career development for new entrants to Health Board administration).

3. <u>To ensure that cooperative working relationships are developed and maintained with all personnel</u> by

3.1 Participating in national negotiations to set standard rates of pay and conditions of service for all Health Board personnel

3.2 Monitoring interpretation at local level of nationally negotiated agreements within the Health Board to prevent uneven interpretation and the setting of unauthorized precedents

3.3 Supervising the conduct of trade union consultation and negotiation within the Health Board and participating personally as required

3.4 Ensuring that all staff are fully aware of agreed conditions of service and that agreed allowances for special work are paid automatically (e.g., temporary appointment of a nurse as a ward sister)

3.5 Keeping in close contact with staff in all Health Board units

- Advising CEO and programme manager concerned of emerging issues, and with their agreement taking action to avoid disputes and staffing problems (within constraints imposed by national agreements)
- Ensuring that staff welfare problems are quickly identified (e.g., cases of personal illness, family problems) and that appropriate action is taken to aid the individual concerned

3.6 Advising CEO and programme managers concerned of possible staff difficulties arising from proposals aimed at reducing unit labour costs, and developing negotiating machinery for effecting change without causing disputes.

LIMITS OF AUTHORITY

1. The Personnel Officer has no authority over staff other than the central personnel staff assigned to him; he therefore negotiates agreement to release staff for training with the programme managers and functional officers concerned, when obtaining approval for his annual training plans. Thereafter, he works through these managers, and the CEO if necessary, to ensure that plans can be implemented.

PERFORMANCE MEASURES

1. Development and execution of training programmes, especially for those personnel (e.g., the lower paid) for whom such programmes have not existed in the past

2. Provision of the necessary manpower to meet Health Board plans and budgets (but this can only be measured over a relatively long period)

3. Avoidance of unnecessary labour disputes and staffing problems (particularly in the short-term acceptance of changes affecting employees, e.g., changes in grading, working practices and scope of appointments).

MAJOR TASKS FOR 1971

(Major tasks for the Personnel Officer should be developed each year with the CEO and programme managers, and should list those major targets that the Personnel Officer must achieve in the year in order to support programme plans and enable Health Board objectives to be attained.)

GRADINGS AND PROMOTION

1. Salary scale for the post of Personnel Officer varies among Health Boards and individuals from £_____ to £_____ depending on the size of the Health Board's budget and staff and the past experience and present professional skills of the holder.

2. A successful Personnel Officer could expect to be a good contender for future appointment as a programme manager.

TERMS OF REFERENCE FOR

HOSPITAL EXECUTIVE COMMITTEES

In the report itself, we recommended that the Health Boards set up executive committees to manage the larger and more complex hospitals*. The CEO would delegate to the committees carefully defined powers, excluding those functions specifically reserved to him by the Health Act, 1970, by the Minister's regulations or by the Board's decision.

Establishing and operating a hospital executive committee in any hospital are complex tasks. A successful hospital executive committee will depend on the commitment and support of all hospital staff; it will require that the hospital has a strong departmental (or divisional) medical organization in which clinicians accept that certain decisions - particularly on resource allocation - need to be taken at the hospital and departmental (or divisional) level; it will involve some highly respected consultant staff being elected to take on a number of management functions while continuing to be, primarily, clinicians. Before forming an executive committee, therefore, the hospital concerned should join with the Programme Manager, General Hospital Care, in studying carefully the people, tasks and organizations involved. The hospital and the programme manager will then draw up a list of preliminary steps and present it to the CEO for his approval. Once he has agreed to the proposed steps, the hospital and programme manager can proceed to establish the committee, whose members should hold office for 2 to 3 years.

In this appendix we suggest some terms of reference for the hospital executive committees under the following headings:

- Purpose and scope
- Membership
- Working relationships
- Principal duties and responsibilities.

However, these terms of reference are merely guidelines since we recognize that one standard type of committee will not serve the needs of every large regional or general hospital. The programme manager and the hospital concerned will set up precise terms of reference and will submit them for the CEO's approval when they submit the preliminary steps.

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* - Specifically, regional and general hospitals, with large consultant staffs

PURPOSE AND SCOPE

Each hospital executive committee receives delegated functions from the CEO to manage the hospital. Although ultimately responsible to the CEO, it reports to him through the Programme Manager, General Hospital Care, from whom it will receive clear guidelines on hospital policy and objectives. Each committee has four main areas of responsibility:

1. Makes recommendations to the programme manager on overall objectives and major policies (and through the programme manager to the CEO and Board)

2. Manages the hospital to achieve the objectives agreed with the programme manager

3. Promotes measures to improve efficiency in the hospital

4. Coordinates activities of the medical, administrative, paramedical and nursing staffs.

MEMBERSHIP

A typical list of a hospital executive committee's members would include:

1. Chairman - a member of the Health Board and of the visiting committee to the hospital, having the right to refer issues to the CEO and the Health Board when he feels that the hospital is not acting in the broader interests of the Health Board

2. Programme Manager, General Hospital Care

3. Hospital administrator

4. Departmental representatives - consultants elected by each medical group and having an agreed level of authority (e.g., acting also as departmental chairman with agreed functions)

5. Matron.

WORKING RELATIONSHIPS

1. Works with the Programme Manager, General Hospital Care,

   1.1 To determine for the hospital major priorities that are consistent with the objectives of the Health Board

   1.2 To set targets for the hospital for the year ahead.

2. Works with Programme Manager, Special Hospital Care (or senior administrative staff in those institutions)

   2.1 To optimize the care of mentally ill and geriatric patients

3. Works with the Regional Hospital Board and Programme Manager, General Hospital Care,

   3.1 To assess the need for capital works and new consultant posts

   3.2 To develop proposals for expenditure on capital works and consultant posts

   3.3 To develop hospital services in the region.

PRINCIPAL DUTIES
AND RESPONSIBILITIES

1. Makes recommendations to the programme manager on overall objectives and major policies, by

   1.1 Recommending objectives for the provision of hospital services in the area

   1.2 Recommending objectives for providing teaching services in the area - both inside and outside teaching hospitals

   1.3 Proposing major changes in policy - e.g.,

   - Change the use of a TB ward
   - Install a 40-bed geriatric assessment unit
   - Establish a new specialty.

2. Manages the hospital to achieve the objectives agreed with the programme manager, by

   2.1 Developing and implementing plans and budgets for the hospital

   - Analysing the major problems confronting the hospital

- Agreeing on the priorities for the hospital with the Programme Manager, General Hospital Care

- Translating these priorities into performance targets for the hospital and for departments/services within the hospital with the help of the programme manager and hospital administrator

- Making decisions on the allocation of funds within the hospital, as long as agreed targets are being met

- Proposing to the programme manager next year's budget for the hospital, in keeping with the overall expenditure guidelines received from him.

2.2 Initiating changes, when the situation alters, in the actions to be taken and in the allocation of resources

- Determining on a regular basis the major targets that are not being met, as well as any related problems and opportunities

- Agreeing on changes in plans with the programme manager when the situation alters

- Implementing agreed changes in plans.

3. Promotes measures to improve efficiency in the hospital, by

3.1 Determining those areas with the greatest opportunities for value improvement

3.2 Initiating projects to study the extent of these opportunities and ways of exploiting them

3.3 Proposing to the programme manager ways of achieving these improvements, when Health Board support is needed

3.4 Initiating action on agreed proposals

3.5 Reviewing progress and, where necessary, initiating changes in the improvement plan

3.6 Reporting annually to the CEO on the state and achievements of the overall improvement plan.

4. Coordinates activities of the medical, administrative, paramedical and nursing staffs, by

   4.1 Resolving problems that cannot be solved at a lower organizational level

   4.2 Consulting with all staff to determine resource needs for now and for the future

   4.3 Communicating items to be considered at forthcoming meetings (i.e., circulating the agenda)

   4.4 Communicating decisions and a summary of meetings to all staffs.

ORGANIZING THE VISITING COMMITTEES

In the main body of the report we noted that the usefulness of visiting committees in the past varied from area to area. While some made a valuable contribution to the improvement of health services by promoting needed changes, others merely sought to avoid controversy. We recommended that the Boards appoint visiting committees composed entirely of Board members and that the size of the committees depend on the size and number of institutions to be visited.

In this appendix we suggest ways of organizing the committees' two major activities - making the actual visits and holding meetings to discuss findings and recommendations - so that the committees may function as effectively as possible.

ORGANIZING VISITS

We have already recommended that the committees visit large institutions once a month and all other institutions - including district hospitals and county homes - at least once a year. For the visits to be successful, however, we recommend that the committees

1. Set up small groups to make the actual visits. Members of visiting committees should continue to split up into several groups to carry out the visits. Each person visiting an institution should be able to meet and talk to both patients and staff and be able to inspect the institution's facilities (see the Proposed Checklist for Visiting Groups - Table F - 1). For each person to accomplish these functions we recommend that no more than four, and no less than two, persons form the visiting group. Every member of the visiting committee will belong to a visiting group. The exact number of these groups will be influenced by the number of institutions to be visited and the frequency with which they need to be visited. For example, a visiting committee of 8 members with 25 visits to make annually might form 2 groups of 4 to visit the institutions in their area. These small groups will be able to gain a great insight into the affairs of the institutions they visit since they will be able to form a close relationship with both patients and staff.

2. Assign groups to institutions within one geographical area. Visiting groups should visit all kinds of institution within one geographical area instead of visiting, for example, only mental institutions. Such an arrangement would allow the groups to see different institutions and to compare their standards of service. At present the standards of mental institutions are under scrutiny. Visiting groups will thus have the opportunity to compare the standards (for example of physical facilities) in mental institutions with those in other institutions.

3. Consider available information about each institution before each visit. Visits to institutions are typically short - a few hours - and, in large institutions, fragmentary in that only a few aspects of the institution are seen. For a visiting group to use its brief visits effectively, it will need to consider available information about the institution before the visit. There are three main sources of such information:

- Outline Indicator Sheets. These sheets contain the key figures (see Table F - 2) pertaining to the institution's performance, provided by the relevant programme manager. He may be invited to a meeting to brief each visiting group on the figures relating to the institution it will visit.
- Proposed Checklists for Visiting Groups. These checklists (see Table F - 1) may be filled out by each group during and after a visit. Before the next visit, they would provide a useful reminder of what was done at the previous visit, and would indicate, in the case of large institutions, whether visits over the past year had provided a balanced view of the institution.
- Action notes and minutes of meetings. These notes and minutes contain the recommendations that have been made to the Health Board for each institution. They will also include any other comments about each institution discussed at meetings.

A consideration of the information available from these three sources will assist the visiting groups to use their visiting time effectively.

4. Use available professional and administrative support. The visiting groups may feel that they need the help of professional advice on a particular visit. They should therefore be free to invite the appropriate adviser to accompany them on their visits.

In addition to this professional support, administrative support will also be available to the visiting committees. An officer from the Health Board will help in organizing and planning visits.

- He will sketch out a rough visiting plan for the year, and will plan and confirm visits for the coming month.

- He will contact the professional staff (i.e., consultants, and - where they work on hospital or county home staffs - GPs) in advance of the visit and will make appointments for the visiting groups, if they so wish, to meet individual consultants and general practitioners.

ORGANIZING MEETINGS

Improving the standard of visits will not in itself lead to improved services in the institutions. The committees will have to meet to discuss their findings and agree on recommendations for submission to the Board before any action can be taken. So that they reach an informed decision without undue wastage of time, the committees must organize their meetings carefully. Specifically, they should

1. Hold meetings once a month. Each visiting committee should meet regularly to discuss points arising from the visits that it has made. The groups themselves will meet more often to decide on the reports they will make to the full committee.

2. Elect a chairman to be responsible for arranging and conducting the meetings. The chairman of each committee will act as its official representative to the Health Board. He will be responsible for chairing the monthly meetings, for drawing up the agenda and for sending it, before the meeting, to each member of the committee. He will receive help in performing these tasks from the Health Board staff.

3. Invite relevant programme managers to attend meetings. We suggest that each committee invite the programme managers responsible for the institutions visited during the last month to attend the monthly meeting. The programme managers would thus gain access to the Board members and the committees would be encouraged to clarify and place in some order of priority the conclusions and recommendations that resulted from their month's work. The programme managers may take the opportunity to brief the visiting groups on visits to be made to their institutions during the coming month, analysing the numerical information available on each institution. The programme manager will have this information (Table F - 2) sent to the visiting groups before each visit.

The result of a monthly meeting will be a list of recommendations, which the committees should keep up to date. They should note which recommendations were and were not accepted, the date of acceptance and the date agreed for action. On the same list the committees should note whether action has been taken on the recommendation and, if so, at what date. They will thus be able to maintain and follow up a list of 'live' recommendations, a list that may be referred to as an 'action note'.

* * *

By carefully organizing their visits and their meetings, visiting committees can contribute significantly to improving the institutional services in their respective areas.

PROPOSED CHECKLIST FOR VISITING GROUPS*

The purpose of the checklist is

1. To assist the visiting groups on their visit to an institution, by providing an outline of people to be seen and facilities to be inspected

2. To help visiting groups to achieve a balance in their visiting activities during the year, both in terms of people seen and facilities inspected.

The checklist itself appears overleaf together with some comments that will help the visiting groups to use it effectively.

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* - This checklist is proposed to cater for the general needs of visiting groups. Individual groups should refine the checklist as required.

Table F - 1b

PROPOSED CHECKLIST FOR VISITING GROUPS

HOSPITAL STATISTICS

1. The hospital statistics are those that appear in the outline indicators sheet (see Table F - 2), presented to the visiting group by the relevant programme manager before each visit.

2. During visits they should be a basis for discussion between the visiting group and senior administrative and clinical staff of the institution.

WARDS VISITED (for future reference)

1. All wards should be seen at least once a year. In large institutions it may be possible to see only a few wards during a visit. In this case, a note should be made of the wards visited, so that different ones may be seen on future visits.

STAFF SEEN (for future reference)

1. Head administrative staff (i.e., RMS/matron/administrator) should be seen on each visit.

2. Large hospitals may have many consultants, all of whom the visiting groups must meet during the year. In advance of the visit, the administrative officer assisting the chairman will arrange for the group to meet the relevant consultants. The group should then make a note of the names and specialties of the consultants they have seen, so that they may arrange to see other consultants on future visits.

3. County homes will also have one or more GPs in attendance. If there are a number of GPs, they should be seen on a basis similar to that suggested for hospital consultants. If there is only one (or maybe two) in attendance, he should be seen on each visit.

4. The group should see many nurses on each visit, and should note their names and ranks. Over the year, the group should meet nurses from all ranks (e.g., staff, ward and student nurses).

Health Board_____ Institution_____

Visiting Group_____ Date_____

PROPOSED CHECKLIST FOR VISITING GROUPS

HOSPITAL STATISTICS

Matters arising from discussion with RMS/matron/hospital executive committees (where applicable)

WARDS VISITED

Description of wards (including their names and numbers)

STAFF SEEN

RMS (name)_____

Matron (name)_____

Consultants (names and specialties)_____

GPs (names)_____

Nurses (names and ranks)_____

Table F - 1c

FACILITIES INSPECTED

1. The condition of wards, corridors, etc., will be evident at each visit.

2. The group should also focus attention on at least one institutional service on each visit. Each of the following services should be followed through at least once during a year's visits:

   - Sanitary - i.e., inspection of all lavatories, washing and bathing facilities

   - Heating - i.e., inspection of the boilerhouse, examination of efficiency of heating and hot water facilities

   - Dining - i.e., inspection of kitchen and cooking facilities following through cycle whereby food is cooked, served to patients and cleared away; on these occasions visiting members should eat the meal served to patients

   - Cleaning - i.e., inspection of the state of cleanliness of wards, theatres, administrative offices and staff living quarters, and estimation of frequency and efficiency of cleaning.

FACILITIES INSPECTED

Wards, corridors, etc.

Sanitary

Heating

Dining

Cleaning

OUTLINE INDICATORS SHEET

Health Board:	*Date to be Visited:*
Name of Institution:	*Date Last Visited:*
Type:	*Visiting Group*

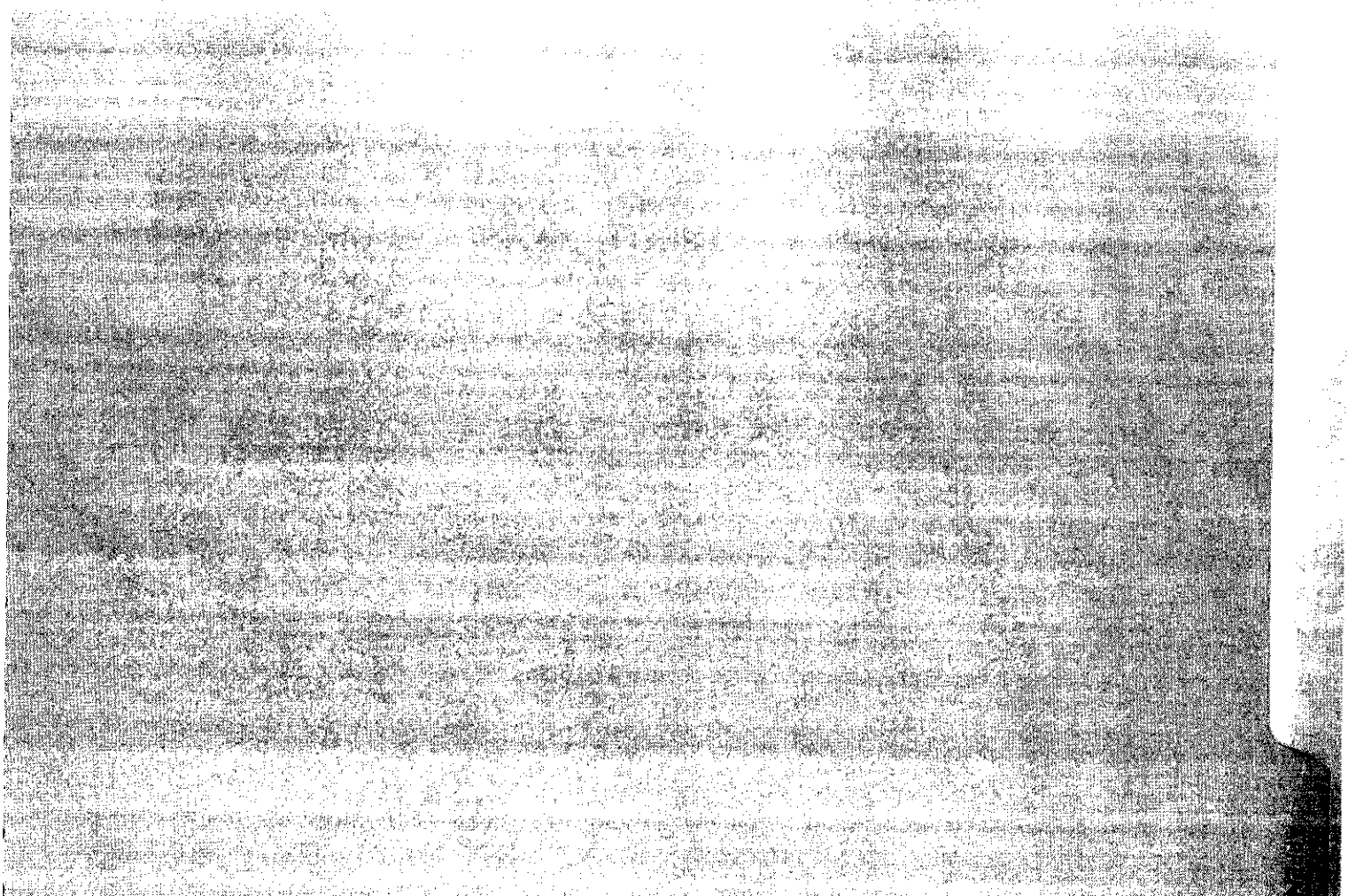
	NUMBER OF PATIENTS DISCHARGED IN PAST MONTH			NUMBER OF PATIENTS DISCHARGED YEAR TO DATE			% OCCUPANCY IN PAST MONTH			% OCCUPANCY YEAR TO DATE			AVERAGE DURATION OF STAY IN PAST MONTH			AVERAGE DURATION OF STAY YEAR TO DATE			NUMBER ON WAITING LIST		
	1968	1969	1970	1968	1969	1970	1968	1969	1970	1968	1969	1970	1968	1969	1970	1968	1969	1970	1968	1969	1970
MEDICAL																					
SURGICAL																					
MATERNITY																					
GYNAECOLOGY																					
PAEDIATRICS																					
TOTAL																					

	AVERAGE AGE OF PRESENT PATIENTS		
	1968	1969	1970
MEDICAL			
SURGICAL			
MATERNITY			
GYNAECOLOGY			
PAEDIATRICS			
TOTAL			

	NUMBER OF CONSULTANTS/ GPS			CONSULTANT AND GP PER PATIENT RATIOS		
	1968	1969	1970	1968	1969	1970
CONSULTANTS						
GPS						
TOTAL						

	NUMBER OF NURSES			NURSE PER PATIENT RATIOS		
	1968	1969	1970	1968	1969	1970
STAFF NURSES						
TEMPS						
PART-TIME						
STUDENT						
TOTAL NURSES						

Comments:



TRAINING OF THE HEALTH BOARDS' OFFICERS

Many of the management processes needed for programme management will be new to the Health Boards' officers. However, the CEOs and their management teams have time to undertake training and to develop their skills before the new Health Boards begin to operate in April 1971.

Three new kinds of job will come into being - chief executive officer, programme manager and functional officer (for planning and evaluation, personnel and finance). These jobs will place new demands on their holders and will require them to exercise new techniques and skills. As individuals and as members of a management team, these men will be expected to identify health service needs and establish objectives and targets for the Health Boards. They will have to develop and execute plans intended to achieve agreed targets, controlling expenditure within levels authorized by the Health Boards and the Department of Health. In addition, they will have to gain the support and commitment of administrative and professional staffs for their plans to provide health services.

If each of these functions is performed effectively, the quality and efficiency of the health services could be improved substantially. The management teams must therefore have the opportunity to practise their new functions in a suitable training environment.

In this appendix we discuss first of all the specific training needs and then we suggest ways in which these needs can be met.

TRAINING NEEDS

We believe that each officer needs an understanding and working knowledge of

1. Strategy formulation and planning in organizations, i.e.,
   - Setting organization objectives
   - Formulating overall strategy to move towards the objectives

- Using the planning process
  - . To translate objectives into targets
  - . To develop action plans
  - . To allocate resources in line with plans
  - . To monitor performance
  - . To take corrective action.

2. Use and application of management information systems, i.e.,
   - Defining information needs
   - Working with accounting techniques
   - Measuring programme performance
   - Reporting programme results/progress.

3. Personnel management and labour relations, i.e.,
   - Developing individual skills and careers
   - Working effectively with other people
   - Defining clearly individual tasks and responsibilities.

Each member of the management teams will have different training needs depending on the job he is to fulfil and on his skills, aptitudes and past experience. In developing our specific training proposals we have tried to allow for these different needs and to recognize that the team members bring with them skills and experience that will allow them to apply basic principles quickly to practical situations.

TRAINING COURSES

We are proposing a number of training courses designed to meet the training needs identified in the previous section. Realistic case studies could be provided on each course and could be used as exercises so that officers can simulate the management processes in the new organization. For example, officers should have the opportunity to develop programme structures, and suggest and test indicators of the service provided. They will thus have a collection of working papers that should be of considerable value when they return to their Health Boards to develop the management processes.

TABLE G - 1

SCHEDULE OF TRAINING FOR THE MANAGEMENT TEAM

Course	For	1970		1971				
		Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May
Visits to hospitals and organizations in United Kingdom, etc.	CEOs		- - -	- - -	- - -	- - -	- - -	- - -
General Management	CEOs			- -				
General Management	Management Teams				- - -	- - -	- -	
Seminars	Functional Officers				- - -	- - -	- - -	- - -

Notes

1. *Groups of management teams would consist of complete teams drawn from 2 or 3 areas - up to 24 officers per course - each course of 5-day duration*
2. *Courses for functional officers would be organized for 1- to 2-day duration and commence when the majority of officers in that position are appointed and available. Courses should be arranged to suit progress with the new management systems*
3. *It is hoped that CEOs would join their functional officers for some courses*
4. *Visits for CEOs (e.g., to U.K. Regional Hospital Boards) should be arranged separately*

The courses should be tailored to individual needs as far as possible and should be held in the sequence shown in Table G - 1. We discuss the proposed courses in turn.

1. Course for CEOs. This course would concentrate upon
   - Setting overall objectives and strategies
   - Establishing planning systems
   - Installing and using management information systems
   - Developing a management team.

It would also provide an opportunity for CEOs to discuss and identify problems that are arising in the establishment of the Health Boards.

2. Course for management teams. Three or so area management teams would attend this course together. It would cover
   - Developing the programme structure
   - Establishing and operating a management information system
   - Managing personnel.

Each of the teams would be expected to bring from their area material that could be used in practical study of the above subjects. They would have to conduct interviews and hold management team meetings and they would be expected to observe and report their progress as a team.

3. Course for functional officers. Each functional officer requires a further and deeper exposure to his functional area than is possible in the course for the management team. This extra training would be provided by a series of 1- to 2-day sessions arranged after the management team course. In these sessions, each functional officer would be engaged in developing plans and processes for his new job. The training session would be fitted into his work plan so that as problems developed he could discuss them with people in other areas and, at the same time, receive any more formal teaching required. The sessions would be flexible and would probably be held in each of the areas in turn. We hope that mixed groups of functional officers - e.g., personnel with finance - would have joint sessions when the problems cross functional boundaries. We also hope that CEOs would join the functional officers for particular sessions - e.g., in developing a management information or programme budgeting system. These initial training sessions could well be continued to foster cross fertilization of ideas.

The courses for the CEOs and the management teams would be residential and would last for at least 1 week. All the courses would rely heavily on the use of practical examples developed by the people attending them. Formal lecturing should be reduced to a minimum and should be backed by handouts and reading lists. Among the advantages of this approach are greater team and individual involvement, cross fertilization of ideas between teams and team members and an opportunity to build relationships in the safe atmosphere of training. We have not considered the role of the Department of Health in these courses but we hope that officers from the Department will contribute ideas on its changing role and in the interrelationships between it and the Health Boards.

Since the officers appointed to the new Health Boards will be experienced, they will be able to undertake considerable personal development if given the opportunity. We recommend that the CEOs in particular have the opportunity to visit selected hospital boards in the United Kingdom and that each officer be provided with a reading list and handouts during his course. These handouts would enable them to develop their knowledge and skills. Each officer, and particularly the Personnel Officer, would be responsible for training and developing his staff. This is especially important at the early stage of development of the Health Boards.

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We believe that the establishment of the new health organization offers an unusual opportunity for training people and preparing them for their challenging new tasks. This appendix, we hope, will provide the Department and Health Boards with guidelines for taking advantage of this opportunity.