Department of Health
An Roinn Sláinte
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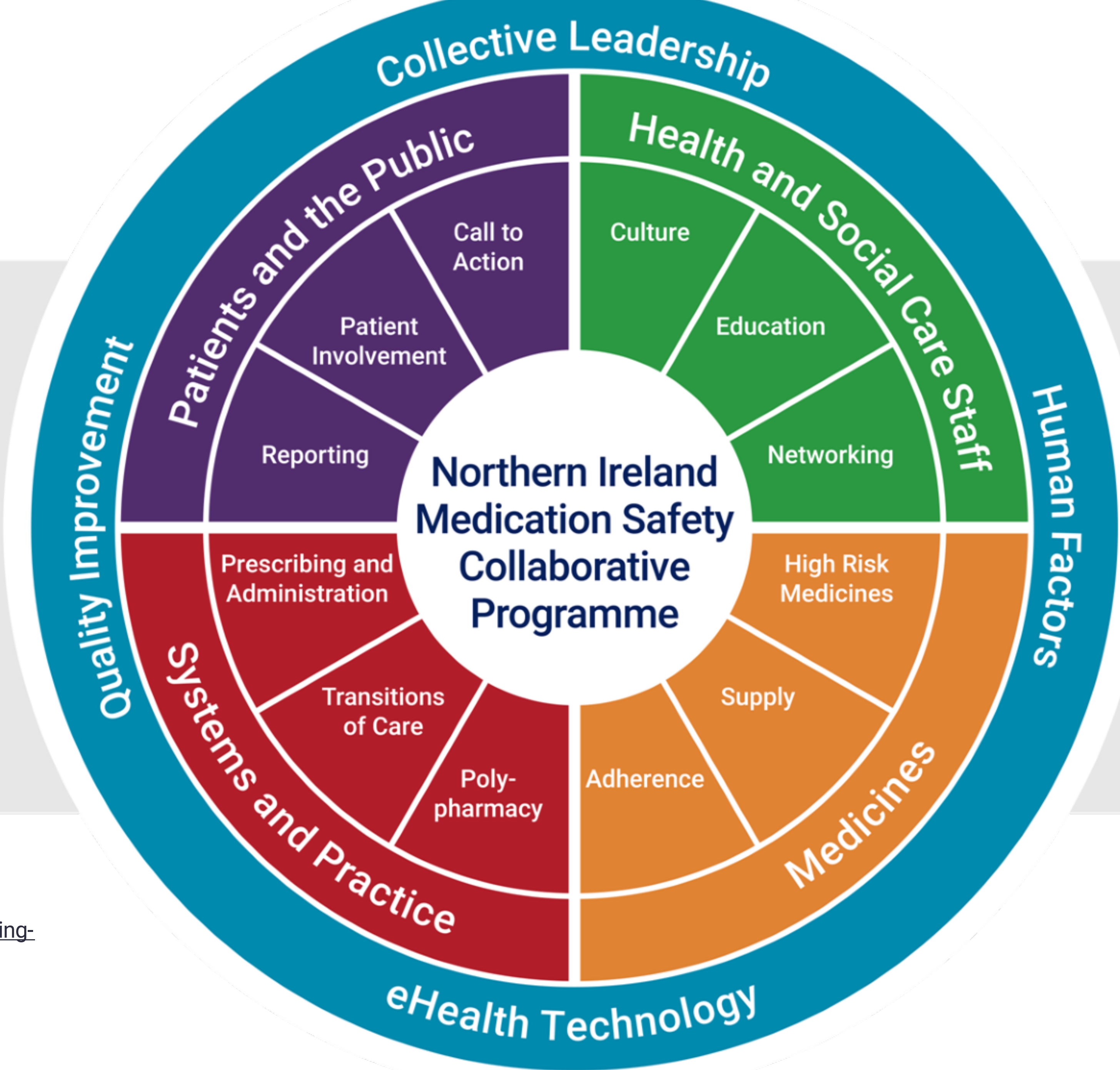
Transforming medication safety in Northern Ireland

Aligning our medication safety priorities to the World Health Organization Third Global Patient Safety Challenge ‘Medication Without Harm’



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MAHI - STM - 089 - 4303

Foreword

Safety matters with medication. Medicines are the most commonly used medical intervention in Northern Ireland, and at any one time 70% of our people take prescribed or over the counter medicines to treat or prevent ill health.

In Northern Ireland, we are fortunate to benefit from effective systems for the safe prescribing, dispensing and administration that have developed over many years. Despite this, the prevalence and burden of medication harm remains too high, and avoidable harm related to medicines occurs too often.

We want medication safety to be a priority for everyone receiving and providing care within our health and social care service. The World Health Organization's (WHO) third Global Patient Safety Challenge 'Medication Without Harm' provides us with the opportunity to re-energise our approach to ensuring the safe use of medicines in Northern Ireland. Our response sets out what we commit to do over the next five years to improve safe practices with medicines and support a medication safety culture within our population. Our commitments have been informed and shaped by those who receive and deliver safe and effective care across Northern Ireland, and we thank all of you for your contributions.

Achieving the WHO target of reducing severe, avoidable medication-related harm by a further 50% over the next five years will be challenging. Our response seeks to harness the energy and impetus provided by the Challenge to tackle some of our known 'wicked problems' through strong collective leadership, increasing public engagement, and new approaches to delivering transformational change. In short, we seek to build a new social movement. Join us on this journey.

Our aim is to build on existing successes and to progress from 'a good position' to one that is 'great'.

WHO Campaign video →

Dr Michael McBride, Chief Medical Officer

Cathy Harrison, Chief Pharmaceutical Officer

Charlotte McArdle, Chief Nursing Officer

Jenny Keane, Chief Allied Health Professions Officer

Sean Holland, Chief Social Worker

Simon Reid, Chief Dentall Officer

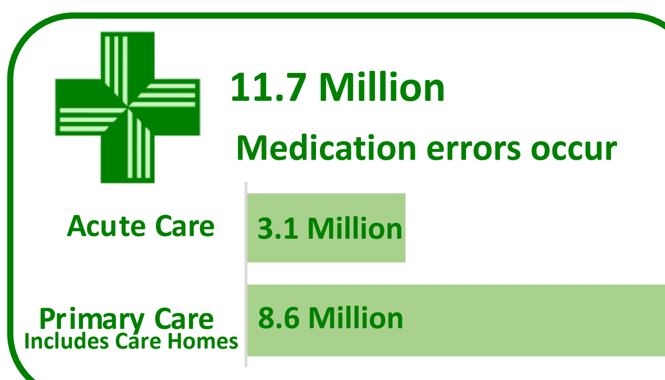
The Need for Safer Use of Medicines in Northern Ireland

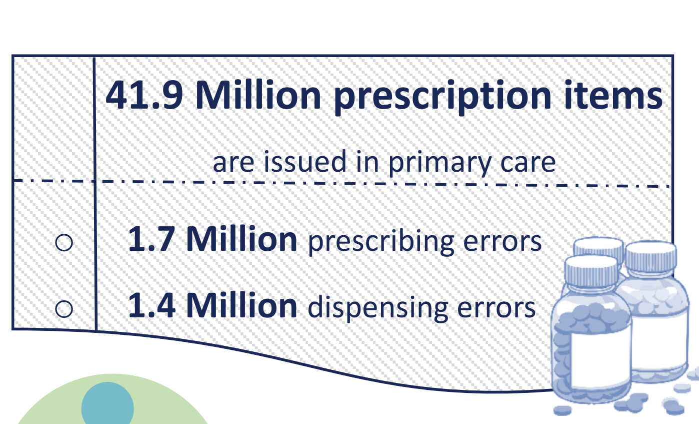
Ensuring that medicines are used safely is challenging. The medicines use process is highly complex, with multiple steps involved: from the decision to initiate treatment to ordering, prescribing, dispensing, administration and monitoring.

Each step is associated with a potential risk of harm and our health service has good systems in place to identify and mitigate risk and ensure patient safety.

However 'to err is human', and both health care workers and patients will make mistakes, often as a result of poorly designed systems, tasks and processes. All medication errors are potentially avoidable and can therefore be greatly reduced or even prevented.

Every year in Northern Ireland it is estimated that...

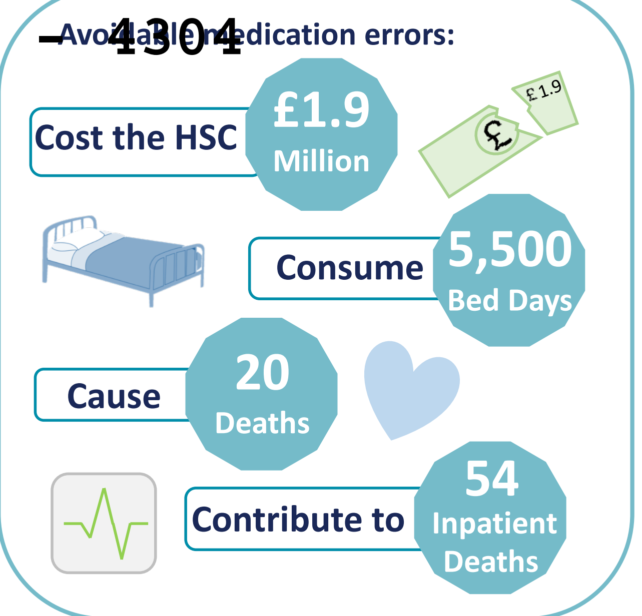


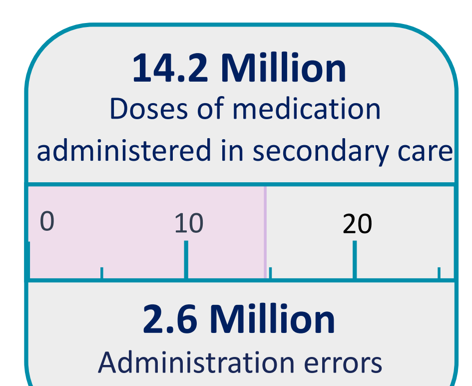


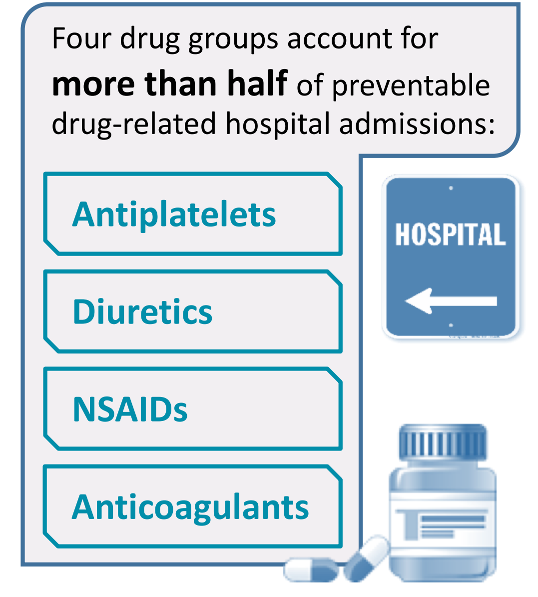
4 in 10 adults are dispensed **5** or more prescription items

9 in 10 patients aged **75 and over** are dispensed **5** or more prescription items

800 non-elective hospital admissions are due to avoidable medication related adverse events







2,000 inpatients experience an avoidable adverse event due to medications

What people said...

Half of people prescribed medication felt fully involved in decisions about the best medication for them

9 in 10 inpatients understood instructions on how to take their medication

The methodology applied to calculate the prevalence and burden of medication errors in Northern Ireland was informed by the 2018 research study, Prevalence and Economic Burden of Medication Errors in The NHS in England. Rapid evidence synthesis and economic analysis of the prevalence and burden of medication error in the UK. Policy Research Unit in Economic Evaluation of Health and Care Interventions. Universities of Sheffield and York.

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The 3rd WHO Global Patient Safety Challenge 'Medication Without Harm'

Global Patient Safety Challenges focus on patient safety burdens that pose a significant risk to global health.

Previous Challenges 'Clean Care is Safer Care' and 'Safe Surgery Saves Lives' sought to gain a worldwide commitment to action to reduce health care associated infection and risk associated with surgery respectively, and have delivered real and lasting improvements thanks to strong and rapid commitment from governments, health system leaders, professionals and civic society.

Building on the success of previous Challenges, the WHO launched their third Global Patient Safety Challenge 'Medication Without Harm' in March 2017. The Challenge focuses on improving medication safety by strengthening the systems for reducing medication errors and avoidable medication related harm.

The goal of the third Global Patient Safety Challenge on Medication Safety is to gain worldwide commitment and action to reduce severe, avoidable medication-related harm by 50% in the next five years, specifically by addressing harm resulting from errors or unsafe practices due to weaknesses in health systems.

The requirements of the Challenge are for countries to:

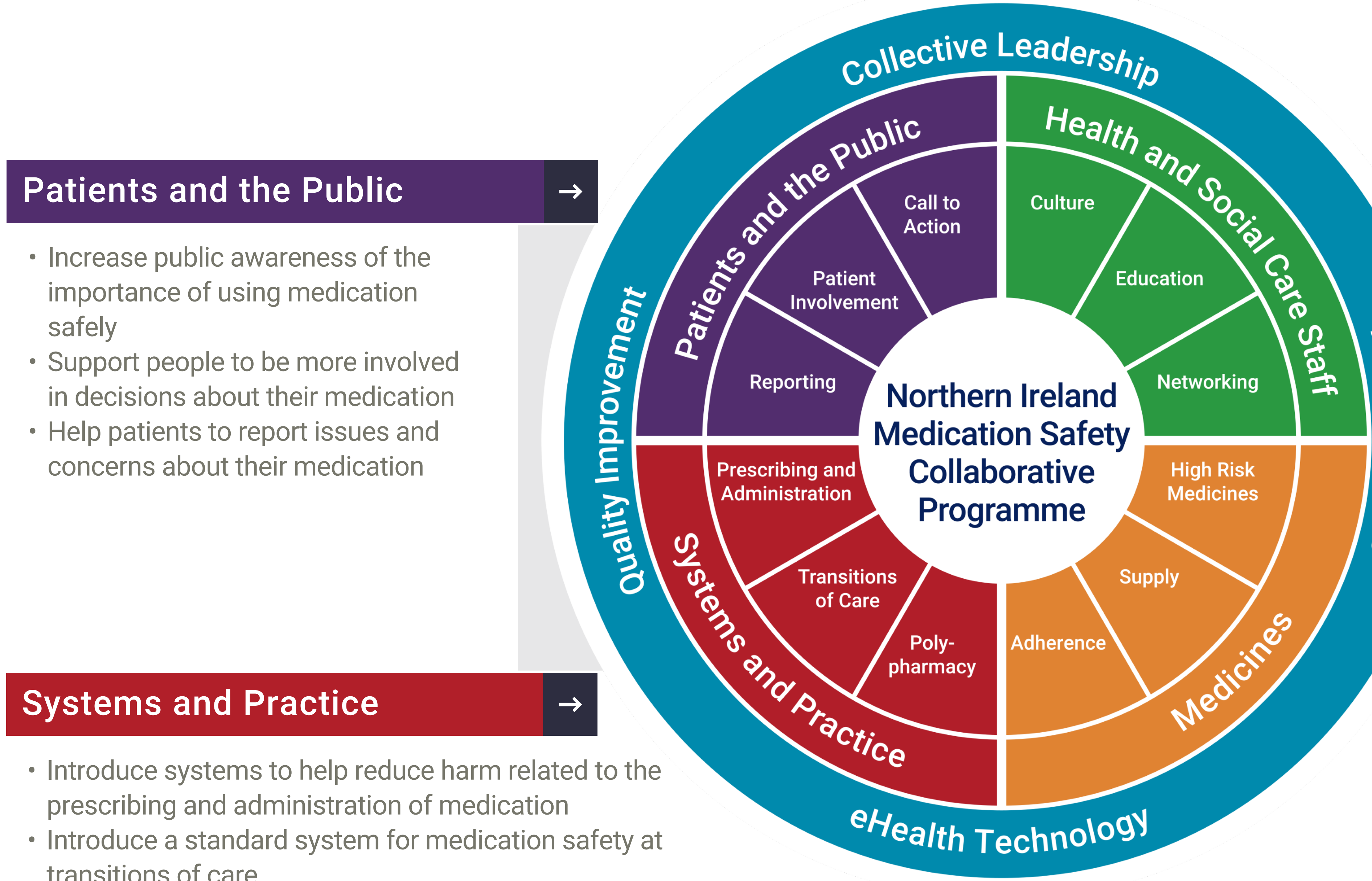
1. Target three priority areas:
   - High-risk situations
   - Polypharmacy
   - Transitions of care
2. Design specific programmes of action for improving safety in each of four domains in which medications can cause inadvertent harm:
   - Health care professionals' behaviour
   - Systems and practices of medication
   - Medicines
   - Patients and the public

WHO's Global Patient Safety Challenge: Medication Without Harm brochures →

The Northern Ireland Response to the WHO Challenge 'Medication Without Harm'

Patients and the Public →

- Increase public awareness of the importance of using medication safely
- Support people to be more involved in decisions about their medication
- Help patients to report issues and concerns about their medication



Health and Social Care Staff →

- Raise awareness among health and social care staff that medication safety is everyone's responsibility
- Ensure health and social care staff have the skills to be medication safety wise
- Facilitate new ways of connecting staff to share and spread best practice

Systems and Practice →

- Introduce systems to help reduce harm related to the prescribing and administration of medication
- Introduce a standard system for medication safety at transitions of care
- Take action to ensure that patients are taking the right medication for optimal benefit

Medicines →

- Reduce the burden of avoidable harm from high-risk medicines
- Build good practice in medication safety into the supply of all medicines
- Support improvements in adherence to medication

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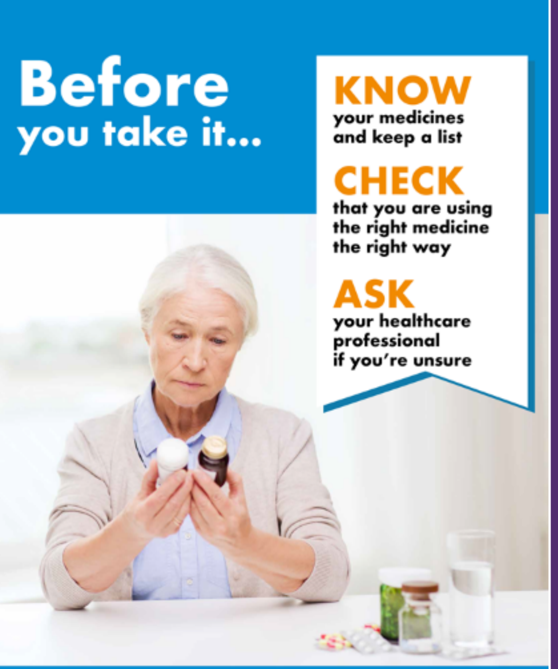
Patients and the Public

"Patients and the public are not always medication-wise. They are too often made to be passive recipients of medicines and not informed and empowered to play their part in making the process of medication safer." WHO



AIMS

1 Increase public awareness of the importance of using medication safely

What do we want to achieve?

We want people to take an active role in the management of their medication and move away from a passive culture where people do not feel able to ask questions of their health care professional and feel they must '*do as the doctor says*'.

This will require us to encourage and help people to be more curious about their medication. They should know what medication they are using and how to use it safely. People should feel able to ask their health care professionals questions about their medicines. Raising awareness that medication safety is important also empowers people to 'speak up' and prevent a potential medication error and harm from occurring.

Our commitments

We will deliver a public 'call to action' based on the WHO 'Know, Check, Ask' campaign. This campaign will be repeated annually to encourage a long term cultural change so that being *'medication safety wise'* becomes the social norm.

We will work with schools and education partners to help equip our children and young people with the knowledge and skills they need to be medication safety wise throughout life.

WHO Know, Check, Ask Campaign →

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AIMS

2 Support people to be more involved in decisions about their medication

Our commitments

We will work with health and social care providers, patient groups, community and voluntary organisations to support patients, families or caregivers to use the WHO '5 Moments for Medication Safety' tool.

What do we want to achieve?

We want to help people to ask their health care professional questions about their medication, treatment and care plan. This will assist them to manage their medication safely and enable them to get the best intended outcomes.

The '5 Moments for Medication Safety' patient engagement tool provides patients, families or caregivers with information about what types of questions they can ask a health care professional.

The '5 Moments' are when medication is started, when they are taking it and when medications are; added, reviewed and stopped.

The tool aims to engage and empower patients to be involved in their own care and when decisions are made about their medicines. It can be used in collaboration with any health care professional during any of these 'moments', and helps patients to record valuable information that will support them to manage their medication safely.

5 Moments for Medication Safety

Starting a medication

- What is the name of this medication and what is it for?
- What are the risks and possible side-effects?

Taking my medication

- When should I take this medication and how much should I take each time?
- What should I do if I have side-effects?

Adding a medication

- Do I really need any other medication?
- Can this medication interact with my other medications?

Reviewing my medication

- How long should I take each medication?
- Am I taking any medications I no longer need?

Stopping my medication

- When should I stop each medication?
- If I have to stop my medication due to an unwanted effect, where should I report this?

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AIMS

3 Help patients to report issues and concerns about their medication

What do we want to achieve?

We want people to feel able and confident to report problems with their medication early and so help reduce avoidable harm.

Reporting problems that have occurred or had the potential to cause harm ('*near misses*') with medicines is essential for patient safety. It can help to identify previously unknown issues with the medication itself, and highlight potential areas for improvement in prescribing, dispensing and administration processes.

Reporting issues helps the health care system to better understand medication safety risks and to learn from mistakes by taking action that can help keep patients safe in future.

Our commitments

We will work with health and social care providers, patient groups, community and voluntary organisations to raise public awareness of the benefits of reporting medication issues, and support patients and carers to report any issues and concerns by addressing barriers to reporting.

Northern Ireland has the lowest rate of adverse drug reaction reporting by members of the public within the United Kingdom

Medicines and Healthcare products Regulatory Agency (MHRA)

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Health and Social Care Staff

"Health care professionals sometimes prescribe and administer medicines in ways and circumstances that increase the risk of harm to patients."

WHO

AIMS

1 Raise awareness among health and social care staff that medication safety is everyone's responsibility

What do we want to achieve?

We want all health and social care staff to recognise their roles and responsibilities to ensure that medicines are used safely.

In addition to those that prescribe, administer or dispense medication, many other staff groups are directly or indirectly involved in the medication use process. This includes healthcare assistants, social and domiciliary care workers, porters and medical secretaries who interact directly with patients and their medication.

All of these staff need to be aware of their own responsibilities and that ensuring medication safety is part of their role. These responsibilities also include reporting and learning from incidents where harm has occurred or potential risks are identified, as well as *learning from excellence* and celebrating when things go right.

A culture of medication safety across health and social care is essential to ensuring patient safety.

Our commitments

We will involve our health and social care staff in the delivery of WHO's 'Know Check Ask' Campaign so that before a medication is prescribed, dispensed or administered by them they:

- **Know** 'the medication'

- Have **Checked** if they have the right patient, medicine, route, dose and time

- **Ask** the patient or carer if they understand.

We will encourage and support our health and social care staff to report and learn from medication related adverse effects and incidents, including 'near misses'.

We will work with the other UK countries to explore the development of a multi-disciplinary medication safety competency framework for health and social care staff to identify their medication safety learning and development needs for current and future roles.

WHO Know, Check, Ask Campaign →

MAHI - STM - 089 - 4311

AIMS

2 Ensure health and social care staff have the skills to be medication safety wise

What do we want to achieve?

We want health and social care staff that work together to learn together in a consistent way about medication safety and to develop self and situational awareness skills that will help them to navigate uncertain and complex scenarios.

Medication safety education is already incorporated within undergraduate and postgraduate training for medical, nursing and pharmacy professionals. Moving towards an integrated approach will better reflect how staff work together after qualification.

Education programmes will need to continually evolve to equip staff with the skills needed to respond to future technological advances that will change how medicines are managed.

Our commitments

We will work with universities, postgraduate training providers and professional bodies to incorporate the principles of the revised WHO Medication Safety Curriculum Guide and Human Factors training within multi-disciplinary medication safety programmes that are responsive to future needs.

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AIMS

3 Facilitate new ways of connecting staff to share and spread best practice

What do we want to achieve?

We want to harness the energy and ideas of our health and social care staff and help them to come together to develop, test and implement solutions for known problems.

Nurturing a medication safety learning and improvement culture is essential for improvement, and is enabled by providing people with the opportunity to meet physically or virtually to share and learn together.

There are already many examples of initiatives and networks within the health and social care system that apply the '*all teach, all learn*' philosophy to support the safer use of medicines which could be further developed and spread to other areas via greater collaboration and engagement.

Our commitments

We will encourage networks that enable people to learn and work together to improve medication safety across the health and social care system, building upon existing communication platforms and structures.

We will hold an annual Northern Ireland medication safety conference that brings practitioners together to share best practice and learn from each other.

We will encourage health and social care staff to showcase examples of exemplar practice through participation in UK, ROI and international safety events.

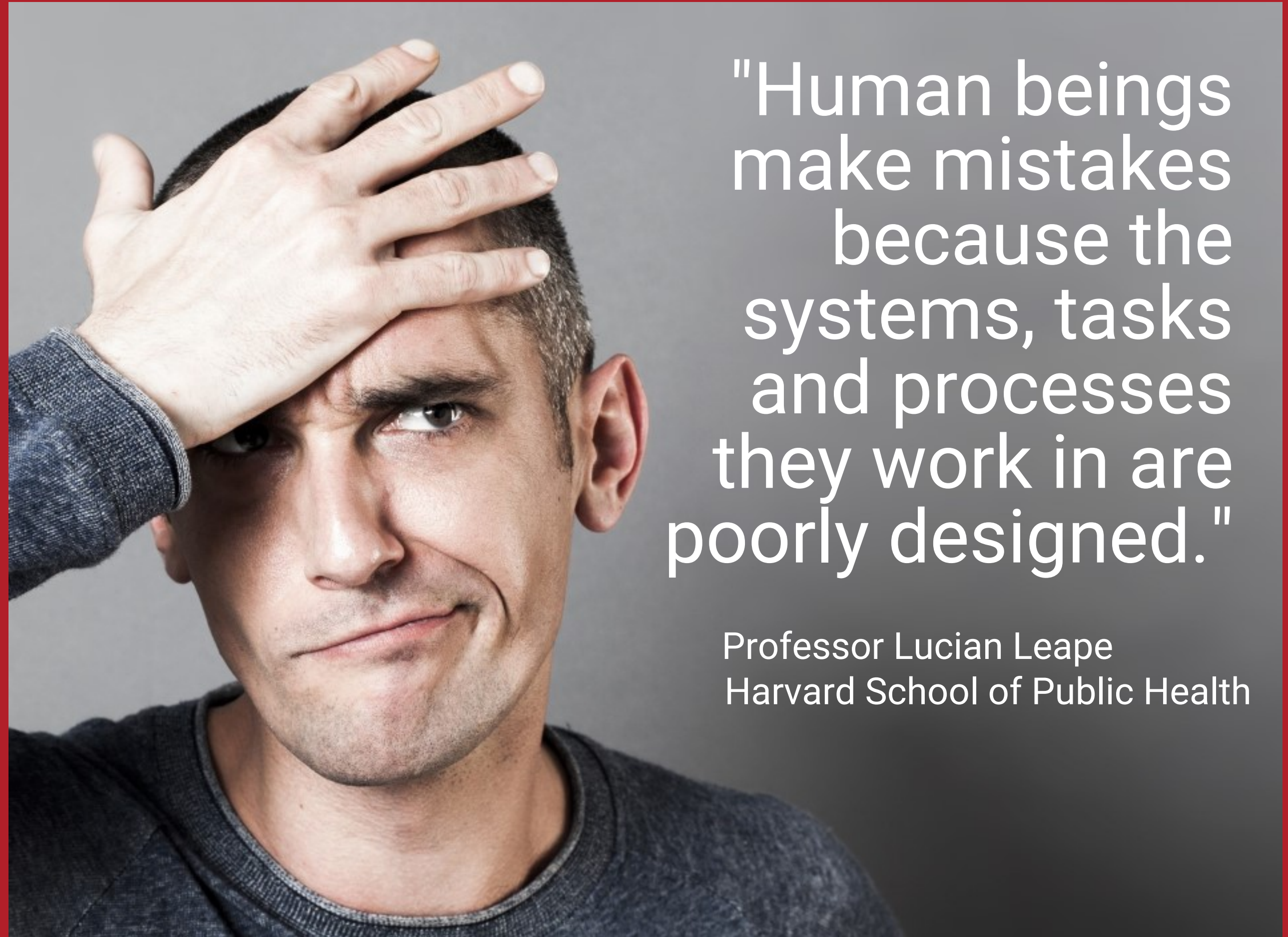
"Networks are primarily innovative creative places, they are useful for rapid learning and development and for amplifying members' effectiveness."

The Health Foundation

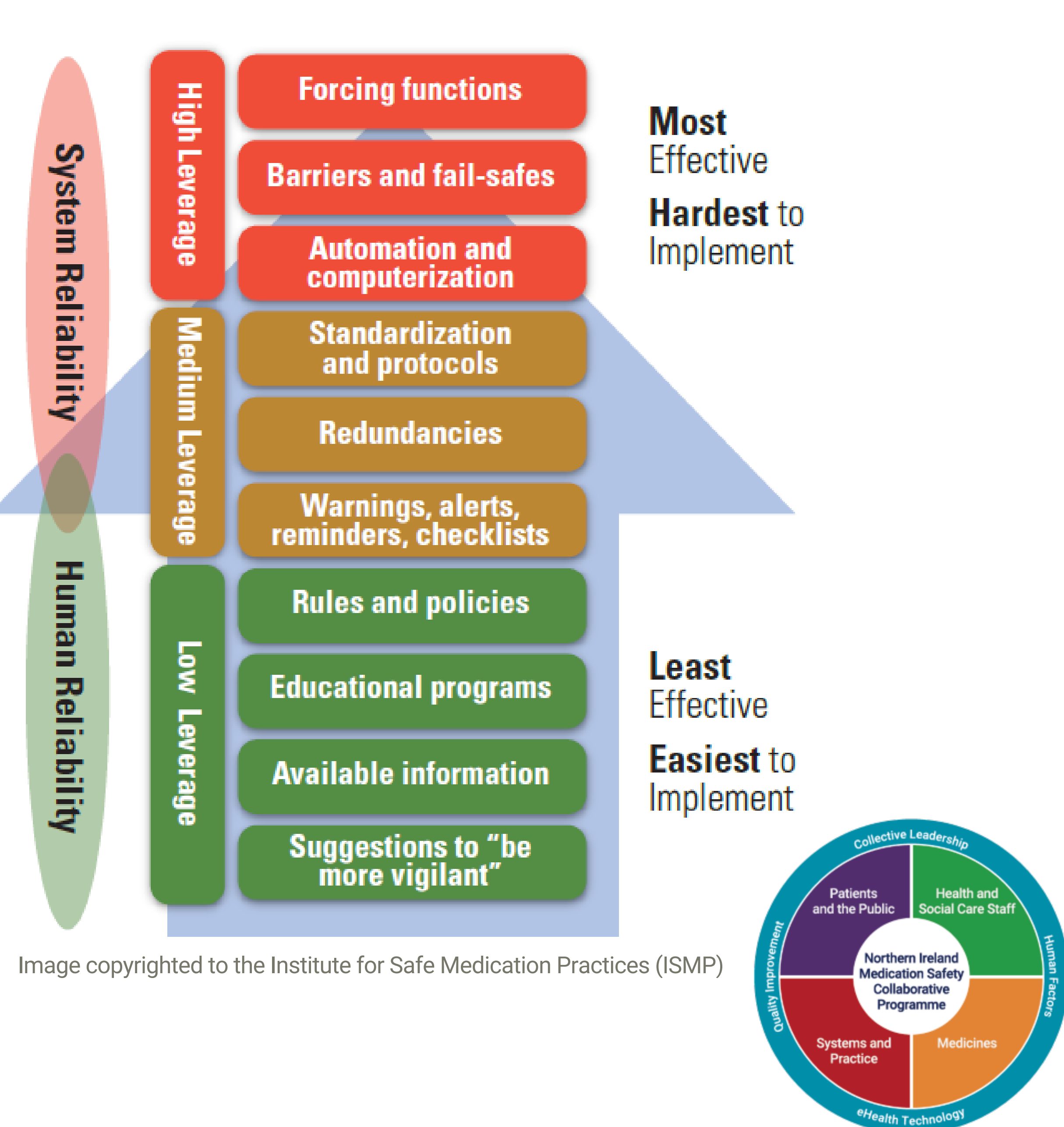
Systems and Practice

"Systems and practices of medication are complex and often dysfunctional, and can be made more resilient to risk and harm if they are well understood and designed."

WHO



The Hierarchy of Intervention Effectiveness



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Medication Safety in High-risk Situations

High Risk Situations

Introduce systems to help reduce harm related to the prescribing and administration of medication

What do we want to achieve?

We want to support safer prescribing and administration practices across the HSC to help staff to '*get it right first time*'.

We want to do this through standardisation of practice, improved access to protocols and guidelines, and better communication between teams.

Our commitments

We will support safer prescribing and administration of medication by introducing Electronic Prescribing and Medicines Administration (EPMA) and Closed Loop Medicines Administration (CLMA) systems in our hospitals, and prescribing decision support and risk identification systems in general practice.

We will undertake a targeted improvement programme to reduce the number of inappropriate omitted doses within our hospitals and care homes.

We will extend the standardisation of our secondary care prescription and administration documentation (Kardex) to our care home settings.

MAHI - STM - 089 - 4315

AIMS

2 Safer Transitions of Care

Introduce a standard system for medication safety at transitions of care

What do we want to achieve?

We want to adopt a co-ordinated approach across Northern Ireland that will help to ensure that medicines reconciliation is deliverable and sustainable for all patients.

Many prescribing incidents in Northern Ireland are attributable to systems failures during transitions of care in a complex health and social care system involving many different care providers.

Communication failures between providers can lead to unintended harm and unnecessary readmissions to hospital. This harm is largely preventable with effective and consistent medicines reconciliation.

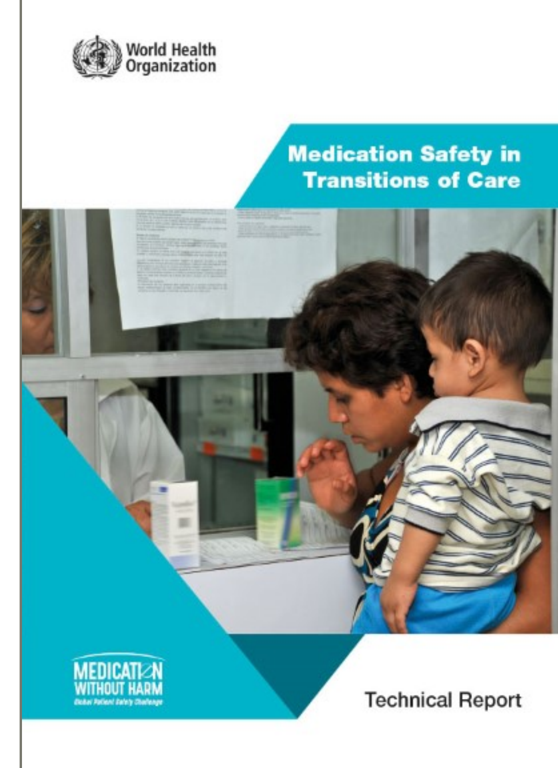
Northern Ireland has established systems that can deliver medicines reconciliation in primary and secondary care. The challenge is to ensure that we have a reliable system whereby every patient, every time, has their medication reconciled when transferring between care settings.

Our commitments

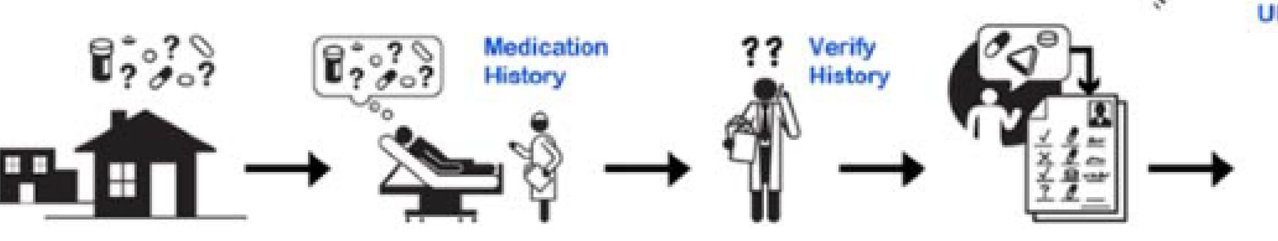
We will develop a co-ordinated Northern Ireland approach to ensure safer transitions of care between care providers, through the consistent delivery of medicines reconciliation that is aligned to the National Institute of Clinical Excellence recommendations.

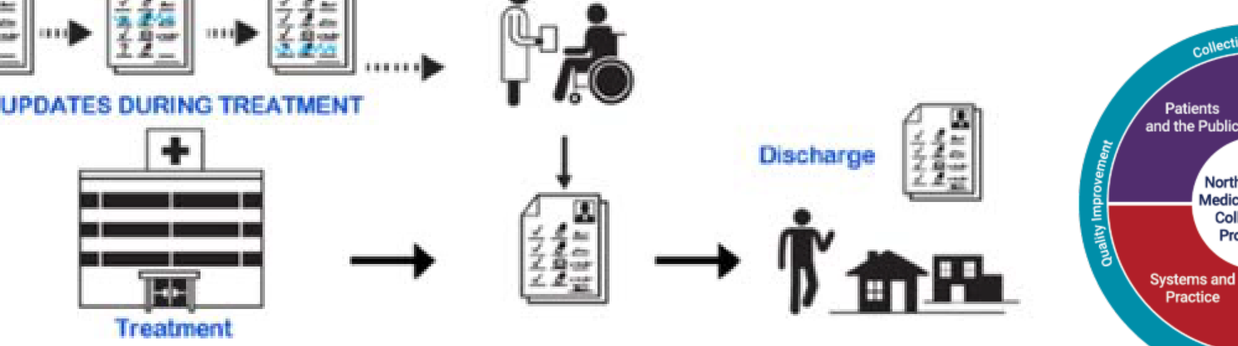
"Meeting the complex challenge of reducing medication-related harm arising at transitions requires long-term leadership commitment, coordination and collaboration, formulation of goals and strategies and investment in resources."

WHO Technical Report Medication Safety in Transitions of Care



A Patient's Journey video





Collective Leadership
Patients and the Public
Health and Social Care Staff
Northern Ireland Medication Safety Collaborative Programme
Systems and Practice
Medicines
Quality Improvement
Human Factors
eHealth Technology

Image reprinted from the World Health Organization's The High 5s project Implementation Guide. Assuring Medication Accuracy at Transitions in Care. Medicines Reconciliation.

MAHI - STM - 089 - 4316

AIMS

3

Polypharmacy

Take action to ensure that patients are taking the right medication for optimal benefit

What do we want to achieve?

We want to build on our existing examples of best practice and reduce harm from inappropriate polypharmacy by adopting a robust and consistent approach to medication review across care settings.

The prevalence of polypharmacy in Northern Ireland continues to increase, with our ageing population suffering from increasing frailty and multiple long-term conditions. Polypharmacy can be appropriate, based on clinical evidence and patient characteristics, or inappropriate, due to the irrational prescribing of too many medicines.

Inappropriate polypharmacy can cause significant harm to patients from increased adverse effects, interactions between medicines, and medication errors, particularly at transitions of care.

Our commitments

We will work to reduce inappropriate polypharmacy by ensuring that all patients who are most at risk from harm receive at least an annual medication review.

32% of patients receiving 5 or more medicines have prescribing or monitoring errors. This increases to 47% in patients receiving 10 or more medicines.

11% of unplanned hospital admissions are attributable to harm from medicines, and over 70% of these being due to older people on multiple medicines.

"Ensuring medication safety in polypharmacy is one of the key challenges for medication safety today."

WHO

Medicines

"Medicines are sometimes complex and can be puzzling in their names, or packaging and sometimes lack sufficient or clear information. Confusing 'look-alike sound-alike' medicine names and / or labelling and packaging are frequent sources of error and medication-related harm that can be addressed."

WHO

AIMS

1 Reduce the burden of avoidable harm from high-risk medicines

What do we want to achieve?

We want to ensure the safer use of medicines where published evidence and our incident reporting data shows are associated with a risk of significant harm if used incorrectly. Causes of error are frequently multifactorial and may involve a range of health and social care staff, patients and carers. They are complex to solve and require multiple approaches and innovative thinking to address inherent risks.

Our commitments

We will undertake a targeted improvement programme with the aim of reducing preventable harm associated with the following groups of high-risk medicines.

- Anticoagulants

- Insulin

- Opioids

- NSAIDs

HSC High Risk Medicines Poster

MAHI - STM - 089 - 4318

AIMS

2 Build good practice in medication safety into the supply of all medicines

What do we want to achieve?

We want to enhance our medication supply processes to reduce the risk of preventable harm involving high risk medicines, look-alike sound-alike Medicines and omissions or delays relating to supply chain issues and shortages. Effective use of technology should be used to support safe supply of medication.

Patients and their carers should receive appropriate advice and support to help them gain the best outcomes from their treatment and avoid harm. Health and social care staff should provide patients with appropriate reassurance of continued efficacy after changes to brand or presentation of their medication.

Our commitments

We will develop strategies that will prevent incidents involving look-alike sound-alike medicines.

We will support better identification and management of medicines supply chain issues and shortages.

We will use risk stratification tools in primary and secondary care to ensure that patients taking high risk medicines receive the advice and support they need to reduce the risk of harm.

We will work with the MHRA and Pharmaceutical Industry to identify and manage existing and emerging medication risks.

We will work to introduce digital solutions including the electronic transfer of prescriptions in primary care.

MAHI - STM - 089 - 4319

3 Support improvements in adherence to medication

What do we want to achieve?

We want all of our health and social care staff to work with patients to reduce non-adherence to prescribed medication. Reasons for non-adherence may include an individual's own concerns and beliefs about their medication, low health literacy or physical, cognitive or visual barriers, and challenges accessing services. Supporting patients to take the right medicine at the right time is the final step in ensuring the safe use of medicines, and can prevent significant harm and sub-optimal clinical outcomes.

Northern Ireland has led the way in the development of many examples of best practice, such as the Medicines Optimisation in Older People (MOOP) model. We want to build on these successes so that people across Northern Ireland are supported at every contact with a health and social care provider to agree the best way for them to use their medicines in a safe and effective way.

Our commitments

We will develop, test and implement integrated models of care that support patients to take their medicines as recommended by their healthcare professional.

Ten days after starting a medicine, almost a third of patients are already non-adherent - of these 55% don't realise they are not taking their medicines correctly, whilst 45% are intentionally non-adherent.

Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need.

MAHI - STM - 089 - 4320

Delivering Our Commitments

Our commitments are ambitious, and are intended to reinvigorate our approach to medication safety while building on past successes. Successful implementation will require a whole system approach, which embraces multi-professional leadership and ownership across the HSC. A new approach is needed to support this, where:

- Collective leadership empowers people to lead in all areas at all levels, enabled to take responsibility for ensuring medicines are used safely.
- Our health and social care staff have the confidence and skills to deliver and lead quality improvement initiatives, and utilise Human Factors principles to improve patient safety.
- Transformation at scale and pace is facilitated by eHealth technologies, including digitalisation of our clinical processes.

These enablers will allow us to build on the collaborative approach utilised in the development of this response, and support the sustained, system-wide transformation that is required to meet the WHO goal of a 50% reduction in severe avoidable medication-related harm over the next five years.

To achieve this, our aim is that a Medicines Safety Collaborative for Northern Ireland will be established during 2020, jointly led by the HSC Board and the HSC Quality Improvement Hub. This will work with multi-disciplinary partners across the system to implement our commitments by fully utilising the expertise and experience of staff, including our HSC Medicines Governance Team and Medicines Optimisation Innovation Centre.

MOIC video →

"Ensuring medicines are used safely must become second nature to all of us, just like washing our hands."

Dr Michael McBride,
Northern Ireland
Chief Medical Officer

From
The Chief Pharmaceutical Officer
Cathy Harrison

Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel:
Email:

BY EMAIL ONLY

Sharon Gallagher, Chief Executive, HSCB
Dr Cathy Jack, Interim Chief Executive - Belfast HSC Trust
Jennifer Welsh, Chief Executive - Northern HSC Trust
Seamus McGoran, Interim Chief Executive - South Eastern HSC Trust
Shane Devlin, Chief Executive - Southern HSC Trust
Dr Anne Kilgallen, Chief Executive - Western HSC Trust

Ref: HE1-17-671~2

Date: 5th May 2021

Dear Colleague,

MEDICINES OPTIMISATION REGIONAL EFFICIENCY (MORE) PROGRAMME

Call to action for a refocus on Medicines Optimisation and Cost effective Prescribing across the HSC

The Permanent Secretary wrote to you previously in March 2018 asking for your support for cost effective prescribing policy to be embedded across the HSC. This is a call to action for a renewed focus on Medicines Optimisation to ensure the safe, clinically effective and cost-effective prescribing and supply of medicines in the HSC.

You will be aware of the Medicines Optimisation Regional Efficiency (MORE) Programme, which has successfully delivered in excess of £126m efficiencies in the medicines budget its first 4 years, 2016-2020. A further £12m savings is expected to be confirmed for 2020/21 against a £20m target. The deficit of £8m has been carried forward and added to the 2021/22 target which is £28m.

The HSC has faced many and unexpected challenges this past year in the on-going response to COVID-19. Already stretched resources have been significantly impacted by the pandemic, including the increase in volumes of medicines dispensed and the impact this has had on the cost and continuity of medicines supply.

It is imperative that during 2021/22, there is a return to cost effective medicines choices in support of the MORE Programme. The implementation and achievement of safe, clinically effective and cost-effective prescribing and medicines supply is in the interests of all patients and healthcare practitioners. It can help by reducing harm, improving adherence to medicines, lowering waste and freeing up resources to treat more patients thus obtaining value for money from vital healthcare resources. The attached policy statement entitled ‘Enabling Medicines Optimisation to ensure the safe, clinically effective and cost-effective prescribing and supply of medicines in

the HSC', has some specific strategies and approaches to be adopted across the HSC to achieve this aim.

I would ask you to ensure that arrangements are in place within your respective organisations to facilitate collaborative working between all healthcare professionals involved in medicines management. The HSCB, PHA, Trusts, Community pharmacists, GP Federations and Allied Healthcare Professionals should work together to ensure the safe and cost effective use of medicines, support effective medication review, reduce inappropriate polypharmacy and optimise the use of medicines by patients.

A sum reflecting your organisation's contribution to cost effective choices savings will be included in the 2021/22 MORE Programme and any future efficiencies achieved through the MORE may be utilised to offset other HSC pressures.

Yours sincerely,

Mrs Cathy Harrison
Chief Pharmaceutical Officer

Enc

Cc: Dr Michael McBride, CMO
Chris Garland, DoH
Bernie Duffy, DoH
Anne-Marie Blaney, DoH
Joe Brogan, HSCB
Eimear McCusker, BHSCT
Julia Tolan NHSCT
Brendan Moore WHSCT
Dr Tracey Boyce, SHSCT
Jill Macintyre, SEHSCT

Policy Statement

Enabling Medicines Optimisation to ensure the safe, clinically effective and cost-effective prescribing and supply of medicines in the HSC

The achievement of safe, clinically effective and cost-effective prescribing and medicines supply is in the interests of all patients and healthcare practitioners. Strategies to achieve this can improve outcomes for patients by reducing harm, improving adherence to medicines and freeing up resources to treat more patients. This policy outlines the approaches to be adopted across the HSC to support this aim.

Medicines are the most commonly used intervention in the treatment of illnesses. With increasing life expectancy and associated health issues, polypharmacy is inevitable for many people, and where used appropriately, will often extend life expectancy and improve quality of life.

However polypharmacy can also lead to increased risk of drug interactions and adverse drug reactions, together with potentially reduced adherence to medication and quality of life for patients. People often do not take medicines as they are intended and may struggle with complex drug regimens; hence it is important that there are systems in place across primary and secondary care to support medicines optimisation so that people gain maximum benefit from their medication with the least harm and waste.

Medicines optimisation is defined as 'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines”. NICE Guideline NG5, (4 March 2015) states that optimising a person's medicines is important to ensure a person is taking their medicines as intended and can support the management of polypharmacy.

Effective medicines optimisation requires health and social care practitioners in all health and social care settings to work collaboratively along with the patient to review the use of medicines, taking into account patients’ needs, preferences and values, as well as best evidence and practice.

Medicines optimisation will usually involve:

(i) Medication Review

A regular, structured medication review is important for all people being prescribed ongoing medication, but is particularly important for those who are taking a large number of medicines, are frail, elderly or have multiple co-morbidities, and /or are taking high risk medicines. Such reviews can identify medicines that should be stopped or need a dosage change, and also if any new medicines are needed, ultimately resulting in a reduction in the risk of adverse events and increased adherence. Self-management plans and patient decision aids should be utilised as part of medication review.

(ii) Medicines Reconciliation

Medicines reconciliation is recognised as a process that supports patient safety by ensuring that the correct medicines are prescribed for patients across transitions of care. Traditionally, there has been a focus on medicines reconciliation for patients on admission to, and discharge from, hospital. However, evidence and guidance indicates action is required at all transitions of care. A cross-sector approach should be in place to support clinical teams across secondary care, general practice and community pharmacy to undertake medicines reconciliation when patients move between sectors of care.

(iii) Arrangements and systems to ensure evidence based, safe and cost effective prescribing

All prescribers should consider the following when prescribing:

- Evidence e.g. scientific literature, training, National (e.g. NICE) and local (e.g. HSCB) guidance.

- HSCB summarises the evidence base and engages clinicians in primary and secondary care to establish and maintain the Northern Ireland Formulary (NIF) https://niformulary.hscni.net/. The NIF promotes safe, clinically effective and cost-effective prescribing of medicines. It provides guidance on first and second line drug choices for prescribers in all HSC settings and covers the majority of prescribing choices in Northern Ireland. The NIF aims to standardise practice and ensure a level of consistency but it is recognised that some individual patients may require medicines which lie outside such guidance.

- HSCB has also established the Managed Entry Process through which the commissioning of medicines is managed and informed by NICE appraisals (or

in the absence of NICE, an alternative technology appraisal body - Managed Entry | NI Formulary (hscni.net).

- Cost-effective prescribing e.g. use of generics, dose optimisation, cost-effective drug alternatives and formulations.
- HSCB STOP and Limited evidence list. Prescribers are encouraged to review all patients prescribed medicines on the Limited Evidence or Stop List to check if the drugs are appropriate, safe and if they are providing HSCNI with value for money.
- Encourage patients to self-care and seek advice from their local community pharmacist to help manage minor and self-limiting conditions.
- Processes to ensure safe prescribing, supply and administration of medicines to patients e.g. repeat and acute prescribing protocols, arrangements for antimicrobial stewardship, use of prescribing support decision software
- Identifying, learning and reporting from medicines related patient safety incidents

(iv) Collaborative working arrangements

There should be local arrangements for collaborative working between all healthcare professionals involved in medicines management. Community pharmacists, GP Federations, Trusts, HSCB and PHA are encouraged to work together to ensure safe and cost effective use of medicines, support effective medication review, reduce inappropriate polypharmacy and optimise the use of medicines by patients.

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Improving Health and Well-being Through Positive Partnerships

A Strategy for the Allied Health Professions in Northern Ireland

2012 - 2017

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A Message from the Minister

I am pleased to publish this document 'Improving Health and Well-being through Positive Partnerships: A Strategy for the Allied Health Professions in Northern Ireland'.

AHPs make a difference to people's lives, whether it be giving our children the best start in life, preventing diseases through health promotion or supporting through rehabilitation and re-ablement those, who through illness or disability, are unable to look after themselves as they would wish. Placing the service user at the heart of the design and delivery of AHP practice and care is crucial to achieving the vision and values in this strategy and to ensuring the best possible outcomes for them.

The diversity and wide-ranging nature of the AHP disciplines and their practices creates additional challenges for the planning, design and delivery of AHP practices to ensure individuals have access to the right person in the right place at the right time. This strategy outlines how we can achieve this by making best use of our AHP workforce.

Whilst we face challenges in the immediate future on the financial front, the examples in this strategy demonstrate how AHPs have met, and can continue to meet, my key objectives by delivering prevention and early intervention measures, helping avoid unnecessary hospital attendances and admissions, driving up the quality of services, improving outcomes and enhancing patient experience.

The increasing demand for AHP services requires that those in leadership roles ensure the skills are in place to enable the AHP workforce to meet the challenges of implementing new models of practice and care.

I am confident that through positive partnerships we can all maximise outcomes for patients and their carers using AHP resources to enhance people's lives and deliver services that are safe, timely, effective and focused on the needs of the population.

Edwin Poots, MLA
Minister of Health, Social Services and Public Safety

Foreword by the Lead Allied Health Professions Officer

The Allied Health Professions (AHP) in Northern Ireland consist of 12 distinct and unique disciplines. AHPs play key roles and add critical value across the full spectrum of primary and secondary prevention, diagnosis, treatment and care.

As Lead AHP Officer I wish to acknowledge the valuable contribution of all those who contributed to the development of this Strategy be that as Steering Group Members or those who engaged in workshops, meetings or focus groups. In particular we must also remember our late colleague Patricia Blackburn for her specific contribution to this Strategy.

'***Improving Health and Well-being Through Positive Partnerships***' sets out a high level road map for the development of the AHP workforce and to support the commissioning and delivery of AHP practices to enhance the health and social well-being of the population in Northern Ireland. Key to the success of this Strategy will be positive partnerships with service users and carers, other health professionals, commissioners, education and other agencies.

The Strategy is based around four Strategic Themes which, whilst generic and wide-ranging in nature, when taken together set out an overall approach for the development of AHP services and workforce to achieve the Strategy's vision. Key areas within specific themes e.g. leadership and education, span all four themes whilst being described in detail under the most relevant theme.

New models of practice and care across all sectors provide challenges for everyone including AHPs. To meet these challenges this requires continued innovation and modernisation in how AHP practices are commissioned, designed and delivered.

I am confident that as AHPs we are ready to make our contribution to these challenges through positive partnerships and this Strategy will support us in achieving this.

Pauline Mulholland
Lead AHP Officer, DHSSPS

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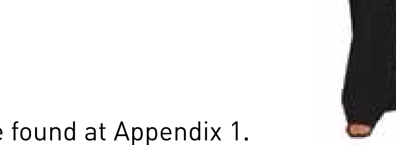
Executive Summary

The purpose of the Strategy is to provide a framework to guide the Department of Health, Social Services and Public Safety (DHSSPS), the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and Health and Social Care Trusts in designing, delivering, reviewing and integrating models of care, as well as providing opportunities for learning and development that will help Allied Health Professionals (AHPs) and therapy support workers deliver high quality outcomes for service users.

This Strategy has been written for the AHP workforce, irrespective of the discipline or care sector within which individuals work. Its aim is to provide a high level road map for the AHPs for the next 5 years. It focuses on the roles and responsibilities of the AHP workforce at all levels and how these can be developed to enhance the planning and delivery of AHP practices that support the health and social well-being of the population of Northern Ireland. Twelve professions are covered by this Strategy[i]:

- Art Therapists
- Dietitians
- Drama Therapists
- Music Therapists
- Occupational Therapists
- Orthoptists
- Orthotists
- Physiotherapists
- Podiatrists
- Prosthetists
- Radiographers – Diagnostic and Therapeutic
- Speech and Language Therapists



i Further details of the AHP disciplines covered in the Strategy can be found at Appendix 1.

Executive Summary

Given the diversity of the AHP disciplines and the wide-ranging nature of AHP practices, the Strategy does not seek to address in detail what services are provided to service users or how they are delivered. Instead it focuses on the approach to care outlining how, by implementing key actions at strategic, organisational and individual levels, the AHP workforce can meet the challenges of planning and delivering high quality services that are person-centred, safe, fit for purpose and provide good value for money.

The AHP workforce has an increasingly crucial part to play in optimising and supporting the health and well-being of our population through:

- undertaking roles in health promotion, health improvement, diagnosis, early detection and early intervention;
- supporting service users to avoid illnesses and complications; enhancing rehabilitation and re-ablement to maximise independence;
- supporting people of all ages to manage long term conditions;
- contributing to physical and sensory disability services, mental health and learning disability services and palliative and end of life care; and
- providing essential support to children and young people living with complex disabilities, their families and carers.

This Strategy reflects the value that is added by AHPs in optimising the health and social well-being of service users and highlights the importance of appropriately facilitating their involvement (either uni-professionally or inter-professionally) in the design, delivery, review and integration of models of care.

The Strategy has been written primarily for AHPs working in the statutory sector, however the principles, values and good practice outlined throughout this Strategy will also be applicable to AHPs not employed directly by Health and Social Care (HSC), including those working in the voluntary, community and independent sectors and in education. For such individuals the Strategy,

including the key actions at organisational and individual levels, should be read in the context of their own organisation and circumstances.

The Strategy sets out a vision for the development of the AHP workforce which is: *that by continuing to work in partnership with colleagues, other professionals, other agencies and, most importantly, service users of all ages, families and carers; AHPs will actively enhance people's lives through the planning and delivery of high quality and innovative diagnostic, treatment and rehabilitation services and practices that are safe, timely, effective and focused on the service user*.

This vision is underpinned by a series of core values which together support the delivery of the best possible outcomes for service users, their families and carers. The vision and values are applicable regardless of the care setting within which therapists and therapy support staff work.

The Strategy is based around 4 Strategic Themes which reflect and support the Strategy's vision and values. These themes are:

- Promoting person-centred practice and care;
- Delivering safe and effective practice and care;
- Maximising resources for success; and
- Supporting and developing the AHP workforce.

By their nature these are broad themes that are applicable to each of the 12 AHP disciplines covered by this Strategy. A number of key areas have been identified within each strategic theme together with associated key actions through which the strategic themes can be delivered. Each key action has been assigned to one of three levels of responsibility – Strategic, Organisational or Individual. A summary of the key actions is set out in Appendix 2 of the Strategy.

Strategic Theme 1 – "***Promoting Person-centred Practice and Care***" – places the service user at the heart of the design and delivery of AHP services and highlights the importance of personal and public involvement in developing AHP practices that take due cognisance of the needs of service users. This section also highlights the need for the AHP workforce to work in partnership with

service users, their families, carers, HSC colleagues, other professionals and organisations, as well as the wider community, to design and develop practices and relationships that are fit for purpose and enhance the service user's experience and outcomes. This strategic theme also acknowledges the role of AHPs in supporting people to manage their own health and well-being.

Strategic Theme 2 – "***Delivering Safe and Effective Practice and Care***" – outlines the importance of effective governance and accountability arrangements to achieve and assure safe and effective care. All AHPs who work within HSC, as well as those in the independent, voluntary and community sectors have an individual responsibility to ensure the delivery of high quality care that is safe, effective and focused on the service user, and to promote excellence and continuous improvement. This section outlines how effective risk assessment and clear accountability processes can support the delivery of quality care.

In Strategic Theme 3 – "***Maximising Resources for Success***" – the importance of innovation and modernisation in how AHP practices are designed and delivered is explored. Innovation and modernisation includes examining existing models of care to identify what is essential, what can be delivered more effectively and what is no longer sustainable, appropriate or necessary based on new evidence and best practice. This means considering how and what AHP services can best be developed and improved to deliver optimum outcomes that are focused on the assessed and agreed needs of service users. The crucial role of AHP leadership in driving forward innovation and modernisation is also considered.

The development of the AHP workforce is explored in Strategic Theme 4 – "***Supporting and Developing the AHP Workforce***". This section highlights the importance of a motivated, influential, patient-focused, appropriately trained, highly skilled and flexible AHP workforce. It considers how workforce planning, learning and development can support the development of an AHP workforce that is responsive to current and future demand in terms of number and composition, as well as ensuring that therapists and therapy support workers have the knowledge, skills and competencies to deliver high quality services that are fit for purpose and meet service needs.

The concluding section - "***Where Do We Go From Here***?" - outlines how the Strategy will be taken forward and implemented across the AHP workforce. It proposes the establishment of a Regional Implementation Steering Group with a remit to ensure that the actions set out within the Strategy are progressed.

A key role of the Regional Implementation Steering Group will be to develop a Regional AHP Strategy Implementation Plan within an agreed timeframe for approval by a DHSSPS Implementation Board. The Implementation Plan will include detailed actions at an operational level, together with appropriate milestones, targets and associated timescales. The Implementation Plan will also detail the monitoring and accountability arrangements for taking forward the approach and key actions set out in the Strategy.

Introduction

Role of AHPs

1. Allied Health Professionals (AHPs) are a diverse group of clinicians working in a range of disciplines to deliver treatment and care to service users[ii] across a wide range of services in a variety of different settings and across all age groups. AHPs play key roles and add critical value across the full spectrum of primary and secondary prevention, diagnosis, treatment and care. At March 2011 there were 4,022 therapists and therapy support staff working in the Health and Social Care (HSC) workforce in Northern Ireland (3,391 WTE).

2. As specialist clinicians and clinical leaders, AHPs are vital to the delivery of high quality, people focussed services. In addition to their core clinical roles of early detection, assessment, diagnosis, treatment, discharge and rehabilitation, AHPs help people to navigate the journey out of hospital and back to home, to return to work and to participate in community life. AHPs also have an essential role in addressing health inequalities through designing and communicating important public health promotion and prevention messages to service users, carers and other partners working both with individuals and the wider community in doing so.

3. Through both leading and working within multi-disciplinary teams, AHPs have a unique contribution to make to the health and well-being of children and adults in Northern Ireland. This includes early intervention and prevention of disease and disability; applying diagnostic skills and expertise to promote early detection of disease or disability which in turn informs appropriate response and treatment; enhancing independence by helping and empowering people to maintain their functionality and supporting self management for people with long term conditions; and providing service users and their carers with strategies that can help them adapt to and manage disability.

ii Throughout this Strategy the use of *"service user"* should also be taken to mean *"people", "patient" or "client"*. It may also include family and carers where appropriate.

4. Twelve professions are covered by this Strategy:

Art Therapists
Dietitians
Drama Therapists
Music Therapists
Occupational Therapists
Orthoptists
Orthotists
Physiotherapists
Podiatrists
Prosthetists
Radiographers – Diagnostic and Therapeutic
Speech and Language Therapists

- **Art Therapists**
  Provide a psychotherapeutic intervention which enables service users to effect change and growth by the use of art materials to gain insight and promote the resolution of difficulties.

- **Dietitians**
  Assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Dietitians translate public health and scientific research on food, health and disease into practical guidance to enable people to make appropriate lifestyle and food choices.

- **Drama Therapists**
  Encourage service users to experience their physicality, to develop an ability to express the whole range of their emotions and to increase their insight and knowledge of themselves and others.

- **Music Therapists**
  Use music, with an individual or group of service users, to improve functioning and develop potential in a number of skill areas impaired by disability, illness or trauma. These areas include communication, physical, emotional, mental, social and cognitive skills. Music therapy aims to

achieve a better quality of life for clients through prevention, rehabilitation or treatment.

- **Occupational Therapists**
  Promote health and well-being though occupation. The primary goal of occupational therapy is to enable service users to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with service users and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do; or by modifying the occupation or the environment to better support their occupational engagement.

- **Orthoptists**
  Diagnose and treat eye movement disorders and defects of binocular vision.

- **Orthotists**
  Design and fit orthoses (callipers, braces etc.) which provide support to part of a patient's body, to compensate for paralysed muscles, provide relief from pain or prevent physical deformities from progressing.

- **Physiotherapists**
  Physiotherapists use a holistic approach in the preventative, diagnostic and therapeutic management of disorders of movement or optimisation of function, to enhance the health and well-being of the community from an individual or population perspective. Physiotherapy practice has the exercise of clinical judgement and informed interpretation, underpinned by best available evidence, at its core. It encompasses a diversity of clinical specialities to meet the unique needs of service user groups with varying health status.

- **Podiatrists**
  Assess the vascular, neurological and orthopaedic status of the service users lower limbs to, diagnose and treat diseases and conditions affecting the feet. Podiatrists focus on relieving symptoms and maintaining functional independence.

- **Prosthetists**
  Provide care and advice on rehabilitation for service users who have lost or who were born without a limb, fitting the best possible artificial replacement.

- **Radiographers – Diagnostic and Therapeutic**
  Diagnostic Radiographers employ a range of imaging techniques to produce high quality images of injury or disease, often interpreting the images so that correct treatment can be provided. They undertake diagnostic work and independent reporting as part of a multi-disciplinary team and are a key part of the delivery of acute as well as community-based services. Early diagnosis is a vital step in care pathways and the delivery of any subsequent treatment.

  Therapeutic radiographers are the only health professionals qualified to plan and deliver radiotherapy in the treatment of cancer. They manage the care pathway through the many radiotherapy processes, providing care and support for service users throughout their treatment.

- **Speech and Language Therapists**
  Speech and Language Therapists (SLTs) are concerned with the management of speech, language, communication and swallowing in children and adults. SLTs contribute to the delivery of specialist, targeted and universal services to service users and their families. They reduce long term demands on services by addressing immediate needs that arise from circumstances as well as needs that arise from underlying impairment. SLTs also provide training for the wider workforce.

5. AHPs are graduates who are statutorily regulated by the Health Professions Council (HPC) which holds an individual register for each of the allied health professions. They are autonomous practitioners from the point of registration. Therapy support workers play an important role in supporting AHPs to deliver front-line services and care for services users.

Introduction

6. References to the AHP "workforce" within this Strategy should be taken to include therapists and therapy support workers in the HSC as well as those employed by the voluntary, community, education and independent sectors.

7. AHPs are an integral part of an increasingly corporate approach to the planning and delivery of health and social care, often working as leaders or members of multi-disciplinary teams with other professionals to provide high quality, integrated services within the primary, community and secondary care sectors. They also interact with a wide range of other services and agencies within and outside the Health and Social Care sector, providing professional expertise and advice to ensure that service users receive timely and accurate support as part of an integrated and co-ordinated approach to service provision.

8. Increasing demand for the skills and expertise of AHPs across care pathways - from health prevention and promotion, detection and diagnosis through to rehabilitation and re-ablement - requires that robust AHP leadership and influence are employed in the analysis and implementation of best practice, utilising skill and grade mix. This will ensure having AHPs with the right skills in the right place at the right time, for the benefit of all those who use their services. The services provided by the AHP workforce must take cognisance of the views and where appropriate be influenced by service users, who should be at the centre of all care planning discussions. The AHP leadership should constantly review the roles and responsibilities of the workforce to ensure that the services and care they provide, often on a clinically prioritised basis, are responsive to need and provide positive outcomes for service users.

9. In reading this Strategy, reference should be made to the definitions of the responsibilities of AHP roles as outlined in the Glossary.

Care Context

10. AHPs and therapy support workers work within a constantly changing environment both in terms of how health and social care is provided and in the nature of the population for which services are designed and delivered.

11. In addition to the demands arising from demographic changes as the proportion of older people increases, the impact of lifestyle factors, such as smoking, poor diet and lack of exercise, is also leading to increased pressure on our health and social care services as lifestyles become less healthy, leading both directly and indirectly to health problems.

12. As children and young people are living longer with complex disabilities and chronic conditions, AHPs have an essential role to play in supporting them and their families and carers. AHPs are also increasingly focusing on supporting people of all ages and their carers in managing long term conditions as well as contributing to physical and sensory disability services, mental health and learning disability services and palliative and end of life care.

13. While the size of our population is estimated to increase over the next ten years, of greater significance to the demand for health and social care is that the average age of our population will continue to increase at a faster rate. Specifically estimates are that between 2008 and 2020:

    - The Northern Ireland population will increase by 142,000 people (8%).
    - The number of people over 75 years will increase by 40%.

14. As people get older they are more likely to develop one or more long term (or chronic) condition. As a result their need for health and social care interventions increases, placing pressure on health and social care services.

15. People's expectations are also changing and increasingly they tell us they want health and social care services with a focus on personal choice and well-being. Service users are becoming more active partners in making

decisions about how their health and social care is designed and delivered, with greater engagement between health and social care professionals and individuals to improve the quality and experience of care. Increasingly, service users are also taking more responsibility for their own health and the health of their family, as well as understanding the impact of their behaviours on health and well-being, especially in terms of rising rates of long term conditions.

16. The changing context of health and social care also impacts directly on how and what AHP services are delivered. Increasingly AHPs work with other health and social care professionals in areas of population health such as health promotion, health improvement and early intervention; in diagnostics and early detection, and in providing advice and support to service users to avoid illnesses and complications developing, enhance rehabilitation and reduce avoidable hospital admissions.

17. Within the context of this changing environment it is important that people receive treatment and care that are appropriate to them delivered in the right place, at the right time, by the right people. In recent years the policy of DHSSPS has been to promote the provision of a wider range of services in the community and facilitate the shift away from dependence on hospital services, with service users, their families, carers and local communities having better access to local primary care services closer to their own homes. The role of many AHPs has changed to reflect this with more services provided by AHPs as part of multi-disciplinary teams working in the community. In some instances however, for example diagnostic radiographers, their roles will continue to be mainly hospital based.

18. At a time of increasing financial pressures, meeting service user expectations and needs will require examination of the models of care delivered to identify, across the whole HSC system, where services can be improved and modernised and how they can provide added value to the public purse - for example through interventions to improve the recovery of stroke survivors or those with musculoskeletal disorders.

19. The Strategy seeks to ensure that existing HSC resources are allocated effectively and efficiently in order to maximise the outcomes for service users. This means considering what is and what is not sustainable as well as how productivity and efficiency can be improved and innovation harnessed without compromising quality and safety. Addressing these challenges will require a phased change in how care is commissioned, planned and delivered, with greater emphasis addressing health inequalities through prevention and health improvement activities and interventions.

Aim and Scope of the Strategy

20. The Strategy has been written primarily for AHPs working in the statutory sector, however the principles, values and good practice outlined throughout this Strategy will also be applicable to AHPs not employed directly by the HSC, including those working in the voluntary, community and independent sectors and in education. In particular the principles of good governance underpinning the Strategy should be integral to the commissioning of services which are provided by AHPs working outside the statutory sector in order to ensure the delivery of safe and effective practice and care.

21. The Strategy provides a high level road map to guide the AHP workforce at all levels over the next 5 years. The breadth of its remit means that the Strategy focuses on the general roles and responsibilities of the AHP workforce and how these can be developed to enhance the planning and delivery of AHP practices that support the health and social well-being of the population of Northern Ireland. The Strategy also highlights the importance of ensuring the development of a skilled and competent workforce to meet service demand and equipped to provide innovative services across all care pathways.

22. Given the diversity of the range of AHP disciplines and the wide-ranging nature of AHP practices, the Strategy does not address the detail of services provided to service users or how they are delivered. Nor does the

Strategy provide a specific road map for the development of each of the 12 professions included within it. Instead it outlines an approach to the planning and delivery of practices that will support the AHP workforce in meeting the challenges of providing innovative services that are person-centred, effective, fit for purpose and provide good value for money. Examples of good practice which demonstrate the added value and positive outcomes which innovative AHP services provide are included throughout the document.

23. The purpose of the Strategy is to provide a framework to guide DHSSPS, the Health and Social Care Board, the Public Health Agency and Health and Social Care Trusts in designing, delivering, reviewing and integrating models of care, as well as providing opportunities for learning and development that will help AHPs and therapy support workers deliver high quality outcomes for service users.

24. The Strategy is the culmination of a process of consultation with key stakeholders through a series of engagement workshops, meetings and focus groups and is based on the principle that the contribution of every member of the AHP workforce is valued and that each has a part to play in ensuring the delivery of high quality care that is safe, effective and focused on service users.

Strategy Vision and Values

25. The Strategy sets out a vision for the AHP workforce to maximise the health and social well-being of service users. In addition, it sets out a series of values to guide the actions of AHPs and therapy support workers in the delivery of treatment and care to service users, families, carers and local communities.

Our Vision

26. Our vision "*is that by continuing to work in partnership with colleagues, other professionals, other agencies and, most importantly, service users of all ages, families and carers; AHPs will actively enhance people's lives through the planning and delivery of high quality and innovative diagnostic, treatment and rehabilitation services and practices that are safe, timely, effective and focused on the service user.*"

Our Values

27. Our vision will be underpinned by a set of core values which reflect the contribution that AHP services and practices make to enhance the experience of service users, and ensure the best possible outcomes and quality of life for them, their families and carers. These core values are common to all areas where AHPs are employed be that health and social care, education, voluntary and community or independent practice. These values are:

- Service users as partners;
- Supportive and integrated teamwork;
- Safe, effective and person-centred practice;
- Positive leadership and innovation; and
- Excellence in our practice through continued learning and development.

28. The vision and values set out above will support the reform and modernisation of AHP services through new ways of working and managing resources. They are applicable regardless of the care setting within which individual AHPs work and seek to ensure that through continuing self development and innovation, AHPs are equipped to meet the needs of individuals and communities in a changing society.

29. While the varying uni-professional AHP core standards, accountability and leadership structures are acknowledged, it is anticipated that every member of the AHP workforce should demonstrate these values in the way

in which they interact with service users, their families and carers and with colleagues. These values are reflected throughout this Strategy.

Strategy Format

30. The structure of the Strategy has been developed around four Strategic Themes. By their nature these themes are generic and wide-ranging to encompass the different disciplines that make up the AHP workforce. It is important that the strategic themes are not considered in isolation - taken together they set out an overall approach to AHP services and the development of the AHP workforce that will support the achievement of the Strategy's vision. They are:

    - Promoting person-centred practice and care;
    - Delivering safe and effective practice and care;
    - Maximising resources for success; and
    - Supporting and developing the AHP workforce.

31. A number of Key Areas have been identified within each theme. These outline core components that together make up the theme. Included within them are a series of Actions through which the strategic themes can be delivered. These Actions have been assigned to each of three levels to ensure that there is alignment between the different levels of responsibility and clarity about how they relate to one another. These levels are:

Strategic:	DHSSPS, Public Health Agency and Health and Social Care Board;
Organisational:	HSC Trust and other service providers;
Individual:	Allied Health Professionals and therapy support workers.

32. At the Strategic level the Public Health Agency, as part of its role, provides professional advice on AHP services (in collaboration with AHP uni-professional leadership as necessary and appropriate) to the Health and Social Care Board to assist the Board in developing its commissioning strategies for services.

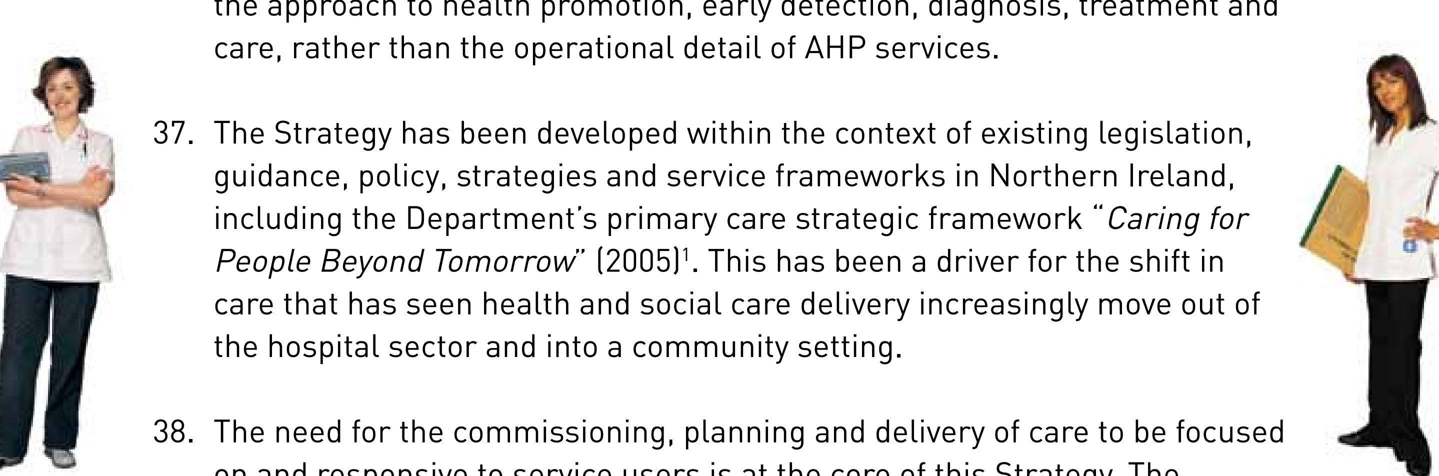
33. Individuals have been identified at Strategic and Organisational levels to have lead responsibility and accountability for taking forward the key actions. In doing so, it is expected that these individuals will work with and through Trust AHP Leads and uni-professional Heads of Service as appropriate.

34. At Strategic and Organisational levels the detail of accountability in the key actions relates primarily to statutory organisations and will not be directly applicable to smaller organisations.

35. At individual level, the principles of the key actions will apply irrespective of where AHPs work – be that statutory, voluntary, community, education or independent sector.

Policy Context

36. This document has been written primarily for members of the AHP workforce at all levels and across all care sectors. It provides a strategic overview of how AHP services should be commissioned, planned and delivered, addressing major themes such as person-centred care, accountability, innovation and staff development. To this end it focuses on the approach to health promotion, early detection, diagnosis, treatment and care, rather than the operational detail of AHP services.



37. The Strategy has been developed within the context of existing legislation, guidance, policy, strategies and service frameworks in Northern Ireland, including the Department's primary care strategic framework "*Caring for People Beyond Tomorrow*" (2005)[1]. This has been a driver for the shift in care that has seen health and social care delivery increasingly move out of the hospital sector and into a community setting.

38. The need for the commissioning, planning and delivery of care to be focused on and responsive to service users is at the core of this Strategy. The Strategy has therefore been informed by and reflects:

Introduction

- Circular HSC (SQSD) 29/07 "*Guidance on Strengthening Personal and Public Involvement in Health and Social Care*"[2];
- "*Improving the Patient and Client Experience*" (2008)[3];
- "*A Partnership for Care – NI Strategy for Nursing and Midwifery 2010-2015*" (2010)[4];
- "*Living Matters:Dying Matters* a Palliative and End of Life Care Strategy for Adults in Northern Ireland" (2010); and
- "*Quality 2020 - A 10 Year Quality Strategy for Health and Social Care in Northern Ireland*" (2011)[5].

39. In addition, account has also been taken of the Department's draft Policy Framework "*Living with Long Term Conditions*" (issued for consultation February 2011) and the draft Physical and Sensory Disability Strategy (issued for consultation December 2010).

Strategic Theme 1 - Promoting Person-centred Practice and Care

Placing the service user at the heart of the design and delivery of AHP practice and care is crucial to achieving the vision and values set out in this Strategy and to ensuring the best possible outcomes for service users.

Person-centred practice and care means working in partnership with service users, their families, carers and communities to design and develop practices, treatment and care that are fit for purpose and responsive to need.

Increasingly, person-centred practice and care are focused on supporting people to take responsibility for their own health and social well-being, including health promotion and prevention of ill health. The AHP workforce, working in partnership with individual service users as well as professional colleagues and partners, plays a key role in supporting people, such as those with long term conditions, to manage their own conditions and to enhance their health and social well-being, independence and quality of life.

"*Improving the Patient and Client Experience*" (2008) complements a person-centred approach to practice and care by defining a series of 5 standards that patients and clients can expect from HSC services and which should underpin the commissioning and delivery of care. The 5 standards are Respect; Attitude; Behaviour; Communication; and Privacy and dignity. These standards, which apply across the HSC workforce, should be central to the planning and delivery of services provided by the AHP workforce.

Increasingly care pathways cross boundaries that reach beyond traditional health care services. AHPs should continue to work across boundaries with a range of stakeholders including other services and organisations to ensure seamless practices and care that optimise resources and service user outcomes.

Strategic Theme 1 - Promoting Person-centred Practice and Care

Promoting person-centred care requires a focus on four key areas:

- Ensuring personal and public involvement
- Improving the service user experience
- Promoting and supporting self management
- Working in partnership

Examplars

Colinglen schools

A nationally recognised partnership model between health and education led by Speech and Language Therapists for Primary 1 children in the Colinglen area of Belfast has resulted in:

- Improved identification of children with speech, language and communication difficulties
- Improved support with goals of therapy linked to class targets
- Increased knowledge, skills and confidence of teaching staff in identifying and supporting children in the classroom
- Increased access to services with a 2 week wait for assessment and 50-70% increased uptake of the service compared to local community clinics
- 59% of those accessing the service were discharged with age appropriate speech and language skills

"The liaison between the SLT and school staff was imperative and valuable. It has provided me with the ability to support pupils who are having speech and language difficulties when the SLT is not here" (Teacher)

Condition Management Programme

Multi-agency Condition Management Programmes (CMP) are designed and delivered by a range of professionals including Occupational Therapists, Physiotherapists and Dietitians. Via this multi-disciplinary programme the cycle of poor health, unemployment, welfare dependency and social exclusion is broken by supporting individuals to self manage their health conditions and improve their potential for employment.

Last year one Trust in Northern Ireland had 560 referrals to CMP. 17% of those who completed the programme are now in paid employment saving an estimated £3.5 million to the Northern Ireland economy.

Music Therapy in Children and Adolescent Mental Health Services (CAHMS)

Within CAHMS services attendance rates at clinics are traditionally low. Music Therapy in two Trusts in Northern Ireland has clearly demonstrated its 'added value' achieving attendance rates of 90% and meeting patients' expectations.

Outcomes for children and young people include:

- building concentration
- helping with aggression and anger
- improving low self- esteem
- addressing difficult behaviour at home and in school

"My son was sent to see if it would help him work out his anger and aggression. He loved music therapy. He couldn't wait for the next session. It was great to have that half hour for someone to work one to one with him... Music therapy made him feel special and from that point it helped."

Strategic Theme 1 - Promoting Person-centred Practice and Care

Ensuring Personal and Public Involvement (PPI)

Effective service user and public involvement is central to the delivery of high quality health and social care services which are safe, effective and focused on the service user. The DHSSPS Personal and Public Involvement Policy (2007)[6] seeks to improve the quality of HSC services through pro-actively engaging and working with individuals, organisations and communities in informing and influencing the commissioning, design and delivery of health and social care services to ensure high quality outcomes for service users and the best use of resources.

PPI seeks to empower the general population, communities and voluntary groups to give them more confidence and opportunities to influence the delivery of health and social care services in ways that are relevant and meaningful to them. At an individual level, PPI means engaging with and listening to service users and carers, drawing upon their knowledge, personal experiences and expertise to improve practices and ensuring they are actively involved in decisions about their care and treatment.

At a Strategic Level

Action 1

Secure the effective engagement of service users and the public in shaping health policy and participating in decisions about the planning, commissioning and delivery of health and social care services.

Led by: The Lead AHP Officer (DHSSPS) to support the Director of Nursing and AHPs in the Public Health Agency (PHA) and the Assistant Director for AHPs and PPI (PHA).

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At an Organisational Level

Action 2

Ensure that the principles of personal and public involvement are continuously embedded within AHP practice.

Led by: The Accountable Executive Director[iii] in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 3

The AHP workforce will engage effectively with service users and as appropriate their carers, as partners in identifying and assessing needs and in the planning and delivery of their practice and care.

Improving the Service User Experience

"*Improving the Patient and Client Experience*" sets out standards and guidance for all health and social care staff. The standards are based around 5 themes aimed at improving how care is provided to patients, clients and, where appropriate, carers. The standards are focused on Respect; Attitude; Behaviour; Communication; and Privacy and dignity. "*Improving the Patient and Client Experience*" recognises that patients and clients have a right to experience respectful and professional care in a considerate, supportive and collaborative environment where their privacy is protected and dignity maintained. The standards set out in "*Improving the Patient and Client Experience*" should be promoted and implemented into practice across the AHP workforce.

iii The Accountable Executive Director is the Director at Trust Board level who has governance responsibility for AHP services within their Trust.

Strategic Theme 1 - Promoting Person-centred Practice and Care

At a Strategic Level

Action 4

Support the DHSSPS and PHA to oversee the regional implementation and monitoring of "*Improving the Patient Client Experience*" standards.

Led by: The Lead AHP Officer (DHSSPS) and the Assistant Director for AHPs and PPI (PHA).

At an Organisational Level

Action 5

Ensure appropriate actions are in place within AHP practice to support the delivery of the "*Improving the Patient and Client Experience*" standards.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 6

The AHP workforce will continue to work with colleagues to deliver services which improve the outcomes for, and experience of, service users in line with the "*Improving the Patient and Client Experience*" standards.

Promoting and Supporting Self Management

Self management provides people with the knowledge and skills they need to take control of and manage their own health with appropriate levels of support, and to be active partners in decision-making about their treatment and care. A key role of the AHP workforce is to work in partnership with service users to maximise health, independence and social well-being through promoting and

supporting self management and helping to prevent other related conditions or complications.

Advances in how long term, or chronic, conditions are managed have led to changes in the planning and delivery of AHP interventions and practices to support people in self management.

At a Strategic Level

Action 7

Ensure that supporting self management becomes integrated within the development of policy and standards and the commissioning and design of AHP practice.

Led by: The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA) and the Assistant Director for AHPs and PPI (PHA).

At an Organisational Level

Action 8

Ensure that the AHP workforce promotes and supports self management as an integral element of their practice.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 9

The AHP workforce will engage and work with people as partners to support them to self manage their own health and well-being.

Strategic Theme 1 - Promoting Person-centred Practice and Care

Working in Partnership

In improving the service user experience and supporting people to self manage their conditions, AHPs work in partnership with service users, their families and carers to ensure the best possible outcomes for health and well-being. In addition to working with individual service users, AHPs also interface with a range of statutory, voluntary, community and independent services and organisations, including housing, education, community and voluntary sector services, prisons and the youth justice system.

Service users often have complex needs which cannot be addressed by a single health care professional. The benefits of multi-disciplinary team working in population health promotion and prevention, early detection, diagnosis, treatment and ongoing care are well recognised. AHPs have a key role to play working in partnership with colleagues as leaders and members of multi-disciplinary and multi-agency teams. They provide professional expertise, advice and support as part of an integrated approach to the planning and delivery of health and social care.

AHP interventions should dovetail with and complement other interventions to deliver what service users require. Establishing and maintaining effective communication, collaborative working, and teamwork are critical to building relationships that deliver co-ordinated and integrated care for the benefit of service users.

At a Strategic Level

Action 10

Develop and further promote partnership working arrangements across relevant Government Departments and other key stakeholders to enhance the health and social well-being of service users.

Led by: The Lead AHP Officer (DHSSPS).

Action 11

Promote and support effective partnership working within AHP services and across other agencies and organisations.

Led by: The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director of AHPs and PPI (PHA).

At an Organisational Level

Action 12

Engage with relevant stakeholders to ensure effective policy development and inter-agency working with other statutory, independent, voluntary and community sector organisations.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

Action 13

Ensure that any barriers to good partnership working, both within and outside the organisation, are identified and addressed.

Led by: The Accountable Executive Director, in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 14

The AHP workforce, with appropriate professional support, will work effectively in multi-disciplinary and multi-agency teams to deliver co-ordinated and integrated practices and care.

Strategic Theme 2 - Delivering Safe and Effective Practice and Care

Safe and effective practice and care is the responsibility of all staff and should be at the heart of all AHP services. Good governance and accountability arrangements, alongside continuing education, research and service development, are essential to achieve and ensure this.

The DHSSPS Framework Document[7] describes the roles and functions of the various HSC bodies, the parameters within which each body must operate and the necessary governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.

Quality and professional standards for health and social care are set out in "*Supporting Good Governance and Best Practice in the HPSS*"[8]. This identifies the standards that the public, service users, families and carers can expect - and the standards the statutory sector is required to meet - in the planning, commissioning, delivery and review of health and social care services. These standards contribute to the implementation of clinical and social care governance and are used by organisations, service users, carers and the wider public to assess the quality of care provision. "*Quality 2020*" the Department's 10 year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland builds on this foundation.

Effective governance frameworks (including risk assessment, risk management and clear accountability arrangements) should be embedded across all levels and be central to the planning and delivery of safe and effective practice and care.

AHPs who work in the health and social care system, as well as those in the independent, education, voluntary and community sectors play a key role in assessing, managing and reducing risks. They have an individual responsibility to ensure the delivery of high quality practices and care that are safe, effective and focused on the service user and to promote excellence and continuous improvement in the services provided. This should be supported by appropriate

training and education and demonstrated by the establishment of clinical audit and evidence-based quality outcomes for practices and care.

AHP registrants must seek to ensure that their Continuing Professional Development (CPD) contributes to the quality of their practice and service delivery and that ultimately it benefits the service user[9].

Delivering safe and effective care requires a focus on two key areas

- Risk assessment and management
- Clear governance and accountability frameworks

Examplars

Home Enteral Feeding Co-ordinators

Dietitians as Home Enteral Tube Feeding (HETF) Co-ordinators have improved the quality of care for patients across Southern HSCT. Working across the primary and secondary care interface they reduced risk of medical crises and emergency callouts through extended scope practice. They act as a single point of contact for patients, families/carers, other professionals and external agencies to support people with feeding tubes at home.

In one year alone they avoided 149 A&E attendances saving in excess of £74,500.

Strategic Theme 2 - Delivering Safe and Effective Practice and Care

A&E Super Hand Clinic

In South Eastern HSCT Occupational Therapy input to hand clinics provides early and comprehensive specialist treatment to reduce risk of complications from hand injuries. Development and centralisation of this specialist service on a single Trust site has achieved the following outcomes for service users and services:

- Reduced need for referral to fracture clinics
- Reduced need for referral to plastic surgery trauma clinics
- Access to extended scope expertise of Occupational Therapists in diagnostics and reading x-rays
- Increased productivity
- More timely access to treatment

Risk Assessment and Management

The AHP workforce, collectively and as individuals, is accountable for the identification, assessment and management of risk in order to support safe and effective practices and care. This requires AHPs to use their specialist skills and competencies to take a pro-active and anticipatory approach to risk assessment and risk management which also includes positive risk taking and enablement. This means prioritising those clinical activities that target effective risk management and in doing so minimising risk for service users, families, carers, colleagues and the organisation.

The planning, commissioning and delivery of AHP practices should be driven by an emphasis on quality, which includes the safety of service users. Adopting a culture of sharing the learning where complaints, serious adverse incidents and "near misses" do occur, and taking appropriate action to ensure that lessons learned are applied, should result in measurable improvements in the quality of care.

At a Strategic Level

Action 15

Contribute to the development of policy to support good practice and ensure that effective risk assessment and management processes for AHP practices are in place and that lessons are learned and applied from complaints, adverse incidents, "near misses" and reviews.

Led by: The Lead AHP Officer (DHSSPS) and the Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director for AHPs and PPI (PHA).

At an Organisational Level

Action 16

Provide an assurance to HSC Trust Board that effective risk assessment and management processes for AHP practices are in place and implemented and that lessons are learned and applied from complaints, serious adverse incidents, "near misses" and reviews.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 17

The AHP workforce will be supported to continue to work to recognised standards, guidelines, policies and procedures for the identification, assessment and management of risk for service users. This will include uni-disciplinary and collaborative approaches appropriate to their scope of practice.

Strategic Theme 2 - Delivering Safe and Effective Practice and Care

Clear Governance and Accountability Frameworks

AHPs are autonomous practitioners who practice across the full spectrum of health and social care both as individuals and as members of multi-disciplinary teams. The decisions made and the practices delivered by the AHP workforce directly impact on the health and social well-being and quality of life of service users.

It is essential that effective accountability arrangements are in place, regionally and at local level, to ensure good governance and the delivery of high quality practices and care that are safe, effective and focused on the service user. Appropriate and effective supervision and support, together with clarity of roles and responsibilities, can provide a structured framework to support good governance. This is particularly so where the scope of AHP roles and responsibilities are being extended.

Where AHPs interface with other agencies and service providers, these relationships and interactions must also be clearly defined so that responsibility and accountability of AHP roles are clear.

At a Strategic Level

Action 18

Establish a Regional Accountability Framework for AHPs.

Led by: The Lead AHP Officer (DHSSPS) in partnership with relevant stakeholders.

Action 19

Establish a mechanism that provides leadership, support and guidance for AHP governance and accountability arrangements.

Led by: The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director for AHPs and PPI (PHA).

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At an Organisational Level

Action 20

Develop, support and monitor AHP workforce compliance with agreed accountability and governance frameworks.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 21

The AHP workforce will be supported to use relevant standards, guidelines, protocols and procedures and to report and escalate issues of concern regarding poor practice or poor performance of others in line with organisational, professional body and regulatory guidance.

Strategic Theme 3 - Maximising Resources for Success

The context within which AHP practices are commissioned, designed and delivered is dynamic and increasingly challenging. Demographic changes, including the increasing prevalence of long term conditions, are leading to greater levels of demand, which inevitably places pressure on financial and other resources as well as having implications for areas such as access to services. Within this context it is essential that all resources are deployed as effectively, efficiently and economically as possible, whilst ensuring that service users continue to receive high quality care that is safe, effective and focused on their needs.

New models of practice and care in the primary, community and secondary care sectors provide a challenge for AHPs. To meet such challenges requires continued innovation and modernisation in how AHP practices are commissioned, designed and delivered. This will necessitate examining existing services and models of care across the whole HSC system to identify what is essential, what can be delivered more effectively and what is no longer appropriate or necessary based on new evidence and best practice. It means optimising and ensuring the most effective and efficient use of resources, including the AHP workforce itself as well as extending the use of technology, aids and equipment that support health promotion, early detection, diagnosis, treatment and rehabilitation. It also means considering the sustainability of AHP services over the longer term and determining how the services AHPs provide can best be developed and improved to deliver outcomes that are focused on the needs of service users, their families and carers irrespective of where services are provided.

Innovation and modernisation will vary across the AHP disciplines however it should be guided and informed by evidence-based best practice which is identified, promoted and communicated. Existing service design and delivery models should be benchmarked against this to inform service development and improvement that ensures the optimum use of resources and the provision of practices and care that are fit for purpose.

Key to successful innovation and modernisation will be capitalising on the knowledge, expertise and professional experience of the AHP workforce and communicating and sharing good practice, particularly in areas such as public health, diagnostics and re-ablement. All appropriate steps should be taken to maximise how the research, knowledge and skills of the AHP workforce are utilised to deliver safe and effective practices and care to meet the changing needs of the population of Northern Ireland, for example, through deploying extended scope practitioners.

Maximising resources for success requires a focus on two key areas:

- Innovation and service modernisation
- Effective leadership

Examplar

"Living your life to the full" A Southern HSCT Re-ablement initiative

Re-ablement is a new exciting, innovative model of care for older people targeted at maximising their independence; choice and control by ***helping people do things for themselves, rather than doing things to or doing things for people.***

Led by Occupational Therapists this service aims to help motivate and support people to regain the ability to live as independently as possible reducing their need for support in the future.

Over a 6 month period 134 referrals were received by the service each week with an average of 50% being discharged without needing other services.

Traditionally these individuals collectively would have commenced services estimated to cost more than £500,000 per year.

Strategic Theme 3 - Maximising Resources for Success

Self Referral

Self referral to Physiotherapy initiatives for people with Musculoskeletal Disorders (MSD) can

- Stop people going off work
- Get people back to work
- Facilitate managed return to work
- Reduced GP visits releasing capacity for other priorities

Cost savings from self referral have been realised across the UK

Cambridge	– 75% of self referrals did not require a GP prescription saving £12,000 per GP practice per year
NHS Scotland	– identified cost benefits of £2.5 million per year
Northern Ireland	– 2008 Audit Office report confirmed 80% of Civil Servants avoided sickness absence – 80% had sickness absence reduced by an average of 6 weeks

Orthoptic and optometry service redesign

A joint orthoptic and refraction clinic led by orthoptists from NHSCT was recognised as Leading Innovation in the 2011 National Advancing Healthcare Awards. This one stop clinic has allowed children to begin treatment immediately with numerous benefits including:

- Single assessment appointment
- Shared care plan and records thus reducing paperwork and avoiding duplication
- Reduced waiting times for refraction clinics
- Fewer appointments for children to attend
- Consistent advice to children and parents
- Administration costs halved
- Enhanced multi-disciplinary working and practice evaluation
- Improved staff morale

Fractures Reporting

Advanced Practitioner Diagnostic Radiographers in South Tyneside have modernised their hip fracture services through redesign of the care pathway with significant outcomes for service users including:

- Diagnostic Radiographers reporting x-rays
- Managing bed admissions procedures
- 97% of patients admitted to hospital bed within 1 hour of arrival at A&E
- Release of Orthopaedic and A&E Medical staff time

Innovation and Service Modernisation

Innovation and modernisation means commissioning, designing and delivering AHP services that ensure the right things are done by the right person, in the right place and at the right time. This requires being positive about change through examining existing models of care holistically to identify how practices can be improved and resources deployed more effectively to ensure capacity building and the longer term sustainability of services. The focus of this should be to ensure that services are in place that are more accessible, flexible and responsive to the needs of service users and which facilitate the achievement of key targets and standards.

Modernising services necessitates identifying quality outcomes for service users and taking a whole systems approach to considering where new or evolving services can be extended or further developed. Utilising research, knowledge, evidence, best practice and the unique skills of AHPs to change and improve ways of working for the benefit of service users is essential.

The AHP workforce, working in partnership with professional colleagues and service users, is best placed to make improvements in practices and procedures to ensure the best possible outcomes. A key element of this will be the promotion of research and identifying evidence-based best practice.

Strategic Theme 3 - Maximising Resources for Success

Examples of how to maximise resources may include working in partnership with colleagues to develop integrated working practices; identifying how multi-disciplinary and multi-agency team working can be improved; extending information and communication systems to share good practice; identifying how new and extended AHP roles can be utilised to improve service design and optimise patient outcomes and utilising technology to support improved outcomes for service users. The knowledge and skills of the AHP workforce can also be used in health promotion and prevention as well as to facilitate earlier diagnosis and interventions, self referrals and effective discharge arrangements.

The development of innovative AHP practices depends on workforce capacity and capability. AHPs should have access to continuing professional development, including opportunities to lead and participate in audit and research projects and education and training that will support the development and improvement of new and existing skills and expertise which will enable staff to be innovative in the development and delivery of high quality, person-centred services. Ensuring that skilled and competent staff are in place is an essential part of maximising resources and this is explored further in Theme 4 - "*Supporting and Developing the AHP Workforce*".

At a Strategic Level

Action 22

Contribute to, and lead as required, the development of policy and strategies to promote the commissioning, design and delivery of evidence based best practice and service improvement.

Led by: The Lead AHP Officer (DHSSPS).

Action 23

Ensure effective service design and delivery models are commissioned and in place which allow for more innovation in the provision of accessible, flexible and responsive services to ensure improved clinical outcomes, user satisfaction and value for money.

Led by: The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director of AHPs and PPI (PHA).

At an Organisational Level

Action 24

Ensure that services are in line with strategic policy and principles, are accessible, flexible and responsive to the needs of service users and carers, and make the most effective use of the AHP workforce.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

Action 25

Work with HSCB/PHA to ensure identification and implementation of effective service design and delivery models which allow for more innovation in the provision of accessible, flexible and responsive services to maximise performance and ensure improved clinical outcomes, user satisfaction and value for money.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 26

The AHP workforce, in conjunction with Professional Heads of Service, will continue to review their practice and consider innovative ways in which the services they deliver can be modernised and improved to the benefit of service users and carers.

Effective Leadership

Positive and effective professional and clinical leadership is vital to achieve the vision for AHP services set out in this Strategy. Effective leaders identify priorities; challenge assumptions; facilitate change; drive the creativity for service re-design and modernisation; motivate and support people to achieve their best; and develop and nurture partnership working.
Effective professional and clinical leadership at all levels, and in particular at strategic level, is an essential resource for ensuring the current delivery and future development of quality AHP services that are focused on achieving optimum outcomes for service users. Developing and supporting the AHP leaders of the future is crucial and this is explored in more detail in Theme 4 "*Supporting and Developing the AHP Workforce*".

At a Strategic Level

Action 27

Provide effective professional leadership for the AHP workforce, working in partnership with relevant groups and other key stakeholders.

Led by: The Lead AHP Officer (DHSSPS) and the Assistant Director of AHPs and PPI (PHA).

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At an Organisational Level

Action 28

Provide effective professional leadership and act as positive role models for staff by demonstrating commitment to the innovation and modernisation of AHP practices, the development of staff and the delivery of high quality care that is safe, effective and focused on best outcomes for service users.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 29

The AHP workforce will take personal ownership of, and demonstrate a high level of commitment to, the delivery of high quality, innovative practices and care leading to improved clinical outcomes, service user satisfaction and value for money.

Strategic Theme 4 – Supporting and Developing the AHP Workforce

A responsive and skilled workforce means that the right people are in the right place with the right skills, at the right time to deliver the right outcome. It is essential to have a motivated, patient-focused, appropriately trained, highly skilled and flexible AHP workforce to meet service needs into the future. A strategic and forward looking approach to workforce planning, including continuing professional development, extended roles and changing work practices, will help facilitate this.

The increasing demand for AHP services requires that those in leadership roles for AHPs should ensure that the skills and grade mix are in place that will enable the workforce to meet assessed demand and service users' needs. Workforce planning should not only take into account existing models of service delivery but should also address essential future skill mix that will support the strategic shift in how and where care is delivered; moving away from the hospital sector to delivering a wider range of more responsive, accessible, timely and integrated services, including prevention and anticipatory management, in the community. Effective workforce planning needs to be supported by appropriate learning and development to ensure the availability of a skilled and adaptable AHP workforce. This will support AHPs to progress in their careers, deliver a quality service and acquire the range of skills needed for delivery of services into the future.

This Strategy encourages, through research, education and learning, the development of the AHP workforce. This is particularly important in the context of the diversity of emerging needs arising from demographic change, the reform and modernisation of services and increasing service user expectations. The development of the AHP workforce should also recognise the need to provide a supportive environment within which AHPs work.

Supporting and developing the AHP workforce requires a focus on three key areas:

- Workforce planning
- Learning and development
- Workforce development

Examplers

Supplementary prescribing

Investment in learning and development of Physiotherapists, Podiatrists and Radiographers as supplementary prescribers provides service users with quicker and more efficient access to medicines.

An audit evaluating more than 1000 non medical prescribing episodes by Podiatrists and Physiotherapists in North West England identified that for those seen by an AHP:

- 20% avoided a GP clinic appointment
- 11% avoided the need for a GP home visit
- 15% avoided both new and unnecessary follow up by a consultant led hospital clinic
- 8% avoided hospital admissions

(North West Allied Health Professional Non Medical Prescribing Audit 2010).

Strategic Theme 4 – Supporting and Developing the AHP Workforce

Skill Mix In Podiatry Services

Podiatry Support Workers in Northern Ireland have successfully completed the Society of Chiropodists and Podiatrists competency programme. Outcomes for podiatry services include;

- Delegation of non-professional tasks e.g. decontamination of equipment
- Professional time optimised and used more effectively
- More timely access to podiatry for patients through more efficient management of waiting lists

In 2010/2011 use of a Podiatry Support worker released 1.0 wte Podiatrist to manage more complex cases and achieved cost savings of £5,500 per year.

Dietetic Support Worker

Southern HSCT invested in the learning and development of Dietetic Support Workers (DSW) through the development of a training and competency framework manual which:

- Identifies key areas for in house nutrition training
- Is formally linked to QCF Level 3 Allied Health Professional Support Qualification
- Provides assurance that DSWs have the level of nutrition knowledge and skills to be competent to perform delegated tasks

Trained DSWs now manage a caseload of routine non-complex review patients safely and effectively, releasing professional dietetic staff thus maximising resources.

Workforce Planning

Good workforce planning means taking account of current, short term and future demand and making plans to ensure this can be met in terms of both the number of staff and their skills and competencies to meet service need. Workforce reviews will seek to inform the effective management of supply and demand across the professions, including support staff.

It is also important that workforce planning takes account of the changing work practices and skills required within the workplace and the wider context of health and social care reform. In particular, both undergraduate and post graduate training and clinical placements should be regularly reviewed to ensure they equip AHPs to meet the increasing demands for AHP services and for innovation in how these are commissioned, designed and delivered to maximise resources. The challenge of growing and sustaining the workforce requires creative and flexible responses from all the professions[10].

At a Strategic Level

Action 30

Continue to ensure that a strategic approach is taken to regional workforce planning to meet identified service needs and take into account the workforce implications of the modernisation of HSC services.

Led by: The Lead AHP Officer (DHSSPS).

Action 31

Carry out, influence and contribute to workforce reviews for individual Allied Health Professions and for multi-disciplinary and multi-professional programmes of care as appropriate.

Led by: The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service.

Strategic Theme 4 – Supporting and Developing the AHP Workforce

At an Organisational Level

Action 32

Ensure appropriate input to organisation level workforce planning, as well as representation and participation to inform regional workforce planning.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 33

The AHP workforce will use their experience and specialist expertise to inform workforce planning.

Learning and Development

Learning and development underpins the establishment of a skilled, competent and adaptable workforce. All AHPs must be registered with the Health Professions Council (HPC) in order to practise and must continue to meet the standards they have been set by the Council in order to maintain registration. Included in these is the maintenance of competency to practise through continuing professional development, applicable to all AHPs irrespective of the care sector or setting within which they practice.

Resources are provided by the DHSSPS and employers to support the commitment to learning and development, including shared learning opportunities with other health and social care professionals. A Workforce Learning Strategy[11] has been developed to help maximise the return on this investment.

At a Strategic Level

Action 34

Inform and support the learning and development of AHPs.

Led by: The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service.

At an Organisational Level

Action 35

Support the commitment to the learning and development of the AHP workforce through mentorship and ensuring that staff are supported in the acquisition of new skills and competencies as necessary to respond to emerging needs of the service.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 36

AHPs, in conjunction with their Professional Heads of Service and managers as appropriate, are responsible for their continued professional development and meeting the requirements for their ongoing professional registration.

Workforce Development

Ensuring the AHP workforce has the skills and competencies to meet emerging needs and challenges within health and social care is essential for continued high quality service delivery, particularly so as AHPs have become more involved in public health initiatives and programmes. Valuing staff and committing to their development is vital for staff retention and motivation. High skills standards and

Strategic Theme 4 – Supporting and Developing the AHP Workforce

staff involvement in service development help ensure that services are designed and delivered based on the most up to date knowledge and best practice.

An ongoing commitment to workforce development is needed to ensure that the range of knowledge and skills required to meet service demands into the future is available, from AHP support staff through to advanced consultant practitioners and those who provide leadership for the AHP workforce at strategic and organisational levels. This ensures support is provided to Therapy Support Workers for skills acquisition relevant to QCF level. Trusts and other organisations should identify workforce development needs and ensure that these are addressed through the commissioning of appropriate training and development.

For their part, individual AHPs and therapy support workers will be expected to build on their core competencies, adding additional knowledge and skills through lifelong learning to enable them to provide new and improved services to service users and carers.

At a Strategic Level

Action 37

Advise DHSSPS of workforce developments in consultation with relevant groups and other key stakeholders and commission appropriate training and development which aligns with service needs.

Led by: The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service.

At an Organisational Level

Action 38

Ensure that appropriate induction, perceptorship and supervision are in place to support transitions along the career pathway.

Led by: The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.

Action 39

Inform and influence the commissioning of appropriate training and development to align with service needs.

Led by: The Accountable Executive Director, Trust AHP Leads and Professional Heads of Service.

At an Individual Level

Action 40

Action: The AHP workforce, in conjunction with Professional Heads of Service and their managers as appropriate, will identify their training and development needs and build on their core competencies, adding additional knowledge and skills through life-long learning and accepting responsibility for improving their own practice through continuing professional development.

Where do we go from here?

This document sets out the strategic direction for the AHP workforce, irrespective of the care setting or sector within which individual AHPs or therapy support staff work. Each of its strategic themes has identified key areas and actions through which, together, we will achieve our vision of working in partnership with service users to actively enhance people's lives through the delivery of high quality and innovative diagnostic, treatment and rehabilitation services and practices that are safe, timely, effective and focused on the service user.

The implementation of the Strategy will be taken forward by a Regional Implementation Steering Group which will be established within 3 months of publication of this Strategy. The Regional Implementation Steering Group will include key stakeholders, including service users, and will have a remit to ensure that the approach and actions set out within the Strategy are progressed. Terms of Reference for the Regional Implementation Steering Group will be developed and agreed by the Department and the Implementation Steering Group. The PHA and HSCB will provide the leadership to the Implementation Steering Group to ensure effective implementation of the Strategy. This may also include considering how the strategic direction and roles for the individual disciplines within the AHP workforce can be developed over the Strategy period.

The PHA/HSCB will be required to provide regular reports to the Department of progress against the Strategy's key actions, including a formal report at least annually.

A key role of the Regional Implementation Steering Group will be to develop a Regional AHP Strategy Implementation Plan within an agreed timeframe for approval by a DHSSPS Implementation Board. The Implementation Plan will include detailed actions at an operational level, together with appropriate milestones, targets and associated timescales. It will detail monitoring and accountability arrangements for taking forward the approach and key actions set out in this Strategy for ensuring the future development of the AHP workforce and the services it provides.

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DHSSPS through the HSCB and PHA will support and monitor the progress of this Strategy and its implementation within the HSC, whilst HSC Trusts will be instrumental in ensuring that the Strategy and its action points are taken forward at an operational level. It will be the responsibility of all members of the AHP workforce however, wherever they work, to embrace the actions expressed in this Strategy as part of their everyday practice.

This Strategy will be reviewed at the end of the five year period to measure progress and to set the future direction of travel.

Appendix 1
AHP Disciplines Covered in the Strategy

- **Art Therapists**
  Provide a psychotherapeutic intervention which enables clients to effect change and growth by the use of art materials to gain insight and promote the resolution of difficulties.

- **Dietitians**
  Assess, diagnose and treat diet and nutrition problems at an individual and wider public health level. Dietitians translate public health and scientific research on food, health and disease into practical guidance to enable people to make appropriate lifestyle and food choices.

- **Drama Therapists**
  Encourage clients to experience their physicality, to develop an ability to express the whole range of their emotions and to increase their insight and knowledge of themselves and others.

- **Music Therapists**
  Use music, with an individual client or group of clients, to improve functioning and develop potential in a number of skill areas impaired by disability, illness or trauma. These areas include communication, physical, emotional, mental, social and cognitive skills. Music therapy aims to achieve a better quality of life for clients through prevention, rehabilitation or treatment.

- **Occupational Therapists**
  Promote health and well-being though occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do; or by modifying

the occupation or the environment to better support their occupational engagement.

- **Orthoptists**
  Diagnose and treat eye movement disorders and defects of binocular vision.

- **Orthotists**
  Design and fit orthoses (callipers, braces etc.) which provide support to part of a patient's body, to compensate for paralysed muscles, provide relief from pain or prevent physical deformities from progressing.

- **Physiotherapists**
  Physiotherapists use a holistic approach in the preventative, diagnostic and therapeutic management of disorders of movement or optimisation of function, to enhance the health and well-being of the community from an individual or population perspective. Physiotherapy practice has the exercise of clinical judgement and informed interpretation, underpinned by best available evidence, at its core. It encompasses a diversity of clinical specialities to meet the unique needs of patient groups with varying health status.

- **Podiatrists**
  Assess the vascular, neurological and orthopaedic status of the patient's lower limbs to diagnose and treat diseases and conditions affecting the feet. Podiatrists focus on relieving symptoms and maintaining functional independence.

- **Prosthetists**
  Provide care and advice on rehabilitation for patients who have lost or who were born without a limb, fitting the best possible artificial replacement.

- **Radiographers – Diagnostic and Therapeutic**
  Diagnostic Radiographers employ a range of imaging techniques to produce high quality images of injury or disease, often interpreting the images so that correct treatment can be provided. They undertake diagnostic work

Appendix 1
AHP Disciplines Covered in the Strategy

and independent reporting as part of a multi-disciplinary team and are a key part of the delivery of acute as well as community-based services. Early diagnosis is a vital step in care pathways and the delivery of any subsequent treatment.

Therapeutic radiographers are the only health professionals qualified to plan and deliver radiotherapy in the treatment of cancer. They manage the patient pathway through the many radiotherapy processes, providing care and support for patients throughout their treatment.

- **Speech and Language Therapists**
  Speech and Language Therapists (SLTs) are concerned with the management of speech, language, communication and swallowing in children and adults. SLTs contribute to the delivery of specialist, targeted and universal services to service users and their families. They reduce long term demands on services by addressing immediate needs that arise from circumstances as well as needs that arise from underlying impairment. SLTs also provide training for the wider workforce.

Appendix 2
Summary of Action Points

Action	Led By
1. Secure the effective engagement of service users and the public in shaping health policy and participating in decisions about the planning, commissioning and delivery of health and social care services.	Strategic The Lead AHP Officer (DHSSPS) to support the Director of Nursing and AHPs in the PHA and the Assistant Director for AHPs and PPI (PHA)
2. Ensure that the principles of personal and public involvement are continuously embedded within AHP practice.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
3. The AHP workforce will engage effectively with service users as partners in the planning and delivery of their practice and care	Individual
4. Support the DHSSPS and PHA to oversee the regional implementation and monitoring of "*Improving the Patient Client Experience*" standards.	Strategic The Lead AHP Officer (DHSSPS) and the Assistant Director for AHPs and PPI (PHA)
5. Ensure appropriate actions are in place within AHP practice to ensure the delivery of the "*Improving the Patient and Client Experience*" standards.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service

Appendix 2
Summary of Action Points

Action	Led By
6. The AHP workforce will continue to work with colleagues to deliver services which improve the outcomes for, and experience of, service users in line with the "*Improving the Patient and Client Experience*" standards.	Individual
7. Ensure that supporting self management becomes integrated within the development of policy and standards and the commissioning and design of AHP practice.	Strategic The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA) and the Assistant Director for AHPs and PPI (PHA)
8. Ensure that the AHP workforce promotes and supports self management as an integral element of their practice.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
9. The AHP workforce will engage and work with people as partners to support them to self manage their own health and well-being.	Individual
10. Develop and further promote partnership working arrangements across relevant Government Departments and other key stakeholders to enhance the health and social well-being of service users.	Strategic The Lead AHP Officer (DHSSPS)

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Action	Led By
11. Promote and support effective partnership working within AHP services and across other agencies and organisations.	Strategic The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director of AHPs and PPI (PHA)
12. Engage with relevant stakeholders to ensure effective policy development and inter-agency working with other statutory, independent, and voluntary and community sector organisations.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
13. Ensure that any barriers to good partnership working, both within and outside the organisation, are identified and addressed.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service.
14. The AHP workforce, with appropriate professional support, will work effectively in multi-disciplinary and multi-agency teams to deliver co-ordinated and integrated practices and care.	Individual

Appendix 2
Summary of Action Points

Action	Led By
15. Contribute to the development of policy to support good practice and ensure that effective risk assessment and management processes for AHP practices are in place and that lessons are learned and applied from complaints, adverse incidents, "near misses" and reviews.	Strategic The Lead AHP Officer (DHSSPS) and the Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director for AHPs and PPI (PHA)
16. Provide an assurance to HSC Trust Board that effective risk assessment and management processes for AHP practices are in place and implemented and that lessons are learned and applied from complaints, serious adverse incidents, "near misses" and reviews.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
17. The AHP workforce will be supported to continue to work to recognised standards, guidelines, policies and procedures for the identification, assessment and management of risk for service users. This will include uni-disciplinary and collaborative approaches appropriate to their scope of practice.	Individual
18. Establish a regional accountability framework for AHPs.	Strategic The Lead AHP Officer (DHSSPS) in partnership with relevant stakeholders

Action	Led By
19. Establish a mechanism that provides leadership, support and guidance for AHP governance and accountability arrangements.	Strategic The Director of Nursing and AHPs (PHA), in conjunction with the Assistant Director for AHPs and PPI (PHA)
20. Develop, support and monitor AHP workforce compliance with agreed accountability and governance frameworks.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
21. The AHP workforce will be supported to use relevant standards, guidelines, protocols and procedures and to report and escalate issues of concern regarding poor practice or poor performance of others in line with organisational, professional body and regulatory guidance.	Individual

Appendix 2
Summary of Action Points

Action	Led By
22. Contribute to, and lead as required, the development of policy and strategies to promote the commissioning, design and delivery of evidence-based best practice and service improvement.	Strategic The Lead AHP Officer (DHSSPS)
23. Ensure effective service design and delivery models are commissioned and in place which allow for more innovation in the provision of accessible, flexible and responsive services to ensure improved clinical outcomes, user satisfaction and value for money.	Strategic The Director of Nursing and AHPs (PHA) in conjunction with the Assistant Director of AHPs and PPI (PHA)
24. Ensure that services are in line with strategic policy and principles, are accessible, flexible and responsive to the needs of service users and carers, and make the most effective use of the AHP workforce.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
25. Work with HSCB/PHA to ensure identification and implementation of effective service design and delivery models which allow for more innovation in the provision of accessible, flexible and responsive services to maximise performance and ensure improved clinical outcomes, user satisfaction and value for money.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service

Action	Led By
26. The AHP workforce, in conjunction with Professional Heads of Service, will continue to review their practice and consider innovative ways in which the services they deliver can be modernised and improved to the benefit of service users and carers.	Individual
27. Provide effective professional leadership for the AHP workforce, working in partnership with relevant groups and other key stakeholders.	Strategic The Lead AHP Officer (DHSSPS) and the Assistant Director of AHPs and PPI (PHA)
28. Provide effective professional leadership and act as positive role models for staff by demonstrating commitment to the innovation and modernisation of AHP practices, the development of staff and the delivery of high quality care that is safe, effective and focused on best outcomes for service users.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
29. The AHP workforce will take personal ownership of, and demonstrate a high level of commitment to, the delivery of high quality, innovative practices and care leading to improved clinical outcomes, service user satisfaction and value for money.	Individual

Appendix 2
Summary of Action Points

Action	Led By
30. Continue to ensure that a strategic approach is taken to regional workforce planning to meet identified service needs and take into account the workforce implications of the modernisation of HSC services.	Strategic The Lead AHP Officer (DHSSPS)
31. Carry out, influence and contribute to workforce reviews for individual Allied Health Professions and for multi-disciplinary and multi-professional programmes of care as appropriate.	Strategic The Lead AHP Professional Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service
32. Ensure appropriate input to organisation level workforce planning, as well as representation and participation to inform regional workforce planning.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
33. The AHP workforce will use their experience and specialist expertise to inform workforce planning.	Individual
34. Inform and support the commitment to the learning and development of AHPs.	Strategic The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service

Action	Led By
35. Support the commitment to the learning and development of the AHP workforce through mentorship and ensuring that staff are supported in the acquisition of new skills and competencies as necessary to respond to emerging needs of the service.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service
36. AHPs, in conjunction with their Professional Heads of Service and managers as appropriate, are responsible for their continued professional development and meeting the requirements for their ongoing professional registration.	Individual
37. Advise DHSSPS of workforce developments in consultation with relevant groups and other key stakeholders and commission appropriate training and development which aligns with service needs.	Strategic The Lead AHP Officer (DHSSPS) in conjunction with the Director of Nursing and AHPs (PHA), the Assistant Director for AHPs and PPI (PHA), Trust AHP Leads and Professional Heads of Service
38. Ensure that appropriate induction, perceptorship and supervision are in place to support transitions along the career pathway.	Organisational The Accountable Executive Director in conjunction with Trust AHP Leads and Professional Heads of Service

Appendix 2
Summary of Action Points

Action	Led By
39. Inform and influence the commissioning of appropriate training and development to align with service needs.	Organisational The Accountable Executive Director, Trust AHP Leads and Professional Heads of Service
40. The AHP workforce, in conjunction with Professional Heads of Service and their managers as appropriate, will identify their training and development needs and build on their core competencies, adding additional knowledge and skills through life-long learning and accepting responsibility for improving their own practice through continuing professional development.	Individual

Appendix 3
Membership of the AHP Steering Group

Martin Bradley (Chair) (until retirement June 2011)	Chief Nursing Officer	DHSSPS
Angela McLernon (Chair) (wef July 2011)	Acting Chief Nursing Officer	DHSSPS
Jacqueline Magee	Service User Facilitator	HSC Board
Michelle Tennyson	Assistant Director of AHPs and Personal Public Involvement	Public Health Agency
Margaret Moorehead	Assistant Director of AHPs	SEHSCT
Paula Cahalan	AHP Services Manager	BHSCT
Denise Killough (wef June 2011)	Acting AHP Services Manager	BHSCT
Carmel Harney	Assistant Director AHP Governance, Workforce Development and Training	SHSCT
Paul Rafferty	Head of AHP Services	WHSCT
Elizabeth McKnight	AHP Professional Body Representative	AHP Federation NI
Hazel Winning	Chair of Health Professionals Forum	NHSCT
Pauline Mulholland (wef January 2011)	Lead AHP Officer	DHSSPS
Gillian Seeds	Primary Care Development Unit	DHSSPS
Michael Sweeney	Physical and Sensory Disability Unit	DHSSPS

Appendix 3
Membership of the AHP Steering Group

Sandra O'Hare	Nursing, Midwifery and AHP Directorate	DHSSPS
Anne Mills	Nursing Officer	DHSSPS
Joyce Cairns	Human Resources Directorate	DHSSPS
Karen Dawson	Primary Care Development Unit	DHSSPS
Mark Anderson	Nursing, Midwifery and AHP Directorate	DHSSPS

Abbreviations and Glossary of Terms

Accountability Framework	Identifies systems of control within an organisation including professional management structures and practices, reporting arrangements, and risk management processes.
Accountable Executive Director	The Accountable Executive Director is the Director at HSC Trust Board level who has governance responsibility for AHP services within their Trust.
Allied Health Professions Federation (AHPF)	The Allied Health Professions Federation (AHPF) is a UK-wide organisation which provides collective leadership and representation on common issues that impact on its member professions and their service users. The AHPFNI is a regional umbrella organisation which works in partnership with key decision makers and stakeholders in health, social care and education to promote better understanding of the unique contribution of the allied health professions. The AHPFNI represents the interests of 11 AHP professional bodies throughout Northern Ireland.
Assistant Director with responsibility for Allied Health Professions and Patient and Public Involvement (PHA)	The Assistant Director for AHPs and PPI (PHA) is responsible (through the Director of Nursing and Allied Health Professions) for AHP leadership and professional inputs both within the Public Health Agency and Health and Social Care Board as well as leadership more broadly across the Health and Social Care system. The key areas through which this is achieved are in setting direction, service delivery and service development.

Abbreviations and Glossary of Terms

Continuing Professional Development (CPD)	A structured approach to skills enhancement through which professionals maintain, improve and broaden their knowledge, skills and professional competence.
Corporate Governance	Corporate governance in healthcare is defined as "the systems and processes by which health bodies lead, direct and control their functions, in order to achieve organisational objectives, and by which they relate to their partners and the wider community" (Audit Commission definition).
Department of Health, Social Services and Public Safety (DHSSPS)	The Department has three main business responsibilities: **Health and Social Care (HSC)** - including policy and legislation for hospitals, family practitioner services and community health and personal social services; **Public Health** - policy, legislation and administrative action to promote and protect the health and well-being of the population; and **Public Safety** - policy and legislation for fire and rescue services.
Director of Nursing and Allied Health Professions (PHA)	The Director of Nursing and Allied Health Professions (PHA) has overall responsibility for nursing, midwives and allied health professionals in the HSC in addition to service and public health issues and the Local Supervising Midwifery Authority.
Health Professions Council (HPC)	A regulatory body established to protect the public. The HPC maintains a register of health professionals who meet specified standards in place for their training, professional skills, behaviour and health.

Health and Social Care (HSC)	Hospital services, family and community health services and personal social services.
Health and Social Care Board (HSCB)	The Health and Social Care Board has 3 main functions: • To commission a comprehensive range of modern and effective health and social services; • To work with the Health and Social Care Trusts that directly provide services to people to ensure that these meet their needs; • To deploy and manage its annual funding to ensure that all services are safe and sustainable.
Lead Allied Health Professions Officer	This is the lead officer in DHSSPS who provides advice to the Minister in relation to AHP issues and leads the professions in Northern Ireland.
Multi-disciplinary Team (MDT)	A group of people from different disciplines who work together to provide and/or improve care for service users. The composition of the multi-disciplinary team will include people from both health care and non-healthcare disciplines.
Personal and Public Involvement	Involving and empowering people and communities to influence the planning, commissioning and delivery of services in ways that are relevant and meaningful to them. It includes involving individuals in planning and decision making about their specific care or treatment.
Public Health Agency (PHA)	The PHA was set up to focus on public health and well-being. It brings together a wide range of public health functions under one organisation. Main areas of responsibility are:

Abbreviations and Glossary of Terms

	• health and social well-being improvement • health protection • public health support to commissioning and policy development • HSC research and development.
Primary care	Family and community health services and major components of social care which are delivered outside the hospital setting and which an individual can access on their own behalf. Primary care will usually be the person's first contact point with the HSC e.g. GP, Community Nurse, dentist.
Professional Head of Service	The term Professional Head of Service in this strategy refers to the most senior uni-professional AHP in the HSC who has professional accountability and governance responsibility for their specific profession.
Secondary care	Care that is usually provided in a hospital or a particular specialised centre. Secondary care may be accessed by a person directly but is usually as a result of referral from primary care.
Self management	Empowering people to take control of and manage their own health and well-being and providing them with the knowledge skills and support they need to be able to do so.
Serious adverse incidents & near misses	Any event or circumstance arising during the course of business of an HSC organisation/Special Agency or commissioned service that led, could have led, to serious unintended harm, loss or damage.

Trust AHP Lead	Trust AHP Lead in this strategy refers to the most senior AHP in HSC Trusts who has a collective responsibility for AHP professional and/or operational service delivery.
Therapy Support Worker	Part of the AHP workforce, therapy support workers provide support and assistance to Allied Health Professionals in the delivery of patient care.

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Produced by:
Department of Health, Social Services and Public Safety

Castle Buildings
Belfast, BT4 3SQ
Telephone: (028) 9052 0626
Textphone: (028) 9052 7668
www.dhsspsni.gov.uk

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UK Allied Health Professions Public Health Strategic Framework

2019-2024

Collaborating Partners

This strategic framework is the first UK wide Allied Health Professions Public Health document, designed through collaboration with partners across England, Northern Ireland, Scotland and Wales. The strategic framework builds on previous strategic documents[1,2] applicable to one or more nations to provide a united, collective approach to Public Health for the Allied Health Professions across all four nations.

This strategic framework was produced by:

Scottish Government

Public Health England

Allied Health Professions Federation

Welsh Government

Welsh Therapies Advisory Committee

Public Health Wales

Public Health Agency Northern Ireland

Department of Health Northern Ireland

Council for Allied Health Professions Research

Council of Deans of Health

Royal Society for Public Health

The Royal College of Speech and Language Therapists

The Institute of Osteopathy

Allied Health Professions Federation Scotland

College of Paramedics

Royal College of Occupational Therapists

The British Dietetic Association

The British Association of Art Therapists

British Association of Prosthetists and Orthotists

The College of Podiatry

British and Irish Orthoptic Society

The Society and College of Radiographers

British Association for Music Therapy

Chartered Society of Physiotherapy

The British Association of Dramatherapists

The Association for Perioperative Practice

AHPs4PH

AHP Directors Scotland Group

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Faculty of Public Health

Authors:

Linda Hindle - Public Health England

Laura Charlesworth - Sheffield Hallam University

Foreword

Shirley Cramer CBE

Chief Executive Royal Society for Public Health

Since the term 'wider workforce for the public's health' was first defined in 2015 following the publication of the RSPH report, *Rethinking the public health workforce*[3], no professional group has done more to embrace and action the term than Allied Health Professionals (AHPs). From the beginning, across the professions that make up the AHPs, there was real enthusiasm and an appetite to understand how prevention and health promotion could be integrated into their daily work. This engagement was evident from the findings of our subsequent report with PHE4, which looked at both the challenges and opportunities for AHPs to have a range of 'healthy conversations' with their patients and clients. AHPs have led the way in showing how a group of professionals with the 'ability or opportunity to improve or protect the public's health' (the official definition of the wider workforce), through a trusting relationship with individuals, can extend their expertise and skills to develop a holistic approach to health and wellbeing.

AHPs were also the first group to consider their impact in public health and prevention so that they could build on their success and begin to measure the scale and scope of their role in improving health and wellbeing. They have been pioneers in using the *Everyday Interactions*[5] tool and showing other professions not only in the health system but across broader professional groups, what it was possible to achieve.

It is therefore unsurprising to me that once again AHPs have shown foresight and leadership in producing this excellent UK wide public health strategic framework for the professions which highlights how AHPs can build on their public health role in the future. A key feature of this framework is that all four nations of the UK have worked together to produce and agree on their shared priorities; developing the workforce, demonstrating impact, increasing the profile of AHPs in public health and strategic leadership are the strands that will keep AHPs at the forefront of public health practice. The strength of this strategic framework is that it allows for flexibility based on each country's stated goals but also enables AHPs across the UK to move forward as a unified professional entity.

It is also notable that this strategy is ambitious and focuses on the complexities of the social determinants of health and combating health inequalities. AHPs have not shied away from the difficult issues and this development of shared priorities is an exciting and progressive development. I look forward to the implementation and outcomes of this strategic framework and congratulate the leadership of the profession for their aspirations and clear purpose to improve the nation's health and wellbeing.

Introduction

This UK strategic framework was produced jointly by the Allied Health Professions Federation (AHPF) and HSC Public Health Agency Northern Ireland, Public Health England, Scottish Government, Welsh Government and Welsh Therapies Advisory Committee. This strategic framework sets out our vision for the role of Allied Health Professionals (AHPs) in public health over the next five years, along with the goals we aim to achieve to realise the vision. It is intended to help AHPs, as well as their professional bodies and partner organisations, to further develop their role in public health, share best practice with colleagues and partners and ultimately embed preventative healthcare across all of their work. This is the first UK wide AHP public health strategy; it builds on and supersedes the previously published strategic documents for England[1] and Wales[2]. Each nation and profession start from different positions and therefore we expect the focus for implementation will differ between each.

This strategic framework is written with input from the fifteen professions represented by one or more of the AHP Chief AHP Officers across the UK. The primary audiences are; AHPs working across health and care sectors, leaders in the organisations they work for, commissioners and educators of AHP services; however the strategic framework will be of interest and relevance to other health and care professions and may be adopted or adapted for use more widely. The strategic framework is written from the perspective of the collaborating partners, and where we have referenced "we", this refers to the entirety of the collaborative partners.

Who Are The AHPs?

The AHPs work across all sectors related to health and wellbeing including but not limited to health, social care, education, justice, voluntary sector, housing, academia, business and private practice. They collectively make up the third largest workforce in the NHS. Chief AHP officers in each of the four nations are responsible for slightly different professions representing a total of fifteen professions. The fifteen professions included in this strategic framework are: art therapy, podiatry, clinical psychology, dietetics, drama therapy, music therapy, occupational therapy, operating department practice, orthoptics, osteopathy, paramedic practice, physiotherapy, prosthetics and orthotics, radiography (diagnostic and therapeutic) and speech and language therapy.

Strategic Context

The Allied Health Professions (AHPs) have been identified as trailblazers within the wider public health workforce agenda, demonstrating their public health contribution and profile. We have identified some excellent examples of AHP-led public health initiatives[6] across the life course, from helping children to have the best start in life to falls prevention for older adults. We now need to progress to support and enable AHPs to improve population health and reduce inequalities and ensure that public health becomes our core way of working over the next 5 years.

Each nation of the UK has highlighted the importance of public health and prevention. All nations have a number of similar priorities; health and wellbeing in early years, supporting healthy lifestyles and self-management and parity of esteem between physical and mental health.

Below we outline the specific strategic drivers in each nation:

England

The NHS Long Term Plan[7], published in January 2019, has given a renewed call for action across the NHS to strengthen its contribution to prevention and reducing health inequalities. This sits in a context of a system-wide vision for prevention, recognising the important role of individuals, business, communities and national government. AHPs have already been identified as professions with the skills, enthusiasm and opportunity to improve the public's health, most notably as part of the All Our Health call to action[8] and Rethinking the Wider Public Health Workforce publications [9,10]. AHPs themselves through the AHPs into Action Strategy[11] highlighted improving health and wellbeing of individuals and communities as one of the four major transformational impacts they can make. Over the past five years there has been an increased contribution to public health and prevention by AHPs in England, the next five years will build on this momentum to deepen and spread the public health role of all AHPs.

Northern Ireland

Making Life Better 2013–2023[12] is the ten year public health strategic framework. The framework provides direction for policies and actions to improve the health and wellbeing of people in Northern Ireland. It builds on the *Investing for Health*[13] strategy (2002–2012) and retains a focus on the broad range of social, economic and environmental factors which influence health and wellbeing. It brings together actions at government level and provides direction for implementation at regional and local level.

The Making Life Better (MLB)[12] framework seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision of Northern Ireland where all people are enabled and supported in achieving their full health and wellbeing potential and to reduce inequalities in health. AHPs in Northern Ireland play an essential part in delivering the outcomes set out in MLB.

Scotland

In June 2018, the Scottish Government and COSLA agreed and published Scotland's Public Health Priorities[14], following extensive engagement with a range of partners and stakeholders from across the whole system of public health, including wider public and third sectors. Setting jointly owned and agreed Public Health Priorities delivers the first of our key public health reform commitments. The aim of the reform is to improve the public's health through a whole system approach, focused on prevention and early intervention, and creating the conditions for wellbeing in our communities. A new national body, Public Health Scotland, will be established in 2019/20. It will have a key role to support and enable action to monitor progress on the Public Health Priorities at the population level, and within an approach of whole system working.

AHPs will continue to demonstrate leadership and impact with renewed effort to reduce health inequalities enable and empower people and communities to take positive action for health and wellbeing.

In December 2016 the national AHP Active and Independent Living Programme (AILP)[15] was identified as one of the Scottish Government deliverables on public health in the National Health and Social Care Delivery Plan. AILP was subsequently launched in April 2017 with its vision 'to support the people of Scotland to live active, independent healthy lives by supporting them with their personal outcomes'.

Wales

Improving health is one of three key wellbeing objectives for the Welsh Government and prioritises a strong public health approach as key to a healthy society, through the delivery of quality health and social care services; promoting good health and wellbeing and building healthier communities and better environments.

A Healthier Wales[16] (2018), the plan for health and social care mirrors this with a clear vision that everyone in Wales should have longer, healthier, and happier lives, and should be able to remain active and independent in their own homes, for as long as possible.

Population health and care will transform into a 'wellness' system which aims to support and anticipate health needs, to prevent illness and to reduce the impact of poor health. This whole system approach will aim to maximise value, be equitable and achieve more equal health outcomes for everyone by focusing on the needs of the population and the individual through person centred services.

The Allied Health Professions in Wales have begun their transformation journey to maximise their impact on preventing ill health and maximising health and social care outcomes. There are unique opportunities to integrate the national public health priorities into AHP leadership, service redesign and workforce development.

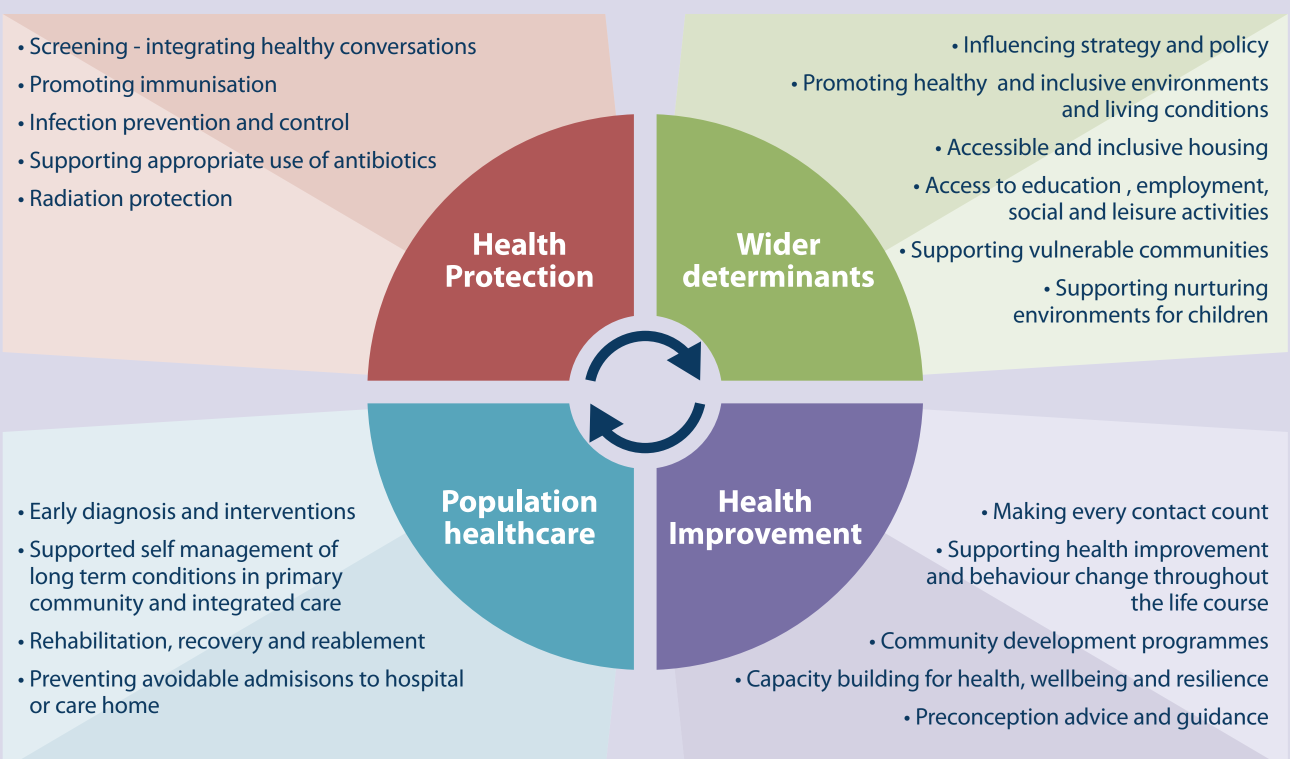
Model of Public Health for AHPs

The Faculty of Public Health define public health as the science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society.

AHPs contribute to public health through interventions affecting the physical, mental and social wellbeing of individuals, communities and populations.

There are a number of definitions of public health; we have used these to develop a model relevant to the roles of AHPs. This model gives examples of how AHPs may contribute to public health across four areas; this is will vary by profession and is not intended to be exhaustive.

- **Wider determinants** – also known as social determinants, are a diverse range of social, economic and environmental factors which impact on people's health and wellbeing. Addressing the wider determinants of health and wellbeing has a key role to play in reducing health inequalities.
- **Health Improvement** - describes the work to improve the health and mental wellbeing of individuals, communities or populations through enabling and encouraging healthy lifestyle choices and developing resilience.
- **Population healthcare** – aims to maximise value, equity and good outcomes by focusing on the needs of the population and delivering person centred services across the entire health and care system.
- **Health Protection** – aims to protect the population's health from communicable diseases and other threats, while reducing health inequalities



Our Strategic Approach

The four nations and all AHP professional bodies have supported the development of this strategic framework and will be working independently and collectively to implement its vision and goals, by:

- Focussing on all aspects of healthcare including physical and mental health.
- Working collaboratively with other innovators, professions and organisations to apply a systems leadership approach[1].
- Integrating public health priorities into other professional priorities such as leadership, service redesign and workforce development.
- Promoting the AHP contribution to public health in alignment with the current national strategic approaches and agendas in each of the four nations, as well as addressing the local context within which AHPs work.
- Identifying the areas where AHPs can make the greatest impact, recognising that this will vary for different professions. This will require a shift to a more upstream[2] and population approach based on need as oppose demand.
- Using our expertise and leadership to shape and support services, recognising that AHP skills can be utilised to provide quality assurance, leadership and oversight as well as direct delivery of services.
- Building on the work of AHPs across diverse populations and within vulnerable communities to ensure our actions contribute to reducing health inequalities.
- Adopting assets based personal outcomes principles within a community development approach by listening and responding to the needs of the communities we serve.
- Embedding a preventative and population health approach, which is informed by evidence of need into everything we do.
- Recognising that each profession is different, and therefore contribution and impact will vary depending on the area of public health. As a result, a broad strategy will apply to the range of professions rather than specific examples.
- Learning from good practice by AHPs and others, across the UK and internationally to evolve our practice to respond to changing needs and contexts.

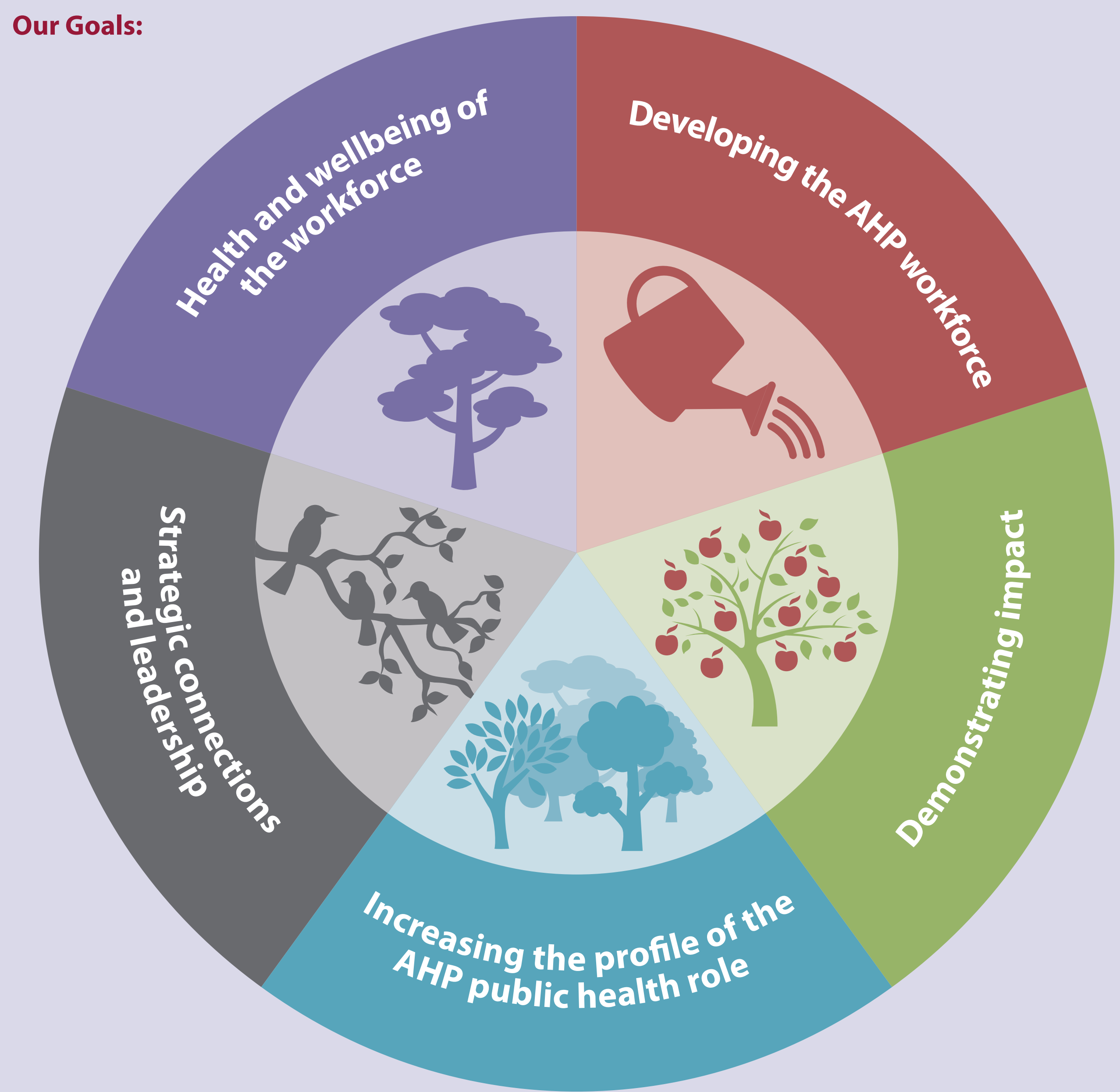
[1]A system leader works with the leaders of other teams and organisations to create mutually beneficial change.

[2]Upstream refers to a preventative approach of intervening earlier to prevent future ill health and minimise long term demand for services

The AHP Public Health Vision

Our vision is that AHPs will improve population health, public health will be a core element of all AHP roles and the impact of AHPs on the population's health and reducing health inequalities will be increasingly recognised.

Our Goals:



Our Goals

1. **Developing the AHP workforce:** The AHP workforce will have the skills, knowledge and behaviours to promote, improve and protect the health and wellbeing of individuals, communities and populations.

2. **Demonstrating impact:** AHPs will be able to demonstrate their contribution to improved population level health outcomes through robust evaluation and research.

3. **Increasing the profile of the AHP public health role:** AHPs will be recognised as valuable public health experts through ongoing profile raising of the AHP contribution to public health.

4. **Strategic connections and leadership:** Effective relationships will exist between AHPs and system leaders at local and national levels to make best use of AHPs to improve public health and reduce health inequalities.

5. **Health and wellbeing of the workforce:** The expertise of AHPs will be used to protect and improve the health and well-being of the health and care workforce.

Achieving Our Goals

The four nations and all AHP professional bodies have agreed the following priority actions to achieve our goals. We will work independently and collectively to develop detailed implement plans for 2019 - 2024:

Goal 1 - Education and developing the AHP workforce

The AHP workforce will have the skills, knowledge and attributes to promote, improve and protect the health and wellbeing of individuals, communities and populations.

We will:

- Work with educational institutions, regulators, employers and professional bodies to ensure public health, prevention and reducing health inequalities are further integrated into AHP pre and post registration education, including practice based education.
- Support AHPs to champion and take ownership of new public health solutions through innovation, research and entrepreneurship, and disseminate and communicate that value widely.
- Advocate for public health competencies as a core part of all AHP job roles.
- Ensure AHPs have opportunities to develop the skills required for advanced public health roles.

Goal 2 - Demonstrating impact

AHPs will be able to demonstrate their contribution to improved population level health outcomes through robust evaluation research.

We will:

- Support increased use of tools to measure and report the impact of AHP interventions on population health and health inequalities.
- Support return on investment analysis of effective interventions backed by good evidence to demonstrate the value of AHP public health interventions.
- Advocate for public health research within the AHP research community and signpost AHPs to relevant funding opportunities to stimulate new contributions to the public health evidence base.
- Create and promote evidence to support the scaling up of effective AHP-led public health interventions and to support the shift of AHP practice to earlier and preventative interventions.
- Provide a repository of public health resources to support AHPs.

Goal 3 - Increasing the profile of the AHP public health role

AHPs will be recognised as valuable public health experts through ongoing profile-raising of AHP contribution to public health.

We will:

- Develop strong and regular messaging to AHPs and external partners about progress across all four nations.
- Promote the work of AHPs in public health through local and national conferences and in publications, planning and policy documents.
- Sponsor and promote awards to recognise how AHPs are working in partnership with others to improve the health of the public.
- Capture, disseminate and support the spread of high quality, evidence based case studies of AHP initiatives that contribute to public health and tackle health inequalities.

Goal 4 - Strategic connections and leadership

Effective relationships will exist between AHPs and system leaders to make best use of AHPs to improve public health and reduce health inequalities.

We will:

- Support AHPs to develop the leadership skills to articulate their contribution and influence the public health, preventative and early intervention agenda.
- Support AHPs to develop stronger relationships with system leaders and facilitate mechanisms to enable access to relevant AHP expertise in public and population health.
- Promote integration of AHPs across the health and social care system to increase co-production with people, partners and communities; supporting place based public health.

Goal 5 - Health and wellbeing of the workforce

The expertise of AHPs will be used to protect and improve the health and well-being of the health and care workforce.

We will:

- Ensure that the AHP workforce is encouraged and supported to protect and improve their own health and wellbeing and that of their colleagues.
- Champion AHPs as leaders in the development of initiatives that promote workplace wellbeing.
- Promote the contribution of AHPs as core members of health and wellbeing/work based services to promote health and wellbeing of employees in their workplace.

Next Steps

The collaborating partners (including professional bodies) of this document will provide strategic leadership to oversee the implementation of this strategic framework and, where appropriate, integrate actions with the work of other partner organisations. We will develop nation specific and collaborative implementation plans to embed this strategic framework across all nations and professions. Implementation plans should clearly identify how success will be measured in relation to each goal.

The collaborating partners commit to:

- Pledge to working together and share learning wherever and whenever it makes sense to do so, including an ongoing relationship across the four nations.
- Developing nation specific implementation plans including methods to measure success.
- Providing strategic leadership to oversee implementation of the strategic framework across professional bodies.
- Developing a suite of public health resources for AHPs.

We call on AHPs to continue to embed public health within their roles, services and partnerships.

To cite this document:

Allied Health Professions Federation. UK Allied Health Professions Public Health Strategic Framework 2019-2024. 2019.

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Public Health
England

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Llywodraeth Cymru
Welsh Government

Scottish Government
Riaghaltas na h-Alba
gov.scot

HSC
Public Health
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AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

A STRATEGY FOR THE DEVELOPMENT OF PSYCHOLOGICAL THERAPY SERVICES

November 2009

FOREWORD

I am delighted to launch *A Strategy for the Development of Psychological Therapies in Northern Ireland*. In doing so, I believe that improving access to psychological therapies has huge potential to improve outcomes for individuals, families and carers, and for the wider community. This psychological therapies strategy is part of my commitment to *Delivering the Bamford Vision – Action Plan (2009-11).*

Improving provision of psychological therapies makes good sense. It can, for example, help individuals and families by providing early psychological interventions and, for established conditions, much can be done to relieve anxiety, depression and distress.

It is expected that psychological therapy services will be integrated into stepped care models for provision of mental health and learning disability services. In addition, links need to be made to other services for other long-term conditions, neuro-disability and challenging behaviours.

This strategy highlights the need for information to be available to the public on what services and interventions are available to them. I aim to promote early intervention, self help and support in the community, but I also recognise the need for specialist services for people with complex conditions, particularly those arising from mental health and learning disabilities.

Services will need to be redesigned around the needs of individuals. Regardless of the settings in which these services are delivered, they will be person-centered and flexible. In addition, services will be delivered to agreed principles and standards, and by competent and skilled staff, who are appropriately supervised and accredited by relevant professional bodies.

The recommendations contained within this document will have far reaching implications for the commissioning and provision of psychological services, not just in the statutory sector, but also in the community and independent sectors.

Relevant actions within the Bamford Action Plan (2009-2011) are being implemented through the HSC Bamford Taskforce, which is jointly led by the HSC Board and Public Health Agency. Through this mechanism, I expect to hear of timely progress to implement the recommendations contained in this strategy.

Michael McGimpsey MLA

Minister for Health, Social Services & Public Safety

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EXECUTIVE SUMMARY

INTRODUCTION

This strategy has the overarching aim of improving the health and social wellbeing of the population of Northern Ireland by improving access to psychological therapies and by being more responsive to service user's needs.

Many people in our society suffer from debilitating conditions, as a consequence of their relatively poor physical, emotional, behavioural and/or mental health. These can affect all age groups, for example, children and young people with emotional and behavioural disorders, young mothers with depression and adults of working age who, because of their ill-health may have relationship difficulties and find it hard to support their family and hold down a job. Older people too may have psychological problems, including those arising from their physical disease and from social and mental health conditions, such as isolation, depression, anxiety and bereavement. In addition, it is acknowledged that carers need psychological support, to maintain and improve their mental health and to assist them to look after their loved ones with long-term physical, mental health and learning disabilities.

Improving mental wellbeing in our society, through improved access to psychological interventions makes good sense. It can help individuals and families, for example, through early intervention and, for established conditions, much can be done to relieve anxiety, depression and distress regardless of the cause of the underlying condition. Psychological interventions can help people to be independent and to live as valued members of their community.

Even in economic terms psychological interventions have benefits, for example, by improving an individual's physical and mental health outcomes, their ability to work and be economically productive. In addition, improved mental and social wellbeing can help prevent anti-social behaviour and family breakdown in children and young people, reduce the burden of anxiety and depression, and input into the rehabilitation of offenders. Also, by assisting in the maintenance of independence it can reduce reliance on medication and on residential and hospital care.

How to Read this Document

This document is divided into sections with recommendations contained throughout the sections and summarised below.

SECTION 1 – This section outlines the aims and objectives of the strategy. The strategy mainly relates to adults and older people's mental health services, child and adolescent mental health services, and learning disability services. However, it is envisaged that appropriate links will be made to other services such as forensic mental health services, physical and neuro-disability services including challenging behaviour.

The strategic context for development of this strategy in the *Bamford Review of Mental Health and Learning Disability (2007)* and the DHSSPS *Delivering the Bamford Vision- Action Plan (2009-11)*. In addition, it is acknowledged that 40 years of civil unrest has led to much Troubles related trauma. The impact of disability on individuals, families and society can be profound, not just in human cost but also in economic cost.

SECTION 2 – This section contains a definition of psychological therapies and further outlines the scope of the strategy. Psychological therapy services should be a core component of mental health and learning disability service provision and should be delivered by staff with the appropriate skills and competence relevant to the level of interventions required.

The strategy recognises the importance of evidence based interventions and the need to translate evidence base into practice. In doing so, it acknowledges that evidence base can change; hence, commissioning and service provision should also change to reflect modern evidence-based practice. The current service provision within HSC organisations and primary care is highlighted. It is recognised that the community, voluntary and independent sectors play a valuable role in service provision. Further detailed mapping of current capacity/demand will be required across primary, community and secondary sectors.

SECTION 3 – This section outlines the principles for service commissioning and highlights that there should be a service specification for the commissioning of

psychological therapy services, recognising the importance of national and regionally agreed standards and guidelines. Psychological therapies should be embedded into stepped care models for service provision. Services should be tailored to individual needs, and low and high intensity interventions provided by a range of professionals with the skills and competence to do so. Where appropriate, staff should be accredited and registered with relevant professional organisations and regulatory bodies.

SECTION 4 – This section deals with the operationalisation of the stepped care models and emphasises the need to incorporate psychological services into relevant settings. There should be agreed threshold criteria and referral pathways for access to HSC secondary care/specialist services which should have a single point of entry with appropriate triage and/or assessment to ensure that referrals are directed to the appropriate service/level of intervention. Examples of stepped care models for adult mental health psychological services, child and adolescent mental health and learning disability services are provided. These aim to highlight what types of interventions are delivered at the various steps and by whom.

SECTION 5 – This section deals with workforce issues and highlights the need for new ways of working and workforce development to ensure that psychological therapy services are successfully delivered. Staffing requirements are highlighted together with the need to have adequate training, accreditation and a supervision framework in place to promote safe and effective care.

SECTION 6 – This section focuses on implementation of the strategy and the need for further research. A Regional Psychological Therapies Group will take forward the recommendations, under the auspices of the HSC Bamford Taskforce which is jointly led by the HSC Board and Public Health Agency. Ongoing monitoring and evaluation of the strategy will be essential to take account of clinical and cost effectiveness, improved accessibility, workforce governance, service user and carer experience and satisfaction.

RECOMMENDATIONS

This Strategy makes the following recommendations:

1. **The provision of psychological therapies should be a core component of mental health and learning disability services. Services should be delivered by staff with the skills and competence appropriate to the level of interventions required, and to national and regionally agreed standards and guidelines.**

2. **Recognising the importance of psychological interventions, if a new care pathway or service framework is being developed, due consideration should be given to the inclusion of psychological therapies within the pathway and service standards.**

3. **The public, service users and clinicians should have information on the range of psychological therapy services that are available and how to access them.**

4. **In order to fully understand current service provision in primary and community settings, a detailed map of current capacity/demand and associated workforce skills is required in:-**

   a) **adult mental health, and learning disability services;**
   b) **child and adolescent mental health services; and**
   c) **child and adolescent learning disability services.**

5. **A detailed map of the remaining specialist/secondary psychological therapy services is required, to ensure that those with more complex difficulties and/or severe and enduring mental health or learning disability needs also have access to appropriate specialist services. This mapping exercise will need to link into forensic mental health/learning disability services for both adults and young people, and physical, neurological disability and challenging behaviour services.**

6. **The HSCB/PHA should develop an agreed service specification for the commissioning of psychological therapies, taking account of the service principles outlined in this document, and national standards and guidelines.**

7. **Trusts should re-design mental health and learning disability services around a stepped care model with access to psychological therapy services at all levels.**

8. **Each Trust should have a single point of access for HSC secondary care/specialist services informed by agreed threshold criteria and referral pathways, which should incorporate appropriate processes for triage and/or assessment to ensure that referrals are directed to the appropriate service/level of intervention.**

9. **Professional and cross-professional workforce reviews, which are of strategic significance in improving access to psychological therapies, should be implemented.**

10. **A consortium of stakeholders should be commissioned to agree a regional approach to training requirements, with particular reference to needs of therapists at the different levels within the stepped care model.**

11. **A supervision framework should be developed, which sets out the core competences and accreditation required for supervisors at the different levels of intervention.**

12. **Psychological therapy services should be subject to evaluation – to include therapeutic outcomes, safety and governance, cost effectiveness of service delivery and the views/experiences of service users and carers.**

13. **In line with the Bamford Action Plan (2009) a prioritised plan for research on mental health and learning disability should be developed**

and should incorporate measurement of effectiveness of psychological interventions.

14. Under the auspices of the Bamford HSC Taskforce, a Regional Psychological Therapies Group should be established to implement this strategy and to advise the Department on the future development of psychological therapy services across the lifespan. Where appropriate, the Group should recognise the importance of psychological interventions for other long terms conditions. The Group should be representative of commissioners, service providers, carers and users.

SECTION 1

Aims & Objectives of the Psychological Therapies Strategy

Strategic Context

The Impact and Cost of Mental Disability

AIMS AND OBJECTIVES OF THE STRATEGY

1.0 The Department of Health, Social Services and Public Safety (DHSSPS) has identified the development of psychological therapy services as an important element of its overall strategy to reform and modernise mental health and learning disability services.

1.1 This document provides a strategic framework for the development of these services, consistent with other strategies to improve health and well being, the management of long term conditions and the recommendations of the Bamford Review of Mental Health and Learning Disability(2007). In this context, the Strategy is part of the Bamford Action Plan produced by the DHSSPS in October 2009.

1.2 The aim is to provide a range of psychological interventions and services that are:

- Clinically effective;
- Safe;
- Cost effective;
- Comprehensive;
- Coordinated and user friendly; and
- Commissioned and delivered to a standard consistent with national and regionally agreed standards and guidelines.

1.3 The strategy has focused on the development of evidence-based psychological therapies and interventions, as defined in Section 2. However, it is recognised that a broad range of generic psychosocial interventions, delivered by health and social care professionals, make important contributions to secondary prevention, care and recovery in mental health services. These should be embraced and utilised, when translating the more specific recommendations of this strategy into operational frameworks.

1.4 The recommendations set out in this strategy will apply to psychological therapies provided across primary, secondary and community sectors to include Adult and Older People's Mental Health Services, Child and Adolescent Mental Health Services and Learning Disability Services. It is envisaged that they will link with other services such as Forensic Mental Health and Learning Disability Services and services for people with physical and neurological disabilities and challenging behaviour. The recommendations will apply to services provided by the statutory sector and to voluntary and independent sector services commissioned by the HSC.

STRATEGIC CONTEXT

1.5 The Bamford Review of Mental Health and Learning Disability (2007) noted the advances in the sophistication and range of psychological therapy services. It also highlighted that research shows that the use of certain therapies are effective in the treatment of particular conditions. However, it found that access to psychological interventions was extremely poor. A need for training across all mental health professional groups was identified to develop the skills of therapeutic relationship building. At the same time there was a need to use evidence based psychological therapies.

1.6 The Bamford findings reflect the impact of Troubles related trauma on both the adult and adolescent population in Northern Ireland and the ad hoc way in which psychological therapy services have developed.

1.7 Almost 40 years of civil unrest during the Troubles continues to impact on society, with services becoming more aware of the impact of trans-generational trauma on children and families. The psychological impact of the Troubles is difficult to estimate for many reasons; however, evidence suggests that significant numbers of people within the population have been psychologically affected by the conflict, with estimates of one in five people having suffered multiple experiences relating to the Troubles and one in ten have been bereaved as a result of the Troubles. Related to this, Bamford

reported an estimated 25% increased psychological morbidity within Northern Ireland compared to neighbouring jurisdictions.

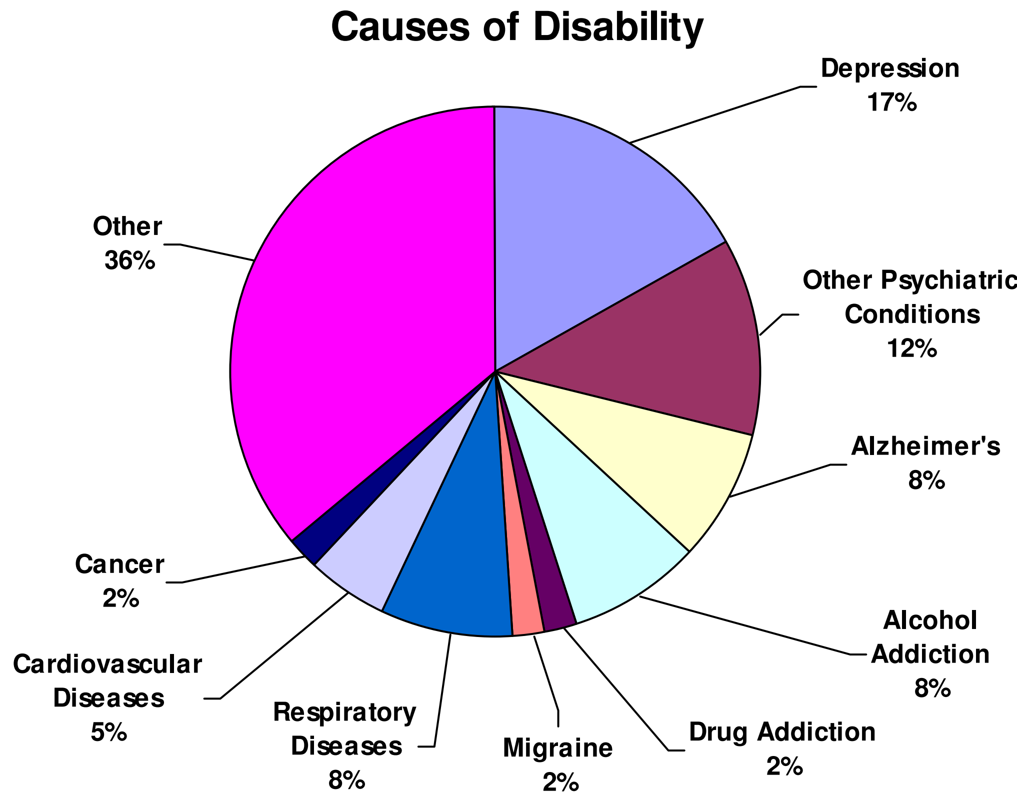
1.8 The Bamford Review highlighted that part of the problem has been that there is no overall framework that acknowledges the effectiveness of psychological interventions on health and wellbeing in Northern Ireland; describes the current service gaps; highlights the settings in which they should be available; and documents the training, competencies, supervision and accreditation which commissioners should take account of when commissioning services.

1.9 In response to the Bamford findings, this document aims to provide a template for moving forward on improving access to psychological interventions. The Strategy is underpinned by an additional investment over the Comprehensive Spending Review 2008-2011 (£7m recurrent). In addition, the Department has included in its 2008/09 and 2009/10 Priorities for Action targets to reduce waiting times for psychological therapy to a maximum of 13 weeks.

THE IMPACT AND COST OF MENTAL DISABILITY

1.10 The impact of disability on individuals, families and society can be profound. For individuals, the suffering and mental anguish arising from mental disability can be extreme. Professor Lord Layard in the *Depression Report* (2006) highlighted how crippling depression and anxiety can be on individuals and our society, and how psychological interventions are both clinically and cost-effective; thus requiring major investment. This is supported by the National Institute for Health and Clinical Excellence (NICE) which acknowledges the place of psychological interventions in a range of physical conditions in addition to the management and treatment of mental health including depression and chronic anxiety conditions.

Figure 1 - Causes of Disability



1.11 *Figure 1* above shows how important mental ill-health, in its broadest sense, is on disability – accounting for over 40% of all disability. Layard et al found that while depression and anxiety accounted for a third of all disability, they attracted only 2% of NHS expenditure.

1.12 Not only does mental ill- health impact on individuals, families and carers, but it also has economic consequences. The cost of mental ill-health to the economy of Northern Ireland as a whole is huge. A 2003 study undertaken by the NI Association for Mental Health and the Sainsbury Centre for Mental Health *'Counting the Costs: The Economic and Social Costs of Mental Illness in Northern Ireland'* found that the cost of mental illness in NI in 2002/03 was £2.8bn. In the same year the total budget for DHSSPS was £2.4bn.

1.13 In addition, figures from the Department of Social Development show that Mental ill health remains the main cause of incapacity with nearly 44% of claimants having mental health or behavioral disorders*

1.14 Improving access to psychological therapies does not necessarily mean that the need for medication will reduce. However, for some service users it does provide an alternative to the need for reliance on medication.

1.15 The table below highlights the number of prescriptions and annual community prescription costs for antidepressants and anxiolytics in Northern Ireland for 2006-2008.

Year	Number of Prescriptions	Ingredient Cost Before Discount
2006	2.04m	£22m
2007	2.2m	£21m
2008	2.24m	£20m

*Department for Social Development: Incapacity Benefit and Severe Disablement Allowance Summary Statistics February 2008

SECTION 2

Definition of Psychological Therapies

Scope of this Strategy

Psychological Interventions- What works? - Applying the Evidence Base

Current Service Provision of Psychological Therapies

DEFINITION OF PSYCHOLOGICAL THERAPIES

2.0 In this document the term psychological therapies means "an *interpersonal process designed to modify feelings, cognitions, attitudes and behaviour which have proved troublesome to the person (or society) seeking help from a trained professional (STRUPP)*. They encompass a range of interventions, based on psychological theory and evidence, which help people to alter their thinking, behaviours and relationships in the present, and process trauma and disturbance from the past, in order to alleviate emotional distress and improve psychosocial functioning.

THE SCOPE OF THE STRATEGY

2.1 The main focus of this document is on psychological therapy services and interventions in the context of commissioning and provision of HSC services in primary, community and secondary care, and training, with particular reference to:-

- adult mental health services, including older adults;
- child and adolescent mental health services, and associated family services;
- learning disability services (adults and children and young people);
- forensic mental health and learning disability services; and
- services for people with physical and neurological disability, especially where it links to mental ill-health, learning disability and challenging behaviour.

2.2 Psychological therapy provision is a multi-professional and multi-agency endeavor. Psychiatrists, psychotherapists, psychologists, counsellors, nurses, social workers, occupational therapists, arts therapists and many other groups are involved, all of whom need to communicate and co-ordinate effectively with one another. Therapy can also be provided by a range of practitioners in the voluntary and independent sectors.

2.3 Psychological therapies/interventions should be available to all age groups in a variety of settings and for a range of physical, emotional, psychological and psychiatric conditions. Their purpose is to provide effective treatment and promote individual, group and family wellbeing and resilience.

2.4 It is recognised that service providers should work in partnership with families and carers of service users as they play an extremely important role in helping the recovery process and preventing relapse in certain conditions. The contemporary model of Family Work aims to educate families and carers about the presenting condition, its management and treatment and its impact on family functioning. This work aims to empower families in enhancing/developing coping strategies, family well-being, maintaining and extending social networks, managing/coping with a crisis and, where appropriate, recognising early signs of relapse.

2.5 The Bamford Review also recognised the importance of the recovery model for those with mental health conditions. Psychological therapies are an integral part of this recovery model and need to be integrated into individual care plans. In addition, it is recognised that psychological therapy intervention can play a significant part beyond the health and social care sector, for example, in schools and youth settings, and in the youth and adult justice systems. It is acknowledged that many services are delivered outside of the statutory system.

2.6 Outside of designated mental health services, psychological therapies have been shown to be beneficial in a range of other conditions, including chronic physical health conditions, long term neurological conditions including acquired brain injury, bereavement and terminal care. They can also assist and support families and carers. Recognising the breadth of conditions that can be assisted by psychological interventions, it is recommended that: during the course of development of a new care pathways and service frameworks, especially for life long physical health conditions, due consideration should be given to the place of psychological therapies within the pathway and service standards

2.7 The place of community, voluntary and independent sector is pivotal and, irrespective of which sector provides the service, standards for service delivery, training, accreditation and supervision should be comparable with relevant national standards and guidelines and local governance arrangements for the commissioning of services.

RECOMMENDATION 1

The provision of psychological therapies should be a core component of mental health and learning disability services. Services should be delivered by staff with the skills and competence appropriate to the level of interventions required, and to national and regionally agreed standards and guidelines.

RECOMMENDATION 2

Recognising the importance of psychological interventions, if a new care pathway or service framework is being developed, especially for other life-long physical health conditions, due consideration should be given to the inclusion of psychological therapies within the pathway and service standards.

PSYCHOLOGICAL INTERVENTIONS – WHAT WORKS? - APPLYING THE EVIDENCE BASE

2.8 The concept of "evidence base", in relation to new treatments and interventions in health and social care, refers to the research to support the claimed benefits of a particular treatment, intervention or medication when used in the management of a particular condition.

2.9 This evidence-based approach seeks to embed research findings into the design, commissioning and practice of services acknowledging that findings may include different outcomes such as - effectiveness, acceptability, safety or quality and also different research methodology (e.g. randomised controlled trials, systematic reviews or qualitative research) all of which have their own validity.

2.10 It is fundamental that the evidence based approach adopted should be broad enough to accept the inevitable limitations in respect of the wide variety of individuals, types of intervention, conditions and settings to which it is applied. Nevertheless, there are several key sources for evidence based practice, e.g. locally endorsed guidelines from the National Institute for Health and Clinical Excellence (NICE) along with emergent and rapidly growing new evidence across the full range of psychological interventions.

2.11 A range of psychological therapies and interventions as applied to adults and older adults, child and learning disabled populations have an increasing evidence base as reflected in NICE and other national guidelines. These have been derived from four schools of psychological therapy (as outlined in **Appendix A** and defined in the National Skills for Health Initiative):

- Cognitive Behavioural Therapy;
- Psychodynamic/Psychoanalytic Psychotherapy;
- Systemic and Family Therapy;
- Humanistic Psychotherapies.

2.12 National occupational standards, and in specific cases protocols, from these models of therapy have been developed for specific problems and contexts. Thus, a range of psychological interventions, derived from these therapy models, have an evidence base and have relevance for the multiple presentations which present to adult, older adults, child and adolescent, and learning disability services. Especially for the complex and co-morbid presentations, including individuals with severe mental illness, specialist training in appropriate therapeutic models will be required, together with the capacity to tailor and integrate interventions from a range of therapeutic perspectives.

2.13 There is now a strong evidence base for the use of psychological therapy services in the treatment of a wide range of conditions particularly for mental health. **Appendix B (1&2)** provides an overview of relevant National Institute

for Health and Clinical Excellence (NICE) guidance on psychotherapeutic interventions for common mental health disorders in children and adults.

These include:

- depression;
- bipolar disorders;
- generalised anxiety states and panic disorders;
- schizophrenia;
- post traumatic stress disorder;
- obsessive compulsive disorders;
- anorexia nervosa and bulimia nervosa;
- self harm; and
- personality disorders.

2.14 In order to make informed choices about the most appropriate therapy to access in relation to a particular need or specific health condition the public, service users and clinicians should have information on the range of psychological therapy services that are available and how to access them.

2.15 Individuals with established and enduring mental health conditions, including those who are inpatients, must also benefit from the provision of information.

RECOMMENDATION 3

The public, service users and clinicians should have information on the range of psychological therapy services that are available and how to access them.

CURRENT SERVICE PROVISION OF PSYCHOLOGICAL THERAPIES

2.16 Attempts to establish the number of professionals and range of therapies being delivered across Northern Ireland have been problematic. This is because staff can only be identified by job title/profession, for example, Psychiatrist, Clinical Psychologist, Social Worker etc., rather than the range of psychological services and therapies they provide. However, Northern Ireland data in 2008/2009 found that there were:

- 158 clinical psychologists, 90 trainee clinical psychologists and psychology assistants;
- 103 established consultant psychiatrists posts in HSC services;
- over 60 other therapists specifically employed within Trusts to provide therapies for a range of conditions;
- 10 designated family therapy posts within CAMHS services, with half of these based in the Regional Family Trauma Centre; and
- 7 qualified Child and Adolescent Psychoanalytic Psychotherapists(CAPt)in NI, 3 of whom are employed in designated HSC child and adolescent posts in two Trusts.

2.17 In addition to the above, there are other staff who provide psychological interventions but who do **not** have this specifically identified **in their job title or description** – for example, psychiatric nurses, social workers, occupational therapists, and a range of therapists. Such professionals will often have completed post-qualification training in, for example, cognitive behaviour therapy, interpersonal psychotherapy, schema therapy, narrative therapy, family therapy, art therapy, child psychoanalytic psychotherapy. It is likely that the therapeutic interventions provided by these professions will vary depending on the services in which they are employed.

2.18 In the context of mental health and learning disability services, there is also a range of HSC commissioned services from the voluntary and independent sectors where staffing levels and the range of psychological interventions and skills available are not well documented. Therefore, attempts to scope have also been difficult.

2.19 Until recently in general medical practice (GMS), there have been no formal therapy services directly available within practice. From 2009, the DHSSPS has provided the funding to introduce computerised cognitive behavioural therapy into every general practice in Northern Ireland. This "Beating the Blues" programme is endorsed by NICE and is primarily designed to treat mild to moderate depression. It is currently being rolled out in GMS and the expectation is that it will be available soon in every general practice in Northern Ireland. It will be available for access by patients and supported by therapists, as appropriate. In addition, a Directly Enhanced Service for depression has also been introduced into general practice. This will provide additional resources for GPs to access counselling services that meet defined standards and recognised accreditation.

2.20 All of the above information indicates that further detailed work is required to fully understand current service provision and its links to respective programmes of care, including primary and community care, and specialist secondary services.

RECOMMENDATION 4

In order to fully understand current service provision in primary and community settings, a detailed map is required of current capacity/demand, and associated workforce skills in:-

a) adult mental health, and learning disability services;
b) child and adolescent mental health services; and
c) child and adolescent learning disability services

RECOMMENDATION 5

A detailed map of the remaining specialist/secondary psychological therapy services is required, to ensure that those with more complex difficulties and/or severe and enduring mental health or learning disability needs also have access to appropriate specialist services. This mapping exercise will need to link into forensic mental health/ learning disability services for both adults and young people, and physical, neurological disability, and challenging behaviour services.

SECTION 3

Principles for Commissioning of Psychological Therapy Services

A Stepped Care Model for Mental Health and Learning Disability Services

Integrating Psychological Therapies into a Stepped Care Model

PRINCIPLES FOR COMMISSIONING OF PSYCHOLOGICAL THERAPY SERVICES

3.0 It is recognised that psychological therapies can be delivered in a range of settings and by staff with different professional backgrounds, for example, psychologists, nurses, occupational therapists, social workers, psychiatrists, counsellors, family therapists and arts therapists. Interventions can be provided by the statutory, voluntary, and independent sectors. But regardless of the profession, the background, the setting, or the sector in which it is delivered the service principles for commissioning and delivery of therapies should be broadly the same.

3.1 The key service principles which service commissioners and providers in the statutory, voluntary, and independent sectors should work to are outlined below. What is needed to underpin the delivery of effective and safe therapy services is:

- <u>Access</u> – to psychological therapies appropriate to age, diagnosis and severity of the condition. Services should be flexibly delivered and take account of local needs, complexity of conditions and available resources; services should follow a stepped care model.
- <u>Information</u> – information in an appropriate format on treatments available, how to access services and likely waiting times should be provided to service users and carers to inform decision making.
- <u>Involvement in decision making</u> – service users need to be involved in decision making about their care. To do this not only involves provision of information but also needs to be condition specific and relevant to the age of the individual.
- <u>Safe and effective evidence based interventions</u> – like any other treatment, psychological therapies can have the potential to do harm; hence there is a need to develop a number of service and quality standards and outcome measures to promote effective practice.

Ideally, such services should be capable of being bench-marked against other comparable services.

- Trained staff and appropriate supervision arrangements- there is a need for an agreed approach to effective selection criteria, recruitment, training and supervision arrangements to provide therapies at all steps of psychological interventions.

- Evaluation criteria – measurement of outcomes should be able to demonstrate, for example, access to services in primary, community and hospital settings, improved patient outcomes in terms of health and wellbeing; promotion of social inclusion, improvement in employment status and, service user/carer satisfaction and experience.

3.2 To ensure psychological therapy services are provided to the same standard across all service sectors throughout Northern Ireland it is recommended that the HSC should develop an agreed service specification for relevant therapies, taking account of the service principles contained in this Strategy.

RECOMMENDATION 6
The HSCB/PHA should develop an agreed service specification for the commissioning of psychological therapies, taking account of the six service principles outlined in this document, and national and regionally agreed standards and guidelines.

A STEPPED CARE MODEL FOR MENTAL HEALTH AND LEARNING DISABILITY SERVICES

3.3 From 2009 onwards, mental health and learning disability services will be structured around a stepped care model. This model provides a framework for the organisation and delivery of mental health and learning disability services with the aim of ensuring that individuals receive the level of required support and/or intervention appropriate to their need. The rationale for this model is to ensure that the best intervention is delivered in the right place, at the right time, by the right person to meet a person's assessed needs. Psychological therapy services should be an integral part of the stepped care

model for delivery of mental health and learning disability services. It is recommended that Trusts should re-design services around a stepped care model ensuring that psychological therapy services form an integral part.

RECOMMENDATION 7

Trusts should re-design mental health and learning disability services around a stepped care model with access to psychological therapy services at all levels.

INTEGRATING PSYCHOLOGICAL THERAPY SERVICES INTO A STEPPED CARE MODEL

3.4 Typically there are 4-5 steps in a stepped care model. It is organised around definitions of psychological need.

Step 1 – Recognition and assessment of an individual's difficulties - this might require early recognition, watchful waiting and general advice;

Step 2 – Treatment for transient and mild disorders – this might require low intensity interventions such as psycho-education, guided self help, brief counselling and computerised cognitive behavioural therapy;

Step 3 – Treatment for moderate disorders – this might require access to specialist services such as cognitive behaviour therapy, interpersonal psychotherapy etc.; and

Step 4-5 Treatment for severe and complex disorders – this might require high level specialist services, capable of delivery of integrative and individually tailored psychological interventions.

3.5 The nature and intensity of therapy services will depend on individuals' needs. At lower steps of the model, a range of "low intensity" therapists may be utilised to deliver circumscribed interventions (with an evidence base) which

have been derived from the major models of therapy. These would address common mild mental health difficulties with limited impact on functioning using, for example, supported self-help, anxiety, management strategies etc. Low intensity therapists are crucial to the implementation of the stepped care model and will, therefore, require careful supervision and their own training programmes to ensure patient safety and governance.

3.6 At the higher steps of care (sometimes referred to as high intensity workers) staff should have accredited and/or regulated training to a higher level. They would use standardised psychological therapies, delivered to protocol, to address those common moderate mental health problems that impact significantly on functioning.

3.7 High intensity specialists will be expected to have received accredited and/or regulated training in one or more of the major psychological therapies to deliver these therapies to individuals with moderate to severe mental health problems including, for example, Schizophrenia, Personality Disorder, Bi-Polar Disorder, Substance Misuse. Psychological services for those service users with complex and enduring mental health problems and high levels of co-morbidity, will require highly specialist individually tailored interventions informed by theoretical and therapeutic models. Such services will be delivered by highly specialist professionals, trained in a range of psychological and therapeutic models to formulate and manage complex problems.

SECTION 4

Operationalising a Stepped Care Model

A Stepped Care Model for Adult Mental Health Conditions

A Stepped Care Model for Children and Young People

A Stepped Care Model for People with a Learning Disability

OPERATIONALISING THE STEPPED CARE MODEL

4.0 The previous section highlighted the need for the integration of psychological therapies into mental health and learning disability services. It described a generic model of stepped care. Implicit in this is the recognition that a stepped care framework needs to link across services, for example, into forensic mental health and learning disability services as well as physical and neurological disability services, and across the life span of the individual taking account of the need for seamless service transitions.

A STEPPED CARE MODEL FOR ADULTS MENTAL HEALTH CONDITIONS

4.1 This Section specifically addresses how such a stepped care model should work within adult mental health services. It describes the how adults with mental health conditions requiring psychological interventions can access services appropriate to their needs.

4.2 Until recently, Mental Health Services had multi access points with regards to referrals for initial assessments and/or psychological treatments. This caused difficulties for referrers and services users and carers, and did not represent the best use of limited resources.

4.3 In order to address these difficulties a transparent, streamlined approach is currently being adopted to ensure timely access to appropriate specialist services delivered in HSC Trusts. Building on this, Trusts are introducing single points of access for specialist services (step 3) and associated threshold criteria and agreed referral pathways. Inevitably this process will require some flexibility to ensure that service users receive the services they require and that they can move between services, as necessary. Therefore, it is imperative that services communicate well within the stepped care model putting the needs of service users at the centre of care.

RECOMMENDATION 8

Each Trust should have a single point of access for HSC secondary care/specialist services informed by agreed threshold criteria and referral pathways, which should incorporate appropriate processes for triage and/or assessment to ensure that referrals are directed to the appropriate service/level of intervention.

4.4 Independent and voluntary sector organisations who have contracts with HSC organisations and primary care will also continue to provide a range of psychological therapy services as part of commissioned arrangements for primary care, community and specialist services. All such contracts will be expected to comply with regionally agreed principles and standards for service provision.

4.5 The diagram below shows the generic stepped care model for adult psychological therapies as part of mental health services. It includes the range of therapies that are delivered at the different levels of intensity and the training and supervision required at the different levels of intervention.

Stepped Care Model of Psychological Therapies (Adult Mental Health)

Step	No. Pts.	Intensity	What Delivered?	Who Delivers / Training?
Step 1 Recognition and Assessment	↑	↓	• Early recognition/advice/support/watchful waiting	• Front line primary care staff – trained to monitor / screen for mental health difficulties – resourced with screening tool kits and liaison with single point of access centre. – Promote positive mental health and emotional wellbeing and use evidence based tool kits.
Step 2 Treatment for Mild Disorders			• Low intensity treatments (e.g. CCBT, brief behavioural and CBT, psycho education, guided self-help, group education, adjustment counselling, further assessment)	• Low intensity (LI) workers (Bands 4-5) – e.g. Assistant / Associate Psychologists, counsellors, mental health workers, OTs, nurses and SWs (Band 6 and above) • Leadership, governance and supervision provided by Band 7-8 Clinical Psychologists OR CBT therapists in ratio relationship to number of LI workers.
Step 3 Treatment for Moderate Disorders			• High intensity specific therapies - e.g. 10 + sessions of CBT or interpersonal; therapy for anxiety, depression, uncomplicated PTSD etc. • Circumscribed psychological therapies where there are evidenced based principles of treatment e.g. for agoraphobia, panic, phobias, adjustment to illness, recent onset non-organic presentations etc. • Supplemented by "single point of access" assessment service to direct to correct step as is appropriate level of intervention.	• High Intensity workers – e.g. Clinical Psychologists, CBT and IPT therapists with liaison from secondary care psychiatry when pharmacological adjuncts to therapy as required. • Capable of delivering CBT protocols for mood disorders, problem solving therapy, EMDR, exposure therapies etc.
Steps 4 – 5 Treatment for Severe / Complex Disorders			• Integrative or highly specialised therapies – e.g. co-morbid and complex presentations (e.g. mood, addictions, trauma, attachment disturbances, personality disorder; psychosis, conversion disorders, persistent self-harm, neurological). • Range of uni-modal, specialist therapies, plus capacity to integrate and fit therapeutic approach to patient where proceduralised pathways are absent or unlikely...	• Secondary care mental health teams comprised of Psychiatrists, Clinical Psychologists and other professions with specialist therapy training e.g. psychodynamic, CBT, systemic psychotherapy, Dialectical Behaviour Therapy, Cognitive Analytic Therapy etc. (all from the three main schools of therapy as specified in SFH); • Specialist psychotherapy services (e.g. for personality disorder, eating disorder, severe and complex presentations. • Psychosocial Interventions in severe mental illness including Psychosis, Schizophrenia and Bipolar disorder • Services will be supported by LI workers to deliver circumscribed elements of therapeutic programmes and psychological assessment.

A STEPPED CARE MODEL FOR CHILDREN AND YOUNG PEOPLE

4.6 Psychological interventions can provide positive long lasting outcomes for children, young people and their families, with longer term cost savings for the HSC, and improved outcomes in education, social care and youth justice systems. Areas requiring psychological interventions include children and adolescents with physical and mental health conditions, children affected by trauma and bereavement, eating disorders, substance abuse, acquired brain injury and other neurological conditions, autism spectrum disorders, learning disabilities and children and adolescents in care, fostering and adoption services and forensic services.

4.7 There is now considerable empirical evidence for the effectiveness of psychological therapies derived from the 4 major schools (see section 2.11) in relation to the following presentations:

- disturbances of conduct, attention and mood;
- psychosis;
- deliberate self harm;
- substance abuse;
- eating disorders;
- pervasive developmental disorders;
- long-term physical conditions; and
- unexplained physical presentations

4.8 Although, still evolving, the evidence base currently allows professionals and commissioners to match the appropriate psychological therapy and level of intensity required to the presenting condition. For example parent training programmes have been shown to be effective in managing mild to moderate conduct disorders in children under the age of 8, whereas for adolescents presenting with severe and enduring disturbance of conduct multi-systemic therapy is evidenced as being most effective. In general, behavioural and cognitive psychological therapies have a strong evidence base in relation to mood and behaviour disturbances, attentional problems, pervasive

developmental difficulties and eating disorders, with systemic and family therapy gaining an increasing evidence base in relation to eating disorders, substance abuse and long-term conditions (*Evidenced- Based Psychotherapies in Child and Adolescent Mental Health Practice*, ACAMH 2007; *Evidenced-Based Approaches to Child and Adolescent Mental Health*, ACPP 2003; *Drawing on the Evidence*, CAMHs Evidence Based Practice Unit, 2006).

4.9 Evidence for the effectiveness of psychoanalytic psychotherapeutic interventions in children and adolescents is also growing (Kennedy 2004), with studies demonstrating its effectiveness in relation to an ever increasing range of presentations.

4.10 As noted above the research and evidence base continues to expand and the applicability of the various psychological therapies to specific conditions described above should not be seen be exhaustive.

4.11 Child and adolescent mental health services are currently provided within a stepped/tiered structure (see below) that mirrors the stepped care approach being promoted in adult services. It is important that the organisational structures within the two areas can work together to allow the seamless transition from child to adult services. It should be recognized that children often require intervention from a number of tiers/steps, sometimes at the same time, in order to achieve the most effective treatment and care plan.

A TIERED/STEPPED CARE MODEL OF DELIVERY OF PSYCHOLOGICAL THERAPIES TO CHILDREN AND YOUNG PEOPLE

TIERED MODEL	STEPPED CARE MODEL/WHAT DELIVERED?	WHO DELIVERS?
TIER 1	• Children/young people/families present with psychological concerns • Vulnerable children and families identified ↓ STEP 1	• General Practitioners • Health Visitors • Adoption/Fostering Services • Midwives – acute and community
	• Advice/Support • Screening/Initial Assessment • Clear pathways of referral ↓	• Projects such as SURE START/ EXTERN • Social Services
TIER 2	STEP 2 • Mild Disorders • Low-medium Intensity Interventions • Group Psycho-education • Guided Self Help • Parent Training Groups • Behaviour Management Groups • Counselling ↓ STEP 3	• Community Paediatricians • Community Paediatric Nurses • Family Centres • PMHW • School Counsellors • Voluntary Organisations eg: PAPPA/NSPCC/Barnardos/New Life Counselling/Contact Youth • Social Services • Behaviour Therapists • Assistant/Associate Psychologists • Educational Psychology • Primary Care Workers
	• Moderate Disorders • High Intensity Interventions • Specialist Therapy Input • Specialist Assessments • ADHD/ASD Clinics • Specific evidence base therapies – CBT/EMDR • Assessments of needs of children in care homes ↓	• High Intensity Workers: Clinical Psychologists/Specialist PMHW/ CBT and IPT Therapists/Family Therapists/Child Psychotherapists/ Specialist SW/Specialist Community Paediatricians • Tier 3 Liaison
TIER 3	STEP 4 • Outpatient treatment for severe and complex mental health disorders • Personality Disorders • Services to Juvenile Justice • Specialist Child Care Centre • Specialist Services e.g.: eating disorders, drug & alcohol abuse • Complex co-morbid disorders e.g.: attachment/ASD/ADHD ↓	• Multidisciplinary child and adolescent mental health teams with specialist training in a range of therapeutic assessments and interventions • Child Psychiatrists, Clinical Psychologists, Family Therapists, Child Psychotherapists and other specialist trained therapists ↓
TIER 4	STEP 5 • Inpatient treatment for severe and complex mental health disorders/personality disorders	

4.12 In keeping with Bamford's recommendations the following principles should inform service developments:

- Children's services should provide for children and young people up to the age of eighteen;
- Early interventions for infants/children and their families are of strategic significance in terms of secondary prevention and such services should be promoted; and
- Historically, there has been a lack of service development within Tiers 1 and 2 of child and family services. Until this gap is addressed Tier 3 & 4 services will continue to be inappropriately utilized to cover this shortfall.

A STEPPED CARE MODEL FOR PEOPLE WITH A LEARNING DISABILITY

4.13 Learning disability is a life-long developmental disorder and categorised into 4 levels: mild, moderate, severe and profound learning disability. People with a learning disability have a high incidence of epilepsy, autistic spectrum disorder, sensory impairments and physical health conditions. They also have a higher incidence of mental health needs than the general population.

4.14 There is a significant and growing body of evidence that demonstrates the effectiveness of psychological therapies for people with a learning disability. This has demonstrated that such therapies are more effective and acceptable than pharmacological interventions for the management of a significant number of mental health difficulties.

4.15 However, simple adaptations to the implementation of traditional psychological therapies are often required when engaging with people with a learning disability. The degree of adaptation will be commensurate with the person's specific needs. For example, a person with mild learning disability

can participate in cognitive behaviour therapy with the adaptations noted above.

4.16 The current policy to support people with a learning disability in the community, rather than in a hospital setting, will shape the development of psychological therapy services and the training needs of staff delivering therapies. An adapted stepped care model will be required and an example is provided below.

AN EXAMPLE OF A STEPPED CARE APPROACH - LEARNING DISABILITY

Person with learning disability presenting to Learning Disability Service Diagnostic and Care Needs assessments completed

↓

STEP 1 – Low Intensity Intervention

Referral to Day Support and/or Residential Support services

Service Inputs
- provide structure and meaningful activity (to enhance self esteem, self efficacy, etc)
- promote and monitor mental health and emotional well-being
- availability of staff to provide emotional support, problem solving approaches to difficult life events etc

Review Arrangements
- Annual review & as required

↓

STEP 2 – Low-Medium Intensity Interventions - Community Learning Disability Teams

<u>Community Learning Disability Teams</u> <u>- Multidisciplinary Team – including Psychiatry, Clinical Psychology (Band 7/8a), Social Work, Community Learning Disability Nursing; Allied Health professionals, etc</u>

Service Inputs
- Monitor mental health & well-being
- Specific Interventions – for example
  - CNLD – assertive outreach for enduring mental illness
    – applied behavioural approaches
  - Social Work – psycho-education
    – counselling
    – problem solving approaches
  - Clinical psychology – targeted interventions (e.g. CBT; Applied Behavioural Analysis; Parent & Carer training,

Review Arrangements
- Monthly multidisciplinary Team review as required

↓

STEP 3 – High Intensity Intervention

Behaviour Support Service
Peripetetic Multi-Disciplinary Team (Clinical Psychology, Behaviour Nurse Therapists, Speech & Language therapist etc)
Target client group
- extreme/severe challenging behaviour
- risk to self &/or others
- subject to restrictive practices

Service Inputs
-Consultation Discharge
- Consultation Assessment & Intervention Programme
- Applied Behaviour Analysis
  - Assessment
  - Proactive strategies
  - Reactive strategies
  - Systemic interventions

Outcome Evaluations
Pre & Post measures
- Frequency & intensity of challenging behaviour
- Quality of life indicators
- Review of service capacity to meet client's needs

Review arrangements
- weekly multidisciplinary team meetings

Hear to Help Psychotherapy Service
- Multidisciplinary service – has included Clinical Psychology, Cognitive Behaviour Therapist, Psychoanalytic Psychotherapist; Therapeutic Social Worker; Speech & Language Therapist

Target Client Group
- Anxiety Disorders – PTSD, OCD, Phobias, etc
- Depression, self harm, suicide
Traumatic life events e.g. childhood sexual abuse, victim of crime/exploitation
- Complex bereavement reactions
- Substance misuse
- Offending behaviours incl sex offending/sexually harmful behaviours
- Anger management

Service Inputs
- Individual psychotherapy (CBT, Integrative approaches, Psychodynamic Therapy, Counselling, etc)
- Group Psychotherapy

Outcome Evaluation
Pre & Post measures + critical points in therapy
- Emotional Problem Scale
- Goals of therapy evaluation
- APES – measure of insight into problems

Review arrangements
- Blocks of therapy negotiated and reviewed (e.g. 10 sessions & review)

<u>Consultant Psychiatry and Clinical Psychology Services</u>

- Uni-professional service input

Consultant Psychiatrists
Target Groups
- functional and enduring mental illness
- organic disorders

Service Inputs
- Pharmacological interventions
- Individual & family based therapy

Consultant Clinical Psychology
Target groups
- complex and atypical mental health presentations
- severe challenging behaviour
- complex and dysfunctional social and support networks

Service Inputs
- multi modal behavioural interventions
- systemic based interventions
- cognitive, behavioural and integrative approaches

STEP 4 – Specialist High Intensity Intervention

↓

Step 4 – Specialist Inpatient Treatment – Referral to Muckamore Abbey Hospital
Target Group
- unstable mental health condition
- significant risk to self and/or others
- complex and unstable epilepsy
- medication review requiring inpatient care

SECTION 5

New Ways of Working – Workforce Development

Staffing Requirements

Training, Accreditation and Supervision

Links to Professional Regulatory Bodies

NEW WAYS OF WORKING – WORKFORCE DEVELOPMENT

5.0 Future development of psychological therapy services will require a competent workforce that has undergone required training in evidenced based therapies, augmented by robust supervision arrangements by appropriately trained and experienced professionals.

5.1 One of the key recommendations outlined in *Ten High Impact changes for Mental Health (2006)* is the "redesign and extension of roles in line with efficient service user and carer pathways designed to attract and retain an effective workforce". Therefore the training and development of the psychological therapy workforce will need to take account of New Ways of Working(2007) (NWW) in both mental health and psychological therapy services.

5.2 A fundamental aspect of NWW is to create a shift in the culture and language in health care contexts so that psychological ways of understanding people's distress become more common place amongst all professionals, and importantly that psychological intervention and therapeutic approaches are mainstreamed across primary, community and secondary care services.

5.3 Key elements of workforce development include:

- Up-skilling of the existing workforce with the requisite systematic and psychological therapeutic skills to maximise self help and recovery opportunities;
- Adaption of multi-professional and multi-sector approaches;
- Appropriate skill mix aligned to stepped care model with robust clinical supervision arrangements;
- Extended roles and the development of new practitioner therapist support roles;
- Integrated care, co-working and consultancy approaches;
- Partnership working through the sharing of skills and competencies across professional and practitioner boundaries; and

- New career pathways e.g. diploma/MSc training pathways for graduate assistant/ associate psychologists.

STAFFING REQUIREMENTS

5.4 New ways of working within the existing workforce is essential to ensure that a psychological therapies workforce is fit for purpose. However, the Bamford Review (2007) highlighted the relative underinvestment in psychological therapy services in Northern Ireland when morbidity and investment is compared to other juristictions.

5.5 Whilst the DHSSPS is not implementing the *Improving Access to Psychological Therapies (IAPT)* programme which is available in England, nonetheless the relevant documents produced by the Department of Health in England are useful tools to inform future staffing requirements and development. The following paragraphs highlight the need for additional resources to underpin the development of psychological therapy services in Northern Ireland. Figures specified below are consistent with estimates made by Bamford.

5.6 '*Improving Access to Psychological Therapy Services*' is designed to deliver NICE-compliant services to help people with depression and anxiety disorders. It estimates that for a population of 250,000 people with average levels of need some 40 trained therapists are needed. The programme recognises the need for a national training programme to provide the necessary number of trained therapists and enables the progressive expansion of local NICE - compliant services in primary care settings. The basic service model envisages a team of therapists taking referrals from GPs and delivering therapies at the required level in primary care or community settings.

5.7 Applying the IAPTS formula (40 therapists per 250,000) to a Northern Ireland population of 1.8m and using best estimates of current provision there is a need for an additional 180 practitioners for levels 1-3 (Primary and

Community service levels). For level 4 (specialist interventions) and level 5 (highly specialist interventions) it is estimated that a further 160 practitioners will be required.

TRAINING, ACCREDITATION AND SUPERVISION

5.8 Those working in psychological therapy services must have relevant training, accreditation and supervision to provide effective and safe services to standards required by relevant bodies.

5.9 Many professional staff, e.g. nurses, social workers, occupational therapists have already undergone training in psychological therapies. Others have obtained post-professional accreditation with recognised therapy bodies.

5.10 Work has already begun to address some of the training needs of a range of staff. For example, the University of Ulster has trained over 100 Health Service staff to certificate level in CBT. QUB has trained 25 staff to qualification level with a Masters qualification in Systemic Psychotherapy and more than 100 Health Service staff to Intermediate and Foundation levels and THORN training has been provided to a range of Health Service professionals, mainly nurses.

5.11 Child & Adolescent Psychoanalytic Psychotherapy (CAPt) is now an established clinical doctorate training programme, accredited by the Association of Child Psychotherapists (ACP), UK. The pre-clinical course has been available in NI from 2009.

5.12 Clinical Psychologists, whose training is commissioned from *The Queen's University Belfast*, constitute a substantial proportion of the psychological therapies workforce in Northern Ireland. In addition to training in theories and models of psychological illness and interventions, supervision and research skills, standards of proficiency and accreditation include competence in delivering CBT plus one other psychological therapy *across* the tiers and complexity of care.

5.13 Innovatively, the 2008 workforce plan for clinical psychology provides a template for *pre-qualification* training pathways at diploma/masters levels in order to populate an assistant and associate psychology workforce - at lower bands and intensity of intervention. This workforce plan is consistent with the stepped care model advocated in this strategy, and such new ways of working and training are encouraged across professional workforce reviews.

RECOMMENDATION 9

Professional and cross-professional workforce reviews, which are of strategic significance in improving access to psychological therapies, should be implemented.

5.14 The development of psychological therapy services will require a regional approach to training that is comprehensive and co-ordinated to ensure that practitioners have the necessary skills and competences to deliver the relevant therapy or interventions at the appropriate level in the stepped care model. Training approaches need to address the range of training needs from new therapists entering this field, existing healthcare professionals wishing to become skilled in a particular therapeutic intervention to those providing very specialist interventions.

5.15 It is recommended that; a consortium of stakeholders should be commissioned to agree a regional approach to training requirements, with particular reference to needs of therapists at the different levels within the stepped care model.

5.16 A complementary training programme for supervisors must also be implemented. It is recommended that: a supervision framework should be developed, which sets out the core competences and accreditation required for supervisors at the different levels of intervention**.**

RECOMMENDATION 10

A consortium of stakeholders should be commissioned to agree a regional approach to training requirements, with particular reference to the needs of therapists at the different levels within the stepped care model.

RECOMMENDATION 11

A supervision framework should be developed, which sets out the core competences and accreditation required for supervisors at the different levels of intervention.

LINKS TO PROFESSIONAL REGULATORY BODIES AND ASSOCIATED ISSUES

5.17 Psychological therapists are not equivalent across professional groups and training pathways. Traditionally psychological therapies have been delivered by chartered clinical and counselling psychologists, psychiatrists, psychotherapists and members of other professional groups (e.g. nurses, social workers, occupational therapists, arts psychotherapists) who have attained additional training in single modality psychological therapies, not part of their core professional training, accredited by relevant professional bodies. Psychiatrists and psychologists who have wished to develop further expertise in specific therapeutic modalities have also undertaken such additional training.

5.18 Whilst psychiatry will continue with statutory regulation by GMC and Royal College of Psychiatrists, applied psychologists (clinical, counselling, health, forensic, educational, occupational and sports and exercise) are subject to statutory regulation by the HPC as of 1st July, 2009, as well as professional accreditation by British Psychological Society for chartered status. It should be noted that arts psychotherapists are already regulated by the HPC. At the same time talks are ongoing to have non-medical psychotherapists regulated by the same body but the timescale for this is unclear at present.

5.19 With regard to services commissioned by the HSC from the voluntary and independent sectors, it is important that practitioners in these sectors are appropriately qualified/accredited and satisfy local service commissioning governance arrangements.

5.20 In relation to counselling services, the 2002 DHSSPS report *Counselling in Northern Ireland – Report of the Counselling Review* (commonly referred to as the 'Park' Report) identified a number of key issues in relation to local standards of counselling practice. These included, the need for statutory regulation; affiliation to a professional body; accreditation with a professional organisation; a rationalisation of training courses; undergoing regular supervision; using evidence based practice; befriending services should meet basic standards; and, those working with individuals affected by the Troubles should seek specialist training. The report's recommendations should inform the governance arrangements for the commissioning of local counselling services.

SECTION 6

Implementing the Strategy

Monitoring and Evaluation of Services

Promotion of Research

Development of a Regional Psychological Therapies Group

IMPLEMENTING THE STRATEGY

6.0 The Implementation of this strategy will need to be coordinated on a regional basis linking with all health and social care services to ensure the integrity of service provision throughout Northern Ireland.

6.1 Over the Comprehensive Spending Review period (2008-2011), an additional investment (£7 m recurrent from 10/11) in psychological therapies will provide opportunities for innovative change. However, the Bamford Vision recognised that additional investment would be required across mental health and learning disability services over a 10-15 year period to address historical underinvestment and increased need in the population of Northern Ireland. Ongoing monitoring and evaluation of psychological services is essential in order to inform further Comprehensive Spending Reviews.

MONITORING AND EVALUATION OF SERVICES

6.2 A service evaluation framework will be required to ensure timely implementation of the strategy and effective use of resources. The framework should evaluate services in terms of:

- Clinically effective evidence-based practice;
- Outcomes (e.g. measures of symptom reduction, improved psychological well-being, therapeutic outcomes and indices of social inclusion), recognising the complexity of individual presentation;
- Efficiency and cost effectiveness;
- Accessibility targets (e.g. waiting times, meeting targeted population etc);
- Governance of workforce (e.g. training and supervision policies); and
- Service user/carer experience and satisfaction.

RECOMMENDATION 12

Psychological therapy services should be subject to evaluation – to include therapeutic outcomes, safety and governance, cost effectiveness of service delivery and the views of service users and carers.

PROMOTION OF RESEARCH

6.3 Linked to evaluation is the recognition of the need for robust and scientific research to inform and expand the evidence base for effective psychological services and interventions. Therefore in line with the Bamford Action Plan 2009 a prioritized plan for research on mental health and learning disability should be developed and should incorporate measurement of effectiveness of psychological interventions.

RECOMMENDATION 13

In line with the Bamford Action Plan (2009) a prioritised plan for research on mental health and learning disability should be developed and should incorporate measurement of effectiveness of psychological interventions.

DEVELOPMENT OF A REGIONAL PSYCHOLOGICAL THERAPIES GROUP

6.4 The Department considers that the most effective way to implement this strategy is through the formation of a regional Psychological Therapies Group. This should be led by the HSC Board and Public Health Agency under the auspices of the Bamford HSC Taskforce. This Taskforce is designed to improve mental health and wellbeing, and enhance the emotional resilience of the population. It will oversee change in commissioning and service provision for mental health and learning disability services.

6.5 The Psychological Therapies Group will play a key role in delivering the Bamford Vision and will focus on:

- Mapping of current psychological therapy service provision to fully understand current capacity and future demand;

- Ensuring that psychological therapy services are embedded in commissioning arrangements to national and regionally agreed standards and guidelines;
- Improving access to psychological therapy services;
- Integrating psychological therapies in a stepped care model of mental health and learning disability services across the lifespan, recognising the need to link with other physical and neurological disability services including challenging behaviour and forensic mental health and learning disability services;
- Coordinating the work of the Psychological Training Consortium to embrace new way of workings, and associated training and supervision frameworks;
- Monitoring and evaluation of implementation of this strategy to include;
  - Organisation and delivery of psychological therapy services;
  - Accessibility;
  - Clinical Outcomes;
  - Cost effectiveness (acknowledging differing models and outcomes for people with complex and/chronic conditions);
  - Workforce governance (e.g. training and supervision);
  - Service user and carer experience and satisfaction; and
- Providing advice to the Department on the future development of psychological therapy services.

RECOMMENDATION 14

Under the auspices of the Bamford HSC Taskforce, a Regional Psychological Therapies Group should be established to implement this strategy and to advise the Department on the future development of psychological therapy services across the lifespan. Where appropriate, the Group should recognise the importance of psychological interventions for other long terms conditions. The Group should be representative of commissioners, service providers, carers and users.

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REFERENCE GROUP MEMBERSHIP

Dr Maura Briscoe	DHSSPS (Chair)
Joyce Cairns	DHSSPS
Dr Ian McMaster	DHSSPS
Colin McMinn	DHSSPS
Lord Alderdice	Psychological Therapy Centre, Knockbracken
Dr Stephen Bergin	Public Health Agency
Dr Cathal Cassidy	Chair, NI Division Royal College of Psychiatrists
Dr Michael Duffy	QUB
Mary Emerson	Head Occupational Therapist Western HSC Trust
Dr Kate Gillespie	NI Centre for Trauma and Transformation
Arlene Healy	Family Trauma Centre
Pauline Mahon	Child & Adolescent Psychoanalytic Psychotherapy (NI) Group
Bernard McAnaney	Western HSC Trust
Dr May McCann	Carer
Dr Chris McCusker	QUB
Dr Maria O'Kane	Chair, Faculty of Psychotherapy, Royal College of Psychiatrists
Tom O'Leary	GP
Isobel Reilly	Pathway Co-Ordinator Systemic/Family Therapy Training QUB
Dr Nichola Rooney	Chair, NI Division of Clinical Psychology
Rodney Morton	Programme Manager (Mental Health, Learning Disability & CAMHS) Performance Management and Service Improvement Directorate
Stephen Herron	Northen Ireland CBT Forum
Mary McShane	Deputy Associate Director Mental Health Nursing, BHSCT
Jean McMinn	British Association for Counselling and Psychotherapy
Anne Cunningham	CAUSE

APPENDIX A

Cognitive Behavioural Therapy

Cognitive and behavioural psychotherapies are a range of therapies based on concepts and principles derived from psychological models of human emotion and behaviour. They include a wide range of treatment approaches for emotional disorders, along a continuum from structured individual psychotherapy to self-help material. The term 'Cognitive-Behavioural Therapy' (CBT) is variously used to refer to behaviour therapy, cognitive therapy, and to therapy based on the pragmatic combination of principles of behavioural and cognitive theories.

(taken from http://www.babcp.com/about-cbt/ - British Association for Behavioural and Cognitive Psychotherapies)

Psychodynamic/Psychoanalytic Psychotherapy

The terms Psychoanalytic Psychotherapy and Psychodynamic Psychotherapy are used interchangeably. Psychoanalytic / psychodynamic psychotherapy can be used in a wide variety of conditions in which people have emotional or relationship difficulties and is not aimed at specific disorders.

(Taken from http://www.psychotherapy.slam.nhs.uk/Default.aspx?tabid=520 - SLAM Psychological therapies)

Psychoanalytic relationships are generated by the desire to find meaning as well as relief from psychological suffering. In psychoanalytic psychotherapy particular attention is paid to analysing transference and resistance issues, so that the patient is helped to find a more creative relationship between conscious and unconscious processes and to discover their own personal truths.

(Taken from http://www.psychotherapy.org.uk/analytical_psychology.html - UK Council for Psychotherapy)

Systemic and Family Therapy

Systemic Family Therapy provides effective help for people with an extraordinarily wide range of difficulties. The range covers childhood conditions such as conduct and mood disorders, eating disorders, and drug misuse; and in adults, couple difficulties and severe psychiatric conditions such as schizophrenia. Throughout the life span, it is shown to be effective in treatment and management of depression and chronic physical illness, and the problems that can arise as families change their constitution or their way of life.

(Taken from http://www.aft.org.uk/docs/evidencedocsept05creditedSS.doc - The Association for Family Therapy)

Humanistic, Person-Centred/Experiential Therapy

Person-centered therapy, which is also known as client-centered, non-directive, or Rogerian therapy, is an approach to counseling and **psychotherapy** that places much of the responsibility for the treatment process on the client, with the therapist taking a nondirective role. Two primary goals of person-centered therapy are increased self-esteem and greater openness to experience. Some of the related changes that this form of therapy seeks to foster in clients include closer agreement between the client's idealized and actual selves; better self-understanding; lower levels of defensiveness, guilt, and insecurity; more

positive and comfortable relationships with others; and an increased capacity to experience and express feelings at the moment they occur.

(Taken from http://www.minddisorders.com/Ob-Ps/Person-centered-therapy.html - Encyclopaedia of Mental Disorders

A summary of NICE guidance for psychological therapies by disorder and client age group

<table>
<tr><th></th><th>Depression</th><th>Bipolar disorder</th><th>Panic & Generalised Anxiety</th><th>Schizophrenia</th><th>PTSD</th><th>Obsessive Compulsive & Body Dysmorphic Disorder</th><th>Anorexia Nervosa</th><th>Bulimia Nervosa</th><th>Self Harm</th><th>Personality Disorder</th></tr>
<tr><td>Children</td><td>MILD
guided self help
Nondirective supportive therapy
Group CBT
MOD-SEVERE CBT, IPT,
Short term FT
Systematic FT
Child Psychotherapy</td><td>Primary intervention of Structured psychological therapy (With medication)

Symptom Focus
Problem solving
Social functioning education</td><td>No current nice guidance</td><td>No nice guidance for childhood onset schizophrenia</td><td>CBT 8-12+ sessions involve families</td><td rowspan="2">CBT
ERP
involve family

Home Visits may be needed

In extreme Cases Inpatient support may be needed</td><td rowspan="2">CAT

CBT

IPT

Focal psychodynamic Therapy

Family interventions</td><td rowspan="2">CBT

Other Psychological Treatments

IPT

DBT</td><td>Focus on underlying problems e.g. Depression/ Anxiety/ Personality Disorder

Developmental Group psychotherapy</td><td></td></tr>
<tr><td>Adults of working age</td><td>CBT & IPT
16-20 sessions
Over 9 months

Couple Therapy

Psychodynamic Psychotherapy

Counselling</td><td>Secondary structured psychological interventions

Symptom focus
Problem solving
Social functioning education

CBT post acute phase 16 sessions for mild to moderate</td><td>CBT
(Home visits may be needed)

Structured problem solving

Counselling

Also need to treat co-morbid problems</td><td>CBT

Family interventions</td><td>CBT

EMDR

Psychodynamic Psychotherapy</td><td>Focus on underlying problems e.g. Depression/ Anxiety/ Personality disorder</td><td>DBT

CAT

Schema-focused CBT

Dynamic Psychotherapy

Therapeutic Community</td></tr>
<tr><td>Older adults</td><td>No specific nice guidance</td><td>Limited evidence as adult</td><td>No specific nice guidance</td><td>No nice guidance for late onset Schizophrenia</td><td>No specific nice guidance</td><td>No specific nice guidance</td><td>No specific nice guidance</td><td>No specific nice guidance</td><td>Extra emphasis on depression, ill health and risk</td><td>No specific nice guidance</td></tr>
</table>

CAT – Cognitive Analytical Therapy *CBT – Cognitive Behavioural Therapy* *IPT – Interpersonal Therapy* *FT – Family Therapy*
EMDR – Eye movement Desensitization and Reprocessing *ERP – Exposure Response Prevention* *Schema – focused CBT*
Dynamic Psychotherapy *DBT – Dialectical Behaviour Therapy* *Therapeutic Community* *Developmental group psychotherapy*
Couple therapy *Counselling* *Structured Problem Solving* *Short term FT*
Systemic FT *Child Psychotherapy*

AN ROINN
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin
an Fowk Siccar

Speech, Language and Communication Therapy Action Plan:

Improving Services for Children and Young People

2011/12 – 2012/13

March 2011

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MINISTERIAL FOREWORD

I am pleased to publish the DHSSPS Speech, Language and Communication Therapy Action Plan: *Improving Services for Children and Young People* (2011/12 – 2012/13). This follows a pre-consultation phase in the summer of 2009, and a formal public consultation on the draft Action Plan during the autumn of 2010. I wish to thank all those individuals and organisations who took the time to provide very informative and helpful responses during both consultation phases.

The publication of this document is an important step forward in improving the delivery of services to children and young people with speech, language and communication needs in Northern Ireland.

The ability to communicate effectively is a vital skill for every child or young person in their home, school and social lives. Indeed, it is such an important aspect of personal development that without good communication skills, children may never develop to their full potential or make the kinds of lasting friendships that characterise a full life.

The Report of the Northern Ireland Commissioner for Children and Young People (2005/06) was a welcome contribution to this work in that it helped identify key issues to be addressed. The Report of the Speech and Language Therapy Task Force (2008) was also helpful, as it involved many children, parents, teachers and therapists in making high-level recommendations about how services might be improved. These useful contributions have provided a challenge to those who design, fund, commission and deliver speech and language therapy services: to work together in a joined-up manner and to put in place real service improvements across community, health and education settings. This Action Plan is one part of the answer to that challenge.

In order to take the initiative in making some real, practical and lasting improvements to services, in July 2009 I established a multi-agency, multi-disciplinary Project Team involving staff from the health and education sectors, the Youth Justice Agency and the Royal College of Speech and Language Therapists. The Team was tasked with developing the specific actions which are now contained in this Action Plan. Whilst

many of these actions relate to health and social care settings, they recognise the importance of collaboration at local and regional levels.

This Action Plan is intended to provide the direction for the further development of speech and language therapy services over the next two years working in partnership with other organisations. It is focused on children who have clinical and social care needs arising from speech, language or communication difficulties. Joint working with other Departments will continue to be important as services will need to be developed in a multi-disciplinary model, designed around the child and their family.

The challenge for us all now is to use this Action Plan as a tool to further transform service provision in order to enhance the lives of children and young people with speech, language and communication needs and their families.

MICHAEL McGIMPSEY MLA
Minister for Health, Social Services and Public Safety

HOW TO READ THIS DOCUMENT

1. The Speech, Language and Communication Therapy Action Plan is divided into four sections:

2. **Section 1:**
This section provides an introduction to Speech, Language and Communication Needs (SLCNs) and the effect these can have on children and young people throughout their lives, as well as introducing Speech and Language Therapists (SLTs) and the role they play. This section also details the scope of the Action Plan and the issues that must be addressed.

3. **Section 2:**
Section 2 details current Speech and Language Therapy provision, and the service improvements that are already underway or complete.

4. **Section 3:**
This section outlines the way forward for Speech and Language Therapy services, and provides a generic care pathway for progression through these services. Principles of best practice are also identified in this section.

5. **Section 4:**
Section 4 contains the Action Plan itself, detailing a series of actions to be completed over the next two years to improve Speech and Language Therapy services. The actions are divided into four themes:
   (a) Commissioning and service redesign to maximise outcomes;
   (b) Supporting and empowering children, parents and carers;
   (c) Enabling HSC staff to promote early recognition, assessment, intervention, treatment, care and support;
   (d) Collaboration between speech and language therapists and teachers and education professionals to enable them to promote early recognition, assessment, intervention and support.

6. Each action also has: a timetable for completion; a person or body responsible for its implementation; the outcome required; and details the benefits for individuals and for society by the completion of the action.

7. Supplementary information is also provided in the Appendices to assist understanding and to complement the main contents of the Action Plan.

NB. If you require the document in an alternative format, please contact the Department to make your request:

Physical and Sensory Disability Unit
DHSSPS
Room D1
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Tel: 02890 522911
Fax: 02890 522500

SECTION 1: SETTING THE SCENE

INTRODUCTION

AIMS AND OBJECTIVES

LEGISLATIVE CONTEXT

STRATEGIC LINKS

POTENTIAL IMPACT OF SPEECH, LANGUAGE AND COMMUNICATION NEEDS

SECTION 1: SETTING THE SCENE

INTRODUCTION

8. Speech, language and communication are crucial to every child's ability to succeed in life. The ability to communicate is an essential life skill for all children and young people and it underpins a child's social, emotional and educational development[1]. It is a key skill in future employment opportunities and defines who we are and how others perceive us.

9. This revised Action Plan builds on a number of pieces of work focused on improving outcomes for children with Speech, Language and Communication Needs (SLCNs), including the Speech and Language Therapy Task Force Report, published in July 2008. The Task Force report emphasised the need for better partnership and collaborative working between health and education professionals to support the early identification of children's needs and to secure better outcomes for them. It also highlighted gaps in speech and language therapy provision for children and young people in Northern Ireland.

10. Following the publication of the Task Force Report, the Department recognised the need for an Action Plan to drive improvements. In July 2009 the Department established a multi-agency Speech and Language Therapy Action Plan Project Team to develop and agree a Speech, Language and Communication Therapy Action Plan, taking account of the recommendations made in the Task Force Report. A full list of Project Team members is provided in Appendix 2.

11. A programme of pre-consultation was also initiated at this time, with an initial focus group event for health and education professionals being held on 12 June 2009. At this workshop, participants identified key areas for improvement.

12. The Royal College of Speech and Language Therapists (RCSLT) facilitated two further focus group events with parents/guardians and children with speech and

[1] The Bercow Report: A Review Of Services For Children With Speech Language And Communication Needs, 2008

language needs. These events were held on 23 and 25 September 2009 in Sperrinview School, Dungannon and Thornfield School, Jordanstown.

13. At these events, parents were given the opportunity to raise concerns about current service provision and highlight areas where improvement or service redesign was required. A children's facilitator enabled the children present to voice their views on speech and language therapy and identify what they wanted from the service.

14. The draft Speech, Language and Communication Therapy Action Plan was launched for full public consultation on 7 September 2010 and placed on the Department's website (www.dhsspsni.gov.uk/index/consultations.htm). An Easy Read version was also provided.

15. The consultation phase closed on 30 November 2010, and 33 responses were received from a broad range of professional, local government and voluntary bodies, as well as the Health and Education sectors and a number of individuals. Some of the issues highlighted during the consultation included:
    - Concerns about the training of HSC and education staff in the identification of speech difficulties;
    - Need for truly collaborative working and joint planning between Health and Education;
    - The importance of Speech and Language Therapy input at Transition; and
    - The difficulties parents have in accessing information about what services are available to them.

16. Each of the responses were carefully and individually considered during the revision of the Action Plan, and have helped the Department and HSC officials understand the needs, wants and expectations of the population in relation to speech and language therapy services. A full summary of responses is available on the Departmental website (http://www.dhsspsni.gov.uk/index/publications.htm).

WHAT ARE SPEECH, LANGUAGE AND COMMUNICATION NEEDS?

17. Speech, Language and Communication Needs (SLCNs) can be primary, such as specific language impairments or a stammer, or secondary and related to other needs like autistic spectrum disorders, hearing impairments or physical disabilities.

18. These needs can include difficulty understanding what people say, difficulty speaking or forming sounds or words, and using language in appropriate social contexts. They can be very severe, for example, when an individual cannot communicate at all without alternative or augmentative communication such as signs or communication aids. They can also be significant, for example, when a child underachieves in class because they are not able to communicate as effectively as their peers.

19. Many SLCNs are identified when the child is very young, perhaps because they are late in starting to talk or because people cannot understand them when they do speak. Others may emerge when the child goes into nursery or primary school, when they start to read, and sometimes even later on when a child is underachieving or becoming withdrawn or frustrated resulting in challenging behaviours.

20. Children and young people may also acquire SLCNs at any time if they have an accident or stroke.

What are the Impacts of Communication Difficulties?

21. **Educational:**
    There is clear evidence that, without early access to the appropriate support from early years and throughout key stages in education, children with communication difficulties will have lower academic attainments.

22. **Social/Emotional:**
    Children with a communication disability are more likely than their peers to find peer interaction and forming real relationships difficult. This puts them at risk of

rejection and isolation. Social isolation has been identified as a risk factor for bullying in children with special educational needs.

23. **Mental Health:**
It is estimated that one third of children with communication problems will go on to develop mental illness if untreated[2]. Often underlying health and medical conditions go unnoticed and undiagnosed in children with communication problems.

24. **Employment:**
The last fifty years have seen a shift in employment patterns, with a move towards service industries, which require sophisticated language, literacy and numerical skills. Without help to develop these skills children with SLCNs will have restricted employment opportunities in later life.

25. The Bercow Report illustrates that there is insufficient understanding of the centrality of speech, language and communication in a child's development and sometimes parents and families themselves fail to recognise the importance it plays in their child's future attainment[3].

What is the Role of the Speech and Language Therapist?

26. Speech and Language Therapists (SLTs) are part of a wider Health and Social Care workforce with responsibility for addressing the needs of children with Speech, Language and Communication difficulties. They are specially trained to diagnose speech, language and communication disorders and have a unique role in the assessment, diagnosis and management of children, young people and adults who have difficulties with communication, and/or eating, drinking and swallowing.

27. Speech and language therapists are statutorily regulated by the Health Professions Council (HPC). The Council maintains a register of all the health

[2] "Life sentence: what happens to children with developmental language disorders in later life?" Clegg, J., Hollis, C. & Rutter, M. (1999) - *Bulletin of the Royal College of Speech Language Therapists*, *571*, 16-18.
[3] The Bercow Report: A Review Of Services For Children With Speech Language And Communication Needs, 2008

professionals it regulates who meet their standards for training, professional skills, behaviour, health, conduct and performance. Speech and Language Therapy is a protected title.

28. Speech and language therapists work closely with parents, carers, psychologists, other health and education professionals and many other agencies. They recognise that the success of intervention requires a team around a child to structure the activities and interaction opportunities of a child's everyday life.

29. In 2006 the speech and language therapy profession produced a position paper entitled "Supporting children with speech, language and communication needs within integrated children's services"[4], which sets out a vision of speech and language therapy to deliver effective support, plan for maximum impact and develop the workforce. Trans-disciplinary working is central, training of others is core and SLT provision must be delivered in partnership with others.

30. This position paper states that: *"SLT services should offer the full range of support for children, including direct intervention where appropriate, while ensuring that overall management includes goals relating to activity and participation, managed by those most relevant to the child".*[5]

[4] 'Supporting children with speech, language and communication needs within integrated children's services' RCSLT position paper, Marie Gascoigne, 2006

[5] 'Supporting children with speech, language and communication needs within integrated children's services' RCSLT position paper, Marie Gascoigne, 2006

AIMS AND OBJECTIVES

Aims:

31. The aim of the Department of Health, Social Services and Public Safety (DHSSPS) is that all children and young people, at risk of or presenting with speech, language or communication needs, will be able to benefit from timely support and integrated services that best meet their needs. We recognise the need for Government departments and agencies to work together in a joined-up manner and to put in place real service improvements across community, health and education settings.

32. This Action Plan will focus mainly on clinical and social care services for children and young people with potential speech, language and communication difficulties. In this context it will also be cognisant of the difficulties experienced in the transition from childhood to adulthood. The Action Plan will consider the particular needs of children and young people in the following groups:
    - 0 – 4 years
    - 4 – 11 years
    - 11 – 18 years
    - 18 – 21 years – transition
    - children and young people in the Youth Justice System.

Objectives:

33. The Department's intention is to produce an Action Plan containing SMART objectives: i.e. Specific, Measurable, Achievable, Realistic and Time Bound. The actions are grouped into four themes:
    - Commissioning and service redesign to maximise outcomes;
    - Supporting and empowering children, parents and carers;
    - Enabling HSC staff to promote early recognition, assessment, intervention, treatment, care and support; and
    - Collaboration between speech and language therapists and teachers and education professionals to enable them to promote early recognition, assessment, intervention and support.

34. Other issues which are addressed are:
    - The needs of parents, families and carers;
    - New commissioning arrangements;
    - Review of waiting times;
    - Making full use of existing skill mix;
    - Mental health needs and other co-morbidities, including ASD;
    - The needs of children with Acquired Brain Injury;
    - The needs of children and young people within the Youth Justice System; and
    - Integrated models of care which have been positively evaluated.

LEGISLATIVE CONTEXT

35. The Department of Health, Social Services and Public Safety is one of the Northern Ireland Departments created in 1999 as part of the Northern Ireland Executive by the Northern Ireland Act 1998 and the Departments (Northern Ireland) Order 1999. Subsequently, on 1st April 2009, following the creation of six new HSC Trusts, four wholly new regional HSC organisations were brought into being by the Health & Social Care (Reform) Act (NI) 2009:
    - The Health and Social Care Board (HSCB);
    - The Public Health Agency (PHA);
    - The Business Services Organisation (BSO); and
    - The Patient and Client Council (PCC).

36. Education and therapy services to children with special needs should be provided in line with current legislation including The Children (Northern Ireland) Order 1995, The Education (Northern Ireland) Order 1996, The Special Educational Needs and Disability (Northern Ireland) Order 2005, The Chronically Sick and Disabled Persons (Northern Ireland) Act 1978, The Disability Discrimination Act 1995 and the relevant Codes of Practice.

STRATEGIC LINKS

37. This Action Plan also draws on a number of other publications. These include:

- The Bercow Report: A Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs (2008)
- Northern Ireland Commissioner for Children and Young People Reports (2005, 2006)
- Speech and Language Therapy Task Force Report (2008)
- The Bamford Review: Equal Lives (2005)
- Delivering the Bamford Vision (2009)
- Healthy Child, Healthy Future (2010)
- Healthy Child, Healthy Future: Speech and Language Therapy for Children – Information and Referral Guidance (2010)
- Acquired Brain Injury Action Plan (2010)
- Healthy Futures: The Contribution of Health Visitors and School Nurses (March 2010)
- Autism Spectrum Disorder (ASD) Strategic Action Plan (2009)
- Our Children, Our Young People, Our Pledge (2006)
- Developing Services to Children and Young People with Complex Healthcare Needs (2009)
- Standards and Guidance for Promoting Collaborative Working to Support Children with Special Needs (2006)
- Good Practice in Consent: Consent for Examination, Treatment of Care (2003)
- Ministerial Priorities of the Sub-Committee on Children and Young People (OFMDFM)
- Proposed Early Years Strategy (DE)
- A Ten Year Strategy for Children and Young People in Northern Ireland 2006-2016 (OFMDFM)

POTENTIAL IMPACT OF SPEECH, LANGUAGE AND COMMUNICATION DIFFICULTIES ON CHILDREN'S LIVES

38. If a child or young person does not receive the right help in combating their communication disabilities in a timely manner, the risks of that disability having a long-term effect on their future lives is greatly increased. SLCNs can, if left untreated, lead to lower education attainment, behavioural problems, emotional and psychological difficulties, poorer employment prospects, challenges to mental health, and in some cases, a descent into criminality[6].

39. Equally, for those who are already experiencing any of these issues, appropriate therapy provision is essential to mitigate the effects of the SLCN and provide a way out.

Prevalence

40. "Speech, Language and Communication difficulties affect more children and young people in Northern Ireland (NI) than any other single condition and are core impairments for many children with a learning, physical or sensory disability". *Northern Ireland Speech and Language Therapy Task Force: Report on Speech and Language Therapy Services for Children and Young People, July 2008*

41. In NI there is a lack of robust quantitative and qualitative research to properly identify prevalence. Therefore regional predictions must rely heavily upon published national research. However, national studies may not be fully comparable due to a number of reasons:
    - The acknowledged higher levels of learning disability in NI; and
    - Children in NI experience relatively higher levels of social and economic disadvantage compared to England, Scotland and Wales[7].

42. In NI the number of children with SLCNs varies according to the criteria used, but it is reasonable to assume there will be at least one child meeting criteria for specialist help in every class in the country (approximately 3 -7% of all children).

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[6] The Bercow Report
[7] Overview of the Health and Social Care Needs and Effectiveness Evaluation, DHSSPS DFP OFMDFM

43. The most widely regarded prevalence study in the field has provided a figure of 7.4%[8]. This American epidemiologic study estimated the prevalence of specific language impairment (SLI) in monolingual English-speaking kindergarten children. 7,218 children were screened. Results provided an estimated overall prevalence rate of 7.4%. The prevalence estimate for boys was 8% and for girls 6%.

44. The prevalence of SLCNs in studies of children with co-morbidities such as Autism or Learning Disability is reported to be much higher. The National Autistic Society prevalence information states that "the indication from recent studies is that the figures cannot be precisely fixed, but it appears that a prevalence rate of around 1 in 100 is a best estimate of the prevalence of Autism in children"[9]. All of these children will have communication difficulties as communication is recognised as one of the triads of impairment for diagnosis.

45. The prevalence of communication disorders in learning disability is also much higher. The British Institute of Learning Disabilities state that "estimates suggest that 50% to 90% of people with learning disabilities have communication difficulties"[10].

46. An American study reports that in a population of 242 children with learning disabilities between 8 and 12 years of age enrolled in a school system in Alabama, a speech, language or hearing problem was exhibited by 96.2% (233) of the 242 children studied. Language deficits were found in 90.5%, articulation deficits in 23.5%, voice disorders in 12%, and fluency disorders in 1.2% of the students with learning disabilities[11].

47. The following table gives the population of all children and young people in NI from 0-19yrs per Health and Social Care Trust, and the projected prevalence of SLCNs. As stated above it is reasonable to ascertain that 3-7% of these children

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[8] Tomblin, J.B., Records, N., Buckwalter, P., Zhang, X.,Smith, E. & O'Brien, M. (1997) Prevalence of specific language impairment in kindergarten children. Journal of Speech Language and Hearing Research, 4, 1245-1269.

[9] Baird, G. et al (2006). Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). *The Lancet*, 368 (9531), pp. 210-215.

[10] The British institute of learning disabilities Campion House Green Street, Kidderminster

[11] Denise P. Gibbs. Prevalence of Communication Disorders in Students with Learning Disabilities, Journal of Learning Disabilities, Vol. 22, No. 1, 60-63 (1989) DOI: 10.1177/002221948902200111

will have speech, language and communication difficulties, therefore prevalence figures have been calculated accordingly at 7% of the total populations.

Table 1: Trust Child Population Figures - 0-19 yrs per HSC Trust - 2009

Age	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Totals
0-19 yrs Totals*	86,380	121,130	89,460	100,730	84,780	482,480
Prevalence Of 7%	6046	8,479	6,262	7,051	5,934	33,772

**Source: NISRA Registrar General Annual Report 2009 - Population Statistics*

48. The Royal College of Speech and Language Therapists guidance on best practice states that "research has also indicated that up to 62% of children with mental health disorders have speech and language difficulties"[12].

49. The Department of Education has also reported that the incidence of children with SLCNs in NI is increasing. In NI 51% of preschool providers recently surveyed cite speech and language difficulties as the most common difficulty that is evident in children attending preschool provision (DE 2007)[13].

50. The information on the following page has been taken from the Northern Ireland Annual Schools Census 2009/2010, and shows the percentage and number of pupils on the SEN Register and the percentage of the overall school enrolment with speech and language difficulties, in each Education and Library Board area.

[12] Communicating Quality 3: RCSLT's guidance on best practice in service organisation and provision, 2006
[13] DE ETI Special Educational Needs in the pre school sector Review March 2007

Table 2: Percentage of Pupils with S&L Difficulties (Stages 1-5) against Number of Pupils on SEN Register in Each EL Board Area

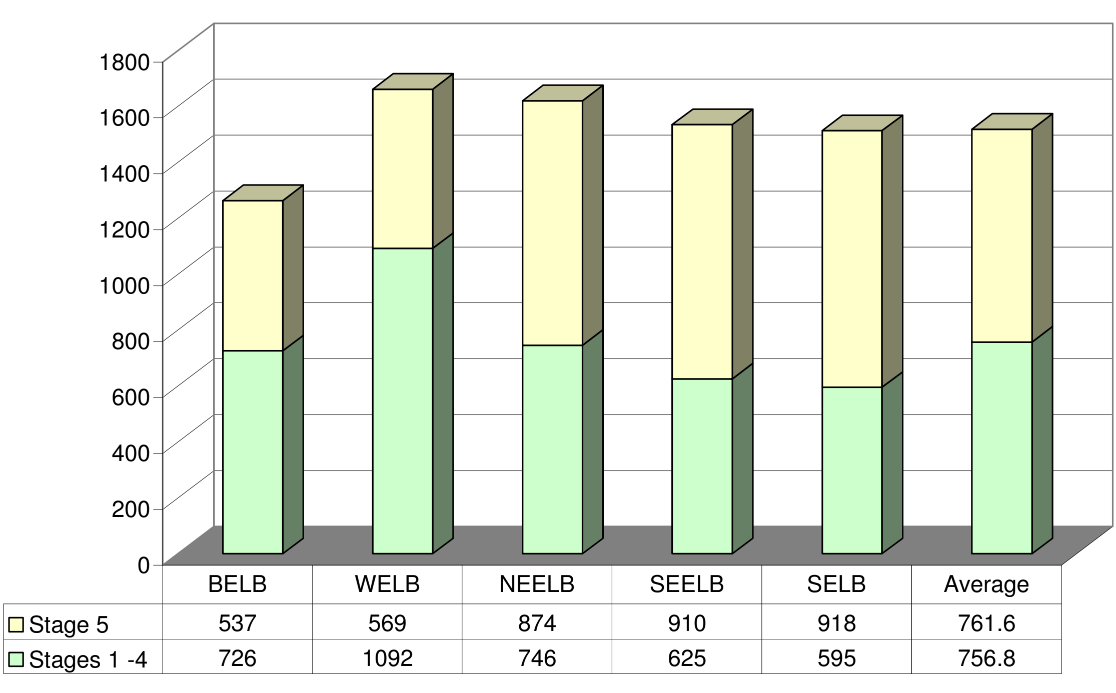
	BELB	WELB	NEELB	SEELB	SELB	Overall
Primary	12.23	16.79	13.50	13.17	15.24	**14.19**
Post Primary	0.97	5.15	3.68	2.19	3.59	**2.93**
Special Schools	32.13	50.16	58.27	50.49	65.25	**48.50**
Overall	**8.75**	**13.96**	**14.24**	**12.79**	**12.90**	**12.36**

Table 3: Percentage of Pupils with S&L Difficulties (Stages 1-5) against Overall School Enrolment in Each EL Board Area

	BELB	WELB	NEELB	SEELB	SELB	Overall
Primary	2.66	4.13	2.80	3.43	3.22	**3.21**
Post Primary	0.22	0.92	0.42	0.36	0.46	**0.47**
Special Schools	32.13	50.16	58.27	50.49	65.25	**48.50**
Overall	**2.28**	**2.95**	**2.30**	**2.50**	**2.10**	**2.40**

Figure 1

Number of Pupils with Speech & Language Difficulties on SEN Register in 2009-10, Split by Stages 1-4 and Stage 5



Source: 2009/10 Annual Schools Census

Health Inequalities

51. Communication difficulties are more prevalent amongst vulnerable groups and children with additional needs.

52. People with communication difficulties may find it harder to express their needs and communicate effectively with health (and social care) professionals. A lack of effective communication creates a barrier to accessing healthcare and appropriate intervention. This often results in substantial social and health care costs[14] [15]. Communication difficulties can also contribute to the creation or reinforcement of inequalities because of the impact that communication impairment has upon a person's ability to experience the same quality of life as their peers and stay healthy.

53. In the Sure Start Children's Centres Practice Guidance (2006) it states that "there should be additional support available for families that are experiencing particular challenges that mean that their children may be at risk of poor outcomes. Among these families may be: teenage parents; lone parents; families living in poverty; workless households; parents with mental health, drug or alcohol problems; families with a parent in prison or known to be engaged in criminal activity; families from minority ethnic communities; families of asylum seekers; parents with disabled children; and parents with learning disabilities. While these families will not always be in difficulty, child development studies have shown that there is a greater risk that their children may have poor outcomes"[16].

Social Deprivation:

54. A study investigating four year olds in areas of deprivation found the prevalence of speech, language and communication needs of children were as high as 55% (Locke et al, 2002).

55. Therapists working within Sure Start projects report high numbers of children being identified as requiring SLT provision who have been discharged due to non -attendance at community clinics (Did Not Attend / DNA).

[14] Snow and Powell Developmental Language Disorders and Adolescent Risk
Current Issues in Criminal Justice 16(2) Australia (2004)
[15] Jerome et al 2002, Young et al 2002, Johnson et al 1999
[16] Sure Start Children's Centres Practice Guidance, Department for Education and Skills and Department of Health, 2006

56. This finding has also been substantiated by the findings of a recent International Development Fund (IDF) project in the Colin area of West Belfast. The Colin area has a population of approximately 20,000, of which approximately 30% are aged between 0 and 15 years. The area falls within the 20 most deprived wards in Northern Ireland, and the local clinic reported high rates of DNAs.

57. The Colin Speech and Language Therapy Service provided a universal and targeted school-based speech and language therapy service to pupils in the Colin area in order to:
    - Improve access to the Speech and Language Therapy Service within the Colin area;
    - Improve the identification and support for children with speech, language and communication difficulties;
    - Develop a model of collaborative practice between therapists, education staff and parents; and
    - Increase education staff's knowledge and skills in identifying and supporting children with speech, language and communication difficulties.

58. The project improved outcomes for both children and the community, with results showing that 52% of children were discharged at the end of P1. SLT has also become embedded in classroom practice, and pre/post assessment has been improved. There is also improved access to services (2 week waiting time).

<u>Minority Groups:</u>

59. Health inequalities disproportionately affect ethnic communities. Individuals with communication disabilities from these communities may therefore need additional help to assist with bilingual input.

<u>Learning Disability:</u>

60. The Equality Commission NI Report: 'The accessibility of health information for people with learning disability' states that "many people with a learning disability will have specific communication needs which may affect access to information about individual health issues and information about health services or options available to meet health needs".

61. The Equality Commission maintains that the lack of knowledge about communication disability among staff is the main barrier to enabling this group to access appropriate health and social care, combined with a lack of support and training to enable them to understand the communication needs of people with learning disability.

Young Offenders:

62. There is now an acknowledged evidence base to support the finding that SLCNs are prevalent amongst young offenders and young unemployed men:
    - Clegg et al. (1999) showed that a third of children with speech and language difficulties develop mental health problems with resulting criminal involvement in some cases;
    - A 2003 Polmont Young Offenders Institute (YOI) survey found that 70% of young men had significant communication problems;
    - 66-90% of young offenders have low language skills, with 46-67% of these being in the poor or very poor range (Bryan et al. 2004);
    - This area of difficulty is likely to cause them significant problems, in particular, in formal settings, such as police interviews, court, job interviews and so on (Lanz, 2009);
    - Many young offenders lack understanding of their communication difficulties and may not know that they have misunderstood or may present as surly and uncommunicative (Bryan, 2009);
    - Half of the UK prison population has been identified as having literacy difficulties and Home Office studies have shown that around 35% of offenders only have speaking and listening skills at a basic level[17].

63. Research shows that speech and language therapy targeted at improving the language skills of individuals can significantly reduce the number of them who go on to offend[18]. A national study carried out in 2001/2002 showed that the recidivism rates were reduced by as much as 50% for individuals who

[17] Davies K. et al (2004) An evaluation of the literacy demands of general offending behavioural programmes, Home Office Findings 233
[18] Bryan, K. Prevalence of speech and language difficulties in young offenders in the International Journal of Language and Communication Disorders, 39, 391-400. (2004)

received targeted speech and language therapy to improve their oral language skills in their first year after release[19].

64. The Youth Justice Agency in partnership with the Royal College of Speech and Language Therapists held a conference entitled 'Locked Up and Locked Out: Communication is the Key' at the University of Ulster on 30 June 2009. The link between offending and communication difficulties was well illustrated and recent research and practice improvements in the UK were highlighted.

65. As a result a paper was put to the Criminal Justice Board to ask the relevant agencies (PSNI, Public Prosecution Service, NI Court Service, NI Prison Service, the then NIO, Probation Board for NI and YJA) to adopt a common framework approach to the issues of learning disability and communication difficulties. The need to liaise and consult widely was accepted as an imperative.

66. In September 2009, a Multi-Agency Steering Group (MASG) on Learning Disability, Learning and Communication Difficulty (LDLCD), was formed by the NIPS following a Penal Reform Trust report "Know One Knows" into the prevalence and response to offenders who may have a learning disability and/or a learning difficulty. Membership is drawn from all the criminal justice agencies (NIPS, PSNI, PPS, NI Court Service, PBNI and the Youth Justice Agency). The Department of Education and HSC Trusts are also represented, along with a number of voluntary sector bodies.

67. The Multi-Agency Steering Group on Learning Disability, Learning and Communication Difficulties covers the following main areas:
    - Awareness raising within agencies and across the system;
    - The development of common early identification tools which will include common definitions and be a reliable source of evidence;
    - Improving the flow of information, as appropriate, within and between agencies;

[19] Moseley, D et al. *Developing oral communication and productive thinking skills in HM Prisons* (Learning and Skills Research Centre, 140. 2006)

- Making reasonable adjustments to policies and practices to better meet the needs of persons with learning and communication difficulties;
- Provide staff training on areas relating to learning and communication difficulties to equip staff to interact more effectively in day to day contact with this vulnerable group.

SECTION 2: CURRENT SERVICE PROVISION

WORKFORCE PLANNING

TRAINING AND DEVELOPMENT

SERVICE IMPROVEMENT

SECTION 2: CURRENT SERVICE PROVISION

WORKFORCE PLANNING

68. The following table provides a breakdown of the Speech and Language Therapy workforce for children and young people as of December 2010.

Table 4

Qualified SLTS		NHSCT	BHSCT	SEHSCT	SHSCT	WHSCT
1	WTE SLT permanently funded posts for 0-18.11 years in children's teams	60.8	53.43	37.19 **	37.71	30.95 ****
2	WTE vacancies in above permanently funded posts 0-18.11 years in children's team	4.5	4.14	0	3.18	1.6
3	WTE temporarily funded posts for 0-18.11 years in children's teams	0.6	4 *	0	0	0.17
4	WTE vacancies in above temporarily funded posts	0.4	0	0	0	0
5	WTE staff on maternity leave	4.46	1	2.72	1.5	3
6	WTE staff on career break (CB) / secondment (sec)	1.5	1.47	1.55	0	1
7	WTE supernumerary staff in posts	0	0	0	0	0
SLT Assistants / Technical Instructors		**NHSCT**	**BHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
1	WTE SLTAs permanently funded posts for 0-18.11 years in children's teams	10.793	7.78	6.99	4.5	8.92
2	WTE vacancies in above permanently funded posts 0-18.11 years in children's team	0	1.2	0	0.3	0
3	WTE temporarily funded posts for 0-18.11 years in children's teams	0	0	1.47 ***	0	1
4	WTE Vacancies in above temporarily funded posts	0	0	0	0	0
5	WTE staff on maternity leave	1.4	0	0	0	2
6	WTE staff on career break (CB) / secondment (sec)	0	0	0	0	1
7	WTE supernumerary staff in posts	0	0	0	0	0
Admin and Clerical Support		**NHSCT**	**BHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
1	WTE A&C staff permanently funded to support Head(s) of Service	0.8	0.2	0.5	0.24	0.2
2	WTE A&C staff permanently funded to support above posts *****	5.96	2.54	2.51	4.78	6.1

* There are also 1.66 SLTs in Surestarts in Belfast area for which the Trust does not have lead responsibility
**Plus 3 working in ASCET Multidisciplinary Team
***0.67 Extended schools project plus 0.8 Surestart (fixed term contracts)
****Surestart = 1.52, West Team = 3.32, ASD Team = 2.0
***** includes staff in m/d teams as well as core service, but does not include staff supporting head(s) of service.

TRAINING AND DEVELOPMENT

69. Speech and language therapy is a graduate profession. DHSSPS commissions the undergraduate BSc Honours course for Speech and Language Therapy in Northern Ireland. The course is situated at the University of Ulster at Jordanstown (UUJ) and has availability for 30 places per academic year. Following graduation, speech and language therapists are eligible for registration with the HPC.

70. Following graduation there is a range of post –graduate development opportunities available through the Beeches Post-Graduate Centre for Allied Health Professions and both Queens University and UUJ, with opportunities up to Doctorate level. This allows for the continuing professional development required within the profession to maintain professional registration with the HPC. There are also considerable opportunities for research and development through the R&D Office at the Public Health Agency.

SERVICE IMPROVEMENT

71. Health service provision for children with SLCNs has improved significantly over the past number of years, with patients and speech and language therapy services having benefitted from substantial investment in elective care reform.

72. The NICCY Reviews of Speech and Language Therapy provision in 2005 and 2006 resulted in additional funding of £1m in 2006/07 to help address the issues raised in the reviews. This funding was baselined from 2008/09.

73. An additional £4m funding was also provided to Trusts in 2006-07 and 2007-08 to establish multidisciplinary teams for children and young people, and was incorporated into baseline figures from 2008/09. Speech and language therapists are recognised as an essential component of those teams.

74. Finally, the Health Minister secured an additional £0.2m of service development investment in 2009/10 under the Comprehensive Spending Review, which has now been baselined.

75. At 30 September 2010 there were 422 (355.9 WTE) Speech and Language Therapists supporting children and adults in the Health and Social Care sector in Northern Ireland, as well as 69 (54.2 WTE) SLT assistants.

76. As part of service improvement, the Department issued a regional Priority for Action (PfA) target to standardise the access criteria across its services in relation to Allied Health Professional (AHP) services. This requires Health and Social Trusts to ensure that, from March 2010, no patient waits longer than 9 weeks from referral to commencement of AHP treatment, including speech and language therapy; a reduction from 28 weeks in 2008. The most recent information available indicates that at 31 December 2010, 106 people had been waiting for longer than 9 weeks for a speech and language therapy appointment. Health and Social Care Trusts are working on reform programmes and implementation plans in order to meet these targets and address assessment and waiting times.

77. Additionally, the Department commissioned Business Consultancy Services within the Department of Finance and Personnel to help improve the commissioning and planning of HSC Trust speech and language therapy services. A scoping exercise has recently been completed, which may inform future service improvement and redesign. This scoping exercise assessed the different demands and delivery mechanisms required from SLT services to children and young people between 0 and 21 years.

SECTION 3: THE WAY FORWARD

COLLABORATIVE WORKING

THE IMPORTANCE OF PREVENTION AND EARLY INTERVENTION

CARE PATHWAY

TRANSITIONS

PRINCIPLES OF BEST PRACTICE

TRANS-DISCIPLINARY WORKING

NEXT STEPS

SECTION 3: THE WAY FORWARD

78. Previous sections have detailed the scale and nature of the issues involved in Speech and Language Therapy provision, and provided an outline of the service improvements carried out to date in terms of investment, staffing levels and waiting times. This section sets out the guiding principles to be used in the further development of services.

COLLABORATIVE WORKING

79. Collaborative, integrated working across statutory and voluntary providers (including health and social care, education, criminal justice, etc) is essential within universal and targeted services to secure effective early support, identification and intervention at all stages in the development of children and young people.

80. In this respect, many models of good practice already exist in Northern Ireland, which demonstrate excellent examples of collaborative working. These should be reviewed and developed on an ongoing basis.

81. The successful delivery of the envisaged holistic support service, which places the child firmly at the centre and which will provide early and effective intervention, will require some redesign in the delivery of speech and language therapy services. Teachers and other staff in educational settings will require further multidisciplinary support and advice from the SL service to ensure children experiencing speech, language and communication difficulties are not only identified early but related educational strategies can be put in place in the classroom to support SLT intervention.

82. The Department of Education has recently issued the policy proposals which have emerged from the Review of Special Educational Needs (SEN) and Inclusion. The policy proposals, as contained in the Department of Education's consultation document *Every School a Good School: The Way Forward for SEN and Inclusion*, reflect the vital importance of joined up working between all professionals in delivering the services for children who require additional support

in learning. A factual summary of the responses to the consultation will issue in Spring 2011 and will help inform further development of policy options surrounding multi agency working. This work will involve further engagement with DHSSPS (and Board and Trust colleagues) and the Department of Employment and Learning (DEL).

THE IMPORTANCE OF PREVENTION AND EARLY INTERVENTION

83. The Child Health Promotion Programme, delivered within Northern Ireland through Healthy Child, Healthy Future (2010), provides a framework for connecting the range of different policies and spheres of activity that support children and young people's health and development in the early years and beyond (Hall & Ellimann, 2003).

84. The universal service is provided to the total population of children and young people aged 0-19 years, irrelevant of need. Even where children receive additional resource e.g. those who are 'Looked After' or with special educational needs, they are still entitled to a universal service.

85. Essentially a universal service is one where a number of contacts are made with children and families to identify health need, through both screening and surveillance and, where necessary, early intervention to mitigate the potential early negative impact of any physical, social or emotional factors.

86. Where early intervention is unable to address need, escalation to a more progressive level of intervention should be considered.

87. In relation to the development of speech and language, parents are supported by health visitors to understand and support the developmental needs of their child (e.g. through play, reading, etc) as they grow and develop and to identify the normal range at each stage within the preschool years. Whilst formal screening of all children is not recommended for speech and language delay, where there is concern, screening will be undertaken and referral to speech and language therapy services made as appropriate. SLTs work closely with health visitors to

develop their skills to identify and support those children at risk of speech, language and communication difficulties.

88. Other factors influencing normal development are important and an increasing evidence base outlining the importance of secure relationships early in life, and of early attachment and good parenting, indicates that early identification of such issues are effective in helping to prevent damaging patterns of behaviour being established. Investing in a preventative approach through early intervention will result in positive outcomes not only in terms of conduct, behaviour, and lifestyle but also in the long term emotional health and well-being of children and young people.

89. The Public Health Agency recently published Information and Referral Guidance on Speech and Language Therapy for Children, as part of the Healthy Child, Healthy Future guidance. This is a training and information resource which supports and reinforces a collaborative approach between speech and language therapists, referrers and parents in the identification and management of children with developmental SLCNs. The aim of the document is to revise and enhance referrers' skills in identifying children's SLCNs. It will provide referrers with additional information to enhance their management options for the child; provide referrers with information to deliver health promotion messages regarding SLC development; and will present referral guidance for children presenting with SLCNs.

90. It is recognised that children and young people with SLCNs may benefit from the use of communication aids. Currently, assessments for these aids are carried out at the Communication Advice Centre (CAC) at Musgrave Park Hospital. Further work is required to scope current provision to support future decision making in this area.

CARE PATHWAY(S)

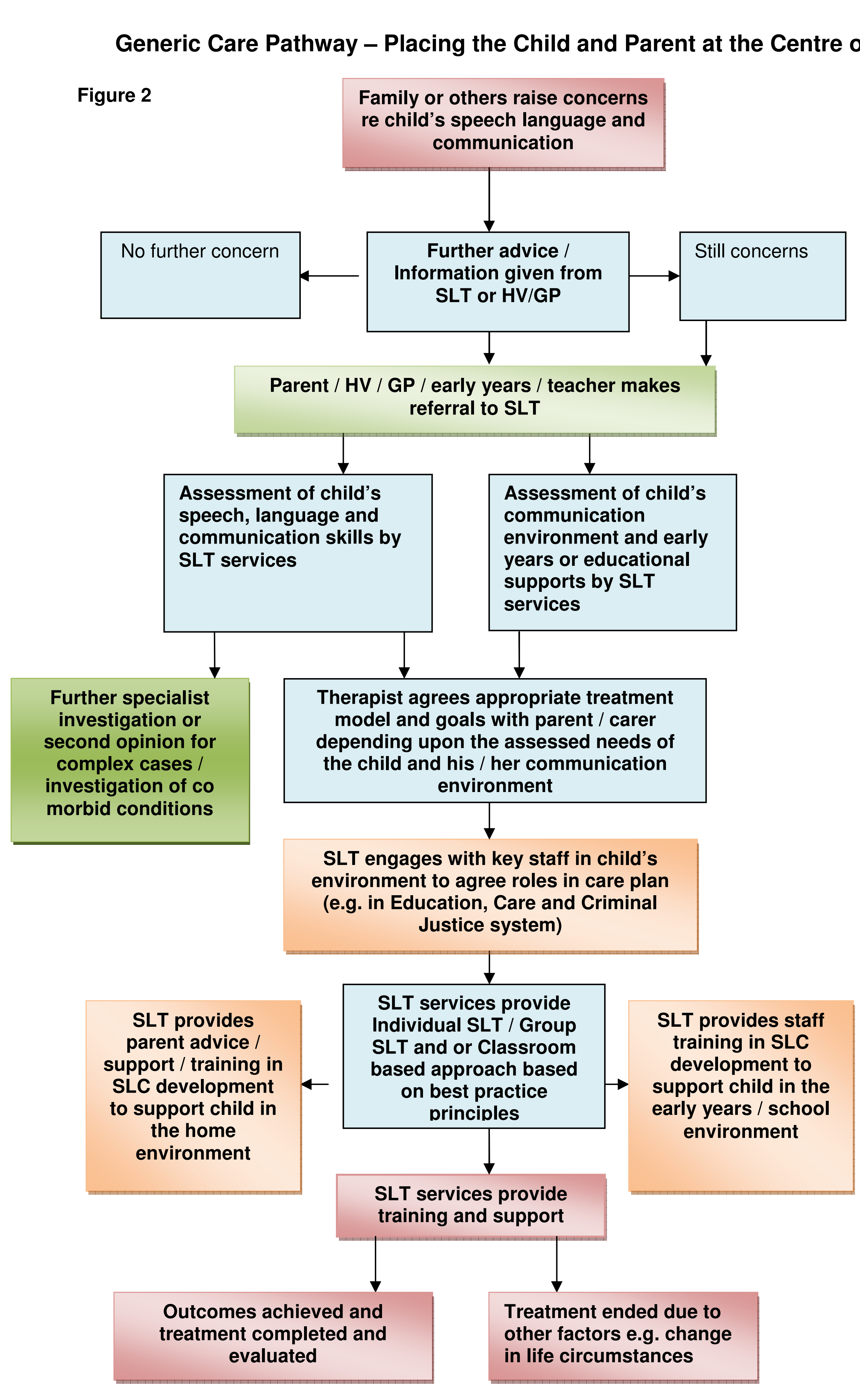
91. It has been agreed that there is a need for a generic care pathway to aid health professionals in making decisions about how to manage the care of children and young people who present with speech, language and communication needs. It should be noted that this generic care pathway is intended to be a tool for guidance, and can be modified, added to or adapted for use with different client groups with specific needs.

92. The care pathway described in this section relates to the child or young person's journey from referral to discharge. It is understood that the speech and language care pathway is embedded in a wider integrated care pathway for all children and young people with speech, language and communication needs. Health Visitors, early years workers, teachers and paediatricians all play an important role in the early identification of children with SLCNs. Currently the DHSSPS is working with speech and language therapists to develop an agreed care pathway model. Speech and Language Therapists believe that it is equally relevant to have an SLT supporting a child with a complex disability as it is to be involved in the preventative work aimed at a general population.

93. The development of this care pathway work will be led by the Public Health Agency in collaboration with the relevant agencies.

Generic Care Pathway – Placing the Child and Parent at the Centre of Care

Figure 2



Speech and Language Therapy Interfaces With Child Populations

94. The following diagram demonstrates that SLTs work at all levels of need within child populations, including:-

95. **Level One:** Base Population - where children and families typically self-refer and access universal and community resources as part of everyday life;

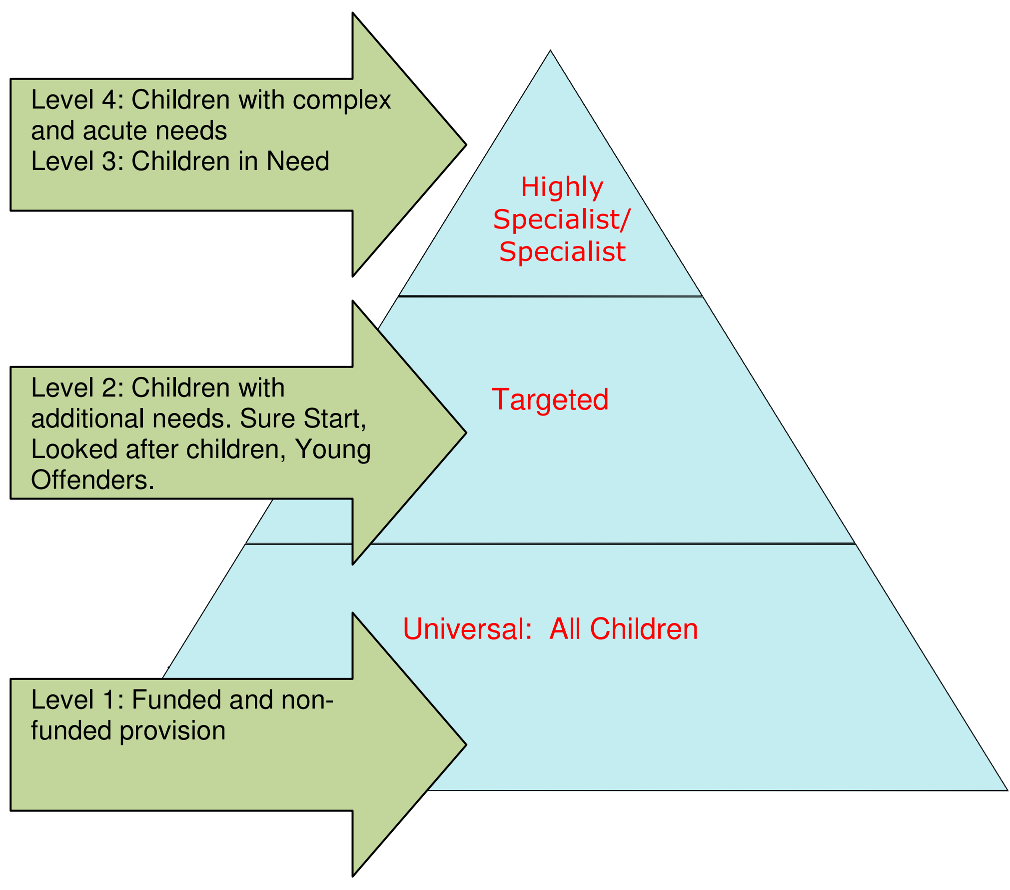
96. **Level Two:** Children with Additional Needs - where some children and families are offered enhanced assistance from universal and other services such as Sure Start;

97. **Level Three:** Children in Need - where children have been identified as children in need including disabled children whose families may require additional services;

98. **Level Four**: Children with Complex and Acute Needs - where children experiencing the most acute, intense or complex difficulties because of health, disability or vulnerability due to their family situations will normally be provided with coordinated support and intervention that may involve a multi-agency response.

99. The model is based on the Thresholds of Need Model (DHSSPS, 2008), *Understanding the Needs of Children in Northern Ireland (UNOCINI)*. Working within this model secures an effective and co-ordinated approach to assessment and identification of needs within integrated children's services.

Figure 3 **SLT Interfaces with Child Populations**



Care Pathway – Contributory Work

100. As a result of the Priorities for Action (PfA) target to reduce waiting times for Allied Health Professions (AHP) services, a range of regional work streams were identified and taken forward by the AHP Reform Network.

101. The network is facilitated and supported on a regular basis through the Performance Management and Service Improvement Directorate (PMSID) at the HSC Board.

102. Initial discussions clarified that each Trust had various pathways, access criteria and means of delivering services for each group of patient. It was felt that this represented an inequity of access across the region.

103. Through a speech and language subgroup (on which all HSC Trusts are represented), the network has defined the access criteria and care pathways and typical patient journey for paediatric cases and adult neurology cases.

104. The care pathways are based on a clinical decision-making approach with clear decision and action points identified along the pathways which also detail the discharge criteria for each patient group.

105. Agreement has been reached that each Trust will accept the care pathway model as developed by the subgroup and replicate these locally.

106. There is currently ongoing work on establishing the demand and capacity of each of the current services and pathways, and the capacity requirements that a new model of service delivery might require.

107. The outcome of this work will further inform the commissioning of services.

108. In conjunction with the regionally agreed care pathway and access criteria, each Trust is also undertaking baseline assessment and developing action plans in relation to the basic steps in the systems and processing of referrals, including the centralisation of registration of referrals, prioritisation of referrals, capacity planning, booking processes, application of appropriate Did Not Attend / Could Not Attend (DNA/CNA) Policy.

TRANSITIONS

109. It is widely recognised and accepted that the transfer and transition periods are "vulnerable" stages of a young person's development, a reality acknowledged by the Hall 4 Report[20].

110. There are two key stages within a young person's educational process:
    - Transfer is the transfer to pre-school, from pre-school to primary education, from primary to post primary and moving between different environments;
    - Transition is the process of moving from post primary to one of the following – Further Education; Higher Education; Training and Employment; Unemployment; and Adult Day Care Services.

[20] Hall 4 Report DHSSPS Nowling, M. (eds) Dyslexia, Speech and Language: A Practitioner's Handbook. 2nd Edition, Whurr Publishers (2006)

111. The processes of Transfer and Transition can also include the transfer and transitioning between other environments such as residential, supported living and respite services. Transition, whether big or small, regular or infrequent, can impact on an individual with SLCNs and every service and new environment needs to meet this challenge to ensure that the individual is properly supported. It is also important to ensure that appropriate information on what services are available at Transition is available to parents and young people themselves as part of Transition planning.

112. Given the importance of transitions in the health and social care sector, there are a number of multi-agency initiatives underway which are considering transitions planning for children and young people with disabilities. For example, in June 2009 the Department launched the document *Developing Services to Children and Young People with Complex Healthcare Needs*, which highlighted service developments to be taken forward under the aegis of a Regional Inter-agency Implementation Group (RIIG).

113. Reference Groups were established to drive specific areas of work forward. The Transition Reference Group aimed to develop a regional response to the transition issues faced by young people with complex healthcare needs by hosting three workshops to look innovatively at developing a regional response to 4 key issues identified by young people and parents: the implementation of a regional transition care pathway; information and mode of delivery; commissioning (how packages continue); and medical issues.

114. Delegates at the workshops agreed to set up a Regional Interagency Transitions Group with representation from child and adult services, young people and parents to lead work, which will include but not be limited to:
   - Agree Terms of Reference for Regional Transitions Group;
   - Carry out a scoping exercise in each HSC Trust to determine the pathways used and the information given to families. The information from the scoping exercise should be reviewed by a regional group and a regional framework agreed;
   - To commission and implement a Regional Integrated Care Pathway for Transition;

- Encourage the formation of multi-agency transition groups at HSC Trust level and ensure meaningful participation from professionals and young people/families;
- Identify professional responsible for Transition at HSC Board, HSC Trusts and DHSSPS.

Transitions Planning in Schools

115. Transitions planning is equally important in an education setting. Factors such as the language of the curriculum, the variety of subjects and the challenges of secondary school can present major difficulties to the post primary school age child. Coping with a new school, new subjects, travel, different teachers, and making new friends can lead to feelings of isolation.

116. The Code of Practice on the Identification and Assessment of Special Educational Needs and the Supplement to the Code of Practice, which are issued by the Department of Education under Article 4 of the Education (NI) Order 1996, require an Education and Library Board to produce a transition plan at the first (and subsequent) Annual Review of a statement of special educational need following the young person's 14th birthday.

117. This education Transition Plan draws together information from a variety of sources, including the young person, his/her parents, the school and any other professional involved with the young person. It aims to plan coherently for the change when a young person moves from school to adult life.

118. Parents of children with SLCNs report that they would benefit from timely information regarding the availability of services that will meet the needs of their child at transfer and transition. The involvement of a speech and language therapist in the transitions team would also be of benefit to the child or young person.

PRINCIPLES OF BEST PRACTICE IN MODELS OF SERVICE DELIVERY FOR CHILDREN WITH SPEECH, LANGUAGE AND COMMUNICATION NEEDS

119. Services should provide equitable access to effective and efficient SLT provision for children with speech, language, communication, feeding and swallowing needs.

120. It is recognised, however, that there are a range of models of service delivery which have developed and which are appropriate in different contexts, e.g. cultural or geographical, and are relevant and appropriate depending on the client group and at the different stages in a child's life.

121. However, the overriding principles of any model of service delivery should reflect the following:

<u>Models should:-</u>

- Be provided in line with professional standards and guidelines of practice to ensure the highest quality of speech and language therapy provision whilst maximising resources;

- Ensure the appropriate range of skills and competencies are available to address the needs of children with SLCNs;

- Work in partnership with the child, their family and other professions and agencies to reduce the impact of the SLCNs;

- Anticipate and respond to the needs of children who may experience speech, language, communication or swallowing difficulties;

- Be provided in a range of working contexts e.g. domiciliary, community clinics, hospitals, child development centres, schools (mainstream & special schools / units);

- Be integrated across health and social care, education and other agencies in both commissioning and delivery of services;

- Reflect a tiered approach to service provision with universal, targeted, specialist and highly specialist levels as appropriate;

- Enable timely and appropriate access to speech and language therapy services in line with the regional access criteria;

- Be provided in line with the N.I regional care pathway models (range of client groups);

- Reflect uni, multi and trans-disciplinary models of service delivery as appropriate.

TRANS - DISCIPLINARY WORKING

122. A trans-disciplinary approach is an integrated model of working to ensure that the holistic needs of the child are met.

123. Within this model of working the child and his or her needs are placed at the centre of the team. Professional skills and expertise are developed amongst members when adopting this approach and specialist core individual professional skills are enhanced. This subsequently enables therapy aims from other professional groups to be integrated into a child's therapy session through joint goal setting, thereby ensuring the delivery of a comprehensive programme. For example, a physiotherapist may deliver a programme to enhance a child's gross motor skills, whilst incorporating concept development to address a child's language difficulties following support and guidance from the Speech and Language Therapist within the team.

124. For example, the Public Health Agency and HSC Board are leading in developing a review of AHP support for children with special needs in both special schools and mainstream education. This will examine equity of access to AHP services for children with special needs, and encourage partnership working with the education sector and parents, along with the development of a tiered model of therapy provision.

NEXT STEPS

125. The Public Health Agency / Health and Social Care Board will be responsible for driving the implementation of the Action Plan over its two-year life cycle. The Department will consider 1 April 2011 as the start point for implementation and will require six monthly progress reports thereafter.

SECTION 4: ACTION PLAN

HOW TO READ THIS ACTION PLAN

ACTION PLAN

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HOW TO READ THIS ACTION PLAN

Four Themes

126. The Action Plan seeks to improve speech and language therapy services to meet the assessed needs of children and young people, families and carers. The plan is made up of key actions, a timetable for completion, the associated outcomes and the benefit of each action for children and young people and their families.

127. The Action Plan is organised around four themes:
    (a) Commissioning and service redesign to maximise outcomes;
    (b) Supporting and empowering children, parents and carers;
    (c) Enabling HSC staff to promote early recognition, assessment, intervention, treatment, care and support;
    (d) Collaboration between speech and language therapists and teachers and education professionals to enable them to promote early recognition, assessment, intervention and support.

Task Force Recommendations

128. The Speech and Language Therapy Task Force Report included a number of recommendations based on the findings of the Task Force. These recommendations were grouped into five key areas:
    1. Strategic Policy, Planning and Commissioning;
    2. Partnership and Collaborative Working;
    3. Delivering Equitable and Effective Models of Service Delivery;
    4. Education and Training; and
    5. Workforce.

129. These areas and the recommendations they cover have been carefully considered during the drafting of this Action Plan. All actions detailed in the following Action Plan will state in the final column which of the key areas above they correspond to, numbered 1 to 5.

Speech, Language and Communication Therapy Action Plan

2011/12 – 2012/13

Key Themes

A Commissioning and service redesign to maximise outcomes;

B Supporting and empowering children, parents and carers;

C Enabling HSC staff to promote early recognition, assessment, intervention, treatment, care and support;

D Collaboration between Speech and Language Therapists and teachers and education professionals to enable them to promote early recognition, assessment, intervention and support.

Theme A – *Commissioning and Service Redesign to Maximise Outcomes*						
Action Plan Point Ref No.	**Key Actions and Service Needed**	**For Action By**	**Outcome Required**	**Timetable for completion and key milestones**	**Benefits**	**Task Force 1-5**
A1	Agree commissioning framework for SLT for children and young people up to age 19. Incorporate care pathway approach and principles of best practice intervention models.	HSCB/PHA in collaboration with HSC Trusts, Primary Care, and voluntary/ community and education sectors Criminal Justice System (CJS) Royal College of Speech and Language Therapists (RCSLT)	Service planners should have an agreed understanding of care pathway approach and agree assessment tools and standards	September 2011	Promotion of equality of access to service provision and seamless care	1, 2, 3

A2	Agree care pathway(s) for speech and language therapy. Key elements to include: • Awareness raising • Information provision • Early intervention • Agreed referral criteria • Clinical prioritisation • Principles of Best Practice intervention • Involvement in treatment planning / goal setting • Agreed discharge criteria • Self management / parental and educational support • Provision for timely re-entry into SLT services for patients who are subject to medium and long term reviews.	HSCB/PHA in collaboration with HSC Trusts, Primary Care, and voluntary/ community and education sectors CJS RSCLT	An agreed understanding and sharing of a generic model of treatment/care that supports early intervention, and the involvement of parents and educational providers An understanding of goal setting and the respective roles of individuals, parents, staff and educationalists, where appropriate.	From April 2011 onwards	Early intervention and improved outcomes for children with a speech, language and communication need. Promotion of self management and information provision to assist parents and staff in ongoing management of the child with a clear understanding of predicted goals and outcomes.	1, 2, 3, 4, 5

A3	Scope SLT services in Northern Ireland.	Commissioned by DHSSPS in collaboration with HSCB / PHA HSC Trusts SLTs DFP	Service level is determined and areas identified for possible improvement.	March 2010 **Action completed**	SLT services are streamlined and work more efficiently.	1, 2, 3, 5
A4	Agree service redesign to reflect a tiered approach to service provision: • Universal • Targeted • Specialist; and • Highly specialist; as appropriate to needs of patients, and families.	HSCB/PHA in collaboration with Health Visitors / school nurses within HSC Trusts, Primary Care, and voluntary/ community/independent and education sectors RCSLT	Promotion of early intervention and up-skilling of staff relevant to the level of specialist intervention required	December 2011	Health promotion, intervention and detection of “red flags” at earlier stages of intervention. Assessment appropriate to need.	1, 2, 3, 4, 5
A5	Standardise speech and language therapy input into Sure Start schemes.	HSCB/PHA in collaboration with HSC Trusts, Primary Care, and voluntary/ community and education sectors	Enhance child development and early recognition and support for children in need.	December 2011	Promotion of health and wellbeing; reduction in inequalities.	2, 3

A6	Develop innovative approaches to reduce "Did Not Attend" (DNA).	HSCB/PHA in collaboration with HSC Trusts, Primary Care, and voluntary/ community and education sectors. May link with GAIN audit programme.	Audit of DNAs and causes of delayed or late referral. Promote models of interventions which improve access to SLT services and reduce DNAs, especially for hard to reach children and families.	March 2012 and beyond	Assist the child, parents and family to achieve goals and improve outcomes.	1, 2, 3
A7	Develop a Partnership Agreement between HSC Board / Public Health Agency and the education sector which identifies the respective responsibilities of each sector to promote speech, language and communication development, and to support a principles-based approach to speech and language therapy interventions.	HSCB/PHA in collaboration with HSC Trusts, ELBs and education sectors and community and voluntary sectors.	Promote speech and language development.	March 2012	Promote wellbeing, and social inclusion for the child, young person and their family.	2, 3

A8	Develop a speech, language and communication care pathway for children and young people who are not in education, training or employment and for Young Offenders.	HSCB / PHA in collaboration with HSC Trusts, education, employment and youth justice organisations / agencies, RCSLT.	An agreed understanding of the linkage with the generic care pathway; a nominated lead to promote coordination of care planning, for those with a SLC need.	March 2012 and beyond	Improved outcomes for individuals, promotion of social inclusion and enhanced "life chances".	1, 2, 5
A9	Reduce waiting times from 13 weeks to 9 weeks for patients from date of referral to first treatment.	HSCB / PHA HSC Trusts	That no one waits longer than 9 weeks from initial referral to treatment.	From April 2010	Patients are guaranteed to begin treatment within 9 weeks and undue delays are avoided.	1, 3
A10	Develop audit criteria to promote and enhance the quality of service provision. Criteria to be agreed but could include: - provision of individual care plan; - best practice models of provision; - reasons for discharge; - Customer satisfaction.	HSCB/PHA in collaboration with HSC Trusts, Primary Care, may link with GAIN audit programme.	Agreed information provision to inform commissioning and development of services.	From March 2012	Promotion of quality services.	2, 3, 4

A11	Scope unmet need in relation to individuals with SLCNs in the Criminal Justice System.	HSCB / PHA / SEHSCT in collaboration with NIPS and CJS.	Data to inform decision making in CJS.	From March 2012	Facilitate intervention and improved outcomes for young people in CJS.	1, 2, 3
A12	Standardise data collection for speech and language therapy information.	HSCB/PHA, HSC Trusts	Standardised data available to be used in planning and commissioning of services.	March 2012	Reliable information is used to inform decision making.	1, 2, 3, 5
A13	Scope current provision of communication aids for children and young people.	HSCB/PHA, HSC Trusts	Data to support future decision making regarding the provision of communication aids.	From March 2012	To maximise the benefits of new communication aids for children and young people.	1, 2, 3

Theme B – *Supporting and Empowering Children, Parents and Carers*

Action Plan Point Ref No.	Key Actions and Service Needed	For Action By	Outcome Required	Timetable for completion and key milestones	Benefits	Task Force 1-5
B1	Promote early development of speech, language and communication through working with parents. Roll out of early years support material, for example, Bookstart.	HSCB/PHA, Health Visitors within Trusts and Primary Care in collaboration with RCSLT, as well as community, voluntary, independent and education sectors	Encourage parental interaction with child to promote early speech, language and communication development.	Ongoing March 2012	Part of universal services, linked to Health For All Children (Hall and Elliman, 4th Edition), delivered locally through Healthy Child, Healthy Future (2010), to support children and young people's health and development.	2, 4
B2	Amendment of Parent Child Health Record to promote earlier identification of child development concerns.	HSCB/PHA in collaboration with HSC Child Health Promotion Programme in NI.	Earlier identification of "red flags" to support parents to identify concerns regarding child development milestones.	October 2010 **Action Complete**	Part of universal services, linked to Health For All Children (Hall and Elliman, 4th Edition), delivered locally through Healthy Child, Healthy Future (2010), to support parents in the health and development of their child.	3, 4, 5

B3	Agree HV actions, where there is parental concern about speech/language/communication development, in line with Healthy Child, Healthy Future: Speech and language therapy for children – Information and Referral Guidance, for use prior to HSC referral.	HSCB/PHA Health Visitors and SLTs within HSC Trusts, in collaboration with Primary Care, RCSLT and voluntary/ community sector.	Earlier engagement with child and parents where concerns have been identified.	December 2010 **Action Complete**	Earlier intervention and appropriate referral.	3, 4, 5
B4	On entry into primary school, a health appraisal will identify concerns regarding speech, language and communication and refer appropriately.	As above School nurses within Trusts.	Earlier engagement with child and parents where concerns have been identified.	31 December 2011	Earlier intervention and appropriate referral.	2, 3, 4, 5
B5	Where need has been identified, discuss and agree treatment plan with parents / carers with agreed outcomes and respective responsibilities of staff, child and parents/families/carers and educationalists, as appropriate.	HSCB/PHA HSC Trusts Speech and language therapists and assistants, child, parents and educationalists.	Realistic treatment goals and greater understanding of treatment plan.	From March 2011	Promotion of a collaborative approach to intervention. A nominated support worker should be known to the child and family and the education sector, where appropriate.	2, 3, 4, 5

B6	Seek written consent of parents/child/young person to share treatment plan and actively encourage sharing of it with other sectors such as nursery, school, college, youth offender establishments, in accordance with DHSSPS guidance in Good Practice in Consent (2003) and the Data Protection Act 1998.	HSCB/PHA HSC Trusts Speech and language therapists and assistants, child and parents.	Greater collaboration and involvement of parents, families and other sectors.	March 2012	Promotion of a collaborative approach to intervention in the interests of child or young person.	2, 3, 4, 5
B7	Harmonise existing sources of information for children, young people, parents and carers, ensuring they are evidence based, can be maintained and aligned with best practice, and periodically evaluated.	HSCB / PHA HSC Trusts ELBs RCSLT Voluntary and community organisations.	A central resource, targeted at children, young people, parents and carers, in user friendly language to assist and encourage self management and involvement.	March 2012	A one-stop-shop approach to the provision of web-based information which can be regularly updated and maintained.	2, 4

B8	Develop standards for communication practices for parents and therapists in a school setting.	HSCB/PHA HSC Trusts SLTs and assistants, parents and teachers RCSLT Afasic.	Agreed standards for dissemination to schools and parents.	From March 2012	To ensure standardisation of best practice across region.	1,2, 4, 5

Theme C – *Enabling HSC Staff to Promote Early Recognition, Assessment, Intervention, Treatment, Care and Support*						
Action Plan Point Ref No.	**Key Actions and Service Needed**	**For Action By**	**Outcome Required**	**Timetable for completion and key milestones**	**Benefits**	**Task Force 1-5**
C1	Review of the training and update available for health visitors within training and 'In-Service Education' programme provision regarding Speech and Language development and subsequent steps to improve speech, language and communication. Recognition of co morbidities and potential impact on communication and behaviour, e.g. moderate acquired brain injury.	HSCB/PHA in collaboration with HSC Trusts, and including Nurse education providers through the University of Ulster and Nurse Education Commissioning Consortia.	Harmonisation of Health Visitor training package and information tools. Earlier detection of hidden co morbidities.	March 2011 (through introduction of updated Child Health Promotion Programme) Training programme for students undertaking Health Visitor training – 31 March 2011 ongoing thereafter	Improved awareness among HVs and school nurses and support to children and parents. Timely re-entry into service to ensure appropriate intervention.	2, 3, 4, 5

C2	Training and awareness-raising for general practitioners on "red flags" regarding child development milestones and subsequent steps to improve speech, language and communication. Recognition of co morbidities and potential impact on communication and behaviour, e.g. moderate acquired brain injury.	HSCB/PHA HSC Trusts NIMDTA GPs RCSLT	Additional information for GP practices and enhanced training. Earlier detection of hidden co morbidities.	March 2012 and ongoing	Improved awareness among general practitioners on speech, language and communication development and assistance to parents. Timely re-entry into service to ensure appropriate intervention.	2, 3, 4, 5
C3	Analysis of late referral of children with speech, language and communication difficulties to SLT services.	HSCB/PHA in collaboration with HSC Trusts and Primary Care. May link with GAIN audit programme.	Additional information to assist HSC staff to promote earlier recognition of needs; better engagement with parents; reduction in DNA rates.	March 2012	Better outcomes for individual children and young people through earlier recognition and referral and systems redesign, where appropriate.	1, 2, 3, 5

C4	Undertake a workforce analysis of SLT skill mix within the context of the Allied Health Professionals Strategy.	DHSSPS HSCB/PHA HSC Trusts	A strategic vision for AHPs, to include SLTs.	April 2012	An appropriately skilled workforce to enhance timely intervention for children, parents, families etc.	1, 3, 5
C5	Include Speech and Language Therapist in Transitions teams within HSC Trusts.	HSCB/PHA HSC Trusts	Increased trans-disciplinary working and SLT involvement in transition planning. Timely information provided to parents and clients prior to transition re availability of services.	March 2012 onwards	SLCNs are equally considered in transition planning, ensuring better outcomes for children and young people during and after transition phase.	1, 2, 3
C6	Trusts will seek to ensure in their registration and monitoring of non-statutory early years services that providers are aware of the indicators of SLCN's in children and young people and also how to refer to SLT services for appropriate intervention.	HSCB/PHA in collaboration with HSC Trusts	Improved awareness of SLCNs in non-statutory early years settings.	March 2012	Improved early identification of SLCNs in non-statutory early years settings.	1, 2, 3, 4

Theme D – *Collaboration between Speech and Language Therapists and Teachers and Education Professionals to Enable them to Promote Early Recognition, Assessment, Intervention and Support*						
Action Plan Point Ref No.	**Key Actions and Service Needed**	**For Action By**	**Outcome Required**	**Timetable for completion and key milestones**	**Benefits**	**Task Force 1-5**
D1	Initiate discussions with training organisations around inclusion of understanding of child development and the relevance of speech and language to learning within undergraduate teacher training courses and Further Education childcare courses.	DHSSPS in collaboration with other government departments and Education providers.	Enhanced understanding and awareness by teachers **and other care providers** of child development milestones.	From December 2010 Initial discussions completed	Improved understanding of child development and the relevance of speech and language to learning in undergraduate teacher training **and other relevant childcare courses.**	1, 2, 3, 5
D2	Develop information and awareness-raising materials for use in pre-school, primary, post-primary school, special school and young offender settings, taking into account current best practice and existing materials.	Regional SLT Group In collaboration with HSCB / PHA, HSC Trusts, community, voluntary and education sectors.	Consistency of information to educational professionals.	March 2012	Increased awareness of SLCNs in pre-school, primary and secondary school settings.	2, 4, 5

D3	Recognition of transition planning as an integral part of the written care plan for the child / young person as appropriate for their need.	HSCB/PHA HSC Trusts Primary care Education sector and community services.	Seamless and integrated service delivery at critical points of transition.	December 2010 ongoing	Improved health, wellbeing and life chances.	1, 2, 3
D4	Teachers and SLTs respect and understand each others' roles and work in a trans-disciplinary manner, sharing knowledge and skills to ensure that delivering education and therapy needs is the responsibility of both teachers and therapists to encourage maximum participation of the child.	HSCB/PHA HSC Trusts SLT staff in collaboration with school principals and staff. DHSSPS to engage with DE.	Integration of individual care plan into educational curriculum in classroom setting.	March 2012 ongoing	Improved outcomes for children and young people and improved communication between education professionals and SLTs.	1, 2, 3, 4, 5
D5	SLTs input into the Individual Education Plan of children with SLCNs, including appropriate support strategies.	HSC Trusts SLTs School Principals DHSSPS to engage with DE ELBs	Increased understanding of need to practice integrated working.	Ongoing	Improved professional practice and outcomes for children.	1, 2, 3

D6	To introduce appropriate training for nursery school and P1 and P2 teachers and SLTs to enhance learning and development outcomes for children with SLCNs.	HSC Trusts in collaboration with ELBs.	Development of existing collaborative working practices.	Ongoing	Improved professional practice and improved outcomes for children.	1, 2, 3, 4
D7	Senior management of the school and SLT managers should ensure that collaborative working is promoted and provide clarity to the joint working of teachers and therapists.	HSC Trusts in collaboration with ELBs School principals SLT Managers SLTs	Development of existing collaborative working practices.	Ongoing	Improved professional practice and improved outcomes for children.	2, 3
D8	Continuing Professional Development of all staff is required to support the development of collaborative working for the benefit of children with SLCNs.	HSC Trusts in collaborations with ELBs SLTs School principals	Further development of existing skills.	Ongoing	Continued staff development and benefits for children.	2, 3, 4, 5

D9	Review, update and extend DHSSPS/DE document Standards and Guidance for "Promoting Collaborative Working to Support Children with Special Needs" to support the number of children with SLCNs in the education sector.	HSCB/PHA in collaboration with relevant organisations and agencies, including education, training and youth justice sectors	Improved collaborative working practices.	From April 2012	Improved outcomes for children.	1,2,3,4

APPENDIX 1

ACRONYMS

A & C	Administration and Clerical
AHP	Allied Health Professional
BELB	Belfast Education and Library Board
CYPFP	Children & Young People Funding Package
DEL	Department of Employment and Learning
DENI/DE	Department of Education in Northern Ireland/Department of Education
DFP	Department of Finance and Personnel
DHSSPS	Department of Health, Social Services and Public Safety
DNA/CNA	Did Not Attend/Could Not Attend
DOJ	Department of Justice
EHSSB	(legacy) Eastern Health and Social Services Board
ELB	Education and Library Board
GAIN	Guidelines and Audit Implementation Network
GP	General Practitioner
HALL	Health for All Children

HPC	Health Professions Council
HSC	Health and Social Care
HSCT	Health and Social Care Trust
HV	Health Visitors
IDF	International Development Fund
IEP	Individual Education Plans
LCG	Local Commissioning Group
LDLCD	Learning Disability, Learning and Communication Difficulty
MASG	Multi-Agency Steering Group
NEELB	North Eastern Education and Library Board
NHSSB	(legacy) Northern Health and Social Services Board
NICS	Northern Ireland Civil Service
NICCY	Northern Ireland Commissioner for Children and Young People
NIMDTA	Northern Ireland Medical and Dental Training Agency
NIO	Northern Ireland Office
NIPS	Northern Ireland Prison Service
OFMDFM	Office of the First Minister and Deputy First Minister

PBNI	Probation Board of Northern Ireland
PfA	Priorities for Action – Issued annually by DHSSPS
PHA	Public Health Agency
PMSID	Performance Management and Service Improvement Directorate
PPS	Public Prosecution Service
PSNI	Police Service of Northern Ireland
RCSLT	Royal College of Speech and Language Therapists
R & D	Research and Development
(R)HSCB	(Regional) Health and Social Care Board
RIIG	Regional Interagency Implementation Group
SEELB	South Eastern Education and Library Board
SELB	Southern Education and Library Board
SEN	Special Educational Needs
SHSSB	(legacy) Southern Health and Social Services Board
SLC	Speech, Language and Communication
SLCNs	Speech, Language and Communication Needs
SLI	Specific Language Impairment

SLT	Speech and Language Therapy
SLTAs	Speech and Language Therapy Assistants
SLTs	Speech and Language Therapists
TIs	Technical Instructors
UNOCINI	Understanding the Needs of Children in Northern Ireland
WELB	Western Education and Library Board
WTE	Whole Time Equivalent
YJA	Youth Justice Agency
YOI	Young Offenders Institute

APPENDIX 2

Project Team Membership

Chair - Dr Maura Briscoe	DHSSPS
Alison McCullough	RCSLT
Heather Crawford	SEHSCT / RCSLT
Mildred Bell	NHSCT
Clare McGartland	PHA
Aidan Murray	HSCB
Rachel McKenzie	HSCB
Debbie Gladwell	DE
Shona Graham	DE
Irene Murphy	DE
Janice McHenry / Alan Patterson	NIPS
Bill Lockhart / Paula Jack	YJA
Valerie Young	SELB & WELB
Ceardha Morgan	NICCY observer
Patricia Blackburn	DHSSPS
Pauline Mulholland	DHSSPS
Angela McLernon	DHSSPS
Michael Sweeney	DHSSPS
Taryn Gray (administrative support)	DHSSPS

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HEALTH & WELLBEING: *INTO THE NEXT* MILLENNIUM

REGIONAL STRATEGY FOR HEALTH AND SOCIAL WELLBEING 1997 - 2002

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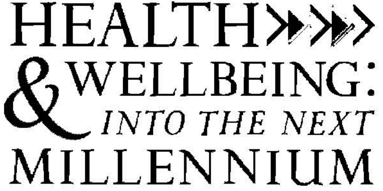


Foreword

We all aspire to good health and a sense of wellbeing. The compassion of any society can be measured by the efforts which it invests in caring for those unfortunate enough not to enjoy full health, the vulnerable, or people who may have special needs.

In Northern Ireland, many thousands of people, across many professional disciplines, are working to promote the health and social wellbeing of the population. This strategy describes the vision of the Department of Health and Social Services for how this work should be taken forward over the five year period 1997-2002. Its primary aim is to secure improvements in the health and social wellbeing of the people of Northern Ireland into the next century.

The strategy is not just for the Department. It sets priorities, objectives and targets for all those working in the health and personal social services and is relevant to other government departments and many organisations in the wider statutory, voluntary, community and private sectors which support their work.

By any standards the strategy presents a daunting agenda. Making it happen will require a major and sustained commitment by many people. Above all, it will require strong alliances and partnerships between a very wide range of organisations, and not just those in the health and personal social services. The wider statutory, voluntary, community and private sectors, as well as individuals and their families, have just as important a role to play in promoting health and social wellbeing.

I believe it is an effort well worth making. Success in implementing the strategy, and in achieving its objectives and targets, will bring real gains for the health and social wellbeing of the people of Northern Ireland. It is for that reason that I am pleased to commit the Department of Health and Social Services to this strategy and to commend it to the many individuals and organisations who can play a part in its implementation.

MALCOLM MOSS
Minister for Health and Social Services

1 CHAPTER ONE SETTING THE SCENE

Introduction

1.1 This is the fourth Regional Strategy produced by the Department of Health and Social Services (DHSS). It is aimed primarily at those working in the health and personal social services and other relevant bodies in the statutory and voluntary sectors and is intended to give strategic direction to their activities over the five year period 1997 to 2002. The strategy builds on the foundations laid in the earlier strategies in seeking to add years to life and life to years. As well as providing a common set of goals for all those working in the health and personal social services, the strategy highlights the need to enlist the support of other agencies and of local people themselves in the pursuit of health and social gain, that is improving the length and quality of life for people in Northern Ireland. The strategy sets priorities, objectives and, where appropriate, specific targets for the next five years which will help the Department to meet its primary responsibility of **promoting the physical and mental health and social wellbeing of the population.** The identification of certain areas as priorities should not lessen commitment to steady progress across the full range of health and personal social services.

1.2 We all value our own health and sense of wellbeing. We expect that, when we are ill or in need, the services will be there to care for us. The role of the health and personal social services, however, encompasses much more than providing care and treatment in our homes, health centres, surgeries, day centres and hospitals. This strategy envisages that those working within health and personal social services will be champions for health and social gain for our community.

1.3 The 1992-97 Regional Strategy[1] recognised that other government departments and their agencies have an important contribution to make to health. This led to the establishment in 1992 of the Inter-Departmental Group on Health, which brings together, under the chairmanship of DHSS, representatives of all the main government departments in Northern Ireland to consider health issues which impact on or are influenced by the policies of other departments. The importance of inter-departmental collaboration on social issues had been recognised earlier with the establishment in 1984 of the Social Steering Group, which has a similar coordinating role in relation to social policy issues. This strategy develops that theme and signals the potential for a greatly enhanced role for others outside the health and personal social services in contributing to health and social gain.

1.4 There is also a need to develop strong alliances for health and social gain with communities themselves. A community - people living in a particular area or people sharing some common characteristics - has a right to be involved in making choices about how health and social care is delivered to respond to its needs. It is crucial that health and social services staff work with service users and potential users to ensure that services are planned and delivered in a coordinated way which people find acceptable.

[1] DHSS.
A Regional Strategy for the Northern Ireland Health and Personal Social Services 1992-1997.
Department of Health and Social Services, 1991.

Current Position

1.5 Over recent years there has been a small but steady increase in life expectancy for both men and women in Northern Ireland. Early deaths from most of the main causes of death have reduced over that timescale. Heart disease remains the major cause of early death and, although rates have been falling over the last ten years, Northern Ireland's death rate from heart disease remains among the highest in Western Europe. Social, economic and environmental factors are bringing about changes in family structures and adding greater stress in daily life, increasing the need for social support.

1.6 There have also been individuals who have been bereaved or seriously affected, both physically and psychologically, by the civil unrest in Northern Ireland. Many of them have been traumatised by violent events but have yet to be identified as victims. The health and personal social services have responded well to a whole range of violent incidents over the years as they have occurred, especially the larger scale events. The voluntary sector has also made an important contribution. It will continue to be necessary to ascertain systematically the extent of current needs for this group of people and the most appropriate ways of responding to them.

1.7 Progress towards achieving the targets in the 1992-97 Regional Strategy has been mixed. Appendix 3 details progress on its main quantitative targets. While there have been substantial reductions in premature deaths from heart disease and from accidents, cancer deaths have shown little or no reduction over recent years; and stroke deaths are reducing too slowly to enable the target set in that strategy to be reached. There has been some increase in the proportion of adults who do not smoke, but there are still worrying increases in the proportion of young people, particularly women, who do smoke. There has been little change over the last decade in the percentages of adults who drink more than the recommended levels of alcohol.

1.8 Good progress has been made in providing care in the community for former long-stay patients in mental illness and specialist hospitals for people with a learning disability. In its recently published review *Opening New Doors: An Evaluation of Community Care for People Discharged from Psychiatric and Mental Handicap Hospitals*[1] the Health and Health Care Research Unit at Queen's University found that most of the people discharged from long-stay mental illness or specialist hospitals for people with a learning disability had been placed in highly staffed accommodation, but that these were less institutional in character. Residents generally preferred their new homes, although for many life in the community was similar in many ways to life in hospital with integration into the wider community proving difficult to achieve. The development of community-based services for elderly people has allowed more of them to live at home. The strategy also emphasised child protection measures and earlier recognition of, and support for, families at risk; good progress has been made in both areas.

[1] HEALTH AND HEALTH CARE RESEARCH UNIT, THE QUEEN'S UNIVERSITY OF BELFAST/PERSONAL SOCIAL SERVICES RESEARCH UNIT, THE UNIVERSITY OF KENT AT CANTERBURY.
Opening New Doors: An Evaluation of Community Care for People Discharged from Psychiatric and Mental Handicap Hospitals. HMSO, 1994.

Changes and Choices

1.9 Choices must inevitably be made in the provision of health and personal social services. Resources are not limitless; priorities have to be decided and resources targeted where there is greatest need. Also, there may be different ways of achieving the same outcome with the same level of resources. People, individually and collectively, have a right to a say in these choices. In order to meet the health and social care needs of the population, those working in the health and personal social services must be able to communicate effectively with people, both to give information and to listen to and take account of their views.

1.10 People must be able to make **informed** choices. Professionals within the health and personal social services must be able to present relevant information on the links between environment, lifestyle and health and on options for treatment and care in a way which will help people to make decisions about their own health and wellbeing and any care which they require. At a strategic level, the public also needs to be given information about the feasibility of different patterns of service provision, and their associated costs and benefits, so that it can have a say in determining priorities. Recent advances by Health and Social Services Boards in locally sensitive purchasing, recognising the differing needs of people in different parts of the province, provide an opportunity for people to have a greater say in the delivery of services in their area.

Health and Social Wellbeing in a Wider Context

1.11 Many of the issues identified in this strategy are also being faced by neighbouring countries in Europe as well as further afield: environmental and lifestyle factors which lead to increased illness and premature death; similar patterns of illness and death; advances in technology which increase the scope for prevention and treatment of disease; inequalities in health and social wellbeing, particularly those associated with poverty; and increasing numbers of elderly people requiring care other than from their immediate family and friends. There is therefore considerable scope for working together. In particular, the existence of health strategies in England[1], Scotland[2], Wales[3] and the Republic of Ireland[4], and the common ground between them in the issues which they address, offers an agenda for cooperation and concerted effort.

The Changing Context

1.12 Since the publication of the 1992-97 Regional Strategy there have been many developments within the health and personal social services. A review of the existing structure for purchasing health and social services in Northern Ireland concluded that Health and Social Services Boards should focus on their commissioning role within their existing geographical boundaries and should cease to engage in the supply of any provider-related services. GP fundholding and other mechanisms for involving general practitioners in commissioning have become well established, again bringing decision making nearer to the patient and client.

1 DEPARTMENT OF HEALTH.
The Health of the Nation: A Strategy for Health in England.
HMSO, 1992.

2 SCOTTISH OFFICE.
Scotland's Health: A Challenge to us All.
HMSO, 1992.

3 WELSH OFFICE.
Strategic Intent and Direction for the NHS in Wales.
Welsh Office Publicity Unit, 1989.

4 DEPARTMENT OF HEALTH (REPUBLIC OF IRELAND).
Shaping a Healthier Future: A Strategy for Effective Health Care in the 1990s.
Stationery Office, Dublin, 1994.

1.13 Health promotion is a core responsibility of the health and personal social services. A recent review of health promotion arrangements has re-emphasised the central position of health promotion within health policy. As a result of the review it has been decided that Health and Social Services Boards should become commissioners of health promotion services, that Trusts should assume the bulk of the responsibility for the provision of local health promotion services and that the Health Promotion Agency should focus on providing strategic services at a regional level.

1.14 Medicines are a crucial aspect of every day living. New therapeutic agents continue to be introduced which offer patient benefits but have major cost implications for the health service. At the same time, during the period of the previous strategy, a number of medicines were deregulated from 'Prescription Only' status to 'Pharmacy Only' status, thus allowing wider opportunity for self-medication. This deregulation process is set to continue. There is therefore an enduring need for pharmaceutical care and medicines management to achieve rational, safe, effective and economic therapy.

1.15 The health and welfare of families and children is a key area within this strategy. The Children (Northern Ireland) Order is expected to come into operation in late 1996. The new Order reforms and consolidates much of the law relating to the care, wellbeing and protection of children and will provide the legislative basis for the provision of social services for children in need, including children with disabilities, and their families. The UK has also ratified the United Nations Convention on the Rights of the Child. The Convention came into force in 1992 and recognises that children are especially vulnerable and have a right to special consideration.

1.16 The Disability Discrimination Act 1995 gives people with disabilities new rights in areas such as employment, access to goods, facilities and services, and in buying or renting land or property. The implementation of the Act's provisions, and in particular the work of the Northern Ireland Disability Council, will have a major impact on several of the groups identified as key areas in this strategy.

1.17 The proposed introduction of direct payments will have an effect on the way community care is delivered during the period of the strategy. It is intended that the Community Care (Direct Payments) Bill, which is currently before Parliament, will be extended to Northern Ireland by an Order in Council. The legislation, which is expected to come into operation later in 1996, will enable Boards and Trusts to offer people cash payments instead of providing them with community care services so that they can buy the services they need for themselves . This will promote the principles of independence and choice and allow people who are offered direct payments, and who wish to avail of the option, more control over how their care needs are met.

1.18 Another major development was the publication in 1993 of the Government's *Strategy for the Support of the Voluntary Sector and for Community Development in Northern Ireland*[1]. This sets out a clear strategic framework for Government's support for the voluntary and community sector and recognises and endorses the value of community development and the role of community groups in Northern Ireland in a wide range of areas, including the health and personal social services. The strategy acknowledges the need to enhance the effectiveness and efficiency of departments' existing commitments to community development and welcomes both the contribution of statutory agencies to this process and the partnerships with voluntary organisations and local groups. In June 1995 *Make a Difference: An Outline Volunteering Strategy for the UK*[2]. was produced as part of the Government-sponsored Make A Difference Volunteering Initiative. In response to this, the Government's Action Plans were published in November 1995, showing how departments throughout the UK are developing ways of encouraging volunteering within their respective policy areas. Volunteering is a key component of community development and the commitment to this in the Regional Strategy, as well as the focus on the needs of carers, will help advance the principles of the Volunteering Strategy.

Implementation

1.19 Implementation of this strategy requires commitment from many sectors, but Boards have a key role. Each Board is expected to adopt the themes and objectives of the strategy. The Regional Strategy will form the framework for Boards' commissioning of services over the next five years and will be reflected in contracts with service providers. Boards must join GPs - both fundholders and non-fundholders - to their planning process and the development of the area purchasing plans. Fundholders' business plans must take account of the strategic planning issues and the agreed area priority objectives. The annual Management Plan[3] issued by the HSS Executive will also set specific targets over each of the next five years based on the strategic objectives.

1.20 Implementation of the 1992-97 Regional Strategy has been promoted by the HSS Executive's publication of a series of Key Area Action Plans[4-10], which contain useful guidance on implementation and point to examples of good practice. The guidance in these Action Plans remains valid for the remainder of the 1992-97 planning period and beyond.

1.21 The strategy also sets an agenda for action outside the health and personal social services. This will require health and personal social services staff at all levels to work in partnership with others. The Department will pursue implementation of these wider issues, much of which will be overseen by the Inter-Departmental Group on Health and the Social Steering Group.

1 DHSS.
Strategy for the Support of the Voluntary Sector and for Community Development in Northern Ireland.
Department of Health and Social Services, 1993.

2 VOLUNTEERING UNIT.
Make A Difference: An Outline Volunteering Strategy for the UK.
Home Office Public Relations Branch, 1995.

3 HSS EXECUTIVE.
Management Plan.
Department of Health and Social Services, Annual.

DHSS Action Plans:
4. **Maternal and Child Health.**
5. **Child Care.**
6. **Physical and Sensory Disability.**
7. **Mental Health.**
8. **Circulatory Diseases.**
9. **Cancers.**
10. **Respiratory Diseases.**
Department of Health and Social Services, 1994.

Target Setting, Monitoring and Evaluation

1.22 Where possible the Regional Strategy sets quantified targets, specifying the amount of change which should be achieved in a given timescale. These targets provide something tangible to aim for and a means of measuring progress. They are intended to be challenging but achievable. In some cases where it has not been possible to set a quantitative or timebounded target, an objective has been set for improvement in health and social wellbeing. In addition, the strategy contains a number of specific recommendations for action over the planning period.

1.23 Monitoring how the Regional Strategy is implemented will be carried out at a variety of levels. At the strategic level, the Department will monitor overall progress against the main objectives and targets set in the strategy, using existing and planned surveys and information routinely collected from the health and personal social services. Annual progress reports will be produced and published. The performance of the health and personal social services in implementing the strategy will also be monitored through the annual accountability processes of the Department. Where appropriate, adjustments may be made to the targets and policies proposed in the Regional Strategy in the light of operational experience and the resources available.

1.24 Throughout the Regional Strategy there is a recurring emphasis on the need for rigorous evaluation of the effectiveness of individual programmes and interventions. Responsibility for this will fall to all those involved in implementing the individual components of the strategy. This will be supplemented by the Department's rolling programme of policy evaluations, under which all the main policy areas of the Department are regularly evaluated. The outcomes of the policy evaluation programme will also inform decisions on any adjustments to the strategy which are considered necessary.

Resources

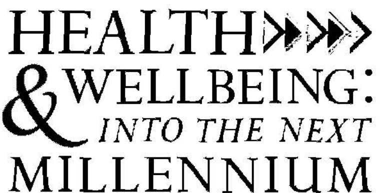
1.25 The resources required to implement this strategy are not just those of finance or capital. Most importantly, they are people. Staff are a key resource in the health and personal social services. Successful implementation of many areas in this strategy will depend on staff within the health and personal social services developing new approaches to how they do their work. Providers must therefore ensure that their staff are equipped to deal with the service changes envisaged in the strategy and are afforded the opportunity to develop their skills to deliver a first class service. Moreover, the comprehensive programme for improving health and social wellbeing set out in the strategy challenges the entire population to play its part, not just the key professions, patients, clients and their families.

1.26 Similarly, the financial resources required for the strategy are not just those directly available to the health and personal social services. Other public sector organisations, as well as voluntary and private sector bodies, can and should contribute to the achievement of our goals. Indeed, given the comprehensive nature of this strategy and its goals, which potentially impact on many aspects of the life of the entire community, it is impractical to quantify the level of financial resources required. It is unlikely, however, that there will ever be sufficient resources to do everything that is desirable to promote health and social wellbeing in Northern Ireland. Even within the health and personal social services the demand for resources seems continually to be growing across all areas of expenditure, whether as a result of the ageing population; the availability of new forms of treatment facilitated by technological developments or new drug therapies; the need for capital investment to develop new facilities or upgrade existing facilities; or the consequences of new policy developments such as Community Care or the Children Order. Not everything is possible, and difficult choices will have to be made. For that reason the strategy identifies the priorities for action within whatever resources become available with appropriate phasing over the strategy period. There is a vast range of essential services, however, which must continue to be provided.

1.27 The pressure on resources reinforces the importance of the critical appraisal of existing patterns of expenditure, drawing on research into cost-effectiveness. This calls for a rigorous and continuous evaluation of the use of resources within the health and personal social services. It is essential that all those working in the health and personal social services actively strive for better use of existing resources.

1.28 Success in implementing much of this strategy depends on getting the balance right between the levels of investment in various services, in particular between care in the community and hospital care. It is clear that resources are needed to improve levels of care within the community, as people move from hospital care into the community, yet medical and technological advances continue to represent a competing demand for resources within the acute care sector. Resources need to be freed up within the acute hospital sector through factors such as shorter lengths of stay, increased day case work and decreased numbers of referrals into hospitals. Boards should ensure that resources freed up in the long-stay hospital sectors are reinvested into developing services in the community and that resources freed up in the acute sector are shared appropriately between priorities in the acute and community care sectors.

2 CHAPTER TWO OVERVIEW OF THE STRATEGY



Strategic Themes

2.1 The overall aim of this strategy is:-

to improve the physical and mental health and social wellbeing of the population.

In working towards this aim the strategy sets objectives within four inter-connected **themes**:-

promoting health and social wellbeing;

targeting health and social need;

improving care in the community; and

improving acute care.

These themes, which encompass the broad policy areas of the health and personal social services, have been carried over from the third, and in some cases the second, Regional Strategy[1]. In each theme, however, new ideas have been added to reflect topical issues and current thinking.

Key Areas

2.2 In addition to the four themes, the strategy identifies seven **key areas** for special attention. They have been chosen because they offer scope for practical action to improve the length and quality of life for people in Northern Ireland. These key areas provide a common set of priorities at all levels throughout the health and personal social services.

Underlying Principles

2.3 The remaining chapters of this document deal in turn with each of the strategic themes and key areas. However, there are four **underlying principles** which recur throughout the strategy and are central to its successful implementation:-

- encouraging public policy which supports health and social wellbeing;
- supporting community development;
- enhancing the role of primary care; and
- placing increased emphasis on effectiveness and measuring outcomes.

[1] DHSS.
A Regional Strategy for the Northern Ireland Health and Personal Social Services 1987-1992.
Department of Health and Social Services, 1987.

These are discussed in more detail below.

Public Policy

2.4 Our health and wellbeing depend on biological factors such as age, sex and heredity, and the lifestyles we adopt. They are also affected by the social, economic and environmental conditions in which we live. These conditions are greatly influenced by the policies and actions of many government departments and their agencies. Increasingly recognition is being given to the need to influence social and environmental factors in ways which protect and promote health and social wellbeing. The actions which are needed to improve health and social wellbeing extend beyond health and social services into wider aspects of public policy. Nevertheless, the health and personal social services have a crucial role in influencing public policy for health and social gain. The health impact of public policy decisions needs to be considered in the policy making process of many sectors, such as housing, environment, social security, training/employment, education, transport, agriculture and energy. Such policies also need to be coordinated to guard against one agency encouraging one form of behaviour while another agency is acting inadvertently to discourage the same behaviour. **The Department, Boards, Trusts and the Health Promotion Agency must seek to influence the coordination of public policies at all levels which have a direct bearing on health and social wellbeing, so that supportive environments are created.** The Inter-Departmental Group on Health and the Social Steering Group are the main fora within central government through which coordination of public policies for health and social wellbeing can be pursued.

Community Development

2.5 The World Health Organisation identifies 'a well informed, well motivated and actively participating community' as a key element for the attainment of its major goal 'health for all by the year 2000'. To this end this strategy adopts community development as one of its underlying principles.

2.6 Community development is about strengthening and bringing about change in communities. It consists of a set of **methods** which can broaden vision and capacity for social change, and **approaches**, including consultation, advocacy and relationships with local groups. It is a way of working, informed by certain principles which seek to encourage communities - people who live in the same areas or who have something else in common - to tackle for themselves the problems which they face and identify to be important, and which aim to empower them to change things by developing their own skills, knowledge and experience, and also by working in partnerships with other groups and with statutory agencies. The strength of community development lies in its diversity; it has the potential to make a major impact on a wide spectrum of policies and programmes delivered through organisations in both the statutory and voluntary sectors. It has a particularly important contribution to make within the health and personal social services in reaching and involving people in need, in encouraging active participation by

local communities in needs assessment and in seeking to maximise the participation of service users and potential users in the decision making process. Local community groups play an important role in this area. The effect of the community development process, including the involvement of community groups, is to make services more responsive to users' needs and to generate a sense of local ownership and control over those matters which affect the lives of the people involved. Community development therefore, has a role to play in many of the themes and key areas in this strategy.

Primary Care

2.7 Inherent in the principle of community development is advocacy on behalf of people. In the period of the last Regional Strategy the health and personal social services have been seeking, under the major programme of reforms, to become more responsive to individual patients and clients as well as to the needs of the population of Northern Ireland as a whole. During the period of this strategy it is the Department's aim to foster the growing relationships between Boards and general practitioners and other members of the primary care team, and increasingly, to build on some very good practice already established for primary care teams and strong partnerships between the different commissioners of care. This will mean that commissioning decisions about the design, purchasing and provision of care are influenced as directly as possible by patients and clients. This strategy recognises the benefits of empowering those working in primary care to influence the process of service commissioning on behalf of their patients and clients.

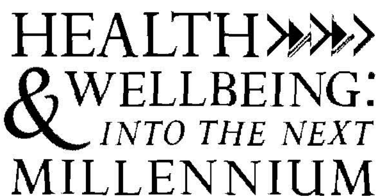
2.8 Primary care plays a vital role in each of the themes and key areas. Those working in primary care have a detailed knowledge of the local community and can make an important contribution to needs assessment. As well as being responsible for the delivery of a substantial share of care and treatment, they form a vital link between the patient or client and any further care or treatment required. This strategy recognises the need to promote primary care by clarifying and integrating responsibilities for service provision, ensuring access for all and developing interfaces with secondary care. There also needs to be further development of opportunities for promoting health and social wellbeing within primary care by building in appropriate advice and support to every encounter with a patient or client.

Better Outcomes

2.9 The Department wishes to see decisions about services and interventions throughout the health and personal social services being based on firm evidence of effectiveness in order to secure the greatest health and social gain from the resources available. The importance of achieving better outcomes is reinforced throughout this strategy. The strength of evidence as to the effectiveness of particular interventions varies. There are some interventions whose effectiveness lies beyond dispute, but many are subject to varying degrees of uncertainty and debate. Professionals within the health and personal social services must be committed to evaluation of their work and dissemination of evaluation results.

2.10 During the period of this strategy the Department expects both purchasers and providers to base more of their purchasing decisions and delivery of services on evidence of effectiveness and to withdraw interventions which are shown to be ineffective. **Purchasers should be able to demonstrate a significant change over the strategic period in the level of investment in a range of services and interventions as a result of using available evidence on effectiveness and cost effectiveness. This range should include services and interventions from primary, secondary and continuing care.**

3 CHAPTER THREE PROMOTING HEALTH & SOCIAL WELLBEING



Introduction

3.1 Promoting health and social wellbeing is central to this strategy. In general people are becoming more aware of the factors which contribute to disease and social problems. They need more help, however, in applying that knowledge in order to make changes in their own lives and in the wider community.

3.2 The Department's aims for promoting health and social wellbeing are:-

to reduce preventable causes of disease and disability;

to encourage and support people to take responsibility for their own lives;

to develop public policies which protect health and promote social wellbeing;

to develop partnerships to promote health and social wellbeing; and

to help people to obtain relevant information and skills.

These aims are consistent with the principles which underpin the World Health Organisation's Health For All strategy[1].

3.3 The next section of this chapter identifies general policy approaches which are considered essential if the health and social wellbeing of the people of Northern Ireland are to be promoted over the period of this strategy. The final part of the chapter sets an agenda for action in a number of specific problem areas.

Approaches to Promoting Health and Social Wellbeing Prevention

3.4 Many of the conditions which lead to premature death or long-term illness such as coronary heart disease, cancers and accidents are preventable. Similarly, many of the causes of social problems are also preventable. Nearly two thirds of all premature deaths in adults in Northern Ireland are due to heart disease and cancers. Risk factors common to the major diseases are smoking, lack of physical activity and poor nutrition. The level of these risk factors is high in the Northern Ireland population, for example, two thirds of the population aged 15-64 have two or more risk factors for heart disease. Equally Northern Ireland is unlikely to be different from any other part of the world in respect of hospital admissions due to medicine induced disease. Many of these admissions are preventable.

[1] WORLD HEALTH ORGANISATION.
Targets for Health for All 2000.
WHO, 1985.

3.5 The interaction of many factors which shape our lifestyles means that prevention is a complex process. Efforts need to be coordinated across a number of areas such as personal and public education, the development of professional skills and the continuous evaluation of policies and services in order to design effective approaches. Holistic approaches to tackling prevention, which take into account the social dimension of people's lives, are preferable to focusing on single risk factors or issues.

Inequalities in Health and Social Wellbeing

3.6 Chapter 4 highlights the need to tackle inequalities between groups within the population and to target services and resources on those most in need. This applies to preventive services as well as to care and treatment. Targeting groups who are most at risk is therefore a recurring message in the agenda for action spelt out later in this chapter.

Health and Social Public Policy

3.7 A comprehensive approach to improving health and social wellbeing must be intersectoral, involving partnerships with organisations responsible for the environment, employment, housing, transport, education, agriculture, health and social services and social security. At the broadest level, each government department's success in its pursuit of its own objectives - improving educational standards or promoting economic development, for example - adds to the overall wellbeing of the population. At a more specific level, several of the policies and programmes of government departments and their agencies contain targets which are directly related to health and social wellbeing, for example in the areas of road accident prevention, the protection of the environment, promoting health and safety in the workplace, environmental health, education and crime prevention.

3.8 These common interests offer opportunities for cooperation and for making best use of limited skills and resources. A good example of such cooperation is *Health Promotion in NI - An Environmental Health Perspective*[1] which was published by the Chartered Institute of Environmental Health in March 1996. The health and personal social services should, where possible, complement and reinforce the approaches of other departments and their agencies. The Department has an important role in ensuring that the plans of government departments or their agencies, which have targets which relate to improvements in health and social wellbeing, are well understood and widely supported by the health and personal social services. Strong alliances need to be created with professionals working in related areas, such as environmental health officers, to exploit to the full opportunities for promoting health and social wellbeing.

[1] DOE (NI).
Health Promotion in NI - An Environmental Health Perspective.
Chartered Institute of Environmental Health, 1996.

3.9 Whilst improving health and social wellbeing may not be the primary aim of policies relating to the economy, housing, transport or agriculture, these policies are nevertheless likely to have considerable impact on health and wellbeing. For example, the Department of the Environment's transport policy statement *Transportation in Northern Ireland - The Way Forward*[1] published in October 1995 acknowledges the link between reduced mobility and poorer health. Public policy often sets the conditions for health and social wellbeing by creating opportunities or barriers for the choices which individuals and organisations can make. There is a need to ensure that policies in all sectors are developed with full consideration of their impact on health and social wellbeing. In 1992 the Government gave a commitment to assessing the consequences for health of different government policies, and to providing guidance on policy appraisal and health. This commitment should be adopted by all government departments in Northern Ireland. **Guidance on policy appraisal and health has been prepared by the Department of Health (London); this will be considered by the Inter-Departmental Group on Health for adoption by all government departments in Northern Ireland.**

Community Development

3.10 Alongside efforts to improve health and social wellbeing through public policy, there is a need to encourage action and change at community level. Northern Ireland has been at the forefront of adopting community development approaches to promoting health and social wellbeing and a strong network of organisations and groups is working in this area. They are developing innovative approaches, promoting good practice and encouraging evaluation. Chapter 4 deals in more detail with the potential of community development for promoting health and social wellbeing and sets objectives in support of such development.

Professional Development

3.11 There is a continuing need for the appropriate education and training of all staff in the promotion of health and social wellbeing. This is relevant to those working in the wider health and personal social services as well as to specialists in health promotion. Training approaches which integrate health and social wellbeing are recommended where appropriate. Boards and Trusts will be expected to commission relevant training at levels appropriate to staff needs. **The Department will by 1998 commission a review of current provision in professional education and training for the promotion of health and social wellbeing.**

Effectiveness

3.12 To achieve success in promoting health and social wellbeing, evaluated approaches should be adopted and rigorous standards maintained. Evidence of the effectiveness of health promotion and of a range of social interventions is growing. Effectiveness is increased when there is a strong research base, both qualitative and quantitative, long term collaborative work, involvement of and sharing of information with other key sectors and organisations and well trained practitioners. Priority must be given to developing the range of indicators for successful interventions and to the dissemination of information about effective approaches.

1 DOE (NI).
Transportation in Northern Ireland - The Way Forward.
HMSO, 1995.

Research and Information

3.13 Both qualitative and quantitative research is vital in informing the promotion of health and social wellbeing. The new Northern Ireland Survey of Health and Social Wellbeing, which will start in 1996 and be repeated at regular intervals, will be a major source of information for monitoring this strategy and for future planning. More attention needs to be given to the collation and use of data from many sources and to the identification of information needed to inform purchasing for effectiveness. Alongside outcome evaluation, process evaluation is equally important, as this can provide an assessment of how programmes should be implemented, what kinds of interventions work under what conditions and what level of effort or resources is required. Methods in process evaluation have been less well defined and require development and investment.

3.14 There are multiple audiences for information on health and social wellbeing issues - the public, and professionals and policy makers in many sectors. **To maximise the range of research and information available to professionals and policy makers, the Department will work towards establishing a centre for information and good practice in promoting health and social wellbeing.** This will assist those working in the health and personal social services to provide the public with clear, authoritative, accurate and tested information on steps they can take to improve their own health and social wellbeing. Such information should be provided in a variety of media taking account of cultural relevance, gender sensitivity, accessibility and the communication needs of people with sensory impairment.

Promoting Health and Social Wellbeing in Different Settings

3.15 An approach, which has gained recognition in Northern Ireland, the UK and internationally, aims to coordinate programmes in different **settings** where people meet, work or live. Appropriate settings for action include early childhood services, schools and colleges, workplaces, the health and personal social services including primary care and hospitals, occupational health and social work services, youth settings, the family and the wider community. Adopting this approach towards creating healthier and more supportive environments will demand the development of partnerships. It highlights the interrelated nature of risk factors and the need to adopt a comprehensive approach. It involves looking at the opportunities for promoting health and social wellbeing in each setting and moves away from a focus on disease. This approach will also demand new standards of measurement in evaluating impact and time to achieve results. The World Health Organisation has given a lead to work in settings and initial work has already been undertaken to develop this approach in schools and hospitals in Northern Ireland and through projects such as Healthy Cities and Healthy Communities. **Boards should commission the development and support of programmes to promote health and social wellbeing in a selected range of settings.**

Guidelines for Promoting Health and Social Wellbeing

3.16 A variety of approaches to promoting health and social wellbeing has been outlined. It is vital that those working to meet the objectives and targets of the Regional Strategy do so in a coordinated way if scarce resources are to be used to achieve maximum effect. In order to ensure that regional and local initiatives are designed to complement each other, the Department will commission guidelines for promoting health and social wellbeing where need is identified in the strategy. Such guidelines should outline:-

- a range of actions to meet this need based on tested approaches;
- proposals for research, development and evaluation;
- standards for achievement;
- prospective partnerships; and
- implementation plans.

Promoting Health and Social Wellbeing - An Agenda for Action

3.17 In setting the direction for the health and personal social services and for other organisations whose activities influence health and social wellbeing, targets have been set against which to measure progress. It is recognised that the achievement of these targets will depend on the actions of a wide range of groups and organisations, often in partnership with the health and personal social services.

Mental Health

3.18 The determinants of mental health include physical health, personality, early childhood influences, particularly the quality of parenting, recent life events and social factors, for example unemployment and social isolation. Good mental health is associated with a positive self-image, healthy and satisfying relationships with peers and family, skills and competencies in decision making and problem solving, self-motivation and social support in facing life events. The changing nature of social roles and factors such as unemployment have a bearing on emotional wellbeing. In particular the issues of anxiety and depression, especially in vulnerable groups such as women, older people, unemployed people and those recently bereaved or traumatised, and of caring for carers, need to be addressed.

Target

Promoting positive mental health is a relatively undeveloped area. The Department will establish by 1997 a regional working group to develop a strategy and an action plan for mental health promotion, with targets for implementation.

Children and Families

3.19 The adage that prevention is better than cure is particularly relevant where families are concerned. Some children whose families come under stress will experience consequences that profoundly affect their own adult lives and the lives of those around them. Timely intervention can reap long-term benefits. The provision of support services at an appropriate early stage may not only avoid an impending crisis but may also remove the need for more intensive and expensive intervention later on.

3.20 The powerful case for prevention is recognised in the Children Order, which seeks to broaden the basis of support work with families. While acknowledging that the prime responsibility for children's upbringing lies with parents, the legislation identifies a role for the state in helping parents to meet that responsibility and where possible in preventing families from breaking down. It places a duty on Boards and Trusts '*to safeguard and promote the welfare of children within their area who are in need*'. The definition of need is drawn widely to encompass not only disabled children and those at immediate risk of abuse, but also where a child is '*unlikely to achieve or maintain or have the opportunity of achieving or maintaining a reasonable standard of health and development without the provision for him of services . . .*'.

3.21 Working so far as possible in partnership with parents, Boards and Trusts are required to organise a range of support services including advice, counselling activities and help in the home. They are encouraged to work in association with other agencies and with the voluntary sector. The legislation places new preventive responsibilities on the appropriate authorities as well as setting new rules for the treatment of children by the courts. The development of a preventive strategy within a consistent framework will be an important component in the implementation of the Children Order. **The Department will, as part of its programme for the implementation of the Children Order, develop with Boards and Trusts a strategy for promotion of wellbeing for families and children in need.** The strategy will build on the interagency approach outlined in the Early Years Policy framework[1], published jointly with the Department of Education in September 1994. It will have regard to the European Council Recommendation on Childcare of March 1992 and to the UN Convention on the Rights of the Child.

Accidents, Trauma and Violence

3.22 Personal attitudes and behaviours, the physical environment and the social environment all contribute to the occurrence of injuries. Therefore, to reduce injuries action must be directed as much at environmental and social factors as at individuals. It is known that a comprehensive approach which includes strengthening public policy, improving awareness, education programmes and creating safer environments is most effective. Coordinated action by the numerous organisations and agencies with an involvement in accident prevention can result in significant long-term injury reduction. The important accident prevention work of bodies such as the Department of Economic Development, the Department of the Environment, the Fire Services, the Department of Agriculture, the RUC, Environmental Health Departments and the

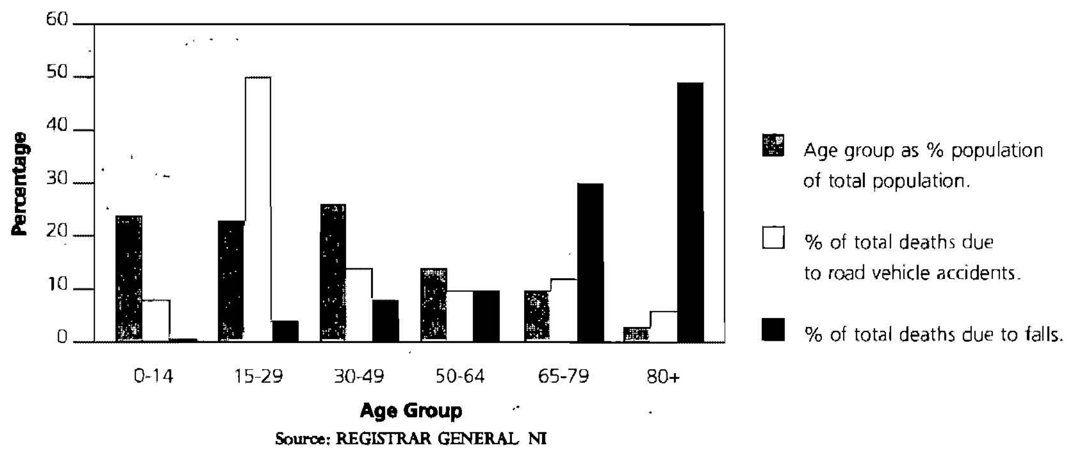
[1] DHSS/DENI.
Policy on Early Years Provision.
Department of Health and Social Services/Department of Education (NI), 1994.

Health and Safety Agency is recognised, as is the voluntary sector contribution. The recent joint publication of a *Road Safety Plan for Northern Ireland 1995/96 - 1997/98*[1] by the Department of the Environment, the Royal Ulster Constabulary and DHSS is a good example of coordinated action. The Department commends the adoption and promotion of the target contained in the Safety Plan for a one-third reduction in fatal and serious road traffic casualties by the year 2000.

3.23 Accidents are a major contributor to deaths in childhood. There is evidence that children in lower socioeconomic groups have more accidents. A multiagency approach is required to address the two main types of accident affecting this age group - road traffic accidents and accidents in the home. **Over the period of the strategy each Board should develop a programme aimed at reducing accidents to children**. Such initiatives should show tangible results over the strategic period in reduced deaths and injuries to children and also in reduced differentials between socioeconomic groups.

3.24 Specific information related to accidents, fatal and non-fatal, occurring in various settings and as a result of various activities is of benefit in understanding precisely where interventions should be best directed. For instance, in 1993 around 50% of the people killed in motor vehicle accidents were aged 15-29 and about 80% of those who died from falls were 65 and over (Figure 3.1). Data systems need to be in place to support work in this area. In addition the link between alcohol use and injury is significant and needs to be stressed.

Figure 3.1
DEATHS FROM ACCIDENTS 1993



Source: REGISTRAR GENERAL NI

3.25 Violence inside and outside the family is a significant cause of injury, death and psychological trauma. The strategy for family and child care mentioned in the previous section will encompass action to protect children from abuse and help those who have already suffered abuse. Action against domestic violence will be carried forward within the framework set out in *Tackling Domestic Violence*[2], published jointly with the Northern Ireland Office in June 1995. The importance of primary prevention in these areas is well recognised and requires continued development and innovation. A multiagency response is vital.

1 DOE/RUC/DHSS.
Road Safety Plan for Northern Ireland 1995/96 - 1997/98.
Department of the Environment (NI), 1995.

2 DHSS/NIO.
Tackling Domestic Violence.
HMSO, 1995.

Target

By 2002 the annual number of deaths from accidents should be reduced by 15%. Special emphasis should be placed on preventing accidents to children and older people.

Air Quality

3.26 Air quality has an important bearing on health and is an issue of increasing public concern, particularly in relation to asthma. At UK level, strategies for reducing indoor and outdoor pollution are currently being prepared. The Government is committed to setting targets for the most significant individual air pollutants. The new strategy includes new targets and plans for tackling all air pollution, including the major problem of poor air quality resulting from urban road traffic. New legislation will be prepared placing a statutory duty on district councils to assess air quality in their area and, in association with other relevant bodies, to draw up plans and take action where local air quality is likely to breach or approach trigger pollution levels. Air quality monitoring throughout the UK is already extensive and of a high quality, but work will continue in improving and completing the main multi-pollutant urban network and integrating national and local government systems.

3.27 The Department of the Environment aims to ensure that air quality standards are met and recognises the importance of a coordinated approach. It is proposed that efforts are made within the health and personal social services to join with those in environmental health to increase awareness about the importance of monitoring and compliance with air quality targets. The Department, together with other agencies, should ensure that air quality standards designed to protect public health and the environment are met throughout Northern Ireland.

Health and Safety in the Workplace

3.28 There is a clearly acknowledged link between economic development and health. The raising of the profile of the Health and Safety Agency is welcomed as much needs to be done, not only to ensure good safety management at work but also, to raise awareness about how employers can contribute to the promotion of good health. **It is proposed that the Health Promotion Agency, with the support of the Health and Safety Agency and relevant central and local government departments, develops by 1998 a framework for health promotion in the workplace.** This framework should encourage a broad approach to the promotion of good health at work and include policies on smoking, nutrition, alcohol, stress and physical activity.

Housing

3.29 There are known associations between health and housing. These include relationships between damp and asthma and respiratory disease, between overcrowding and infections, between faulty design and accidents and between cold and cardiovascular disease. Although major improvements have been made in tackling unfit and substandard housing in Northern Ireland due to the efforts of agencies such as the Northern Ireland Housing Executive and district councils' Environmental Health Departments, problems remain in terms of high levels of unfitness in certain localities and in ensuring that the needs of special groups and those in acute need are met. The health and personal social services has a role to play in raising public awareness about the relationship between health and housing, and encouraging continued investment in public housing programmes.

Transport

3.30 Transport is an integral part of modern living. Easy access to means of travel can bring enormous benefits to individuals in opening up opportunities for work, leisure and the choice of where to live. The Department of the Environment's policy statement *Transportation in Northern Ireland - The Way Forward* sets out a framework for action aimed at achieving greater harmony between the needs of the economy, the needs of the environment and the desire for personal mobility.

3.31 Lack of personal mobility can result in loss of personal independence, poorer health and greater reliance on health and social services. Older people and people with disabilities in particular have much to gain from the provision of suitable transport services which can provide them with opportunities for social interaction, thus reducing problems such as isolation and marginalisation. Such services can also prolong the ability of elderly people to enjoy an independent lifestyle in their own homes, and increase employment opportunities for people with disabilities. The Department welcomes the recognition in the Department of the Environment's policy statement of the impact of suitable transport services on health and wellbeing.

Education

3.32 There is widespread acknowledgement of the importance of strong links between the education and health sectors. The concept of the health promoting school, which incorporates the ethos of the school, its curriculum, its environment and links with the community, is an example of an integrated approach to health. Following joint work between the health and education sectors to develop guidelines on the health promoting school, a network of health promoting schools is now being developed. Health education is one of six cross curricular themes, mandatory for all school children in Northern Ireland. **It is proposed that, to assess the extent to which health education is currently being carried out, a review of health education in schools is commissioned jointly by the Department of Education and DHSS by 1997.**

Other initiatives within the education sector which would contribute to the aims of the Regional Strategy include:-

- the identification of appropriate nutritional guidelines for schools;
- support for the Department of Education's action plan on drug misuse; and
- the development of a mental health strategy to incorporate the current work on suicide and self-harm in young people.

Smoking

3.33 Smoking remains the largest preventable cause of ill health and premature death. Tobacco use is responsible for nearly 3,000 deaths per year in Northern Ireland. The Department's aim is to reduce smoking prevalence in the province. With the advent of the European Union open trade market there is the need for a broad based approach to tobacco control. Although there has been a fall of nearly one quarter in adult male smoking in the last 20 years, levels of smoking amongst young women have not fallen in the last 10 years. Smoking rates are highest in lower socioeconomic groups. Four main issues need to be tackled:-

- the prevention of smoking recruitment;
- the development of smoke-free environments;
- assistance to smokers to give up; and
- the promotion of non-smoking as the norm in society.

Priority should be given to work in this area with children, young people, women and those on low income. District councils in particular have an important role to play in controlling cigarette smoking in teenagers through their enforcement powers under the Children and Young Persons (Protection from Tobacco) (NI) Order 1991 which prohibits the sale of tobacco products to anyone under 16 years. It is recognised that community pharmacists can contribute to smoking cessation programmes by facilitating public access to, and availability of, Pharmacy Only Medicines to assist smoking withdrawal. Figures 3.2 to 3.4 show the extent of smoking among children and variations in smoking by age, sex and socioeconomic group.

Targets

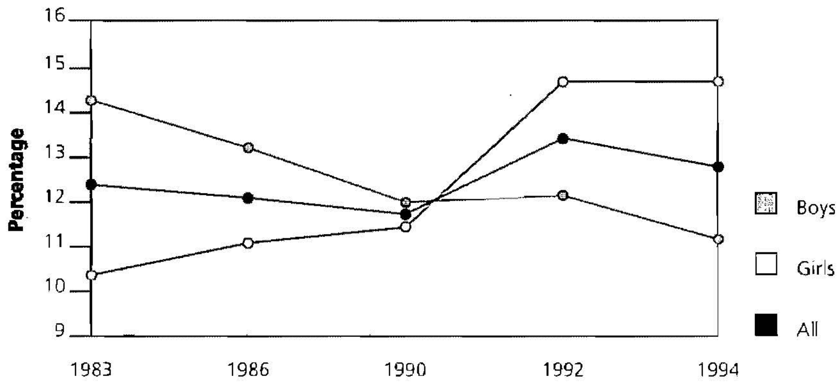
By 2002 the proportion of the adult population aged 16+ who do not smoke cigarettes should have increased from 72% to 74%.

By 2002 the proportion of the population aged 11-15 years who do not smoke cigarettes should have increased from 83% to 85%.

Figure 3.2

SCHOOL CHILDREN WHO SMOKE REGULARLY - 1983 TO 1994

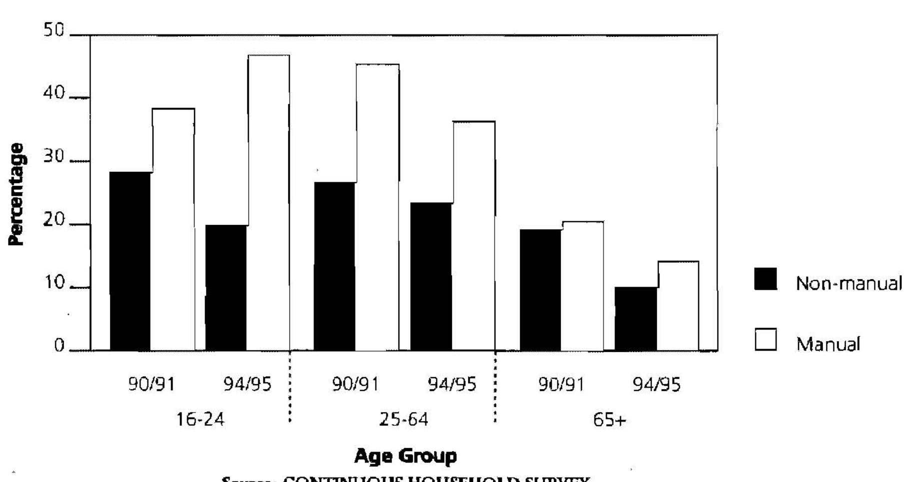
(Ages 11, 13 and 15)



Source: THE HEALTH BEHAVIOUR OF SCHOOL CHILDREN IN NI: REPORT OF THE 1994 SURVEY

Figure 3.3

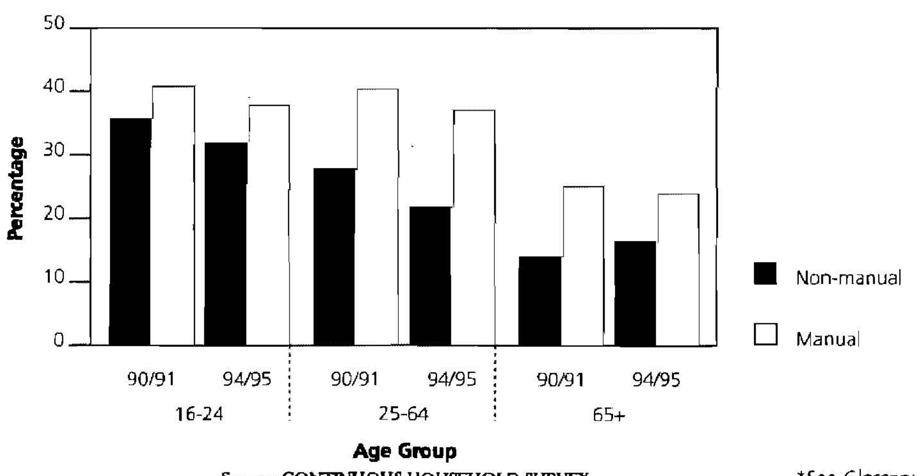
FEMALES SMOKING BY AGE AND *SOCIOECONOMIC GROUP 1990/91 AND 1994/95



Source: CONTINUOUS HOUSEHOLD SURVEY

Figure 3.4

MALES SMOKING BY AGE AND *SOCIOECONOMIC GROUP 1990/91 AND 1994/95



Source: CONTINUOUS HOUSEHOLD SURVEY

*See Glossary