Nutrition

3.34 Nutrition plays an important role in preventing heart disease and cancers, as well as other important health problems such as obesity and oral disease. Eating patterns are changing for the better but this trend needs further development and support. Public education to raise awareness of the importance of healthy eating needs to be accompanied by increased availability and affordability of healthy food choices. This can only be achieved through joint action by relevant sectors. Those on lower incomes are likely to eat more unhealthy diets than their better off counterparts. A number of surveys have also demonstrated that foods which are higher in fibre and/or lower in fat, sugar or salt are often more expensive than their lower fibre, higher fat, sugar and salt alternatives. A food and nutrition strategy for Northern Ireland will have been developed by 1996. This will set specific targets for achievement.

3.35 Maternal nutrition has a major impact on infant health. Research has shown that a mother's ability to nourish her baby is established by, among other things, her diet over many years before her pregnancy. Thus nutrition needs to be improved particularly among young women in disadvantaged groups. The importance of increasing folic acid/folate before conception and during the first twelve weeks of pregnancy to reduce the risk of neural tube defects is recognised. Breastfeeding is of significant benefit for infant health. A new target to increase breastfeeding was introduced in 1994. Efforts to promote awareness of the benefits amongst professionals and the public have been undertaken in Northern Ireland, but levels of breastfeeding remain very low. Boards should monitor rates of breastfeeding and set achievable targets for improvement relevant to their local situation.

Targets

By 1997 an implementation plan for the food and nutrition strategy will be developed.

By 2002 the proportion of women breastfeeding during the first two or three days after birth should be increased to 50%.

By 2002 the proportion of women breastfeeding at 6 weeks should be increased to 35%.

The Department will commission by 1997 a study on effectiveness of approaches to the promotion of breastfeeding and will draw up guidelines for effective interventions.

3.36 The *National Food Survey*[1], which is being extended to Northern Ireland from January 1996, will be used to set further targets in relation to:-

- reductions in the proportion of energy derived from fat and saturated fat in the diet;
- an increase in the proportion of calories derived from carbohydrates, excluding sugars, in the diet; and
- an increase in fibre in the diet.

Alcohol

3.37 Alcohol consumption is a public health issue which has special significance for a wide range of agencies with responsibility for health and social services, family protection, youth, employment and economic development, public order, road safety, crime, trade and taxation. In 1988 the Department published a strategy for the prevention of alcohol misuse[2]. Since then there has been an increase in efforts to prevent the harm done by alcohol. Recent research has identified a new generation of drinkers and suggests that the level of abstinence is decreasing and the number of drinkers, particularly young female drinkers, is increasing. A re-examination of an appropriate regional strategy needs to be undertaken involving a wide range of interests. In addition, there is a need to educate patients and clients of the potentially adverse effects of alcohol-medication interactions. Boards should also seek, in partnership with relevant organisations, to reduce underage drinking.

3.38 There is a need to ensure that the public is aware of the health risks associated with excessive and other inappropriate drinking. This strategy endorses the recommendations made in *Sensible Drinking - The Report of an Inter-Departmental Working Group*[3] published by the Government in December 1995. Among these recommendations was that it would be more helpful for people to think of a daily benchmark for drinking rather than a maximum number of units per week. As a result, the Department will work towards providing new baseline information incorporating the revised daily limits described in the report of the Inter-Departmental Group. This information will be used to set appropriate targets for alcohol consumption in Northern Ireland.

Target

By 1997 the Department will commission a review of its regional strategy on alcohol. Guidelines for implementation of the revised regional strategy will be produced.

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[1] MINISTRY OF AGRICULTURE FISHERIES AND FOOD.
National Food Survey.
HMSO, Annual.

[2] DHSS.
Health Promotion Strategy for the Prevention of Alcohol Misuse in Northern Ireland.
Department of Health and Social Services, 1988.

[3] DEPARTMENT OF HEALTH.
Sensible Drinking: The Report of an Inter-Departmental Working Group.
DoH, 1995.

Illicit Drugs

3.39 Studies show that there is a rapidly rising proportion of young people now being offered and taking a variety of illicit drugs. *Drug Misuse in Northern Ireland: A Policy Statement*[1], prepared by the Northern Ireland Committee on Drug Misuse, has now been accepted by the Government as official policy. The policy statement provides a common statement of purpose and identifies five priority areas for action, along with associated objectives, to guide the activities of all the organisations engaged in tackling drug misuse. The policy statement also stresses the need for effective interagency cooperation and collaboration in this area between the health and personal social services, education services, youth service, RUC, Customs and Excise, Probation Board and the voluntary and community sectors. In the area of health promotion, there is a particular role for the health and personal social services to play in education and prevention, working with other organisations as appropriate.

Target

DHSS will support the Government's drug prevention strategy, with particular emphasis on a public information programme on drug misuse aimed primarily at young people. By 1997 the programme will have been developed and implementation will have commenced.

High Blood Pressure

3.40 The common complications of high blood pressure are strokes, kidney disease and heart failure. It is also a major risk factor for coronary heart disease. Ill health and death from these complications make high blood pressure a major health problem in Northern Ireland. Increased physical activity, and reduction in obesity and in alcohol and salt consumption, will contribute to a reduction in the condition. It will be necessary to raise both public and professional awareness and knowledge about this issue and, where drug treatment for high blood pressure is instigated, about the need for compliance with medication. The new Northern Ireland Survey of Health and Social Wellbeing, planned to begin in 1996, will be used to set targets for the detection and control of high blood pressure in the adult population.

Physical Activity

3.41 Physical inactivity is an independent and important risk factor for coronary heart disease. It also contributes to obesity and high blood pressure. Educating children for lifelong regular and enjoyable physical activity is an essential element of any strategy to increase adult participation. Following the publication of the results of the Health and Activity Survey 1992[2] it is clear that most people (70% of males, 80% of females) in Northern Ireland do not take sufficient exercise to protect or improve their health. Wide consultation on a strategy to promote physical activity was undertaken in 1995 to engage the interests and efforts of a range of organisations. Intersectoral cooperation in planning, resourcing and implementation of the strategy will be vital in improving health.

[1] NORTHERN IRELAND COMMITTEE ON DRUG MISUSE.
Drug Misuse in Northern Ireland: A Policy Statement.
Department of Health and Social Services, 1995.

[2] THE QUEEN'S UNIVERSITY OF BELFAST/DEPARTMENT OF FINANCE AND PERSONNEL/ULSTER HOSPITAL.
Northern Ireland Health and Activity Survey Report.
HMSO, 1994.

Targets

By 1997 the Department will commission guidelines to implement the Northern Ireland Physical Activity Strategy and to monitor its progress.

By 2002 the proportion of men and women aged 16+ who are classified as sedentary should be reduced from 20% to 15%.

By 2002 the proportion of men and women aged 16+ who achieve recommended age-related activity levels should be increased from 30% of men and 20% of women to 35% of men and 25% of women.

Sexual Health

3.42 A comprehensive strategy to promote sexual and reproductive health needs to be set in the context of personal relationships. Important elements of such a strategy are:-

- the reduction of sexually transmitted diseases, including HIV infection;
- the positive expression of sexuality without oppression or exploitation;
- the reduction of unplanned pregnancies; and
- ensuring accessibility and uptake of preventive services.

Boards' purchasing plans should continue to reflect these elements.

3.43 In 1993 the Department issued a strategy for HIV and AIDS in Northern Ireland[1]. This recognised the need for increased efforts in public education, alongside education programmes in schools and youth settings and the need for support for those involved in this work. It continues to be necessary to create a general climate of opinion which recognises the importance of providing public information about safer sexual practices.

Targets

By 1998 a comprehensive health promotion programme for schools in relation to sexual and reproductive health, which emphasises the importance of personal relationships, self-esteem and decision making skills, will have been developed and implemented.

By 2002 there should be a further fall in unplanned births to mothers aged under 20, with the effect that the overall number of births to teenage mothers is reduced by 10%.

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[1] DHSS.
HIV and AIDS in Northern Ireland: A Strategy.
HMSO, 1993.

Oral Health

3.44 In 1995 the Department issued *An Oral Health Strategy for Northern Ireland*[1]. The oral health strategy emphasises the need to increase public awareness of, and to take action to address, the main risk factors for tooth decay and gum disease. Specific targets have been set for the reduction of caries. A reduction in the quantity and frequency of sugar and sugary foods are necessary for the improvement of oral health, particularly for children. A reduction in tobacco and alcohol use will influence the incidence of oral cancers. The Department is convinced of the benefits of fluoridation. To this end the oral health strategy sets a target for a substantial increase in the proportion of the population who have access to fluoridated water supplies. As well as an overall improvement in dental health, this should bring about a reduction in the variation in the prevalence of tooth decay in Northern Ireland. **The Department, Boards, Trusts, Health Promotion Agency, health professionals and other relevant organisations will commit themselves to implementation of the oral health strategy.**

Genetic Services

3.45 Demand for genetic services has increased because, for many genetic disorders, it is now possible to identify the carriers of genetic diseases and to make a diagnosis before birth. **Appropriately staffed genetic counselling services should be further developed over the life of this strategy to facilitate ease of local access to this important service.**

Rational Use of Medicines

3.46 Medicines are an activity of daily living producing both positive and negative health outcomes. The Committee of Ministers of the Council of Europe has recommended the following measures in respect of the rational use of medicines. We support the adoption of these, namely:-

- the establishment of priorities for the availability of medicines based on clinical need, therapeutic value and efficiency in comparison with other medicines;
- the rational prescribing of medicines supported by the distribution of objective and independent information on medicines, particularly through multidisciplinary Drug and Therapeutic Committees in both hospital and community settings;
- the development of clinical pharmacy services in both hospital and community settings and pharmacist training to support these functions;
- establishing medicines education and information programmes for the public; and
- reduction of medicines wastage and improved patient adherence to prescribed treatment.

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[1] DHSS.
An Oral Health Strategy for Northern Ireland 1995.
HMSO, 1995.

Immunisation

3.47 Childhood immunisation is one of the most effective ways to protect against childhood infections. Immunisation rates in Northern Ireland now compare favourably with those elsewhere in the UK. This has resulted from sustained effort by those involved in the service and this strategy aims to build upon this effort. However, further work is required to achieve uniform immunisation rates throughout the province.

Target

By 2002 each Board should have an uptake rate of 97% for all primary immunisations.

4

CHAPTER FOUR TARGETING HEALTH & SOCIAL NEED

HEALTH
& WELLBEING:
INTO THE NEXT
MILLENNIUM

Introduction

4.1 In recognition of the inequalities in health and social wellbeing which exist in Northern Ireland, as elsewhere in the developed world, a new theme of targeting health and social need was introduced in the 1992-1997 Regional Strategy.

4.2 Since then, the Department has set up a working group comprising representatives from the Department, HSS Executive, Boards and the Health Promotion Agency to consider how this theme might best be taken forward. This chapter reflects some of their work and sets the agenda for the next five years.

4.3 Inequalities in health and social wellbeing persist. They are linked with a range of often interlinking factors such as socioeconomic status, lifestyle, location, age, sex and community background. For example, research shows that people in disadvantaged groups not only suffer more ill health and die younger, but they are also less likely to receive or benefit from health and social care. Moreover, relative as well as absolute disadvantage is important, as health and social wellbeing tends to vary with each step in social advantage; there is no cut off point at which differences disappear.

4.4 Action is needed to address those inequalities which are avoidable and unacceptable. Therefore, the theme of targeting health and social need remains an essential element of this strategy. The overall aim is:-

to minimise inequalities in population health and social wellbeing and in need for, and access to, health and social care in Northern Ireland.

4.5 In pursuit of this aim, the priorities for action over the next five years will be to:-

secure the involvement of local people in decisions about service provision through:-

- **locally sensitive purchasing;**
- **community development;**

involve agencies outside the health and personal social services;

develop the capacity to assess need for health and social care;

evaluate the effectiveness of interventions;

target resources and services where they are most needed; and

encourage relevant research and development.

4.6 This strategic theme is compatible with:-

- the Government's targeting social need initiative which requires all Northern Ireland departments and their agencies to target programmes and resources on individuals, groups and areas rated highest on objective need; and
- the complementary policy appraisal and fair treatment initiative, the aim of which is to ensure that issues of equality and equity influence policy making and action throughout Government and public services.

Involving Local People

4.7 The last Regional Strategy emphasised the need for the public to be involved in decisions about their health and social care needs and the services to be provided. While Health and Social Services Councils formally represent user interests in each Board area, complementary arrangements are necessary to ensure that local people have a variety of ways to bring their needs and preferences to bear on the planning and delivery of health and social care services. **Commissioners and providers should continue to explore different approaches to involving users, and potential users, of services and their carers in the decision making process.**

Locally Sensitive Purchasing

4.8 New locally sensitive purchasing arrangements for buying health and social care are being developed by purchasers to take account systematically of the views of all people who have an interest in particular services. These include past, current and potential users and their carers, as well as providers of services.

4.9 Purchasers need to ensure that information about needs, options for service delivery, availability of resources and outcomes is made available to local people, who should be consulted and whose concerns should be addressed throughout the planning and purchasing process. Purchasers also need to ensure that the views of local people are sought at an early enough stage for them to be considered, along with other aspects like professional advice, regional priorities and resources, when strategies are being developed or services are being evaluated.

Community Development

4.10 As noted in paragraph 1.18, the Government's *Strategy for the Support of the Voluntary Sector and for Community Development in Northern Ireland* recognised the potential of community development to reach and involve people in need and thereby influence and improve policies and programmes in both the statutory and voluntary sectors. The methods used in community development include:-

- policy analysis and profiling of need - supporting local people to develop community profiles and analyse how local, national and international policies affect them;
- capacity building - training people in the skills they need to achieve their goals;
- building sustainable organisations around issues that are defined by the community as important;
- networking with other groups and individuals with similar interests to help achieve shared objectives;
- resourcing groups by providing links to outside expertise and support;
- developing relationships with service providers and policy makers in order to help groups and people within the community gain access to influence; and
- negotiating with service deliverers to encourage them to adopt a community development approach within their particular field.

4.11 Within the health and personal social services variations in health and social wellbeing can be addressed through a variety of community development approaches which would:-

- promote the development of partnerships between health and personal social services professionals, other agencies, voluntary and community groups and local people;
- empower individuals and communities, both by their active involvement in decisions about their health and social needs and the services to be provided and by taking steps themselves to address their needs;
- make use of local knowledge;
- help target resources, including those of other agencies, where they are most needed;
- maximise the participation of service users and potential service users and make services more responsive to users' needs;
- bring about a sense of local ownership and control; and
- strengthen the social fabric and social support systems within disadvantaged communities.

4.12 **During the period of this strategy the Department, Boards and Trusts should encourage, support and expand community development approaches throughout the health and personal social services.** For instance, at regional level a community development and health resource project is being set up to promote, support and develop the philosophy and practice of community development in addressing health and social need. Evaluation should be an integral part of all community development programmes and the Department, in consultation with other departments, has work in hand to develop and produce practical guidance on a core set of indicators to measure the effectiveness, efficiency and equity of the community development process in Northern Ireland.

4.13 To ensure that the health and personal social services play their part in such community based projects the Department will, by the end of 1997, commission a training programme which will better equip staff in the health and personal social services and in the voluntary sector to work in partnership with other agencies and with local people to identify and tackle the most pressing health and social needs of the community. This programme will take account of the wider work of the Inter-Departmental Group on Voluntary Activity and Community Development to address the education and training needs of those in the voluntary, community and statutory sectors who are involved in community development. **Boards and Trusts should ensure that those staff who would benefit most from such education and training have access to it.**

Involving Other Agencies

4.14 The health and personal social services on their own can have only limited success in addressing variations in health and social wellbeing due to the many cultural, social and economic factors which are all interconnected. Likewise the health and personal social services cannot be effective in involving local people if they work alone. A holistic approach is needed and the Department and Boards have a key role in alerting agencies outside the health and personal social services to the contribution they can make to the health and social wellbeing of the population and in encouraging them to take action, particularly where their actions might otherwise increase existing variations.

4.15 The work of the Inter-Departmental Group on Health, which was established as a result of the last Regional Strategy, is a key element in this work. At a local level, Boards and other commissioners have established alliances with agencies whose work influences health and social need in areas such as environment, housing, local government and education.

4.16 During the period of this strategy, Boards and other commissioners should strengthen and broaden alliances with other agencies and formulate local strategies and action plans to address variations in health and social wellbeing along with monitoring and evaluation systems. A wide range of organisations, including those within the voluntary and private sectors, should be involved in drawing up the strategies and action plans which should include specific targets for improving the health and social wellbeing of disadvantaged groups.

Assessing Need for Health and Social Care

4.17 Assessing people's health and social wellbeing and their need for health and social care, at both individual and population level, is vital to achieving overall improvements in the population's health and social wellbeing and to meeting the targeting health and social need objectives. This involves looking not only at the effectiveness and availability of treatment or care for a particular problem, but also at the effectiveness and availability of preventive measures, diagnosis, continuing care and rehabilitation. Where possible, each population needs assessment should include details of the:-

- prevalence and incidence of the particular condition or social circumstance, including variations associated with such factors as socioeconomic status, social grouping, lifestyle, personal mobility, location, age, sex and community background;
- efficacy of interventions in general;
- efficacy of interventions in reducing variations;
- availability of, resourcing of and access to services, including variations as above;
- effectiveness and cost-effectiveness of service delivery;
- views of users and potential users of services, their carers and representatives, and service providers; and
- outcome measures and targets for improvements in the population's health and social wellbeing and for reductions in any variations.

4.18 To date various approaches to population needs assessment have been used by Boards. **Within the period of this strategy each Board should develop a population needs assessment programme which would apply the set of principles summarised in paragraph 4.17** to each key area highlighted in this strategy.

4.19 However, in many cases the necessary information is not yet available to support effective population needs assessment. Beginning with the key areas, **the Department and Boards should identify and seek to secure the information needed by individuals and local communities and by commissioners to carry out their functions related to population needs assessment.** This will include improvements in:-

- health and personal social services routine and survey data, including primary health care and social services data; and
- other survey data, including small area demographic statistics between censuses;

and investigation of a means to aggregate up from individual needs assessments to population level, for example by using a unique identifier. In addition, the Department and Boards will also consider whether there is a need to establish a regional facility, possibly including a Northern Ireland data bank, to support needs assessment.

Interventions

4.20 Specific variations in health and social wellbeing within Northern Ireland and associated objectives and targets are outlined in Chapters 3 (Promoting Health and Social Wellbeing), 8 (Family and Child Health and Welfare), 12 (Circulatory Diseases) and 13 (Cancers). **During the period of this strategy, commissioners should identify, implement and evaluate interventions which might be successful locally in reducing these variations and extend this work throughout all key areas. In each case targets should be set to improve the health and social wellbeing of disadvantaged groups, both absolutely and relative to the population as a whole, and effective monitoring systems should be established.**

Targeting Resources and Services

4.21 It is fundamental to targeting health and social need that resources should be targeted where needs are greatest. Likewise, the effectiveness of the targeted resources, programmes and services must be assessed to ensure that they are succeeding in reducing, and not inadvertently perpetuating or increasing, variations in health and social wellbeing or in the availability of, or access to, health and social care.

4.22 The Department has work in hand to produce a resource allocation formula for use in the distribution of resources to Board level, which is based upon the estimated relative need for health and social care in each Board area. Beginning within the key areas of concern, **Boards and other commissioners should establish formal links between their population needs assessments and the consequent allocation and use of resources, and by 2002 Boards should be able to demonstrate shifts in resources** to improve equity and efficiency of resource distribution relative to health and social care needs.

Research and Development

4.23 The last Regional Strategy highlighted the importance of research into health and social care inequalities. There is substantial and far-ranging research literature on variations in health and social wellbeing and on their association with a range of factors like:-

- natural biological differences;
- influences which continue from early life;
- absolute or relative levels of deprivation;

- social or psycho-social factors, such as stress and self-esteem;
- health-damaging behaviour (either freely chosen or where choice of lifestyle is restricted by socioeconomic or other factors); and
- differences in access to, or provision of, health or social care.

4.24 However, there has been less research on effective ways to address variations including:-

- equitable and cost-effective allocation of resources through soundly based estimates of need which would maximise the use of readily available data;
- cooperation with other agencies; and
- the involvement of local people in the decision making process.

In addition, research on the causes of inequalities in health and social wellbeing has been hindered by the complex interaction of the factors outlined above.

4.25 **During the period of this strategy the Department and Boards should undertake or commission further work in the above areas, particularly on the causes of, and effective ways to address, variations in health and social wellbeing.** This work should include studies to assess the effectiveness and cost-effectiveness of interventions to minimise inequalities, starting with interventions which are either already in use within the health and personal social services, including the voluntary and private sectors, or proposed elsewhere in this strategy. In the medium term, studies should be carried out to develop and evaluate new interventions to address recognised variations. Also of relevance will be longer-term investigations into the origins - socioeconomic, cultural, behavioural etc - of ill health and social need in high risk groups. Where appropriate the Department and Boards should seek to link their work with wider research on variations in health and social wellbeing.

4.26 In addition, the Department, in conjunction with Boards, will develop and maintain a database which will be accessible to other agencies to assist in the collation and dissemination of published and unpublished information on interventions to minimise inequalities. This will include:-

- interventions which are undergoing evaluation;
- interventions which have been implemented and evaluated;
- the evaluation methodologies; and
- the results of the evaluations.

5

CHAPTER FIVE IMPROVING CARE IN THE COMMUNITY

HEALTH
& WELLBEING:
INTO THE NEXT
MILLENNIUM

Introduction

5.1 The vast majority of health and social care is delivered in the community - in people's homes, health centres, surgeries, residential care and nursing homes, and a variety of day care settings in the statutory, voluntary and private sectors.

The Department's overall aim in this area is:-

> **to support people at home or in their own community unless their needs can be met more appropriately and effectively in hospital.**

This includes care for people with a mental illness, learning disability, physical or sensory disability and frail elderly people.

5.2 The principles and objectives contained in *People First*[1] form the basis for the future development of care in the community. Services should:-

> **respond flexibly and sensitively to the needs of individuals and the relatives and friends who care for them;**
>
> **wherever practicable, offer users and carers a range of options;**
>
> **intervene no more than is necessary to promote and foster independence; and**
>
> **concentrate on those with the greatest needs.**

These principles are reflected in the issues identified in this chapter for improving care in the community over the next five years.

Prevention

5.3 Prevention is a crucial element of care in the community. It is vital that practical assistance with daily living is provided to enable people to retain their independence. The continuing development of such basic services remains fundamental to effective community care. Domiciliary care has been provided by home helps, district nursing, physiotherapy and occupational therapy and chiropody services. Further diversity of services to meet the needs of people living at home and their carers needs to be developed.

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[1] DHSS.
People First: Community Care in Northern Ireland in the 1990's.
HMSO, 1990.

Assessment of Need

5.4 At an individual level proper assessment of need, backed up by good care management in appropriate cases, is central to improving care in the community. Paragraph 4.17 sets guidelines for needs assessment at population level. A major concern is the lack of information, affecting purchasers' ability to assess the real extent of need at population level. Paragraph 4.19 sets an objective to improve information sources. **During the strategic period each Board should develop a strategy to identify the numbers and needs of vulnerable people within the community**. It is also vital that assessments carried out are shared with all relevant professionals, users and carers as appropriate.

5.5 It is obvious that needs-led assessment will be of limited value if service responses remain inflexible. There are examples of imaginative and flexible care packages in place but this is an area which requires much more work. Boards need to ensure that there is increasing flexibility in the creation and review of care packages within the resources available. The purpose of designing care plans and providing care packages should be to meet explicit objectives which are discussed and agreed with users and carers.

Carers

5.6 The value and importance of carers must have a high priority over the next strategic period. Boards should make explicit their policy in relation to carers and promote choice about taking on the role of carer and about whether to continue providing care. A great deal of support for carers is provided through the voluntary sector and this is a valuable service which should be further developed.

5.7 Purchasers and providers should:-

- provide information and advice to carers about services and benefits and how to manage the particular problems posed by the person being cared for;
- ensure that carers have access to separate assessment to address their needs;
- ensure that services are tailored to meet the requirements of individual carers;
- ensure opportunities for breaks and for regular respite for longer periods;
- provide practical help to lighten the burden of caring including domestic help, continence services and help with transport; and
- recognise and value the significant contribution made by carers, and the responsibilities they shoulder.

Target

By 1997 carers should be offered a separate assessment of their own needs.

Advocacy

5.8 Empowering individuals to participate in decisions about their future is central to improving community care. As far as possible, users should participate actively in their own assessment. However, some people are not able to express their views, or take an active part in the assessment. As the views of users and carers may differ, it is important that 'advocates' are available to speak on behalf of those whose voice would not otherwise be heard. In most instances care managers will be the direct link between the person and range of services available and will act as an advocate for the person. However, there may be circumstances where it would be appropriate to use an independent advocate, for example, where the service user is in dispute with the Board or Trust and wishes someone not employed by the Board or Trust to represent them. **Providers should be required to establish links with independent advocates and make these links known to service users.**

Primary Care

5.9 GPs working in conjunction with nurses, social care professionals, pharmacists and professionals allied to medicine are a key element in community care. Primary care is the first port of call for most people when they need either health or social care. The primary care team plays a major part in providing the right care in the community by:-

- assessing the extent of the problem; and

- recommending what care is needed.

The necessary care may be provided by the primary care team, or the patient or client may be referred on for more specialised diagnosis or assessment and care. In the context of improving care in the community, it is essential that more effective links are forged between primary care teams and those directly responsible for assessment and care management arrangements.

Care Management

5.10 For those with greatest needs care management must become central to the way that services are delivered. **There is a need for the development of dedicated care managers whose function is clearly separated from the day-to-day operational management of service provision. Personnel should therefore be specially identified, and allocated to the care management task.**

5.11 **Care managers need proper training, especially in care planning; this should be addressed as a matter of urgency.** There is a need to strengthen training for care planning and ensure that the training requirements of GPs and others in the primary care team are addressed together with the training needs of those who undertake care management. Training should also take account of the needs of users and carers.

Interface between Primary Care and Care Management

5.12 **Boards should ensure that there is effective contact between GP practices and those responsible for care management within the practice area.** This may be achieved in a number of ways, including social work/care management attachments to GP practices.

5.13 Trusts should be required to:-

- establish and develop clearly written procedures and protocols giving effect to close working relationships between primary care teams and others working in the community;
- ensure that all written assessments and care plans are shared with members of the primary care teams involved in their formulation;
- ensure that contributions are automatically sought from primary care team members in respect of all reviews which may address:-
  - issues of common concern
  - issues arising from individual assessments and care plans
  - new referrals
  - case reviews; and
- ensure that there are regular meetings between care managers, general practitioners and other primary care professionals.

Alliances with Community Groups, Voluntary Bodies, the Private Sector and Other Agencies

5.14 *People First* called for the development of a mixed economy of care in partnership with the voluntary and private sector and housing agencies. The 1992-97 Regional Strategy encouraged Boards to establish firm interagency working arrangements with key agencies whose work impacts on health and social need. In the last few years the value of working in partnership with a wide variety of voluntary, private and community groups, as well as other agencies, has been clearly established.

5.15 However, the relationship between the statutory and the smaller voluntary and community groups and small independent providers requires much more work, in particular the impact of the contracting culture on the voluntary sector. These issues were the subject of a major seminar sponsored by the Department. Arising from the seminar, the Department intends, during 1996, to produce a draft circular of guidance on relationships with the voluntary sector covering both policy and operational issues, and incorporating guidance designed to improve and clarify working relationships in areas such as:-

- the development of Trust purchasing prospectuses;
- the format and content of service contracts with the voluntary sector; and
- the treatment of voluntary income in the contracting process.

Evaluation of Care in the Community

5.16 It is vital that providers should have in place systems for monitoring the provision of care in the community and particularly the implementation of care plans. The key elements are that:-

- systems should be established to identify and prioritise unmet need, measure the effectiveness of the care provided and report gaps and inadequacies to the purchaser;
- staff responsible for monitoring and evaluating should be independent of service delivery; and
- monitoring should lead to adjustments in service delivery in appropriate cases.

During the period of the strategy Boards and Trusts should continue to develop and put such mechanisms in place.

Outcomes

5.17 Outcome measures which have already demonstrated their value include:-

- patient/client satisfaction surveys;
- health of clients/carers;
- re-admission rates; and
- social gain/quality of life.

More work is required on the development of outcome measures and there is a need for an audit to be carried out into the implementation of care in the community at Trust level covering:-

- publicity and information strategies;
- assessments and care plans;
- effectiveness of service; and
- hospital/community interface (including discharge protocols).

Boards should work closely with Trusts to carry out:-

- **practice and service audits on a uni- and multidisciplinary basis; and**
- **assessments of the effectiveness of health and social care interventions.**

Resources

5.18 It is vital that, as people move from long-stay hospital care into the community, resources are also transferred to provide the necessary care. This is in keeping with the message in paragraph 1.28.

The Spectrum of Care

5.19 Paragraph 5.5 has already highlighted the need for imaginative and flexible care packages. The following paragraphs signal the key developments which the Department wishes to see over the next five years.

Domiciliary Care

5.20 The range of services provided in the home has been expanded to include:-

- laundry;
- home from hospital schemes;
- home carer and sitting schemes;
- respite for carer schemes;
- counselling and befriending services;
- medicine care services; and
- palliative care.

While the bulk of residential and nursing home care is being purchased from the private and voluntary sectors, progress in the development of day care and domiciliary care within the independent sector has been much slower and needs to be encouraged. **During the period of this strategy Boards will be expected to demonstrate developments in the area of domiciliary and day care services.**

5.21 As increased reliance is placed on domiciliary and day care provision it will be important to ensure that the quality of such care is maintained. **Boards and Trusts should establish monitoring arrangements for auditing the standards of provision in the domiciliary and day care fields.**

Sheltered Housing

5.22 In collaboration with other agencies, sheltered housing should be developed to support independent living by vulnerable people for as long as possible, and preferably to the end of their lives. A joint Northern Ireland Housing Executive/Northern Ireland Federation of Housing Associations review of the social housing needs of older people[1] foresees a more focused role for sheltered housing for such people in the future. Boards and Trusts will be required, in partnership with housing providers, to:-

- ensure that sufficient resources are allocated to deliver care to those people who need it in sheltered housing;
- ensure that community staff are briefed, not only on the revised aim of sheltered housing for older people, but also on the important contribution which housing associations make in achieving delivery of responsive and appropriate care for people with a range of needs; and
- encourage 'outreach' activities which use the communal facilities of sheltered schemes as their base but primarily assist people living near the accommodation. These activities could include lunch clubs, assisted bathing and diversional therapy.

Residential Care/Nursing Home Provision

5.23 The focus of residential and nursing home care has changed to some extent in recent years. As well as providing long-term care for people who need it, residential care homes and nursing homes have begun to diversify into providing respite and day care on their premises and also to act as centres for outreach to support people living nearby in their own homes. The Department wishes to see further development of these roles over the strategic period. The Department also wishes to see the development of specialised residential and nursing home care for people with dementia.

5.24 It would be the Department's aim to support younger people in their own homes and communities. However, a small number will have specific needs which require specialised care and the Department wishes to see the development of appropriate specialised care to meet these needs.

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[1] NORTHERN IRELAND HOUSING EXECUTIVE/NORTHERN IRELAND FEDERATION OF HOUSING ASSOCIATIONS.
Joint Review of the Social Housing Needs of Older People in Northern Ireland.
NIHE, 1996.

Respite Care

5.25 There have already been several references in this chapter to the need for a range of respite care services. For many clients and their carers an opportunity for respite can only be achieved by admitting the client to a residential care or nursing home. Such provision should be on a planned basis, rather than to meet crises as they arise.

Continuing Care Beds

5.26 In the Regional Strategy l992-97 the Department set targets aimed at reducing the number of long stay hospital beds in respect of the three main user groups - elderly people and people with a learning disability or mental illness. Substantial progress towards meeting all of these targets has been made and significant changes are also signalled in this strategy in respect of people with a mental illness or learning disability. Purchasers should also examine the extent to which both the statutory and independent sectors can provide continuing care over and above the present patterns of residential and nursing home care. **During the period of the strategy Boards should carry out an exercise to assess the overall balance of care required and tailor their purchasing requirements accordingly.**

Specific Needs of Elderly People

5.27 The remainder of this chapter deals with the specific needs of elderly people, who account for a substantial proportion of those receiving care in the community. People are living longer, but increasing old age often brings with it increasing frailty and vulnerability. Over the period of the strategy the number of people aged 85 and over is expected to rise from 21,000 to 24,000 - a substantial increase in a five year period. Elderly people with greatest needs include those living alone, those with a physical disability or limited mobility, those living in poor conditions and those who are socially isolated. Another group with special needs - those suffering from dementia - is dealt with later in this section. Purchasers and providers must ensure that services are in place to meet the needs of elderly people, in particular those groups identified above, many of whom will require intensive service provision if they are to remain at home.

5.28 Care for elderly people should aim to:-

- promote healthy ageing and help elderly people to maintain their dignity and independence;
- support elderly people and their carers, who may themselves be an elderly spouse, in their own homes;
- for those who become ill or dependent, provide treatment and rehabilitation to restore independence as far as possible; and
- for those who need it, provide high quality residential and nursing care.

5.29 Elderly people represent a growing proportion of the population. Their need for, and their use of, medicines in particular is considerable. All the evidence suggests that they are at greater risk than the rest of the population from the adverse effects of drugs, those prescribed and those bought over the counter. Services need to be developed to address the pharmaceutical care needs of these individuals.

5.30 Evidence suggests that increasing numbers of elderly people are choosing to remain in their own homes for as long as possible given appropriate support. The 1992-97 Regional Strategy required Boards to ensure that the level of service provision in the community was sufficient to meet the assessed needs of elderly people so that it is possible to increase the proportion of people aged 75 years and over who are cared for in their own homes to at least 88% by 1997. The indications are that good progress has been made and that the target has been achieved. The anticipation is that, as domiciliary, day care and respite care services are developed, more people will choose to remain at home.

Target

During the period of this strategy the target remains that at least 88% of people aged 75 and over will be supported in their own homes. Regional variations to take account of local circumstances will be monitored.

5.31 Achieving and maintaining this target impacts on providers outside the health and personal social services, including housing providers such as the Housing Executive and housing associations. Close working relationships with such agencies are vital in order to develop imaginative schemes for appropriate housing and care for elderly people.

Dementia

5.32 The report of the Dementia Policy Scrutiny[1] undertaken in 1994 took a wide ranging look at all aspects of dementia services in Northern Ireland. It found that:-

- there are an estimated 12,500 people in Northern Ireland suffering from dementia. It is expected that this figure will increase by a further 2,800 by the year 2001;
- perhaps only 10% - 15% of people with dementia are diagnosed and receiving health and personal social services in Northern Ireland. In the main they are located in the more formal care settings;
- the majority of people with dementia live at home where they may rely on carers with little outside support;

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[1] DHSS, 1995.
Dementia in Northern Ireland: Report of the Dementia Policy Scrutiny.
Department of Health and Social Services, 1995.

- the services provided for people with dementia are currently patchy and of variable quality; and

- while dementia is strongly age related, a small but growing number of younger people under 65 develop the condition.

5.33 The Department has fully endorsed the recommendations in the report . A number of these were for immediate implementation and should already be in place. **During the period of the strategy Boards and Trusts should continue with their programmes for the implementation of all the recommendations in the report.**

5.34 One of the major weaknesses identified by the report is the lack of information about people with dementia. **In the first year of the strategy period commissioners and providers should conduct a detailed audit in their areas of the needs of people with dementia and the services available to meet those needs.** The aim is to establish a baseline from which progress on implementing the recommendations contained in the report can be measured. To achieve this commissioners and providers should make use of all available sources of information including the 75+ GP assessments, the mental health inpatient system, SOSCARE, and, if appropriate, commission surveys or other research.

5.35 Building on this baseline the Department will establish quantifiable targets on dementia for the remainder of the strategy period.

6

CHAPTER SIX IMPROVING ACUTE CARE

HEALTH
& WELLBEING:
INTO THE NEXT
MILLENNIUM

Introduction

6.1 Acute care encompasses a wide range of inpatient, outpatient, day patient and accident and emergency services and consumes a significant proportion of total investment in the health and personal social services. It is important that this resource meets the needs of patients by providing responsive, appropriate and clinically effective care, as efficiently as possible. The vast majority of patient contacts with the health services take place in primary care or outpatient settings. Acute services must therefore be seen within the wider context of the whole range of the health and personal social services.

6.2 Acute care has changed significantly over the years and will continue to do so. New treatments, unheard of not so many years ago - laser treatment, keyhole surgery, coronary artery bypass grafts, joint replacements, organ transplantation and advanced drug therapies - are now improving the quality of life for many patients and have dramatically altered the way in which acute hospitals function. This process of change will continue.

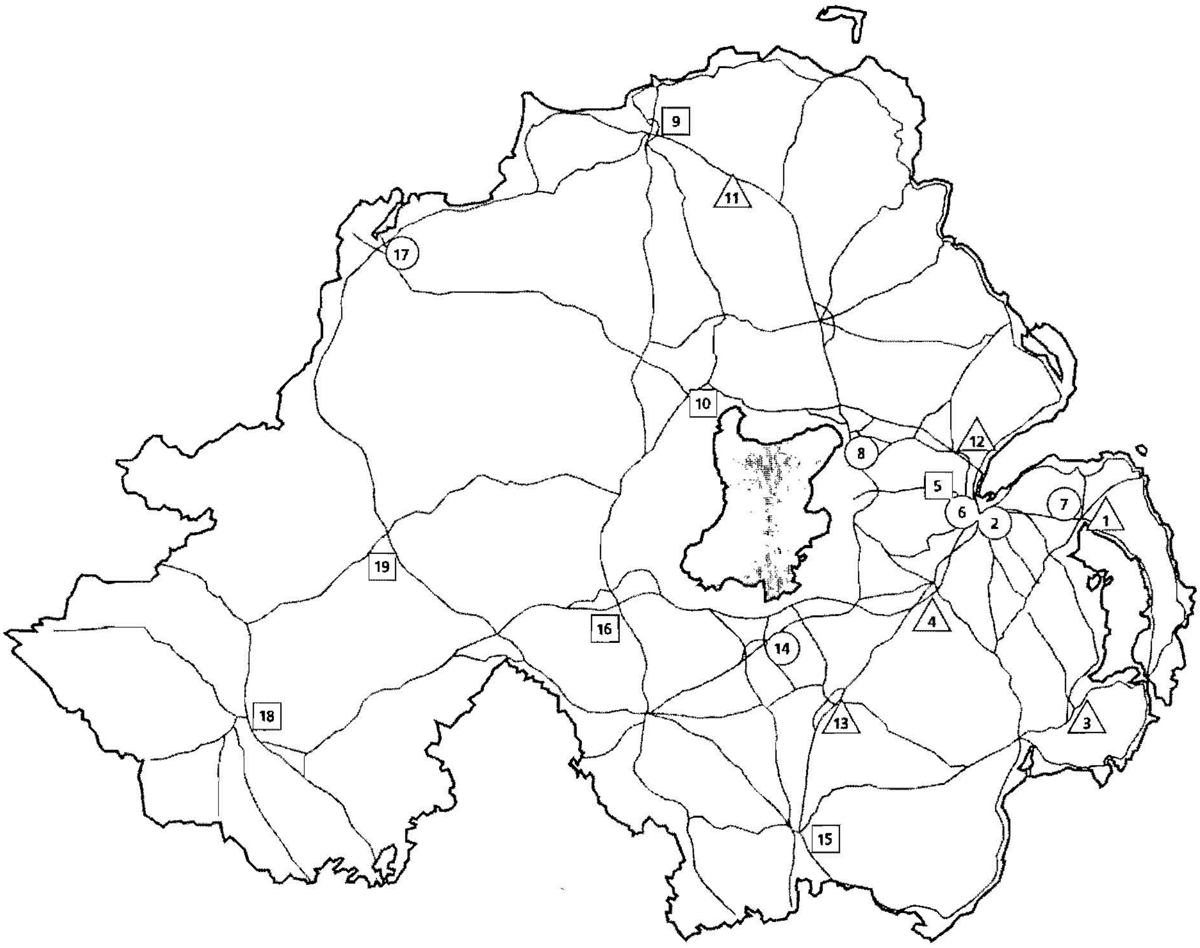
Context

6.3 Northern Ireland has 19 hospitals providing inpatient acute care. Their location is shown at Figure 6.1. Together these hospitals provide around 4,200 acute inpatient beds. Trends over recent years show that the number of beds available for acute specialties has been falling, while the volume of activity overall has been rising. Between 1990/91 and 1994/95 the average number of available beds in acute specialties fell by 15%. By contrast, over the same period the number of inpatient admissions rose by 12% from just over 265,000 to almost 300,000. There was also a 12% increase in first referrals for outpatients in acute specialties. The number of day cases in acute specialities rose by 82%, from 49,724 to 90,590. Beds have been used more intensively. Over the period 1990/91 to 1994/95 there was a 21% increase in patient throughput for acute specialities. The average length of stay for acute specialties fell by 17% over the same period.

6.4 It is worth placing this activity in a wider context. If the ratio of acute hospitals to population which currently obtains in England were applied to Northern Ireland, there would be no more than 10 acute hospitals in Northern Ireland. Thus many acute hospitals in Northern Ireland serve much smaller populations than acute hospitals in England. The provision of acute beds is also higher in Northern Ireland than in England. There are about 31 beds per 10,000 population in Northern Ireland compared to 28 beds in the Northern Region of England, which has similar levels of hospital admission rates to the Province, and 24 in England as a whole (or 26 if acute beds in the independent sector are included).

Figure 6.1

ACUTE HOSPITALS IN NORTHERN IRELAND - MARCH 1995



EHSSB

1 Ards
2 Belfast City
3 Downe
4 Lagan Valley
5 Mater
6 Royal Group
7 Ulster

NHSSB

8 Antrim/Massereene
9 Coleraine
10 Mid-Ulster
11 Route
12 Whiteabbey

SHSSB

13 Banbridge
14 Craigavon
15 Daisy Hill
16 South Tyrone

WHSSB

17 Altnagelvin
18 Erne
19 Tyrone County

KEY

Number of Acute Beds

○ 250+
□ 125 - 249
△ Less than 125

6.5 During the 1992-97 Regional Strategy period there has been a number of significant developments in acute services. Northern Ireland's first new hospital for many years opened at Antrim in March 1994, resulting in the removal of a range of acute hospital services from the Waveney Hospital in Ballymena and the Moyle Hospital in Larne. In the same Board area, work is proceeding with the design, development and commissioning of the new Causeway Hospital which will offer acute services to the residents of the catchment area of Coleraine Hospital, the Route Hospital in Ballymoney, Robinson Memorial Hospital in Ballmoney and Dalriada Hospital in Ballycastle.

6.6 The Eastern Health and Social Services Board published its Strategy for General (Acute) Hospital Services into the 21st Century[1] in 1993. Following on from that Strategy, a reorganisation project examining acute hospital services at Northern Ireland's two largest hospitals, the Royal Group of Hospitals Trust and the Belfast City Hospital Trust, is now under way and consultation papers have been issued making proposals for the future of a number of specialties. The project will lead to rationalisation of acute services between the two sites. Formal approval has been given for a major reconstruction scheme at the Royal Group of Hospitals Trust, costing £65 million. The Down Lisburn Trust has been given approval to test proposals for replacement of the Downe Hospital, estimated at a cost of £10.5 million, for private finance. In addition, it has been decided to amalgamate acute hospital services provided on the Ards Hospital site onto the Ulster Hospital site.

6.7 The Southern Health and Social Services Board has taken decisions about the future pattern of acute and general hospital services in its area following a major review which began in 1992 with the issue of the consultative document *Making Choices*[2]. The Board is considering a proposal to cease purchasing inpatient services from Banbridge Hospital by 31 December 1996. Meanwhile a programme of remedial work costing approximately £12 million is currently under way at Craigavon Area Hospital.

6.8 In the Western Health and Social Services Board area a £40 million redevelopment programme at Altnagelvin Hospital is under way. In 1994 consultant obstetric services moved from the Tyrone County Hospital in Omagh to the Erne Hospital in Enniskillen. Paediatric services were developed in the latter. The fact that the Tyrone County and Erne Hospitals are within the new Sperrin Lakeland HSS Trust will facilitate closer cooperation between the two hospitals in the provision of acute services to the southern sector of the Western Board area.

[1] EHSSB.
The Strategy for General (Acute) Hospital Services for the Eastern Board Area - Into the 21st Century.
Eastern Health and Social Services Board, 1993.

[2] SHSSB.
Making Choices.
Southern Health and Social Services Board, 1992.

The Changing Environment

6.9 Several factors are acting together to shape the future pattern of acute hospital care. They reflect both a continuation of longer term trends and issues which have emerged more recently. Their common characteristic is that they will result in better quality care for patients.

- Changes in clinical practice are increasing the scope for routine procedures to be performed outside the hospital setting. Advances in telecommunications, such as telemedicine, may open up new opportunities for the provision of diagnostic services at local level. There is a trend towards services which were once provided only in acute hospitals being made available in other more local settings. Increased cooperation between hospital and primary or community based teams will improve accessibility and convenience for patients.

- New ways of diagnosing diseases and treating people, often with the need for less surgery, mean that many procedures which in the past required patients to remain in hospital overnight or longer can now be carried out on an outpatient or day case basis, resulting in less disruption for the patient. Average lengths of stay in hospital for many procedures are falling. These developments point to a continuing reduction in the requirement for inpatient acute hospital beds in the future.

- Increasing attention is being paid to the effectiveness of clinical interventions, and to the outcomes of care and treatment. A variety of developments, such as the work of bodies like the Clinical Outcomes Group in England and the Clinical Standards Advisory Group, reports of confidential enquiries, multi-professional clinical audit and the increasing development and use of clinical standards, will increase scrutiny of where and how work is done and lead to more appropriate and effective treatment.

- Consultants are increasingly developing their expertise in more focused areas of work, rather than covering the full range of a specialty. This trend towards greater specialisation will mean that specialised work will have to be concentrated on a smaller number of sites which can generate a sufficient caseload to permit the development and retention of skills among specialist staff. The recommendations of the report *Hospital Doctors: Training for the Future*[1] will result in a move to a more consultant-provided service, and will reinforce the trend towards consultants working in larger teams and the corresponding concentration of caseloads on fewer sites. Acute hospitals which undertake small volumes of activity will find it difficult to sustain these larger teams. There is evidence that, for some specialties and procedures, better results for patients can be achieved where clinical teams are treating a significant number of cases. The overall impact of these changes will be to enhance the standards of care available to patients.

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[1] DEPARTMENT OF HEALTH.
Hospital Doctors: Training for the Future - The Report of the Working Group on Specialist Medical Training.
HMSO, 1993.

- This trend towards doctors working in larger teams will be reinforced by reductions in the working hours of junior doctors in order to provide them with more acceptable working conditions. Moreover, the training requirements of the Royal Colleges require junior doctors to undertake a variety of work in sufficient volumes to ensure that they develop the requisite expertise.

- Advances in medical technology have opened up, and will continue to open up, new opportunities for diagnosis and treatment. An increasingly well-informed public expects that this technology should be quickly and generally available so that they can benefit from the enhanced quality of care which it offers. However, new technology and equipment can often be expensive, and may require more specialised and higher levels of skills among clinicians. There will always be a tension between what is clinically viable, technically possible and affordable. Expensive equipment and skills must be used intensively to secure full value for money. Moreover, such equipment should be used in accordance with locally agreed protocols based on assessments of clinical effectiveness.

- National and local policy developments, designed to improve the quality of care in individual specialties, will affect the shape of acute services provision in Northern Ireland. In particular, following the publication of the Report of the Expert Advisory Group on Cancer *A Policy Framework for Commissioning Cancer Services*[1], the Department set up a Working Group, chaired by Northern Ireland's Chief Medical Officer, to consider how the recommendations contained in that report might be implemented in Northern Ireland. The report of the Cancer Working Group *Cancer Services; Investing for the Future*[2] concluded that there should be three levels of cancer care in Northern Ireland - primary care, cancer units and a designated cancer centre. The report recommended that each Board area should have one cancer unit, providing the focus for the treatment of common cancers for its catchment population. In addition, a regional cancer centre, located at the Belfast City Hospital Trust, should be established to provide a specialised centre for cancer care in Northern Ireland. The implementation of these recommendations would have significant implications for the organisation of acute services in Northern Ireland.

- *A Charter for Patients and Clients*[3] will continue to lead to a greater focus on the quality and timeliness of acute services. In addition, the efforts of major purchasers and the impact of GP fundholding will continue to stimulate improvements in services.

[1] DEPARTMENT OF HEALTH/WELSH OFFICE.
A Policy Framework for Commissioning Cancer Services.
DoH, 1995.

[2] DHSS.
Cancer Services: Investing for the Future.
Department of Health and Social Services, 1996.

[3] DHSS.
A Charter for Patients and Clients.
HMSO, 1992.

6.10 Restrictions on the availability of resources will also impact on decisions about the future provision of acute services. Acute hospital services are hugely expensive and consume about 40% of total expenditure on the health and personal social services. The amount earmarked for the capital development programme for 1996/97 is £48 million, including minor work schemes, health and safety projects, information technology developments and equipment. Major capital schemes already approved and under way represent a total value of some £175 million. Yet the pressures for increased resources are relentless, with demographic factors such as the growing number of elderly people placing greater demands on services. Proposals for new capital development and for the enhancement of services such as renal and regional rehabilitation services are also competing for additional funding. The resources available for health and social care are limited. Cost-effectiveness must be a priority for acute services and any unnecessary duplication of services, or the inappropriate provision of services which fail to meet recognised quality standards, must be eliminated as far as possible. New capital projects must be tested for the availability of private finance.

6.11 The combination of all these factors will determine the direction in which acute services will develop. There will in future be opportunities for a growing range of diagnostic and therapeutic services to be provided at local level, closer to patients' homes, through enhanced cooperation between hospital and primary or community based teams. At the other end of the spectrum, highly complex and expensive specialised services, which can be provided viably only at a regional level, will tend to be concentrated on one centre serving the whole Province. Other acute specialties and inpatient procedures will be concentrated on fewer acute sites so that patients receive care to optimum levels of quality and clinical effectiveness.

Strategic Priorities

6.12 In the light of these background factors, the Department's overall aim for acute care is:-

to provide the highest quality of care appropriate to the needs of the patient.

6.13 In pursuit of this aim, the priorities for action during the period of this strategy will be to:-

move increasingly towards the purchasing of acute services based on evidence of clinical effectiveness;

secure further improvements in the quality of service to patients;

provide locally accessible services for more routine procedures through enhanced cooperation between primary and community based and hospital care teams;

concentrate specialised services on fewer acute hospital sites in order to secure optimum levels of clinical effectiveness, quality of care and value for money;

continue to move from inpatient to day and outpatient investigation and treatment;

ensure that patients continue to have access to high quality regional medical services; and

secure greater efficiency in the use of resources.

6.14 These priorities are discussed further below.

Clinical Effectiveness

6.15 The needs of patients will best be met through services which are proven to be effective. It is important therefore that efforts are invested to establish the evidence of outcomes for clinical interventions. Equally, it is important to discard ineffective interventions to reduce inappropriate use of resources. The proposed new Research and Development Office for the health and personal social services, and the new Director of Research and Development, will have a particularly important role to play in promoting evidence-based purchasing and the application of information about the effectiveness of interventions. **Over the life of this strategy purchasers will be expected to demonstrate how they are using evidence about clinical effectiveness in their contracting for acute care.**

6.16 A considerable volume of material about clinical effectiveness and clinical standards is currently produced from a wide variety of sources. There is, however, no local mechanism for ensuring that this information is systematically disseminated or applied to the health and personal social services in Northern Ireland. **The Department will put in place new arrangements, under the direction of a Clinical Effectiveness Group, to assist the health and personal social services to make optimum use of evidence on clinical effectiveness. One of the purposes of this initiative will be to assist in identifying effective treatments and standards which should be incorporated into the contracting process for acute hospital services.**

6.17 Changes in clinical practice, the development and application of clinical standards and the development of policy in some specialties are improving information about how services should best be delivered to patients. A particular example is cancer services. **Over the life of this strategy purchasers will be expected systematically to keep services in individual specialties and across specific diseases under review to ensure the most appropriate framework for service delivery, taking account of evidence of clinical effectiveness, professional guidelines and appropriate levels of specialisation and caseload. Purchasers will be expected not to purchase services which do not meet accepted standards for quality of care.**

Quality of Care

6.18 Quality of care also extends to the non-clinical aspects of services, and patients have a right to expect services that are delivered to a high level of quality. *A Charter for Patients and Clients* has set specific standards and targets in respect of a range of hospital services, covering waiting times for inpatient treatment and outpatient appointments, registration in accident and emergency departments and the percentage of day cases out of total non-emergency admissions for certain procedures. **The Department will continue to develop the Charter, setting more refined targets as appropriate. The Department will also improve the quality and quantity of information provided to the public about the performance of hospital services, taking into account the nature and complexity of the services offered.**

Developing Local Services

6.19 The vast majority of people receiving health care do not require the sophisticated services of an acute hospital. The Government's policy is to encourage an enhancement of the role of primary care and a shift of services from the hospital care sector to primary and community settings so that people can have services provided as closely as possible to the communities in which they live and work. The aim is to ensure that, so far as possible, services should be re-shaped around the needs of local communities.

6.20 The benefits to patients of such a shift in the delivery of services may include improved patient satisfaction due to the provision of services closer to home, resulting in less travelling time for patients and their families; reductions in waiting times at acute hospitals; greater continuity of care, with patients receiving care under the management of a primary or community care team with whom they may be more familiar; and reductions in inappropriate admission and referral to acute hospitals.

6.21 Some of the services which can appropriately be provided, and are already being provided, in a local setting include:-

- minor surgery, carried out by GPs on minor surgery lists;
- specialist outpatient clinics, with consultants from acute hospitals providing clinics in local settings in a range of specialties where the volume of patients is sufficient to justify this arrangement;
- minor casualty services;
- chronic disease management in general practice for such conditions as diabetes and asthma;
- specialist nursing services, for example for diabetes, stoma, rheumatism, etc;
- a range of such therapeutic services as chiropody, physiotherapy, orthoptics, occupational therapy, speech and language therapy etc;
- diagnostic services;
- day procedures, where these can be provided safely and effectively;
- post acute rehabilitation;
- convalescent care;
- respite care; and
- terminal and palliative care.

6.22 There is no single organisational model or blueprint for how services should be provided locally. Many models exist, such as outreach clinics, polyclinics, hospital at home schemes or minor injury clinics. Some existing acute hospitals will have to evolve to provide the kinds of services listed above, rather than inpatient acute care. The strength of such services will lie in their innovation, diversity and local responsiveness. Precisely what services should be made available locally will depend on a variety of factors, including local health and social services needs; the demography of the catchment population; local infrastructure; the existing pattern of care and access to services; the proximity to an acute hospital; the capacity and willingness of the primary care team to contribute to the provision of such services; and the availability of resources.

6.23 Training and professional updating may need to accompany any transfer of services from the hospital care to the primary and community care settings. It will be important to have in place operational policies so that the scope of local services are carefully and clearly prescribed. The links between primary and hospital care will need to be clearly agreed with policies to define thresholds for entry to and exit from hospital care. Local communities will also need to be made aware of exactly what can be expected from local services. There will be a need to avoid providing inpatient care in hospitals which is more appropriate to residential care or nursing homes or domiciliary settings. Similarly, local facilities should complement services provided by acute hospitals and should not seek to duplicate them, without having the staff, expertise and facilities to do so. Outpatient clinics will require careful management to avoid undermining the ability of acute hospitals to provide a comprehensive service, or wasting scarce staffing resources through excessive travelling time.

6.24 **During the life of this strategy the Department will expect purchasers to work with each other and with providers to identify new and cost-effective ways of meeting patients' needs by providing locally accessible services, and to secure a progressive shift in the pattern of care with appropriate services being provided in primary and community settings.**

Concentration of Specialised Services on Fewer Sites.

6.25 The modern acute hospital will have to be able to attract a sufficiently large caseload to ensure not only that expensive equipment is used intensively, but also that there is a sufficient volume of work to sustain the skills of staff across a range of specialties. These factors, coupled with shorter lengths of stay and a reduction in the proportion of patients requiring inpatient treatment, mean that it will not be possible to sustain the current pattern of 19 acute hospitals in Northern Ireland without adverse consequences for clinical quality and efficiency in the use of resources, which might otherwise be released for the development of community-based services. **The Department expects to see progress towards a future pattern of significantly fewer acute hospitals serving larger populations.**

6.26 Given these trends and pressures, inpatient acute care will, in the future, be built around the core framework of the major teaching hospitals - the Royal Group of Hospitals Trust and the Belfast City Hospital Trust - and the other major acute hospitals in each Board area at Altnagelvin, Antrim, Craigavon and Dundonald. While investment where appropriate will be made in other hospitals, it is expected that those six hospitals will provide the main focus for future investment in inpatient facilities.

6.27 The concentration of specialised services onto fewer sites raises issues of accessibility, and purchasers will continue to have to balance ease of access to services against consideration of clinical effectiveness and quality standards. **It remains the Department's policy that quality and safety of care should have primacy over geographical accessibility, and purchasers will be expected to reflect this when securing the provision of acute services.**

6.28 This policy obviously has implications for other smaller acute hospitals in Northern Ireland. It is neither appropriate nor possible to be prescriptive about the precise role of each such hospital in this strategy. That will be a matter for purchasers and providers to determine taking into account local needs. Some hospitals may need to adjust their services to ensure that they complement the services provided by the major acute hospitals by providing more local services along the lines outlined at paragraphs 6.19 - 6.24. Services may be withdrawn from other hospitals altogether, with alternative models of care developing at local level in their place. What is clear, however, is that Northern Ireland cannot have 19 acute hospitals all aspiring to provide a full range of inpatient acute care in the light of quality of care and value for money considerations. **Commissioners will be expected critically to review the pattern of provision of inpatient acute services in their areas to establish whether it is appropriate for the future in terms of quality of care, cost-effectiveness and meeting need.**

6.29 Boards, as overall commissioners of services, will be expected to engage primary care, including GP fundholders, non-fundholding GPs and the other members of the primary care team, in planning the action to secure these strategic shifts in the provision of acute care. The commitment of primary care to this strategy will be crucial in ensuring its successful implementation.

Securing Regional Medical Services

6.30 The low volume of activity and the degree of sophistication of some services are such that they cannot viably be provided in Northern Ireland and are provided collectively for several regions of the United Kingdom or for the United Kingdom as a whole. Therefore, a small number of patients whose conditions require exceptionally complex diagnosis and treatment may have to travel to Great Britain. However, a range of highly specialised medical services, known as the Regional Medical Services, are provided in Northern Ireland on a Province-wide basis, that is they are normally provided from one or two hospital sites serving the whole of Northern Ireland.

6.31 The main characteristics of the Regional Medical Services are that they are relatively low volume and demand particular diagnostic and clinical expertise and the concentration of skills and resources. Developments in clinical practice and techniques may lead to services which were once provided regionally becoming established at a more local level. Conversely the opposite process may take place, and increasing specialisation may result in the creation of new regional services.

6.32 Responsibility for policy on the development of new, or the extension of existing, regional medical services rests with the Department. Purchasers are responsible for securing the services on behalf of their respective resident or practice populations. **The Department will ensure, as far as possible, that Northern Ireland remains self-sufficient in the full range of medical services which are generally provided in other regions of the United Kingdom. Purchasers should work together to ensure that the population for each Board has access to reliable, high quality, specialised regional medical services and that all regional medical services are provided in an equitable and cost-effective manner.**

Efficiency

6.33 Against the background of the overall resource framework for this strategy, and the current public expenditure climate, it is more important than ever that the substantial resources invested in acute care are used efficiently.

6.34 Measures of efficiency for acute hospital services have concentrated on the proportion of patients treated on a day case or outpatient basis, and throughput in the use of beds. Recent years have seen a significant improvement in these measures. Since 1990 throughput has increased, average stay has reduced and day cases, expressed as a percentage of all admissions, have risen. **Through the annual Management Plan the HSS Executive will continue to encourage purchasers to seek the provision of efficient hospital services.**

6.35 Despite these improvements, performance in Northern Ireland in some areas still tends to lag behind the performance of some regions in Great Britain. Straightforward comparisons can be misleading and are often too crude to take account of important differences in case-mix and demography. Nevertheless, it is important that Northern Ireland should aspire to the best efficiency standards set throughout the United Kingdom, consistent with appropriate professional standards. **Over the strategy period, the Department will, as part of its research programme, encourage research to establish the reasons for any significant differences in performance between acute services in Northern Ireland and Great Britain, and will encourage the development of more meaningful forms of performance indicators.**

7

CHAPTER SEVEN KEY AREAS

HEALTH
& WELLBEING:
INTO THE NEXT
MILLENNIUM

7.1 The following chapters set specific objectives and targets in respect of seven **key areas**. These key areas have been selected because they are substantial contributors to ill health, premature death and social need in Northern Ireland and are amenable to specific actions which will lead to health and social gain.

7.2 The key areas are:-

(i) family and child health and welfare;

(ii) physical and sensory disability;

(iii) learning disability;

(iv) mental health;

(v) circulatory diseases;

(vi) cancers; and

(vii) other non-communicable diseases.

7.3 In each key area a small number of objectives and targets is set. An indication is also given of the action needed to achieve these. There is also a strong inter-linking between the targets and actions within the earlier chapters and those in the key area chapters which follow. The agenda set in Chapter 3 in relation to risk factors such as cigarette smoking, poor nutrition, physical inactivity and alcohol misuse are crucial elements in reducing ill health and premature deaths from causes such as circulatory disease and cancer. Chapter 4 on Targeting Health and Social Need singles out the key areas as priorities for population needs assessment and for identifying, implementing and evaluating interventions which might reduce variations in health and social wellbeing. Chapters 5 and 6 paint a broad picture of the future direction of services for the population in general. The messages in these chapters apply equally to the care of people identified in the key areas.

7.4 Some long-term targets for the reduction of premature deaths in the key areas of circulatory disease and cancer have been carried forward from the 1992-97 Regional Strategy. The baselines for these targets were therefore established some years ago. The targets which have been carried over are marked as such in the chapters which follow.

8

CHAPTER EIGHT FAMILY & CHILD HEALTH & WELFARE

The Issues

8.1 Northern Ireland continues to have one of the youngest populations within the European Union - 24.2% of the population is aged under 15 years. Recent years have seen rapid change in the family structure in Northern Ireland with more children being born outside marriage and being brought up by lone parents. In addition, employment trends over the past decade indicate that the number of women in paid employment is increasing whilst fewer men are employed. Lone mothers are the least likely group to be involved in employment.

8.2 There is a close relationship between family poverty and higher infant mortality, poor levels of general health, poor educational qualifications, higher risk of abuse and neglect, and increased risk of social problems like drug abuse and delinquency. While the infant mortality rate in Northern Ireland has shown overall reductions, it continues to have a disproportionate impact on certain vulnerable groups. The major cause of mortality and morbidity in childhood continues to be accidents and there has been a substantial growth in the prevalence of childhood asthma, which is resulting in an increasing number of admissions of children to hospital.

8.3 The overall thrust of policy for family and child health and welfare must be provision of well coordinated, comprehensive family support services targeted at families most in need and aimed at assisting parents to become independent and confident in the proper development of their children. The implementation of the Children Order will assist this process as it provides:-

- for the establishment of children as citizens in their own right;
- a satisfactory contemporary definition of parental responsibility;
- a re-definition of the role of the state to support parents; and
- an emphasis on the statutory services working in partnership with parents at all times.

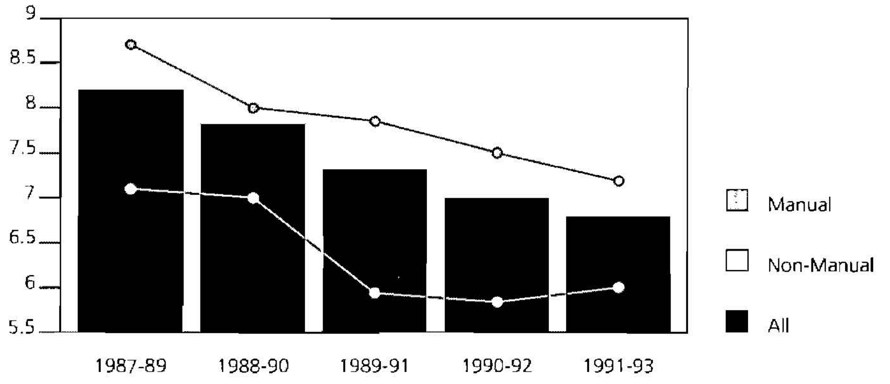
8.4 The Children Order requires Boards to assess the extent to which there are children in need in their areas and to commission services for them. As part of this process the Department will require Boards to produce Children's Services Plans. In addition, the Department, in conjunction with Boards, will develop a research and monitoring strategy to ensure that the implementation of the Children Order is kept under regular scrutiny and that the lessons learned are disseminated widely.

8.5 Overall in the past two decades there has been a very significant decline in the rate of stillbirths and deaths of babies in Northern Ireland. However, some sub-groups of the population remain particularly vulnerable with persistently high rates of infant mortality. For instance, Figure 8.1 shows how infant mortality rates vary by socioeconomic group and illustrates the need for resources and services to be targeted on groups which have identifiably high perinatal rates, including teenage mothers, mothers with diabetes and mothers in travellers' families.

Figure 8.1

INFANT MORTALITY RATES BY *SOCIOECONOMIC GROUP

(Deaths of Infants Under One Year Per 1,000 Live Births)



Source: REGISTRAR GENERAL NI

*See Glossary

8.6 Under the provisions of the Children Order, Boards have a duty to assess the needs of the children in their areas. It is essential that Boards recognise the long term advantages for adult health and social wellbeing to be gained from investing in early years services to children. A long term study (Schweinhart and Weikart 1993)[1] of a cohort of children provided with a structured early years programme has shown considerable health and social gain for those children throughout their lives into adulthood. The expansion of these services will enhance the personal, social and educational development of the children and should contribute significantly to a reduction in the number of children cared for by the statutory authorities and to the reduction of children abused and neglected in family settings.

8.7 It is accepted that children are best cared for by carers known to them and in their own home. This is particularly true if a child is injured or unwell since the anxiety and trauma of prolonged hospitalisation and removal from known carers not only delays recovery but may lead to secondary problems of emotional and behavioural difficulties. Currently the information base on morbidity rates for children is very poor. However, it is clear that an increasing number of children are being admitted inappropriately to hospital for short stays. This appears to be due to a number of factors including the nature of the childhood illness; the increase in childhood asthma; the rise in assessment admissions of children with gastroenteritis referred by general practitioners; the inappropriate use of hospital beds for respite care for children with severe chronic diseases and complex disabilities; and the perceived inability of the parent to cope with the child's illness.

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[1] SCHWEINHART, L J, WEIKART, D P.
Significant Benefits.
High-Scope Research Foundation, 1993.

8.8 All of these can be reversed and the services to children and their families enhanced by the adoption of the following general strategies:-

- the expansion of respite care facilities for children with severe chronic disease or complex handicap;
- the provision of training and support for parents so that they are better equipped to care for their children without the need for hospitalisation;
- the development of self-management programmes for chronic conditions such as asthma; and
- the application of agreed admission and discharge guidelines between the community and hospital sector.

8.9 The successful safeguarding of children requires coordinated action from a wide range of statutory and voluntary agencies most notably the police, courts, prosecutions service, health and social services, education and professional services. Each of these agencies must assume some responsibility, in particular for communicating their concerns and involvement with the family to appropriate services.

8.10 Between 1989 and 1993 there was an overall reduction in the numbers of children on child protection registers and in the rates per 1,000 children under 18 years. However, the numbers of children on child protection registers are not necessarily a good reflection of the incidence and prevalence of child abuse. The number of confirmed cases account for approximately 40% of the total registered. The remainder include those children who are suspected or in danger of being abused. Those not on the register include a significant number of children who are known to have been abused and whose names do not appear because no child protection plan is deemed necessary.

8.11 It is critical that the Children Order produces a real improvement in children's lives. The primary target must be to prevent the children from being abused and permit them to lead their lives in safety and security. When this primary prevention fails, the major objective must be to prevent reabuse of the child. The development of appropriate treatment services for the survivors of abuse will lead to positive work with the child and the family and help safeguard the child from the abuse.

8.12 *Targets*

By 2002 there should be a 10% reduction in stillbirths and deaths in children under one year old.

By 2002, of the children assessed by Boards as children in need,

- **those below compulsory school age should receive good quality early years services within their own homes or elsewhere, or a combination of both; and**
- **those of school age should receive family support services operating out of school hours.**

By 2002 there should be a reduction of at least 25% in the total number of acute hospital bed days occupied per annum by children aged 0-15 years.

By 2002 there should be a 50% reduction in the number of children abused or reabused who are on child protection registers.

8.13 Action

(i) *Stillbirths and Infant Mortality*

- The Department should continue to ensure that the annual commissioning plans of Boards incorporate the developments in good practice identified by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI).
- The Department should in accordance with *Delivering Choice*[1] and its policy guidance on maternity services ensure that a flexible and responsive maternity service is provided in keeping with women's needs and views, whilst maintaining the safety of mother and baby.
- Boards should assess the specific needs of mothers identified as coming from vulnerable groups and ensure that their plans offer health education and promotion, including sex education and access to advisory and family planning services.
- Providers should provide information which enables women to make informed choices about their maternal care.

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[1] NI MATERNITY UNIT STUDY GROUP.
Delivering Choice: Midwife and General Practitioner Led Maternity Units.
Department of Health and Social Services, 1994.

- Providers should inform appropriate patients of the availability of genetic screening and prenatal diagnostic services, and provide these on a timely basis to all potential parents requesting such services.

- Providers should ensure that all women are encouraged to breastfeed after birth and are provided with appropriate support to do so, whether by a named midwife or health visitor or by other means.

(ii) *Children in Need*

- The Department should issue guidance on the means of assessing needs of children, including children with a disability, so that Boards employ comparable methodologies in the assessment of need. It should also issue guidance to Boards on the format and content of Children's Services Plans which ensure equity and access to services across the Province.

- The Department should develop a research strategy and programme of monitoring to ensure that the implementation of the Children Order is kept under regular scrutiny and that lessons learned, both within Northern Ireland and elsewhere, are disseminated.

- Boards should develop, taking into account the Department's guidance, a locally appropriate means of assessing the needs of children. They should also develop strategic approaches to children's services which coordinate different disciplines to provide comprehensive family support services, and coordinate services to children across agency boundaries eg with Education and Library Boards, the RUC and the full range of voluntary and community groups.

- Providers should develop models for comprehensive support services to families, and peer support networks in areas of high social need which can provide family support and reduce social isolation.

(iii) *Child Health Services*

- The Department should develop a health awareness campaign aimed at parents and general practitioners to explain the benefits in terms of health gain of caring for sick children in their home, and likewise, the possible negative, unintended consequences arising from hospital admission.

- The Department should promote models of good practice which combine and develop skills of hospital and community - based services in a coordinated fashion.

- Boards should produce plans for family support services which coordinate family health and social care; provide parents with the necessary skilled support to give them respite from caring for the child with severe chronic illness or complex disability, including learning disability; and assist with the care of children returned home from hospital to be cared for in the community.

- Boards should monitor childhood prescriptions, all child hospital admissions, child hospital bed days and general practitioners' referral rates of children to hospitals, and take action as appropriate. They should also agree admission and discharge protocols.

- Providers should develop a range of 'diversionary' facilities by means of which children can be cared for without requiring hospital admission.

(iv) *Child Abuse*

- The Department should consider ways of quantifying the full extent of known and suspected child abuse throughout Northern Ireland.

- The Department should coordinate a review of evaluations of family intervention programmes in order to identify practice which is effective in terms of positive outcome behaviours for the child and family, and should publish and promote examples of evaluated good practice.

- Boards, working where appropriate with Area Child Protection Committees, should develop a child protection information system which records and analyses the abuse and reabuse of children.

- Boards should ensure that their purchasing prospectuses and quality standards for family support programmes are directed at families where abuse has been identified. These plans should be compatible with what has been shown to be effective by evaluated research.

- Providers should implement a programme of training and skill development for appropriate staff who will be involved in family interventions with children who have been abused.

- Providers should ensure the full implementation, monitoring and evaluation of all multidisciplinary child protection plans.

9 CHAPTER NINE PHYSICAL & SENSORY DISABILITY

HEALTH
& WELLBEING:
INTO THE NEXT
MILLENNIUM

The Issues

9.1 The Policy Planning and Research Unit Surveys of Disability (1992)[1&2] show that in Northern Ireland around 100,000 people, 40,000 of whom are under 60 years of age, have levels of physical or sensory disability which significantly affect the quality of their lives. The inadequacy of service provision for this group was acknowledged by its inclusion as a key area of concern in the 1992-97 Regional Strategy. The objectives set in that strategy remain vital for people with disabilities, especially those with sensory impairments. Although some important advances had been made, significant further work is required.

9.2 Encouraged by community care policies, promoting choice and independence, people with disabilities increasingly seek greater control over their own lives and alternatives to traditional models of service delivery. Boards, in partnership with other agencies and with users, must aim to develop a comprehensive range of flexible and responsive services, underpinned by principles of empowerment and autonomy, in order to ensure quality of life and equality of opportunity for disabled people in Northern Ireland.

9.3 The targets chosen to take the Regional Strategy positively forward into the next century highlight areas where early intervention and focused action will have the greatest effect. They focus primarily on people aged up to 65 years who suffer from physical and or sensory disability, and who need support in order to live independently. The strategy, however, recognises that age transitions can be arbitrary and that achievements for this group will also bring improvements for older people with disabilities.

9.4 Successful implementation of the strategy will be based on three underpinning principles:-

- meaningful **user involvement** at all levels of service planning, commissioning and provision, and support for the development of user-led groups and services;
- multiagency **coordination** of service planning, resource allocation, commissioning and delivery, including housing, education and other statutory and voluntary agencies as well as health and social services; and
- collection and analysis of **information** about needs, shared across Boards and with other agencies, and information about services available to users in accessible formats/communication methods.

Application of these principles to services for people with disabilities in general will serve to perpetuate and strengthen many of the initiatives set in place to achieve the objectives set in the 1992-97 Regional Strategy.

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[1] POLICY PLANNING AND RESEARCH UNIT.
The Prevalence of Disability Among Adults in Northern Ireland.
Department of Finance and Personnel, 1992.

[2] POLICY PLANNING AND RESEARCH UNIT.
The Prevalence of Disability Among Children in Northern Ireland.
Department of Finance and Personnel, 1992.

9.5 *Objectives*

Boards should work with other agencies, in particular in the education and employment sectors, to ensure that young people aged 16-25 with disabilities have the same opportunities as their non-disabled peers to gain personal, social and economic independence in the community, setting out in purchasing plans how the level of services to meet assessed needs will be secured.

Boards should recognise the needs of people newly disabled and make available the range of services needed in order to maximise opportunities to continue their usual and planned lifestyles/activities.

Boards should recognise the needs of disabled parents with dependent children and commission a range of services to meet the identified needs of the whole family, including young carers.

Boards should develop strategies for the commissioning of well integrated, accessible and complementary hospital and community services for individuals with traumatic brain injury and their families.

9.6 Action

(i) *For People Aged 16-25*

- In collaboration with education authorities, Boards should ensure effective implementation of Sections 5 and 6 of the Disabled Persons (Northern Ireland) Act 1989.

- Boards should collect information at school leaving time via assessments under the 1989 Act.

- Boards should carry out an annual analysis of combined assessments and review of the extent to which needs are being met, ensuring that sufficient resources are allocated to carry out these tasks.

- Boards and Trusts should establish protocols covering the links between child and adult services.

- Boards and Trusts should establish multiagency and multidisciplinary working practices to optimise the links between hospital and community services and those of other agencies.

- Young people and their parents should be involved in assessment and care planning, recognising that their views may differ and conflict.

- Boards should seek to promote local advocacy and self-advocacy schemes and user-led support networks/groups.

- Boards and Trusts should work together to develop a continuum of targeted health and social services (eg acute and rehabilitation services) to optimise individual choice.

(ii) ***For Newly Disabled People***

'Newly disabled' people include those who are disabled (physically and sensorily) by acute events (eg trauma) and those who may be potentially disabled by a progressive condition.

- Boards and Trusts should promote positive sharing with the person involved about his or her diagnosis and prospects, including information about available practical/communication/ support services (including voluntary sector services) and about how to access them.

- People with disabilities should be involved in the education and training of professionals in the acute, community and voluntary sectors.

- Boards and Trusts should ensure multiagency and multidisciplinary coordination and delivery of services, based on joint needs assessment, planning and commissioning.

- Peer group support networks, advocacy services and user fora should be promoted and developed.

- Boards and Trusts should ensure timely provision of relevant services (eg rehabilitation, continence treatment and promotion, equipment, adaptations) to ensure continuity and quality of individual lives (eg employment, family responsibilities, leisure pursuits).

(iii) ***For Disabled Parents with Dependent Children***

- The Department, with Boards and other statutory and voluntary agencies, should commission qualitative, short-term, locally focused research into the needs of disabled parents with dependent children.

- Strategies should be developed at inter-departmental level to promote an understanding of the needs of disabled parents and their dependent children.

- Providers should work in partnership with voluntary/user organisations to support parents and to develop innovative models of support.

- Purchasers should seek to secure provision of a range of counselling services and practical support (eg personal and communication assistance, transport, adaptations and equipment).

- Particular attention should be given to those children of disabled parents who fulfil the role of carers, and their specific needs should be addressed as a matter of urgency.

(iv) *For People with Traumatic Brain Injury and their Families*

- The Department, in cooperation with other relevant departments, should give priority to the prevention of accidents.

- The Department should undertake as a matter of urgency to resolve jointly with Boards the provision of rehabilitation services for people with traumatic brain injury. This should involve the development of locally sensitive hospital and community services, the establishment of a Regional Rehabilitation Unit and each Board's relationship with that Unit.

- Boards should develop standards and protocols for traumatic brain injury with regional and local providers so that appropriately skilled and timely help is assured for each individual and his/her family. The information needs of patients and their families at all stages of intervention and training for staff should be essential elements of these standards.

- The Department, purchasers and providers should ensure the development of case management structures so that continuity, coordination and clarity of responsibility throughout the whole spectrum of care is assured.

- Boards and Trusts should form alliances with a wide range of agencies to foster the development of services which meet the needs of people with traumatic brain injury and their families.

- The Department should establish a regional multidisciplinary forum to disseminate information about good practice, promote and stimulate research, develop a monitoring framework and act as a reference group regarding the development of services throughout Northern Ireland.

- The Department will distribute widely a booklet of the proceedings of a workshop on traumatic brain injury in Northern Ireland (October 1995) to inform and assist in the development of this service.

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10 CHAPTER TEN LEARNING DISABILITY

HEALTH
& WELLBEING:
INTO THE NEXT
MILLENNIUM

The Issues

10.1 There are over 8,000 people with a learning disability in Northern Ireland. The report of a comprehensive review of policy for people with a learning disability[1] was published in 1995. The Department fully endorses the review's conclusions which identify policy aims appropriate to the end of the 20th century and its recommendations which address the key issues for policy into the next century. The review highlighted the importance of including people with a learning disability in society. Access to mainstream services can broaden their horizons and social circle, widen experiences, offer opportunities and challenges, and stimulate achievement.

10.2 Supported by evidence in the Health and Health Care Research Unit's report *Opening New Doors*, the review concluded that care in the community for people with a learning disability was preferable to long-stay hospital care. The review recommended that settlement in the community of those long-stay patients still in hospital should be pursued. At present, however, underdeveloped community services are resulting in over-reliance on treatment in specialist hospitals and inappropriate residential care and nursing home placements. Repeated short-term admissions can disrupt long-term care and training programmes and can have an adverse affect on functioning.

10.3 Additional challenges are being presented by more very profoundly disabled children and by people with a learning disability living longer.

10.4 ***Objective***

To provide the individual with a choice of living accommodation and day activities appropriate to assessed needs, the Department, Boards and Trusts should develop links which promote interagency cooperation. These links should be with other departments, agencies and organisations responsible for housing, further education, training for, and support in, employment and leisure activities.

Targets

Each Board and Trust should develop a comprehensive range of supportive services for people with a learning disability and their carers. The overall objective is that, by 2002, long-term institutional care should no longer be provided in traditional specialist hospital environments.

As an integral feature of the comprehensive services, specialist provision should be linked to community-based care and treatment which should reduce the number of adults with a learning disability admitted to specialist hospitals by 50% and the number of children, other than in exceptional cases, to zero by 2002.

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[1] DHSS.
Review of Policy for People with a Learning Disability.
HMSO, 1995.

10.5 Action

(i) *Better Information about People with a Learning Disability*

The Department, purchasers, providers and practitioners should agree common definitions, data requirements and arrangements for sharing information, and put in place information systems capable of measuring need, unmet need and emerging needs and facilitating planning, contracting, monitoring and evaluation.

(ii) *Reallocate Resources*

Financial and manpower resources should be fundamentally reallocated to facilitate the development of comprehensive community care geared to the resettlement of hospital patients and a reduction in hospital admissions.

(iii) *Residential Placements*

Trusts should have in place monitoring arrangements to ensure that residential placements and settings remain appropriate and provide a choice of alternatives when they are not.

(iv) *Respite Care Services*

Providers should develop a range of respite care services designed to meet the needs of and provide choice for both client and carer, and promote the availability, awareness and take up of those services.

(v) *Community Learning Disability Teams*

Trusts should review the composition and role of community learning disability teams, including the development of mobile emergency support provision. Services should ensure an interface with other agencies, comprehensive assessment, periodic reviews and the delivery of high level emergency domiciliary support.

(vi) *Cross-professional Education and Development*

Employers and professional organisations should develop practical ways for those working with people with a learning disability, including carers, to have cross-professional education and development.

(vii) *Advocacy*

Purchasers and providers should ensure that people with a learning disability have access to an independent advocate or are empowered to advocate on their own behalf to enable them to make informed choices about their lives.

(viii) *Discharges from Hospital*

Provision should be made to ensure that no one remains in hospital unduly on completion of their treatment through lack of alternative community care.