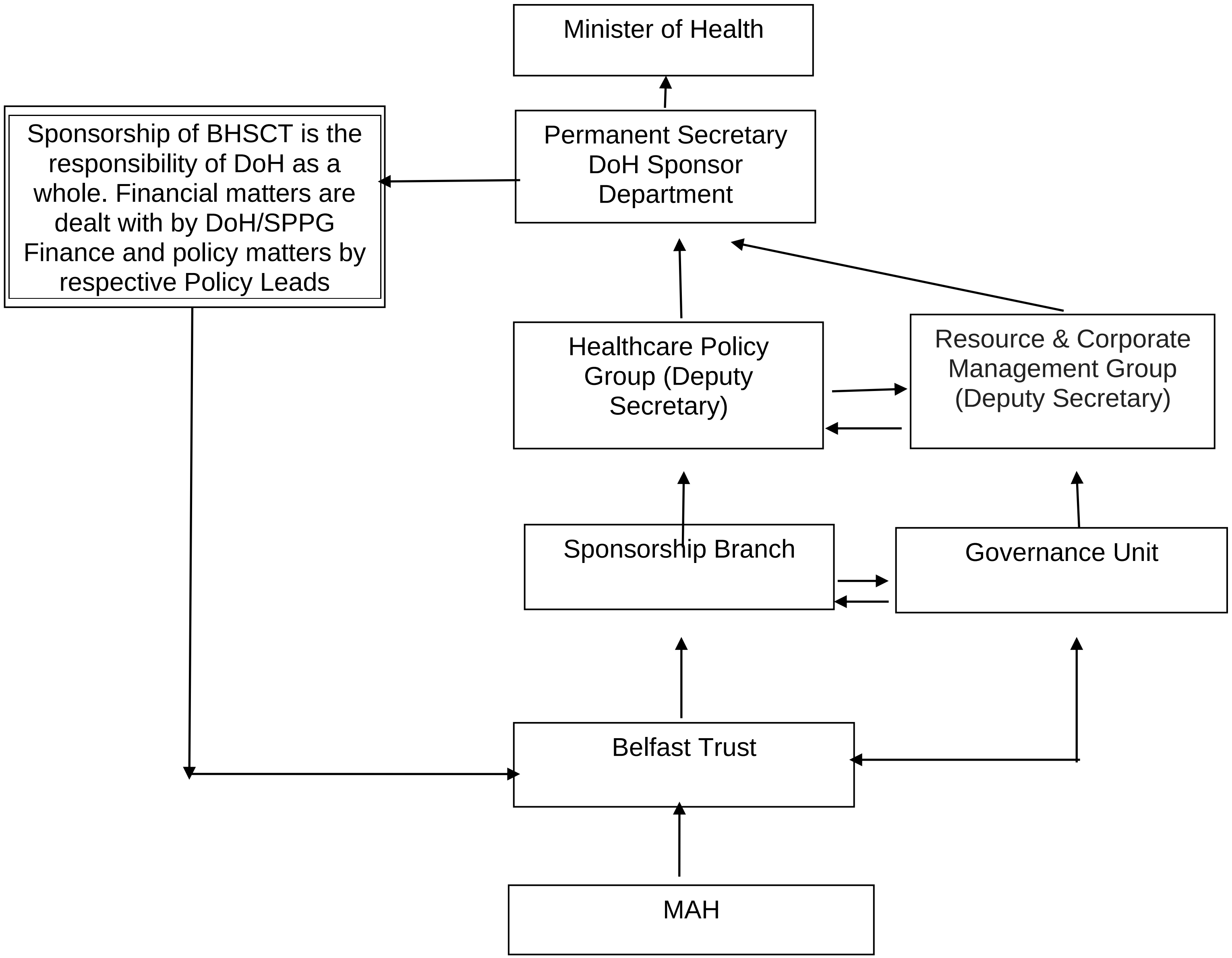
MMcG- 1

Muckamore Abbey Hospital – Sponsor Department Governance Structure



Ref	**Full Name:**
MAH	Muckamore Abbey Hospital
DoH	Department of Health
MDAG	Muckamore Departmental Assurance Group
HSC	Health and Social Care
ToR	Terms of Reference
SPPG	Strategic Planning and Performance Group
DHSSPS	Department of Health, Social Services and Public Safety
DHSS	Department of Health and Social Services
HSSBs	Health and Social Services Boards
HSS	Health and Social Services
HSSTs	Health and Social Services Trusts
HSCB	Health and Social Care Board
HPSS	Health and Personal Social Services
HSCTs	Health and Social Care Trusts
HSC	Health and Social Care
POC	Programme of Care
PHA	Public Health Agency
ALBs	Arm’s Length Bodies
AfC	Agenda for Change
PCC	Patient and Client Council
MH	Mental Health
LD	Learning Disability
NICE	National Institute for Health and Care Excellence
SQSD	Safety, Quality and Standards Directorate
NMC	Nursing and Midwifery Council
CNO	Chief Nursing Officer
NIPEC	Northern Ireland Practice and Education Council
NMTG	Nursing and Midwifery Task Group
CNOG	Chief Nursing Officer Group
DoLs	Deprivation of Liberty Safeguards
PSNI	Police Service of Northern Ireland
RQIA	Regulation and Quality Improvement Authority
NIO	Northern Ireland Office

Ref	**Full Name:**
LIN	Local Intelligence Network
CPO	Chief Pharmaceutical Officer
AHPs	Allied Healthcare Professionals
NHS	National Health Service
PIDO	Public Interest Disclosure Order
SAIs	Serious Adverse Incidents
HRRI	Healthcare Risk Resources International
ISO	International Organisation for Standardisation
OFMDFM	Office of the First Minister and Deputy First Minister
OSS	Office of Social Services
NISCC	The Northern Ireland Social Care Council
NDPB	Non Departmental Public Body
KSF	Knowledge and Skills Framework

MMcG- 3

PEOPLE FIRST

DHSS

COMMUNITY CARE IN NORTHERN IRELAND FOR THE 1990s

MAHI - STM - 089 - 94

PEOPLE FIRST: COMMUNITY CARE IN NORTHERN IRELAND IN THE 1990s

FOREWORD

It has been said that the best measure of a civilised society is how well it cares for those of its members who for whatever reason cannot live totally independently. Most of this care is given outside hospital: in people's own homes, in various residential settings, whether in the public or independent sector, and in nursing homes. The Government's vision of care needed in the community at large has three central principles: first, to help such people to lead, as far as possible, full and independent lives; second, to respond flexibly and sensitively to the needs and wishes of individual people and the relatives and friends who care for them; and third to concentrate professional skills and public resources on those who need them the most.

The proposals in this paper open up new opportunities for everyone whose business it is to care for and support people living in the community. The new arrangements for financing and managing community care will equip the Health and Social Services Boards - and the many other agencies which have a contribution to make - to meet the substantial challenges of the next decade. They will give the users of the caring and supportive services a wider choice. They will also ensure that individuals' needs are properly assessed and that appropriate services are provided to meet them.

A great deal of excellent work is already being done to turn the Government's vision of community care into a reality. The Regional Strategy for the Health and Personal Social Services for 1987-1992 has already focused attention on the need to develop humane and high quality caring services - services which enable people who are vulnerable through age, physical disability, mental illness, mental handicap or other causes to live as full and independent lives as possible in whatever setting best suits their needs.

As in all modern industrial societies, the health and social services in Northern Ireland are having to satisfy increasing demands and meet rising public expectations out of budgets which are necessarily limited. We are fortunate in that we already have an integrated structure for these services, an advantage not enjoyed by other parts of the United Kingdom. The progress that has been made since 1987, in particular, is a tribute to the energy and enthusiasm of the many different professional and other groups working in the field, and to the efforts of numerous dedicated individuals working in the statutory health and social services and in other public, private and voluntary agencies. I know that my colleague Roger Skelmersdale is committed to building on the excellent foundations which they have laid to enhance further the quality of life of everyone in Northern Ireland who needs care in the community.

The proposals in this paper, coming as they do on top of the substantial programme of reforms heralded in the White Papers "Working for Patients" and "Promoting Better Health", present a major challenge to the staff of the community health and personal social services. I do not underestimate the size of the task. But I am confident that, if everyone works together towards the common objectives set out in the first chapter of the paper, we shall greatly strengthen our collective capacity to help many of the most needy and vulnerable people in our society.

Peter Brooke

PETER BROOKE
Secretary of State for Northern Ireland

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CHAPTER ONE: BETTER CARE IN THE COMMUNITY

Introduction

1.1 Community care matters to everyone, and it is in everyone's interest to consider it objectively and to move forward together to realise fully its potential. Community care matters especially to the many people who are or will become vulnerable through ageing, mental illness, mental handicap or physical disability, and to those looking after them. Community care, which consists of both health and social care, has as its overriding objective to enable people to live as full a life as possible, in whatever setting best suits their needs.

1.2 This paper complements the White Papers "Working for Patients" and "Promoting Better Health", which set out the Government's plans for the future management of the hospital and general practitioner services. The purpose underlying those plans was to improve the quality of the services by extending people's freedom of choice, by delegating responsibility to those who actually deliver services and by ensuring value for money.

The Griffiths Report

1.3 The proposals in this paper originated in Sir Roy Griffiths' report "Community Care: Agenda for Action", published in March 1988. He identified as one central aim "to provide structure and resources to support the initiatives, the innovation and the commitment at local level and to allow them to flourish; to encourage the success stories in one area to become the commonplace of achievement everywhere else". A second central aim was "to spell out responsibilities, insist on performance and accountability and to evidence that action is being taken". This paper subscribes to these aims.

1.4 In making his recommendations, Sir Roy noted that they would "increase the ability of managers in all community care services to ensure that:

- the right services are provided in good time, to the people who need them most;
- the people receiving help will have a greater say in what is done to help them, and a wider choice;
- people are helped to stay in their own homes for as long as possible, or in as near a domestic environment as possible, so that residential, nursing home and hospital care is reserved for those whose needs cannot be met in any other way."

1.5 Although the Griffiths Report did not extend to Northern Ireland, its broad thrust is very much in keeping with the Regional Strategy for the Northern Ireland Health and Personal Social Services 1987-1992. The Regional Strategy places great emphasis on the successful and humane implementation of the community care policy. It calls for close targeting on the main priorities; gives high priority to support for families caring for dependent relatives; and notes the importance of clear arrangements for co-ordination and joint planning between Health and Social Services Boards and other agencies, including voluntary organisations. It also seeks to secure a more appropriate balance of care between hospital and community services.

"Caring for People"

1.6 In November 1989, the Government published the White Paper "Caring for People", which set out in detail its proposals for improving community care in Great Britain. This paper explains how the national policy objectives in the White Paper are to be pursued in the context of Northern Ireland's unique integrated health and social services, and in the context of the new role which Boards will assume in line with "Working for Patients".

Recent developments

1.7 The successful implementation of the community care policy depends on the availability of adequate, appropriate and accessible services. The past decade has been one of substantial growth in community care services, made possible by a significant increase in public expenditure.

1.8 Chapter 2 indicates how different forms of care in the community have been developing in Northern Ireland. The following figures illustrate this development in general terms:

* by 1988/89, expenditure on community health and personal social services stood at £177m, up from £69m in 1979/80 - an increase of 36% in real terms;

* the number of people in independent residential care and nursing homes receiving social security support rose from under 300 in 1979 to some 3500 in 1989;

* over the same period, the number of places in statutory and registered residential care homes rose by 24%, from 4964 to 6163; and the number of places in registered nursing homes by 698%, from 307 to 2450.

The need for change

1.9 Although the past decade has been one of substantial growth and achievement and despite the advantage of our integrated structure, progress has been slower and more uneven than the Department would like. The arrangements for public funding have contained a built-in bias towards residential and nursing home care, rather than services for people at home. In some places, there have been great strides in the development of community services, but in others they are less well advanced. The Department's aim is that in future all contributors to community care should strive to achieve a more consistent performance in line with people's needs.

1.10 For most people, effective community care offers a better quality of life and a wider range of choice than they would have expected in the past. The Department recognises that community care is not an easy policy to implement successfully and may in some cases make intensive demands on resources and manpower. It is not a narrow task but a broad programme designed to enrich the lives of those it helps. It requires inputs from and co-operation amongst various agencies: the Department of Health and Social Services, Health and Social Services Boards, Social Security Offices, the Department of the Environment, the Housing Executive, the Department of Economic Development, the Employment and Training Agency, the Department of Education, Education and Library Boards, and independent sector service providers. The Department's aim is to ensure that better working relationships and partnerships are formed; that inter- agency planning and negotiation takes place; and that there is a common understanding of community care policy objectives.

1.11 The focus of this paper is on clarifying the roles and responsibilities of Health and Social Services Boards. However, the achievement of this aim will require these various agencies to re-examine their roles and responsibilities. They all have a contribution to make in enabling people to live independent lives in their own homes or in homely surroundings; to help them to realise their full potential and contribute to the community in which they live; and to allow them a full say in how they live their lives and in the services they need.

Principles

1.12 The great bulk of community care is provided by family, friends and neighbours. The decision to take on a caring role is often difficult. However, many people make that choice, and it is right that society should support them in looking after those close to them.

1.13 The principles underpinning the Government's approach to community care are that:

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

Central objectives

1.14 "Caring for People" sets out six central objectives, which apply as much to Northern Ireland as to Great Britain:

- to promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever possible;
- to ensure that service providers make practical support for carers a high priority;
- to make proper assessment of need and good case management the cornerstone of high quality care;
- to promote the development of a flourishing independent sector alongside good quality public services;
- to clarify the responsibilities of agencies and so make it easier to hold them to account for their performance;
- to secure better value for taxpayers' money by introducing a new funding structure for community care.

Main changes

1.15 In order to achieve these objectives, the Department proposes to make seven main changes in the way in which community care is delivered and funded in Northern Ireland:

first, the role of Health and Social Services Boards as co-ordinators, purchasers and quality controllers will be strengthened relative to their present primary role as service providers;

second, Boards will be expected to target resources more effectively by assessing individuals' needs more systematically, tailoring care packages more precisely to meet these needs within available resources;

third, Boards will be expected to make full use of the independent sector:

fourth, there will be a new funding structure for those seeking public support for residential and nursing home care from April 1991;

fifth, from April 1991 applicants with few or no resources of their own will be eligible for Income Support and Housing Benefit on much the same basis, whether they are living in their own homes or in independent sector residential care or nursing homes;

sixth, Boards will be expected to establish registration and inspection units, at arm's length from the management of their own services, which will be responsible for monitoring standards in Boards' homes as well as independent sector residential care and nursing homes;

seventh, planning procedures will be improved to focus more clearly on the development, monitoring and evaluation of community care services.

Services for children

1.16 The Government is preparing new children's legislation to replace the Children and Young Persons Act (NI) 1968, and intends to publish a proposal for a Draft Order in Council later in the year. This will include provision for disabled children. The child care and community care programmes are consistent and complementary and, taken together with the health service reforms, set a fresh agenda and new challenges for the Boards for the new decade.

CHAPTER TWO: COMMUNITY CARE IN PRACTICE

A spectrum of care

2.1 Community care is not a new concept. The term, however, means different things to different people. This paper uses the term to mean care outside hospital.

2.2 In providing such care, the aim has been and will continue to be to ensure as far as practicable that a full spectrum of services and facilities is available. Ideally, this spectrum ranges from support offered to people at home, with access to respite and day care as necessary; through family placements, sheltered housing, group homes and hostels where increasing levels of care are available; to residential care and nursing homes for those for whom other forms of care are either inappropriate or no longer enough. An essential characteristic of community care is that it helps people to live as independently as possible in their own homes or in homely settings in the community.

2.3 While this paper focuses largely on the role of statutory agencies working in partnership with the independent sector, most care is given by relatives, friends and neighbours - the so-called "informal carers". Most informal carers take on their extra responsibilities willingly, but many need help. Their lives can be made much easier if the right support is there at the right time, and it is one of the Health and Social Services Boards' main responsibilities to do all they can to see that it is.

2.4 Although families, and usually women, continue to be the principal source of care for dependent people, informal care can no longer be taken for granted. Higher participation rates by women in the work force, increased geographical mobility, a rising divorce rate and the trend towards smaller families (which changes the ratio of informal carers to those who need care) are all tending to reduce the availability of informal carers. Nevertheless the family will continue to be the major supplier of social and personal care, and the obligations of kin and affection will remain powerful motivators. It is in society's interest to sustain that motivation and to see that appropriate packages of support are assembled for people who are able and willing to care for others.

2.5 The personal social services have an important contribution to make not only in supporting carers but also, directly, in providing or securing care and practical help for people who need it. The essential services which they offer include information, advice and counselling; help with personal and domestic tasks such as cleaning, washing and preparing meals; help with disablement equipment and home adaptations; and help with transport, budgeting and many aspects of daily living.

2.6 Health care in the community is also important. The primary care team has a vital part to play. The general practitioner is commonly the individual's first point of contact with the health and social services, and often the first to identify new problems or needs.

2.7 The private and voluntary sectors have been making their own distinctive contributions to the development of particular community care services. Individual people and organisations in those sectors have been to the fore in translating the policy into practice in imaginative and innovative ways.

The Regional Strategy

2.8 The central themes of "Caring for People" are already covered in or are complementary to the Department of Health and Social Services' most recent statement of strategic aims and policy objectives - the Regional Strategy for the Northern Ireland Health and Personal Social Services 1987-1992 - to which the Department remains committed.

2.9 The Regional Strategy emphasises that elderly people and people with a mental illness, mental handicap or physical disability should be enabled to live in the community, in their own homes whenever possible, and to participate as fully as possible in regular work, social and educational activities. It also calls on the Health and Social Services Boards to make a substantial shift in resources from hospital to community care.

2.10 Good headway has already been made towards the attainment of these objectives. The remainder of this chapter will look at some recent developments in community care which point the way forward towards improving provision for each of the four groups which make the greatest demands on community care services.

Elderly people

2.11 There were 192,300 people over 65 years of age in NorthernIreland in 1988, roughly 1 in 8 of the population. Most elderly people live in the community and are active, energetic and independent citizens. However, illness and disability, often age-related, result in some elderly people having significant needs for help and support. At present, about half of public expenditure on the personal social services in Northern Ireland is devoted to the care of the elderly.

2.12 The pattern of care for elderly people in Northern Ireland owes much to a major review of health and personal social services provision for the elderly, which took place in the early 1980s. The resulting report "Past 65 - Who Cares?" pointed to the importance of domiciliary, day and respite services in maintaining vulnerable elderly people in their own homes; advocated a multi-disciplinary approach to targeting services at those in greatest need; highlighted the need to develop a range of services for elderly people suffering from dementia; stressed the importance of co-operation amongst professions and agencies caring for the elderly; and underlined the importance of taking full account of service users' wishes.

2.13 The Regional Strategy in turn drew heavily on the major themes of this report. It highlighted the importance of targeting domiciliary care on those in greatest need; of supporting carers; of improving the quality of life of elderly people; and of improving co-operation amongst agencies and between the statutory, voluntary and private sectors.

2.14 The voluntary sector, in particular, has played an important part in pursuing these objectives. A good illustration of how innovative packages of care can be put together for dependent elderly people in their own homes is provided by the North and West Belfast Dementia project. This scheme stems from a partnership between Extra Care and the Eastern Board. As well as providing relief on a regular basis for those caring for elderly confused people at home, the project offers intensive short-term support for carers at times of crisis.

People with a physical disability

2.15 Some 40,000 people are recorded by Health and Social Services Boards as suffering from some form of physical disability. This is roughly 1 in 40 of the population. There is a high correlation between disability and age. More than 60% of those physically disabled people known to the Boards were over 65.

2.16 In Great Britain, recent OPCS surveys have shown that over 6,000,000 adults have some degree of physical, mental or sensory disability. More than 66% of these people were aged over 65. The OPCS surveys do not cover Northern Ireland. However, a parallel survey is now being conducted here, which will provide comparable information on all aspects of disability.

2.17 Most physically disabled people live in their own homes, and services are geared to enabling them to stay there. A small number need continuing care in residential care or nursing homes or in hospital.

2.18 The Regional Strategy recognised a considerable overlap between programmes of care for people with a physical disability and those for elderly people and people with a mental handicap, who may also have a physical disability. It noted that services for people with a physical disability required substantial improvement and that there was an urgent need to improve services for those with impaired sight or hearing. It proposed that Boards should enhance their paramedical and other services to reduce disparities across their areas; that artificial limb and appliance services should be further developed; that Boards should strengthen their links with voluntary and other agencies at local level, specifically in the housing field; and that there was a need to improve day care facilities. It also asked Boards to reduce the numbers of young people with a physical disability in residential units for elderly people.

2.19 In the wake of the Regional Strategy, services have grown and developed in a number of directions. There has been a significant increase in the number of staff employed in the therapeutic professions allied to medicine; new contract arrangements have been introduced for the supply of artificial limbs and appliances which should improve these services; and the number of housing adaptations has continued to increase. There have also been several worthwhile initiatives for people with sensory disabilities.

2.20 An example of a project which promotes both independent living and integration with the rest of the community is run by the Northern Ireland Council for Orthopaedic Development (NICOD) in partnership with the Habinteg Housing Association. It is organised around a housing scheme at Duke Street in East Belfast for six people, including three who use wheelchairs. The housing scheme is supported by NICOD staff, who help residents to cope with the activities of daily living. A community assistant employed by Habinteg provides 24 hour emergency cover. This development is integrated with a larger Habinteg scheme accommodating families, single people and other people with physical disabilities. The whole scheme is located near shops and other facilities.

People with a mental illness

2.21 Each year around 8,000 people are admitted to psychiatric hospitals, including 3,000 new patients. Most of them stay in hospital for less than a year, and of these people the average stay is six weeks. At any one time there are about 2,200 patients in psychiatric hospitals who have been there for a year or more. However, most people with a mental health problem are now able to live at home, and to receive the medical treatment they need from their general practitioners or from specialists through outpatient clinics. This treatment is backed up in the community by services ranging from an occasional visit by a nurse or social worker for those with minor transient conditions to a full package of nursing and social care for those who suffer from permanently disabling disorders.

2.22 The Regional Strategy emphasises the development of comprehensive community based services with a corresponding reduction in dependence on inpatient places. It sets a specific target of a 20% reduction over the five years to 1992 in the numbers of patients in psychiatric hospitals. At the same time, the Regional Strategy emphasises that this target is merely a guideline and that alternative and better forms of care in the community must be developed **before** patients are discharged from hospital; and that some patients will always need sanctuary for periods. It requires Boards to develop effective rehabilitation and resettlement programmes in all continuing care units. Finally, it calls for the monitoring and evaluation of changes in the pattern of care.

2.23 Services for people with a mental illness have traditionally been concentrated in and around the six major psychiatric hospitals and in psychiatric units in general hospitals. Since the publication of the Regional Strategy, however, there has been significant progress in the development of community based services and rehabilitation programmes. This development has opened up opportunities for a better quality of life for the patients concerned. All four Boards have created or are planning for more day care and day hospital places and special housing arrangements, and all six psychiatric hospitals now have rehabilitation and resettlement programmes at various stages of development.

2.24 The progress which has already been made is a credit to the energy and enthusiasm of many committed individuals, including dedicated people working to develop community services from within the hospitals.

2.25 The Audit Commission has commended the use of bridging finance in England and Wales as a means to enable service providers to develop new community services while reducing hospital bed numbers. In Northern Ireland such money has already proved highly effective as a force for change since 1987 towards meeting the Regional Strategy targets for the mental health and mental handicap programmes.

2.26 Bridging finance was first made available in 1987, and £18m had been committed by January 1989 for the period to 1992. These resources are allocated to Boards against specific schemes which meet certain criteria - primarily that the project will enable people with a mental illness or mental handicap who have spent a long period in hospital to move into the community with sufficient care and support. They have been used to free staff to co-ordinate special initiatives; to appoint more community psychiatric and mental handicap nurses, social workers and psychologists; to support rehabilitation teams and discharge projects; to train staff; and to provide more places in day hospitals, day centres, special housing projects and work therapy schemes.

2.27 A second significant factor in the recent development of community services for people with a mental illness has been the successful partnerships forged in many places between the statutory and voluntary sectors: Boards have allocated a substantial proportion of their bridging finance to voluntary sector projects.

2.28 The Regional Strategy emphasised the importance of close collaboration between hospital and community services. The development of integrated mental health services in the Coleraine, Magherafelt, Cookstown and Dungannon districts has been hampered by the fact that, since psychiatric hospital catchments originally related to county boundaries, they have looked to the Western Board for psychiatric hospital services and to the Northern or Southern Boards for community services. To rectify this historical anomaly, the Northern and Southern Boards are now in the process of assuming responsibility for the full range of mental health services for these districts in accordance with a phased programme which is to be completed by March 1991. The Department will be providing an additional £1.76 million to the two Boards on a recurrent basis for this purpose. The consequential savings to the Western Board will be available for the further development of community mental health services in its area.

2.29 In September 1989, as part of its undertaking in the Regional Strategy to evaluate the policy of care in the community, the Department commissioned an independent study which will trace all people with a mental illness or mental handicap discharged from hospital over a three year period after a stay of at least one year. Costing £300,000, the study will be the most comprehensive ever in the United Kingdom of the effects of the policy on the dependency and quality of life of individual service users and on the use of resources for their care. It is being conducted by a consortium led by the Health and Health Care Research Unit of the Queen's University of Belfast, and including Research and Development for Psychiatry and the Personal Social Services Research Unit of the University of Kent. As far as possible, the study will be integrated with the local monitoring systems which some hospitals have already put in place.

2.30 The way in which health and social care for people with a mental illness can be integrated, while taking into account the characteristics of a particular geographical area, is exemplified by the proposed Fermanagh psychiatric day care programme. This programme provides for a rural area with a scattered population and no established infrastructure for tackling mental illness. Its aim is to bring individually tailored packages of service to people's homes rather than requiring them to travel long distances to a single centre. Two community mental health teams will bring support to people in their own homes, including support normally associated with day hospitals and day centres. One team will deal with people over 65, the other with younger people. Each team includes both health and social service professionals. They will operate from a common base, but otherwise the Board is not investing in bricks and mortar. The scheme incorporates multi-disciplinary assessment, using a case management approach, and quality control procedures. The case management function is discharged by key workers who are professional members of the team, supported by assistant community workers. The programme will include the voluntary sector. The Industrial Therapy Organisation is to organise employment training and work therapy on a decentralised basis. The Northern Ireland Association for Mental Health is supporting a number of patients who have been discharged from hospital and who are living in housing provided by the Habinteg Housing Association.

People with a mental handicap

2.31 There are over 7,300 people with a mental handicap in Northern Ireland, some 70% of whom live at home. The core of the Department's policy, which will continue to be the basis for service development in the coming decade, is to help them lead their lives as normally as possible and to keep to a minimum the need for care in a hospital or other institutional settings.

2.32 From 1979 to 1987, the number of patients in hospitals for people with a mental handicap fell from 1,476 to 1,238 - a modest reduction. The number of people under 16 in these hospitals fell from 113 to 31.

2.33 The Regional Strategy gave a sharper focus to this policy. It set a target reduction of at least 20% in the numbers of people in mental handicap hospitals and said that within this general target the Department placed a particular emphasis on reducing the number of children with a mental handicap in hospital. The Regional Strategy also called for effective rehabilitation programmes in all continuing care units; improved respite care services for families caring for relatives with a mental handicap; and the development of the genetic counselling service.

2.34 Since 1987 the pace of change has quickened, assisted to a large extent by the use of bridging funds, and a number of significant new developments have occurred. The three mental handicap hospitals in Northern Ireland have developed rehabilitation and resettlement programmes. Boards have continued to develop respite care schemes in hospitals, residential care homes and family homes. More potential parents have used the genetic counselling service. The number of children with a mental handicap in hospital dropped from 31 in 1987 to 13 in 1988.

2.35 The general thrust of the community care strategy was advanced in 1987 by transferring responsibility for educating children with a mental handicap to the education authorities. The transfer involved over 1,200 children, and at the same time the Government provided £850,000 to improve paramedical services in special schools. These funds enabled Health and Social Services Boards to appoint 25 speech therapists, 19 occupational therapists, and 15 physiotherapists.

2.36 The development of community services is evidenced to some extent by the expansion in the number of places available in Adult Training Centres and in multi-client day centres. These provide valuable respite for informal carers as well as social training and occupation activity aimed at assisting people with a mental handicap to achieve their full potential. However, it is widely recognised that ATCs, which provide mainly centre-based activities, do not satisfactorily meet the needs of all people with a mental handicap. Other forms of daily activity making use of leisure centres, colleges of further education and work training places, together with other forms of support for carers, have recently begun to be developed to complement them.

2.37 Community mental handicap teams are now operating successfully in many places and have responsibility for co-ordinating the shift in the balance of care from hospital to community. Families have been identified who are willing to foster people with a mental handicap on a permanent basis. New and expanding forms of special housing include core and cluster schemes, residential homes run by voluntary organisations and housing associations, and residential care and nursing homes run by the private sector.

2.38 Success in the provision of community care services for people with a mental handicap in future will depend upon innovation, co-operation, mutual understanding and diversity. Some general elements of this approach have already been indicated. A specific illustration is provided by the Bridge Association Training Unit at Antrim, which opened in January 1988. The Unit provides places for 36 people with a mental handicap from 16 to 50 years of age. It aims to equip the more able for work on the open market or under the Department of Economic Development's Sheltered Placement Scheme. The Unit is an example of a successful partnership between a locally based voluntary body and the Northern Board. It has been supported with bridging finance and has received funding from the European Social Fund. The Bridge Association also plans to run a 15-place residential scheme being provided by the Nih Housing Association with support from the Department of the Environment. The scheme is designed to dovetail with the Training Unit and to help people with a mental handicap to move from hospital into the community.

The way forward

2.39 Although there have been many promising developments in services for these four client groups over the past two years, and significant progress towards meeting the main Regional Strategy objectives, provision remains uneven and there are still substantial gaps in the spectrum of care in many places. As a consequence, people are still being inappropriately admitted to hospitals, residential care homes and nursing homes; people who have successfully completed rehabilitation and resettlement programmes are having to stay in hospital; domiciliary care services are uneven and sometimes poorly targeted; and packages of care are not being tailored appropriately to meet individuals' needs. This policy paper identifies ways of addressing these deficiencies and of improving the quality of community care.

CHAPTER THREE: CARING IN THE 1990s

Rising to the challenge: elderly and physically disabled people

3.1 Over the next 10 years, the number of people over 65 in Northern Ireland is expected to increase by 4,000, or 2%, and of those over 85 by 6,000, or 40%. The number of frail elderly people, often exhibiting interacting physical, social and mental problems, will increase significantly. This change in the age profile will have major implications for health and social services in the community.

3.2 As indicated in Chapter 2, many elderly people suffer from a physical disability. The number of people with a physical disability will undoubtedly rise as the population ages. Trends in the incidence of disability amongst younger people are less easy to discern. Preventive measures may reduce disability, but any decline will be offset by medical advances which have increased the life expectancy of those born disabled. While it is not clear how these trends will affect the number of the young disabled, it is likely that the nature of their disabilities will change over time.

3.3 The needs of people with a mental illness are diverse. Many have relatively simple medical needs, which will be met by the straightforward use of the community health services. More complex needs demand special measures of intervention and support. The Regional Strategy emphasises the importance of providing properly for patients being discharged back into the community from hospital after a lengthy period of care. This emphasis will continue, but there are other groups who will pose the main challenges for the community mental health programme in the 1990s. They include the growing number of elderly people with a mental infirmity and younger people with substantial and continuing disability, particularly resulting from schizophrenia. For this latter group, refined programmes of rehabilitation and resettlement and special packages of community support will need to be developed.

3.4 As many people with a mental handicap are living longer, their carers are themselves ageing and finding it progressively more difficult to look after them. As an increasing proportion of babies with a mental handicap survives, the demand rises for services for such children.

Rising to the challenge: elderly and physically disabled people

3.5 The Department remains committed to the policies set out in the Regional Strategy. In services for elderly and physically disabled people, it places particular emphasis on the following priorities which are reflected in all four Boards' current operational plans:-

* reducing the need for inpatient and residential care by promoting healthy lifestyles and developing effective health surveillance and screening programmes;

* continuing to provide for those who require it a full spectrum of care, including acute inpatient services, specialist geriatric and psychogeriatric services, rehabilitation services and a range of therapeutic and social services;

* ensuring that decisions on the provision of services are based on careful assessment of individuals' needs, and that adequate domiciliary care and day care services are available;

* involving users of services in their development; and

* improving access to information about services, including respite care.

3.6 Carers are often the cornerstone of support for an elderly or physically disabled person in the community. The presence of a caring relative or friend does not, however, mean that the person being cared for has no need of support from the health and personal social services. Indeed to preserve this caring relationship Boards must ensure that a range of services is available to assure the carer that at times of crisis expert or professional help will be provided immediately and to assist the elderly or disabled person and the carer to live as normal a life as possible.

3.7 Caring 24 hours a day inevitably places a great deal of pressure on the carer. For this reason Boards should actively plan for the provision of respite care to allow for periodic breaks for carers. Respite care may take various forms. For example, it may be the relief provided by day care, or the type of support offered in the home by voluntary organisations such as Crossroads. While the availability of support at times of crisis provides a major reassurance to carers, it is important that support is also available as a preventive measure to prevent crises from occurring.

3.8 If elderly and physically disabled people are to be supported in the community, they must have ready access to treatment and rehabilitation. Otherwise increasing handicap may make long-term hospital care unavoidable. Boards should ensure that effective rehabilitation and resettlement programmes are available for elderly people and people with a physical disability. They need to have access to such programmes not only in hospital, but also, following their discharge, in the community, if they are to be able to resume their normal lives successfully.

3.9 Deaf and blind people in the community have additional problems related both to isolation and communication. The need to improve services for these client groups, spelt out in the Regional Strategy, has still to be met, especially outside the Belfast area.

Rising to the challenge: people with a mental illness or mental handicap

3.10 In taking forward the Regional Strategy the Department recognises that the need for respite care services is particularly pressing for parents who are looking after profoundly mentally handicapped children. It intends over the next year to review the level of demand for and adequacy of these services. It also attaches particular importance to achieving by 1992 the objective that no child should grow up in a mental handicap hospital. In other words, no child with a mental handicap should by then be the subject of continuing care in hospital.

3.11 The Department is taking several steps to improve the care of people suffering from a mental illness or handicap. First, in view of the success of bridging finance in supporting the move of patients from hospitals into the community, it will be committing a further £6m for this purpose over the 3 year period from 1990 to 1993. This brings the total so far committed to bridging up to £24m.

3.12 Second, the Department will be setting aside a development fund of £150,000 for pilot schemes in the voluntary sector which pioneer forms of community care, new to Northern Ireland, for people with a mental handicap or mental illness. Priority will be given to projects which offer or complement home or respite care; offer additional support for carers; or involve users in the planning, development and operation of services.

3.13 Third, the Department is preparing a Code of Practice dealing with the guardianship or admission to hospital and medical treatment of the small proportion of people with a mental illness or mental handicap who present such a substantial threat to themselves or to other people while they remain in the community that special powers under the Mental Health (Northern Ireland) Order 1986 have to be exercised in caring for them.

CHAPTER FOUR: MEETING INDIVIDUALS' NEEDS

4.1 The Department recognises that in responding to the challenges of the 1990s highlighted in Chapter 3, Boards will need to ensure that services are better targeted towards the specific requirements of those individuals who need them most. This will require well co-ordinated and flexible systems for assessing individuals' needs and planning and delivering packages of care to meet them. Responsibility for these functions will have to be clearly assigned.

4.2 Combined with the changes set out elsewhere in this paper, the Department expects that an improved capacity to respond flexibly to individuals' needs will result in a shift of emphasis towards domiciliary care services. A range of such services is already available to enable people to continue to live in the community. However, their provision is uneven and in some places poorly co-ordinated. There is a tendency to fit clients to services, rather than adapting services to clients' needs. A report published by the Social Services Inspectorate in February 1990 has revealed considerable variations in the level of resources allocated to domiciliary care, and in how these resources are targeted. There is clearly scope for improvement.

Assessment

4.3 Sir Roy Griffiths saw as an essential basis for community care the requirement, within the resources available, to "identify and assess individuals' needs, taking full account of personal preferences (and those of informal carers), and design packages of care best suited to enabling the consumer to live as normal a life as possible". A primary purpose of these assessments is to ensure that services are tailored to individuals' particular needs. The Government has accepted this recommendation.

4.4 It is not the Government's intention that everyone needing care and support in the community should be referred for a comprehensive multi-disciplinary assessment. For example, people with exclusively health care needs which can be met in the community - including nursing care - will continue as at present to have direct access to and receive service directly from the community and primary care services. People who need straightforward social services support, including practical help, advice and information, will continue to look directly to the personal social services. In many cases such as these, the need will be identified by the client's general practitioner, who will be able, as at present, quickly and informally to make arrangements directly with the provider of the service his or her patient needs.

4.5 Boards will be expected to reach their own views about when a more comprehensive assessment or reassessment involving two or more professional disciplines should be triggered. In so doing, they will have to take into account the complexity of the case and the level of resources involved, and to acknowledge that in any individual case the decision on what services to provide will be ultimately a matter for professional judgment. In most cases, it should be possible to build on existing arrangements, making present roles explicit and ensuring that all the available information relevant to a client's needs and circumstances is brought together. This information will include not only the contributions of health and social services professionals, but also the views of the client, his or her informal carers, and material from other agencies.

4.6 The comprehensive assessment process should always be activated when the decision to be taken is whether the client should move on a permanent basis into a residential care home, nursing home or continuing care hospital unit, or back from one of these into the community. The decision to move into a home or hospital is a critical one in the life of any person. Once he or she has moved out of his or her own home into any form of institutional care, it may become difficult to go back to independent living. The purpose of requiring a full assessment at this important juncture is to establish whether a co-ordinated package of domiciliary care - perhaps including personal care, emotional support and help with mobility, domestic tasks, financial affairs, accommodation, leisure and employment - would enable the person to go on living at home. Equally, no vulnerable person should be discharged from hospital without a complete assessment involving all appropriate disciplines.

4.7 Assessments should take account of the wishes of the individual and his or her carers, and of carers' ability to continue to provide care. Where possible, they should include clients' and their carers' active participation. An effort should be made to offer a range of options which enables individuals and carers to make choices.

4.8 The objective of a comprehensive assessment is to decide on the best means available to help individuals and their carers. It should focus positively on what the individual can and cannot do, and can be expected to achieve, taking account of his or her personal and social relationships. It should not focus only on the person's suitability for a particular existing service. The aim should be to review the possibility of enabling the person to continue to live at home, even if this means arranging a move to different accommodation within the local community; and, if that possibility does not exist, to consider whether residential, nursing home or continuing care in hospital would be appropriate.

4.9 All agencies and professions involved with the individual and his or her problems should be brought into the assessment procedure as appropriate. These may include social workers; general practitioners; community nurses; hospital staff working in geriatric medicine, psychiatry and rehabilitation; physiotherapists; occupational therapists; speech therapists; psychologists; pharmacists; dietitians; dentists; chiropodists; continence advisers; community psychiatric nurses; staff dealing with vision and hearing impairment; housing officers; social security officials; Department of Economic Development resettlement and rehabilitation officers; home helps; home care assistants; and voluntary workers.

4.10 Decisions on admission to continuing care beds in hospital are a medical responsibility. They should be based on full assessment including social as well as medical factors, just as when a move to residential care or nursing home is being contemplated. Multi-disciplinary assessment is already common practice for non-urgent admissions to hospital geriatric units. Where admission is required so urgently that the scope for prior assessment is limited, more comprehensive assessment should be undertaken after the patient goes into hospital. While the decision to admit is the responsibility of the consultant, general practitioners should contribute by providing information on relevant medical and other factors, and should consider invoking the community care assessment process before requesting hospital admission. There should be close collaboration between hospital teams and those responsible for assessment in the community, particularly in considering possible alternatives to prolonged hospital stay. Such collaboration is equally essential when decisions have to be made by hospital doctors about the discharge of vulnerable patients.

The organisation of assessment

4.11 In Great Britain, local authority social services departments will have a specific responsibility for the organisation of comprehensive assessments. This is in keeping with the Griffiths principle that responsibilities should be clearly assigned. In Northern Ireland, Boards' Area General Managers will be expected to ensure that efficient and effective assessment procedures are in place throughout their areas. In line with the approach adopted in Great Britain, the Department expects that social services will usually have the lead responsibility at Unit level for the co-ordination of assessments. In some circumstances, another profession might be given lead responsibility: this might be appropriate, for example, in a psychiatric Unit of Management. Whichever profession is assigned lead responsibility will co-ordinate all assessments, regardless of the placement or services under consideration.

4.12 Within that profession, a single worker should be given responsibility for ensuring that each assessment is conducted in accordance with the established procedures. He or she will receive requests for assessment; co-ordinate any contributions by other professions and interested parties; ensure that comprehensive assessments are properly conducted whenever they are appropriate; and see that the resulting recommendations are taken forward.

4.13 There are a number of ways in which an individual may seek help and may therefore need an individual assessment. For example, he or she may apply for a package of home care services or a place in a Board residential care home. In addition, as will be explained in Chapter 6, it will from April 1991 be possible for people to ask for Board funding towards the cost of a place in an independent sector residential care or nursing home. Boards should aim to develop common procedures for all these situations, and to ensure that people are offered the help they need irrespective of the basis on which their first contact with the Board is made.

4.14 Boards' assessment procedures will need to take account of local circumstances. They should be straightforward and efficient, and responsibility for their operation should be clearly assigned. Assessments should be carried out without undue delay. Contributions should be sought quickly and informally. It is not always necessary for all contributors to attend meetings. Costly and time-consuming case conferences should be avoided, as should duplication of effort, for example between hospital and community based professionals.

4.15 In allocating responsibility for assessment and subsequent action, Boards should take account of the important part played by general practitioners and the fact that their practice areas are not co-terminous with Units of Management. The allocation of responsibility for assessment should therefore be as straightforward as possible, and Boards should tell all general practitioners who is the responsible officer in each Unit which overlaps with their practice areas.

Further guidance

4.16 The new assessment arrangements outlined above will involve significant changes in the way professional workers operate. The Department proposes two measures to facilitate this:-

- it will circulate guidance on the workings of the new system, to be prepared following consultation with professional and representative bodies;
- each Board will be expected to publish a local guide to the principles and workings of its own assessment system. These guides should be made available to all those involved in assessments, to local agencies and voluntary groups, and to members of the public. They should explain the means of referral to and criteria of eligibility for assessment and reassessment, and should include details of contact points.

Action following an assessment

4.17 Once a comprehensive individual assessment has been completed, and a decision has been taken that publicly funded care can and should be arranged, it will be the responsibility of the Board at Unit level to design appropriate care arrangements, in consultation with the client, his or her informal carers, and all care professionals involved. These arrangements should take account of the local availability of services and support, and should, where necessary, include help and respite for informal carers.

4.18 Assessments will have to be made in the context of the Department's strategic guidance and the Board's operational priorities. Although the ideal is to meet all the person's health and social care needs in full, decisions on service provision will inevitably have to take account of what is available and affordable, and priority will have to be given to those whose needs are greatest.

4.19 Each Board should monitor the outcomes of its assessment process, and the implications of these outcomes for the future development and procurement of services.

Case management

4.20 People's care needs may change over time and must be monitored. Where an individual's needs are complex or significant levels of resources are involved, the Department sees considerable merit in Sir Roy Griffiths' recommendation that a single professional worker should be assigned as that individual's personal contact, to ensure that each individual's needs are regularly reviewed and that resources are managed effectively.

4.21 The idea of a 'key worker' emerged during the 1970s as a single contact point for an individual client faced with an array of agencies offering different services. In the 1980s, the concept evolved into that of the 'case manager'. A case manager is the principal contact for the client. He or she takes responsibility for designing and assembling a package of services tailored to the client's needs; and for ensuring that these services are effectively co-ordinated, delivered and monitored.

4.22 The case management model is increasingly being used within existing multi-disciplinary approaches. A particular member of the team is given responsibility for a number of clients. As case manager he or she acts as a broker between the various agencies concerned with each client; monitors the client's progress; plans social and occupational programmes; and, above all, maintains a supportive caring relationship with the client.

4.23 Many agents may contribute to a person's care in the community. They include social services, housing agencies, general practitioners, hospital and community health staff, Department of Economic Development resettlement and employment personnel, Education and Library Boards, social security offices, private and voluntary organisations and others. Without proper co-ordination, they may not know which other services a client is receiving and whether the total package is sufficient. The case manager will be aware of all the client's needs, the extent to which they are being met and by whom. He or she should keep the different parties informed of what is being done and bring to their notice any apparent unmet need.

4.24 The case manager may or may not be the designated person responsible for the original assessment of the client's needs and design of the package of care. He or she should be the person best fitted to help the client with those problems which are predominant at the time, regardless of his or her particular professional or career background.

4.25 Case management provides an effective method of targeting resources and planning services to meet the specific needs of individual people. The approach has already been used successfully in a number of projects in Northern Ireland. The Department believes that the wider introduction of the key principles of case management would confer considerable benefit, particularly for clients with complex needs, and it will seek to encourage their application more widely.

4.26 The Department also sees advantage in linking case management with delegated responsibility for budgetary management. This need not be pursued down to the level of the individual client, but, used flexibly, is an effective way of enabling those closest to the identification of client needs to make the best possible use of the resources available.

CHAPTER FIVE: ROLES AND RELATIONSHIPS

"Working for Patients"

5.1 The White Paper "Working for Patients" set out the Government's plans for improving the quality and efficiency of the National Health Service. Together with the proposals in "Caring for People", those plans are being taken forward in the National Health Service and Community Care Bill, which was published in November 1989. Corresponding legislation is being prepared for Northern Ireland.

5.2 The principles underlying the health service reforms apply as much to care in the community as to hospital care, and to the personal social services as much as community health services. Central features of the reforms include:

* delegating as much power and responsibility as possible to the local level;
* strengthening management at local level through the appointment of Unit General Managers throughout the health and personal social services;
* Units increasingly assuming responsibility for delivering contracted services within quantity and quality specifications to a number of clients which may include the 'parent' Board;
* developing a simpler system for resource allocation which will fund Boards for their resident population, weighted to take account of demographic factors, rather than for the services they provide;
* developing Boards' role at Area level as the purchasers of services and quality controllers;
* reconstituting Boards as management bodies, linked to the development of new advisory and consultative arrangements.

5.3 The remainder of this chapter will look at Boards' evolving role and responsibilities for the design, delivery and monitoring of community care services in the context of the "Working for Patients" reforms. It will also look at Boards' relationships with the private and voluntary sectors and with housing agencies in the exercise of those responsibilities. There are in addition many statutory agencies such as social security and employment and training, with which Boards must work in partnership.

Boards' role and responsibilities

5.4 Boards already have a wide range of statutory powers and duties to help vulnerable people in the community. They are responsible for meeting community care needs in their areas by arranging the provision of residential and nursing home care, day care, community nursing and domiciliary care services and respite care.

5.5 The development of the community care initiative in the context created by the "Working for Patients" reforms will require Boards to work towards the following goals:

- to assess the community care needs of their areas, set local priorities and service objectives, and develop plans for addressing these needs, in consultation with the Housing Executive and other statutory agencies, housing associations, voluntary and private sector service providers;
- to make arrangements for clearly assigning responsibility for co-ordinating the assessment of individuals' needs for health and social care;
- to arrange for the design of packages of care which are tailored to meet the assessed needs of individuals and their carers;
- to secure the delivery of community care services not simply by acting as direct providers, but also by developing their purchasing and contracting roles; to ensure that information is readily available to the public about community care services, where and how to seek them;
- to establish procedures for receiving comments and complaints from service users;
- to monitor the quality and cost-effectiveness of services;
- to establish arrangements for assessing clients' ability to contribute to the cost of residential and nursing home care.

5.6 Other chapters consider some of these responsibilities in greater detail. In strengthening their systems for planning, accountability, financial control, purchasing and quality control to implement the proposals in "Working for Patients", Boards will have to bear in mind the effective and efficient discharge of their community care responsibilities, and to recognise that special arrangements may be needed for the community care services.

Integrated health and social care [illegible]

5.7 A central theme in "Caring for People" is the need for stronger links between health authorities and local authority social services departments in Great Britain, and improved co-ordination between the professional groups which they employ. Northern Ireland already enjoys the advantage of an integrated organisational structure embracing both health and social care. It is not therefore necessary to introduce formal arrangements such as those set out in "Caring for People" for joint working and planning between health authorities and social services authorities. Nor would it be appropriate for the Department to assign responsibilities to specific professional groups. It is nevertheless essential that responsibilities for the co-ordination of assessment, identification of priorities, planning, monitoring and service specification and delivery should be clearly assigned to individuals, both at Area and Unit level, and related to responsibilities for programmes of care for all client groups.

5.8 General Managers at Area and Unit level will be expected to ensure that the caring professions work closely together at all operational levels, with each recognising and respecting the others' contributions and responsibilities, cross-referring cases when appropriate, and seeking advice and information when relevant. Acute hospital care, continuing hospital care and community care should be complementary and should be planned to provide a well co-ordinated range of services. There is no room in community care for a narrow view of individuals' needs nor of ways of meeting them. It is also essential that the caring services recognise the need to work in partnership with other agencies.

Developing a mixed economy of care

5.9 The Government's aspiration is to see a range of different service providers, with the statutory, private and voluntary sectors working together. It is intended that such a range should establish a framework within which Boards as purchasers can offer a choice to their clients of good care at a realistic cost to the public purse. The Department will expect Boards, in discharging their new and expanded responsibilities, to use services provided by the independent sector whenever it is appropriate and cost effective to do so. Boards will continue to play an important role in the provision of services, but where they are still the main or sole providers, they will be expected to take all reasonable steps to promote diversity of provision.

5.10 The Department believes that stimulating the development of independent sector service providers will result in a range of benefits for the consumer, in particular:

- a wider range of choice;
- services which meet individual needs in a more flexible and innovative way;
- competition between providers, resulting in better value for money.

5.11 At present, independent sector activity in Northern Ireland is largely concentrated in the residential care and nursing home field. Independent sector domiciliary care, day care and respite care is less well-developed. The Department hopes that the proposals in this paper will result in greater diversification by independent sector service providers.

5.12 Boards will be expected to develop sound working relationships not just with the voluntary sector but also the private sector. The objectives of this partnership approach will be to communicate clearly to independent sector providers the care needs which Boards have identified, the localities where they most urgently require them to be met and the categories and levels of dependency of clients for whom they are seeking to purchase care. The Department believes that the independent sector should be encouraged to provide care for people with various degrees of dependency, including profound and severe handicap and frailty.

5.13 Boards should promote a mixed economy of care in a number of ways, which might include:

- determining clear specifications of their service requirements;
- establishing clear procedures for tendering and contracting and making sure that they are widely known and well understood by potential providers;
- taking steps to stimulate the setting up of "not for profit" agencies;
- identifying areas of their own work which are sufficiently self-contained to be suitable for floating off as self-managing units;
- stimulating the development of new voluntary sector activity.

5.14 The Department believes that the wider use of service specification and tendering is likely to be one of the most effective ways of stimulating new activity in the independent sector. It has decided against extending compulsory competitive tendering to community care services, and favours giving Boards an opportunity to make greater use of service specifications, agency agreements and contracts in an evolutionary way. This will require Boards to define clearly the outcomes they want; to be more specific about the nature of the service they are seeking to provide to achieve those outcomes; and to identify the necessary inputs.

5.15 At the same time as seeking to increase the contribution of the independent sector, Boards will need to consider carefully the advantages and safeguards attaching to the direct provision of care by themselves for different groups of clients and different levels of dependency. In doing so, they should bear in mind the value to them of maintaining in-house care management experience and expertise and of having a base of comparison for the proper level of charging that should be made for different types of care. The Department will expect Boards to retain the ability to act as direct service providers if other forms of provision are unavailable or unsuitable, or break down; and Boards' direct services should not be confined to people who are difficult to place elsewhere.

The partnership with the voluntary [illegible]

5.16 The value of grants paid by the Department and Boards to voluntary bodies has increased in real terms over the past decade by 255%, well in excess of the overall increase in spending on services.

5.17 Sir Roy Griffiths identified the need for a stronger basis for funding the voluntary sector. He recommended that there should be a clear contractual relationship between a public agency and a voluntary body. This is in line with the Government's overall strategy for working with the voluntary sector, and Boards will be expected to develop an increasingly contractual relationship with each of the voluntary bodies which they fund. This will help to clarify the role to be played by voluntary organisations and Boards' expectations of them; give voluntary bodies more certainty in planning for the future; and stimulate innovation and flexibility.

5.18 Some voluntary organisations may need to make major changes in their approach to service planning and delivery if they are to make the most of the opportunities now on offer, and there is likely to be advantage for both sides of the partnership if they are involved at an early stage in the negotiation of a contract. Contracts should be related to clear specifications and fully understood by both partners.

5.19 The Department recognises that some important voluntary sector activities are not suitable for a contractual funding approach. Furthermore, it will be important to allow scope for the emergence of new, small-scale groups and to avoid the over predominance of large, well established voluntary bodies. For both these purposes, Boards will continue to make grants towards the local administrative expenses of voluntary organisations. The Department itself will continue to offer grants towards the regional administrative expenses of voluntary organisations and towards innovative local pilot projects.

The partnership with housing agencies

5.20 Housing is often the key to independent living. If dependent people are to be helped to continue living in the community, their homes must be places where they can go on caring for themselves and where it is possible for others to provide the support they need. It is essential that there should be a close working relationship between Health and Social Services Boards, the Housing Executive and the voluntary housing movement. In assessing their clients' needs and trying to assemble packages of care to meet those needs, Boards will recognise that the housing dimension is crucial.

5.21 It is important that owner-occupiers receive advice and help at the right time to enable them to go on living in their own homes for as long as possible. Voluntary bodies run local care and repair schemes through which they offer advice to elderly people on how to keep their homes in good repair and on finance for repairs and adaptations. With increasing disability, people may only be able to stay in their own homes if these are suitably adapted. Adaptations may include the provision of hand rails, chairlifts and alarm systems; or they may be more substantial. People who are more severely disabled might be helped by a move into some form of specialised accommodation, such as purpose designed housing for people in wheelchairs, or core and cluster developments for people with a mental handicap. There are various forms of sheltered housing for elderly disabled people.

5.22 The Housing Executive and the voluntary housing movement have been working closely and with increasing success for over a decade on the provision of high quality accommodation for people with special housing needs. The Housing Executive, the single comprehensive housing authority for Northern Ireland, has a total stock of over 170,000 dwellings. Applicants with special care needs are given priority status under its Housing Selection Scheme. The voluntary housing movement, which has grown rapidly since 1976, now includes 46 independent registered associations, funded by the Department of the Environment, which have a total stock for rent of about 9,000 dwellings.

5.23 The present policy of the Housing Executive and for housing associations is that all new homes for general needs should include some features which contribute to better mobility. All new bungalows and ground floor flats are designed to be convenient to all walking disabled tenants, including those who use wheelchairs but are not chairbound. In 1988/89 some 33% of new dwellings built by the Executive were built to full mobility standards. Such standards are also applied to most sheltered accommodation provided by housing associations for elderly and disabled people.

5.24 Adaptations to existing stock represent an important contribution to community care. In 1988/89 the Executive carried out over 6,500 adaptations to meet special needs and paid more than 650 grants towards the carrying out of similar work in the private sector. Public and private sector adaptations in 1988/89 represented a total investment of over £2m.

5.25 At 1 April 1989 special provision accounted for about 9% of the Executive's total stock, as follows:-

- old people's dwellings	7,098
- homes built to mobility standards	5,643
- sheltered dwellings	1,962
- wheelchair accessible homes	102
- adapted stock	1,495

5.26 The Executive also makes available dwellings to be let on a shared basis to patients leaving institutional care. Recently the Executive has been working with voluntary organisations on the development of dispersed intensively supported housing (DISH) schemes. The Executive provides housing to a voluntary group which sublets to people in need and provides a package of care and support.

5.27 Housing associations are playing an increasing role in housing and caring for special needs groups. Since the current funding arrangements were introduced in 1976, they have provided some 4300 sheltered and other specially designed units for the elderly, some 140 units for people with a mental handicap, 50 for people with a mental illness and 160 for people with a physical disability.

5.28 At regional level, the Departments of Health and Social Services and the Environment have agreed that priority in the allocation of funds for special needs housing schemes during the period from 1990 to 1993 should be given to projects for people with a mental illness or mental handicap and heavily dependent elderly people. The Department of the Environment has asked the Housing Executive to identify the extent and distribution of future special housing needs, in consultation with Health and Social Services Boards and the Northern Ireland Federation of Housing Associations.

5.29 At present there is a measure of consultation at local level amongst Boards, the Housing Executive and individual housing associations over specific schemes. It is in Boards' interest to develop this process of communication. The aim should be for these three parties to agree local priorities and plans, on the basis of which they can contribute to an overall strategy to meet the accommodation needs of client groups throughout Northern Ireland.

5.30 To achieve the best possible results from the partnership between Boards and housing agencies, the two Departments will explore the possibility of harmonising the planning cycles of Boards, the Housing Executive, and housing associations.

CHAPTER SIX: RESIDENTIAL CARE AND NURSING HOMES

Role

6.1 One of the Government's main objectives is to promote the development of domiciliary, day and respite care services to enable people to live in their own homes wherever feasible and practical. Nevertheless residential care homes and nursing homes will continue to play an important part in meeting people's care needs. Some people will always need more support than can reasonably be provided in their own homes or in sheltered housing. Much depends not only on their physical needs but also on their emotional needs and their personal and social circumstances. The Government's proposals for reforming the funding of residential and nursing home care are intended to ensure that people enter homes with public funding when - and only when - a proper assessment of their needs and all their circumstances has established that this is the right form of care for them.

Recent growth

6.2 Provision for those people in Northern Ireland requiring residential or nursing home care is made in a range of homes in the statutory, private and voluntary sectors. Although these homes cater increasingly for people with a physical disability, mental illness, mental handicap or terminal illness, most residents are elderly. The table below shows the growth in the number of places provided from 1979 to 1989.

	Residential Care		Nursing Homes		Total	
Sector	1979	1989	1979	1898	1979	1989
Statutory	3597	4034	0	0	3597	4034
Independent	1367	2129	307	2450	1674	4579
Total	4964	6163	307	2450	5271	8613

6.3 There was a substantial increase from 1979 to 1989 in the number of places provided by the independent sector: a 56% increase in residential care homes and 698% in nursing homes.

The effects of social security payments

6.4 This increase can be attributed to the ready availability of social security funds. Special arrangements for social security benefits, principally Income Support, apply at present to most residents of independent sector homes. The arrangements embrace all registered homes and a few others, such as those run by the Abbeyfield Society or by organisations established by Royal Charter or Act of Parliament.

6.5 Income Support is available to people on low incomes, provided they do not have capital of over £6000, to help with the home's fees and the cost of any meals not included in the charge. A separate personal expenses allowance is provided. Housing Benefit is generally not available. The amount which can be paid towards fees is subject to an overall limit. Limits vary according to the type of home and the nature of the care provided. Because Income Support provides help with accommodation and care as well as living costs, a claimant in a home obtains substantially higher benefit than someone outside a home claiming the normal Income Support personal allowances and premiums.

6.6 These arrangements have undoubtedly been of real value to many vulnerable people and their families and have been the channel through which significant public resources have been invested in the provision of community care. However, their unintended consequence has been that priority in the development of community care services has not been given to services which enable people to stay in their own homes. Sir Roy Griffiths noted that" ... the ready availability of social security makes it easy to provide residential accommodation for an individual regardless of whether it is in his best interest .. if overall resources are limited residential accommodation may take an undue proportion of available money to the exclusion of more satisfactory alternatives of keeping people in their own homes."

6.7 The social security system does not readily permit any assessment of whether its individual payments represent good value for money. Social Security Adjudication Officers have neither the duty nor the expertise to determine whether the charges met from Income Support are reasonable for the level and quality of care provided. There is a considerable variation in the cost of appropriate care across different client groups and levels of dependency.

New funding arrangements

6.8 Sir Roy recommended that public finance for people who require residential home care or nursing home care should be provided only following an assessment of their need for care. The Government has accepted this recommendation, and now proposes that the costs of community care should be drawn from the same budget, whether the care is provided in a person's own home or in an independent residential care or nursing home. This budget will include the care element currently contained in social security payments to people in these homes. In Northern Ireland, the budget will be managed by Health and Social Services Boards. They will be given responsibility for making the best use of the funds available in the light of their assessments of individuals' needs and of their overall priorities.

6.9 Consequential changes will be needed in the way in which Income Support is paid to people in independent sector homes. People who enter these homes under the new funding structure and who need public financial support will no longer have their care costs met by the social security system. In place of the special limits, help will be available from the normal Income Support system of personal allowances and premiums and from Housing Benefit. Clients will receive assistance on much the same basis as when in their own homes. The financial incentive towards residential and nursing home care under current Income Support rules will therefore be eliminated. Other than any necessary adjustments to the Housing Benefit entitlement, the sources of income from the benefit system will remain the same when a person enters or leaves an independent sector home.

6.10 Under the new arrangements the Housing Executive, which administers the rent rebate and allowance schemes in Northern Ireland, will be responsible for determining what constitutes the "eligible rent" on which Housing Benefit can be paid. The Government will bring forward proposals on the method to be used.

6.11 The Government intends to introduce these changes from 1April 1991. In order to secure a smooth transition, the new arrangements for social security benefit will apply only to people who become resident in the homes concerned on or after that date. Chapter 7 sets out the arrangements for people who are already resident in homes on that date.

Securing places

6.12 If, after carrying out an assessment of a person's needs, a Board decides that a residential care or nursing home place represents the right choice for the person involved, it will arrange a place in one of its own homes or an independent sector home. A place in a nursing home will be arranged only if the assessment establishes a need for nursing care as the whole or main component of the care required.

6.13 Each Board will have to estimate the number of places it will need and then arrange, subject to the constraint of available resources, to meet the projected demand. There will be no nationally set limits to the level of fees which it may meet: Boards will exercise their purchasing power to achieve best value and quality of care for their clients.

6.14 There are several ways to achieve this: a Board could, for example negotiate fees with an individual proprietor for an agreed number of places or set limits on the level of fees it is prepared to pay. In any event, it is important that all purchasing arrangements should be firmly based on a clear contractual foundation.

6.15 As with all other services, contracts will have to be drawn up carefully and will need to specify precisely the level and quality of service required. Specifications might usefully require proprietors to set up and operate systems for evaluating their own performance. The Board's own procedures for monitoring and evaluating performance should be clearly stated from the outset.

6.16 The Department believes that the introduction of contractual arrangements and possibily also of competitive tendering in relation to the purchase of residential and nursing home care will enhance Boards' ability to obtain value for money. They will be well placed to use their new purchasing power to give priority to those with the most pressing needs and highest levels of dependency; to ensure high quality care; and to determine what range of care is provided, and where.

6.17 Once a charge has been negotiated and agreed with an independent sector home, the Board will itself meet that charge. It will then assess the ability of its clients to contribute towards the cost from any benefits or other income. In most cases a financial assessment will already have been carried out for social security purposes.

6.18 The Department recognises that the need to assess each applicant's financial means will result in extra work for Boards. However, the new system builds on existing arrangements for the residents of Boards' homes.

Consumer choice

6.19 For many people, entering a residential care or nursing home will mean moving permanently from their own home and neighbourhood where they may have lived for a long time. This can be a difficult step, which requires sensitivity in helping the individual reach a decision. Subject to the availability of resources, people should be able to exercise the maximum possible choice about the home they enter and its location, which need not be in the area of the Board making the arrangements. The preferences of relatives and other carers should also be taken into account. If individuals, their relatives or friends wish and are able to make a contribution towards the cost of care, they may decide to look for a place in a more expensive home. Boards' arrangements should be sufficiently flexible to permit this.

6.20 Some people will wish to enter a home in an area other than that in which they normally live, for example to move nearer to family or friends. Subject to the availability of resources, people will continue to be able to do this under the new funding arrangements. Their needs will be assessed by the Board in the area in which they are living. If they are assessed as needing residential or nursing home care, that Board will indicate how much it is prepared to pay towards the cost, either allowing the clients to find places for themselves, or making arrangements directly with the Board into whose area the clients wish to move.

People with a terminal illness [illegible]

6.21 Most terminally ill people wish to spend their remaining days in familiar surroundings, and services are available to support the individual and their family by providing skilled home care. Hospice facilities are available to support those who require more concentrated care in a centre specially designed and organised and with staff skilled in pain relief and symptom control. Increasingly they also provide day care and support to those wishing to live at home as much as possible. Responsibility for planning and co-ordinating the provision of terminal care rests with Health and Social Services Boards whether they use their own facilities or those provided by independent sector organisations.

Boards' homes

6.22 There will be no change in the arrangements for paying social security benefits to residents of Boards' homes. Boards will continue to meet the full cost, including the costs of accommodation and food. In these circumstances, they may wish to review the extent to which they should maintain homes of their own. In so doing, Boards are asked to bear in mind the benefits outlined in Chapter 5 of retaining some level of capacity, skill and experience in this area.

CHAPTER SEVEN: HELP FROM SOCIAL SECURITY

7.1 The Government will continue to provide financial support for those who need care and for their carers. The social security system does this in a number of ways: through Invalid Care Allowance, Disability Benefits, Income Support, Housing Benefit and the Social Fund. Social Fund Community Care Grants will continue to complement the Boards' funding of community care.

7.2 Chapter 6 has outlined the main changes proposed to the way in which social security benefits will be paid to people in independent residential care and nursing homes when the new funding structure is in place. This chapter sets out the Government's proposals for paying Income Support to people who are already in homes when the new arrangements come into effect and describes the effects of the new structure on residents' entitlement to social security benefits other than Income Support.

Preserved rights for existing residents

7.3 The Government intends to preserve the present scheme of special Income Support limits for existing claimants who are in residential care and nursing homes when the new funding structure is introduced on 1 April 1991. The right to claim Income Support under the preserved scheme will also be safeguarded for residents who are not claimants at that date but who subsequently claim.

7.4 Access to the preserved scheme will be given if, on 31 March 1991, a resident or claimant is, or would normally be, living in a residential care or nursing home where the Income Support limits apply. Income Support will continue for claimants, including existing residents who subsequently become claimants, whose entitlement in a home is not interrupted. Entitlement will not be affected by a claimant or resident moving to another home or, in most circumstances, leaving a home for long periods - for example to go into hospital.

7.5 These rules will apply to the residents of all registered homes and to the residents of those homes which are not registerable but are specially catered for in the present Income Support scheme, such as homes run by the Abbeyfield Society.

Respite care away from home

7.6 Elderly or disabled people, normally cared for at home by relatives, may be placed temporarily in alternative accommodation, to give their usual carers a break. Such temporary placements are provided by the Boards in their own accommodation and in independent sector residential care and nursing homes, but Boards and voluntary organisations also support a range of schemes in less formal environments. The funding of such respite care is affected by the new arrangements only insofar as it is currently provided through Income Support. In future, the funding of respite care away from home will reflect Boards' primary responsibility for arranging and purchasing it. The existing rules which preclude the payment of Housing Benefit to meet the accommodation costs of admission to respite care will be retained. However, the transfer of resources to be made to Boards after April 1991 will take into account their responsibility for this developing area.

[illegible]

7.7 Attendance Allowance is a non-means-tested benefit paid to severely disabled people who need a great deal of support. It is paid at two rates, one for people who have attendance needs by day or by night, and a higher amount for people with attendance needs by day and night. Together with the Invalid Care Allowance, it is an important part of the social security support for community care.

7.8 The proposed changes in the funding of community care will not alter the present arrangements for paying Attendance Allowance to people in private households or to people who go into independent sector residential care or nursing homes without any assistance from public funds other than state benefits. The transfer to Boards of responsibility for assisting with the care costs of residents in independent sector homes will however require a change in the current rules intended to prevent double funding.

7.9 At present, Attendance Allowance is offset against any Income Support paid to residents in independent sector homes and is not paid at all to residents in Board and other publicly funded accommodation. For people in independent sector homes with preserved rights to Income Support, the position on or after 1 April 1991 will be the same as it is now.

7.10 However, Attendance Allowance will not be paid to residents in independent sector homes who from 1 April 1991 will be assisted by a Board. This new rule will make no difference to the residents concerned, nor will it remove any continuing, underlying entitlement to Attendance Allowance. It will, however, put such Board assisted independent sector care on the same footing as other publicly funded accommodation. Any underlying entitlement to Attendance Allowance established before or during any period of Board assisted residence and still in force when that period stops can be activated once that period stops, and Attendance Allowance then paid immediately in the normal way.

[illegible]

7.11 The Independent Living Fund is a charitable trust whose purpose is to help very severely disabled people with the cost of employing domestic help or personal care which they need to enable them to live independently in the community. There would clearly be an overlap between the Fund and the intended responsibilities of Boards, and this will be reviewed.

CHAPTER EIGHT: QUALITY CONTROLE

8.1 The Department attaches great importance to ensuring that publicly funded community care services are of the highest quality possible within the resources available. Chapter 1 outlined the main attributes of a high quality community care system: flexibility, responsiveness to individuals' particular needs, consumer choice, and promoting users' independence. These attributes will be the touchstone against which quality can be assessed. This chapter will outline some of the means through which this is be done.

Quality of life

8.2 The term "quality control" refers to a whole array of different procedures for monitoring and evaluating quality, from the analysis of crude activity indicators to in-depth research programmes. Action is already in hand, at both Board and Department level, to improve arrangements for the collection and analysis of statistical indicators of performance. As quality control procedures are developed, they will increasingly be slanted towards and used to measure the quality of life for users and their carers. Quality control procedures will pay more attention to factors such as the appropriateness of services to individuals' needs, homeliness in residential settings, the opportunities afforded to users for maintaining and developing personal relationships and respect for users as individuals.

8.3 The purposes of the quality control system include providing management and staff at all levels with regular feedback on the success of their activities; helping managers to plan and review policies and procedures; helping professional staff review and improve their practice; ensuring that minimum standards are being met; and promoting efficiency in the use of resources. Issues to be addressed include the quality of users' physical and social environment; the appropriateness and effectiveness of care, treatment and rehabilitation programmes; impacts on carers; and user satisfaction.

8.4 Quality control is not an isolated activity to be undertaken exclusively by researchers or inspectors coming into a facility or service from outside. The most immediately effective form of quality control is that undertaken by staff as part of their day to day activity, and staff should always be alert to feedback from service users. Quality control is a fully integrated component of good professional and management practice. At operational level, for example, case conferences, peer review procedures, quality assurance groups and patient follow-up studies all contribute to the quality control system as a matter of routine.

8.5 The introduction of a contractual relationship between purchasers and providers will give quality control a sharper focus at all organisational levels. Performance measures will have to be clearly specified, and systems put in place to ensure that agreed standards are secured and sustained. Contracts will have to include provision for monitoring and break-clauses in the event of specifications not being met.

8.6 Where these do not already exist, the Department will expect Boards to establish and publicise straightforward procedures for receiving comments and complaints from service users. Such procedures are an essential safeguard for consumers and an important monitoring and managing instrument for both purchasers and providers.

8.7 Arrangements for external monitoring and evaluation will also be needed, primarily to ensure that internal quality control systems are working properly and that comparable standards are being applied throughout Northern Ireland and in both the public and independent sectors.

Inspection [illegible]

8.8 Arrangements are already in place under existing legislation to safeguard people in independent residential care and nursing homes. The Department is currently reviewing this legislation in light of the experience gained in England and Wales through the operation of the Registered Homes Act 1984. The Department issued a consultative paper in 1988 as a first step in the process of promoting a Registered Homes Order for Northern Ireland, which would consolidate and update the existing legislation, and intends to publish a legislative proposal later his year. Independent sector homes are subject to registration and inspection by Boards. This has given rise to concern about the standards required by Boards, by comparison with the standards achieved in statutory homes. Of those who addressed the issue in responding to the Department's consultative paper, the overwhelming majority called for greater independence of the inspectorate.

8.9 The Department believes that common standards should apply across all sectors. To assist this, it proposes that Boards should set up arm's length inspection units, charged with inspecting and reporting on both statutory and registerable residential care and nursing homes. The Department proposes to transfer the responsibility for the registration and inspection of voluntary children's homes to Boards. The new units could ultimately be responsible for inspecting these homes together with statutory children's homes.

8.10 The arm's length units would be independent of the day to day management of statutory homes at Unit level and would be accountable directly to the Area General Manager. They would apply the same quality assurance criteria to all homes. They would include inspectors recruited from outside their Board's employment: for example former owners or managers in the independent sector or former Board staff experienced in residential or nursing care.

8.11 Boards may also wish to call upon the new units to inspect residential and non-residential services delivered by other agencies under contract. They should be willing and able to advise those whose responsibilities include preparing service specifications, tender documents and the terms and conditions of contracts.

8.12 There will be consultations with Boards, professional and independent sector interests on the detail of this proposal. These will cover such matters as the organisation and management of the new inspection units, arrangements for the submission and scrutiny of reports, the follow-up of reports, recruitment of staff from outside the Boards, reports to Area Health and Social Services Councils, and the role of the units in monitoring compliance with contracts and in investigating users' complaints.

8.13 The Department proposes to issue further guidance for registration and inspection staff on the conditions to be expected in a good home, after consultation with Boards, professional and independent sector interests. This guidance will complement the advice in the code of practice for residential care, "Home Life" and in the handbook "Registration and Inspection of Nursing Homes". It will give special emphasis to assessing the quality of care provided and residents' quality of life, as well as physical conditions.

Regional bodies [illegible]

8.14 As Chapter 9 will outline, the Department will be using the operational planning and accountability review system to monitor more systematically the management, co-ordination and delivery of community care services and the use of resources. In addition, from time to time it will commission one-off, in-depth independent studies of particular aspects of service provision.

8.15 The Department will participate in or keep in close touch with national development initiatives, including the three year development programme now under way in Great Britain, which aims to test and promote new ways of improving the quality of life of people in residential care. The programme is based on recommendations in the report of the committee chaired by Lady Wagner, "Residential Care: A Positive Choice". This programme aims at better training for staff in homes, better information for users; effective, readily accessible arrangements for making suggestions and complaints, a closer relationship between homes and their local communities; and better management.

8.16 The Department's social services and nursing advisers will retain their current responsibilities for monitoring the quality of services. They will also play an important role in advising Boards on the introduction of new quality control arrangements, including the establishment and operation of the arm's length registration and inspection units. They will report to the Minister and the Department on the effectiveness of local quality control arrangements and the methods and standards to be applied when measuring quality.

8.17 The Northern Ireland Hospital Advisory Service will continue to monitor standards in continuing care hospital units; advise on good practice; and report to the Department. In due course, the Department will review the Service's role in the light of experience following implementation of the proposals in this paper and in "Working for Patients".

8.18 The Mental Health Commission will continue to make an important contribution to quality control, with its specific emphasis on the rights and welfare of individual patients.

CHAPTER NINE: PLANNING AND RESOURCES

The planning system

9.1 The integration of health and personal social services in Northern Ireland under the total management responsibility of the four Health and Social Services Boards provides an opportunity unique in the United Kingdom, to plan a coherent and comprehensive range of community care services. The arrangements for securing the achievement in Northern Ireland of the main objectives set out in Chapter 1 must make the most of this integrated structure. This chapter sets out the Department's proposals for doing so in relation to the planning and monitoring of community care services and the allocation of funds. It also explains how these proposals will be taken forward in conjunction with the proposals set out in "Working for Patients".

9.2 Good progress has been made in recent years in developing the planning system for the health and personal social services. Under this system, the Department sets guidelines for, and Boards prepare, five-year strategic plans and annual operational plans. Both sets of plans are based on a programme of care approach. Boards are expected to plan a comprehensive service for each client group, ranging from home care to hospital services. The key programmes of care in the context of this paper are those for people with a mental handicap, a mental illness or a physical disability and elderly people.

9.3 Recent developments have resulted in a more quantitative approach at the strategic planning level with a clear emphasis on shifting the balance of care towards helping people to live full and independent lives in the community. Specific targets have been set for reductions in the in-patient populations of psychiatric and mental handicap hospitals. As indicated in Chapter 2, significant progress has already been made towards meeting these targets. The operational planning system has also developed, with Boards on an annual basis identifying how to progress towards achieving the Regional Strategy objectives within the resources available to them.

Developing the planning system

9.4 As a result of the changes proposed in "Working for Patients", strategic planning will in future take a different form at all levels of the health and personal social services. Changes in the pattern of provision will be effected, largely through changes in the rolling three year contracts that Boards, at Area level, will enter into with Units of Management. Strategic planning at Area level will provide a framework for those changes and will be the means whereby an assessment of the health and social care needs of the population is translated into a statement about the type and volume of services that are required to meet those needs. Each Board's strategic plan will identify specific objectives for changes in the balance of care for particular services and client groups. It will also include clear statements on how these objectives are to be met.

9.5 At present, the Regional Strategy for 1987-92 constitutes the only comprehensive statement of the Department's policies and objectives for the future planning and provision of integrated health and personal social services across the spectrum of care.

Since its publication in 1987, a number of important policy initiatives have been taken by the Government, including those set out in "Working for Patients" and in this paper. The implementation task facing the Department and the Boards is a considerable one, not least when set against the overriding importance of maintaining high quality services during a period of considerable organisational change.

9.6 The progressive implementation of these initiatives requires a planned approach. To this end the Department's Management Executive will be developing in consultation with Area General Managers a three-year rolling management plan for the health and personal social services. This plan will reflect available resources of finance and staff and will set out key objectives, identify priorities and determine performance targets over the three-year period, particularly in the year ahead. The plan will constitute a strategic management framework to secure the efficient and effective delivery of high quality services, within the Department's overall policies for the delivery of services, including those set out in the Regional Strategy.

9.7 The preparation of the management plan will provide an annual opportunity to review the workload facing the Department and Boards and to co-ordinate action. It will also provide a framework for the preparation of Boards' own operational plans, including statements on individual programmes of care. In these plans, Boards will be expected, in their new purchaser role, to set out for the programme of care for each client group:

- their assessment of the need for the programme;
- the extent to which this need can be met during, and their priorities for, the year ahead;
- the resources which will be made available and the level of service to be provided;
- how these services will be provided through contracts, whether with directly managed units, self-governing units or the independent sector;
- the quality of services expected from providers;
- the extent of co-ordination with other agencies, including housing agencies and the independent sector.

9.8 Boards' operational plans are already public documents intended to communicate Boards' policies and priorities to a wide audience. In future Boards will be asked to ensure that the community care sections in their plans are produced in such a way as to give a good overview of the main programmes of care and the direction in which they are moving and to be as informative as possible to interested parties outside the Boards. The first plans under the new arrangements will concentrate on the management and delivery of the main changes set out in this paper and in "Working for Patients". In particular, Boards will be expected to explain:

- how they intend to identify and meet their needs for the information on which to base future planning;

- the arrangements at Unit level for assessing individual applicants for care;
- how the new purchasing tasks are to be organised and managed;
- how services for people at home, including their carers, are to be improved;
- how they are co-ordinating plans and activities with those of housing and other agencies;
- what preparations they are making for the introduction of case management, including training;
- what information is to be provided to service users and their carers about services;
- what training is to be provided for relevant staff groups;
- how the contribution of the independent sector is to be stimulated, particularly in fields other than residential and nursing home care;
- what progress has been made on the establishment of arm's length registration and inspection units;
- what quality assurance systems are to be established, including complaints and contract compliance procedures.

[redacted]

9.9 The Department will have to assure itself that the Boards' plans are in line with its strategic guidance and that action is being taken to put the above elements in place without undue delay in the light of available resources. Boards' performance is monitored through the annual accountability reviews led by the Minister. These reviews will be reshaped to take account of the structural changes introduced in the Department and the creation in January 1990 of the post of Chief Executive. The objective will be to develop stronger accountability and monitoring arrangements reflecting the greater delegation to Boards and their Units of Management of responsibility for determining the pattern and quality of services.

[redacted]

9.10 It is a matter for each Board, within the strategic framework set out by the Department, to determine the pattern of services appropriate to its local needs and priorities. The current Regional Strategy has identified that too great a share of the overall funding is devoted to the hospital sector, and Boards are required to plan to remedy this. The Strategy envisages that by 1991/92 the proportion of funds going to community services will rise from 26% to around 30%.

9.11 In line with "Working for Patients", the arrangements for allocating funds to Boards will change from 1992/93, reflecting their new roles as purchasers of care for their resident populations. The distribution of funds provided through the Public Expenditure Survey process will be determined by a formula which will take account of the age and sex of each Board's population and relative levels of need. With the resources provided each Board will be expected to purchase a comprehensive range of services including community care for its local population.

9.12 The whole thrust of development in management and accountability in the health and personal social services in recent years has been to devolve responsibility for managing and developing services to the operational level, as re-affirmed in "Working for Patients". Boards will have maximum operational flexibility (subject to strategic guidance from the Department) to make their own decisions in the light of their knowledge of local needs and circumstances. The Department will expect Boards to devote an increasing proportion of their expenditure to community services in line with the Regional Strategy.

9.13 The Department recognises that Boards will need adequate resources to enable them to discharge their expanded responsibilities for assessment, case management and service delivery. In keeping with the Government's proposals for reforming the funding of residential and nursing home care, as set out in Chapter 6, the Department will provide additional resources to the Boards to finance the care of people in independent sector residential care and nursing homes.

9.14 The quantum of additional resources will take account of the following factors:

- the Income Support that would have been payable under the present scheme;
- the normal Income Support and Housing Benefit that will be payable to new residents;
- the continuing commitment to those residents with preserved rights to the current scheme, as described in Chapter 7;
- the rate at which Boards will assume responsibility for the care of new clients. Account will be taken both of natural turnover and growth in demand due to demographic and other factors.

Account will also be taken of the changes in the payment of Attendance Allowance described in Chapter 7. Decisions on resource issues will be taken following the 1990 Public Expenditure Survey.

9.15 The additional provision will be phased to reflect the declining proportion of residents in independent sector homes previously eligible for Income Support who continue to be supported entirely by social security. This phasing will ensure a smooth transition to the new structure and enable Boards to build up their activity as the numbers of people requiring financial support from them increase.

9.16 In due course, the additional provision for community care will be distributed through the capitation formula. There will, however, be a transition period linked to the phasing in of capitation funding. Since the changes in funding for residential and nursing home care will be introduced from April 1991, the additional funds will be distributed for an initial year in line with the existing allocation arrangements.

Information needs

9.17 The availability and effective use of relevant, timely and accurate information is crucial to the successful implementation of the proposals in this paper. Information provision in community care is particularly complex in that

- several programmes of care are involved;
- different staff groups are included in each programme;
- there are many connections between programmes;
- there are many connections amongst various parts of the health and personal social services;
- there are many connections to other statutory and voluntary agencies providing complementary programmes.

9.18 Information for assessing the needs of individuals and of the community as a whole, and for delivering the appropriate services, will need to be brought together from various programmes and bodies. Careful planning will be essential to ensure that everyone in the chain has a common understanding of the information presented. There will be great variation in need, ranging from the detailed, instant data required to support day to day case management through to the more comprehensive, aggregated information needed to support functions such as inspection, monitoring, contracting and planning.

9.19 Existing information systems will have to be examined to assess their relevance, to identify gaps within and between organisations and to confirm that the frequency at which they provide information is compatible with the uses to which the information is put. Systems will have to be established to ensure that data are captured from the appropriate source, processed and delivered in the correct format and in time. This will require close co-operation across a range of professions and bodies. Important issues such as common access to and confidentiality of data will have to be resolved. Many of the information needs identified are likely to overlap with those arising from "Working for Patients", and Boards will have to address the requirements of the two sets of reforms together. In this context, the Department will be working with the Boards to develop, before the end of 1990, a comprehensive information strategy for the health and personal social services.

The workforce

9.20 The provision of community care services is a labour intensive activity. In taking on their new responsibilities, health and social services staff will be building on existing skills and competencies, but their training will need to reflect their new roles.

9.21 The community workforce is diverse, with staff operating at vocational, professional and managerial levels. Boards will have to ensure that their workforces are properly trained and appropriately deployed to discharge their expanded responsibilities.

9.22 The proposals in this paper have implications for the roles of all staff involved in community care, including management and planning staff, staff with assessment and case management responsibilities and staff directly involved with the delivery of care and support. There will also be implications for staff working in the independent sector.

Training

9.23 The Department's Working Paper "Education and Training in Northern Ireland", published in February 1990, deals with the education and training implications of "Working for Patients". The management development needs arising from this policy paper are similar, and Boards will be expected to address them together. In designing skills training for managers in areas such as service specification and contract management, Boards should take the community care dimension fully into account. It cannot be assumed that training in contracting for hospital services will be sufficient to equip management for contracting in the community care field.

9.24 Professional staff working not only in the social services but also in nursing are increasingly being trained to work in both community and hospital settings. Pre-registration training for nurses will include preparation for caring in both hospital and community settings.

9.25 Professional staff working in the community have traditionally been trained separately. Further work will need to be done to promote multi-disciplinary training for professional groups at both qualifying and post-qualifying levels. New programmes of in-service training on assessment and case management should as far as possible be conducted on a multi-disciplinary basis.

9.26 In association with the Department of Health, training authorities and professional and representative bodies, the Department will be taking further action to identify and prioritise the training implications for professional staff of the proposals in this paper, including the proposals for assessment and case management.

9.27 The Social Services Inspectorate will participate in the national development projects on assessment and case management and purchasing and budgeting, and will be available to offer advice and guidance on these and on training issues.

9.28 Vocational staff, such as care assistants and home helps, will become increasingly important as the number of dependent people to be cared for in the community grows and as greater emphasis is placed on supporting them in their own homes. These staff will have to be properly trained and adequately prepared for their extended responsibilities.

9.29 In the past the training needs of vocational staff have not generally been well met. In order to address these shortcomings, the Government set up the National Council for Vocational Qualifications in 1986. A consortium of interests (the Care Sector Consortium) representing employers and staff from the statutory and independent sectors is working to secure a recognised national pattern of vocational qualifications and training for all those working in the care sector. Their further work on the NVQ will take account of the Government's proposals for community care. Northern Ireland's interests are represented by a Shadow Care Consortium which will keep local agencies in touch with developments in this area.

9.30 Boards need to plan for their workforces as a whole and ensure a suitable mix of skills. Shortages of professionally qualified staff may have a limiting effect on what can be achieved, but Boards have to ensure that they are making the most effective use of the skills of their professional staff. They should aim to complement and support the efforts of their professional staff through the appropriate deployment of suitably trained vocational staff.

9.31 The independent sector will equally need to consider the implications of the proposals in this policy paper for the skill mix and training of its workforce. This is essential if private and voluntary sector employers are to meet effectively the needs of clients assessed by Boards as requiring particular forms and levels of care. Staff in the independent sector should have the same access to training opportunities as those in the public sector. In some instances, joint training may be appropriate. Whether or not training is provided jointly, independent sector employers will have to invest in induction and in-service training for their staff.

CHAPTER TEN: WHAT IS TO BE DONE

MMcG- 3

10.1 Community care is being practised, with varying degrees of energy, financial input and success, in every area of Northern Ireland. The proposals in this paper are intended to create a clearer framework and better opportunities for its successful practice.

10.2 Good progress has already been made in shifting the balance of care from hospital to the community and in enabling clients to stay in the community. Much more remains still to be achieved. The Department expects further work to be done in the spirit of this policy paper and in line with the central objectives set out in Chapter1.

10.3 Although this paper calls for changes in the way in which community care is planned and delivered, the overall direction of these changes is not new. Because the paper presents a vision for the decade, in its totality it offers a great many challenges. However not all the changes which it foreshadows have to be introduced immediately, and some will have to be made gradually, over a period of years. The availability of resources overall will naturally influence the pace at which the new policy is implemented.

10.4 New social security arrangements will take effect in April 1991. They will require Boards to have in place by then procedures for assessing individuals' care needs, for securing care, including residential and nursing home care for those who need it, and for working out how much people should pay for residential and nursing home care. Those receiving care in Board homes will from the same date be subject to a new system of financial assessment aligned to the systems used to assess eligibility for Income Support and Housing Benefit. Boards will have to reassess their present residents' financial contributions.

10.5 There are associated changes which Ministers also want to see implemented by April 1991. By that date, arm's length inspection units should be established and accessible and effective complaints procedures should be in place.

10.6 Boards' operational plans for 1991/92 will have to state the arrangements which they have made to give effect to the changes required by April 1991 and the arrangements which they plan to make to implement the other changes proposed in this paper.

10.7 The evolutionary nature of some of these changes means that Boards will plan systematically for their introduction over a longer period, building on existing good practice and piloting innovative services. These longer term changes include developing the case management approach, promoting a mixed economy of care and introducing new purchasing and contracting arrangements. This developmental work should all be driven by the central aim of identifying and meeting clients' individual needs. In taking this work forward, Boards will have to take the initiative in creating a partnership with the independent sector which allows for frank and open discussion of the needs which Boards identify and of the provision which they wish to purchase. A partnership of mutual trust and understanding should enable the independent sector to assess market opportunities more accurately and should permit Boards to identify the most appropriate contribution to be made by that sector to their clients' care.

10.8 The Department intends to support Boards in the implementation of the changes in this paper by issuing guidance; by linking into implementation work under way at national level; and by participating in and disseminating the outcomes of national professional development projects.

Include

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Management Executive
Office of the Chief Executive

Chief Executives of HSS Trusts and
Shadow Trusts - for action

METL 2\93

Area General Managers)
UGMs) for information
GP Fundholders)

(October 1993

Dear Sir\Madam

ACCOUNTABILITY FRAMEWORK FOR TRUSTS

1. This letter sets out the framework of accountability which will exist between the Management Executive (ME) and HSS trusts in the future. It reflects both the statutory responsibilities of trusts and the role they will be expected to play in the pursuit of the corporate objectives of the HPSS currently summarised annually in the Management Plan.

Relationships

2. In developing and articulating this accountability relationship it has been recognised that some refinements may be required in the future. The need for these will be kept under review. It is also intended to develop a set of statements addressing the major relationships which now exist within the HPSS involving the ME, Boards, trusts and GP Fundholders.

3. The reforms of the HPSS brought forward in the Health and Personal Social Services (NI) Order 1991 are designed to enhance the capacity of the HPSS to secure improvements in the health and social well-being of the population by improving performance, raising standards and enhancing quality. The separation of the purchasing and providing roles will in particular allow the delegation of management responsibility to the local level. HSS trusts established under the 1991 Order are independently - managed provider units which are statutory bodies and remain within the HPSS. They are expected to maintain good relationships with purchasers based on collaboration and partnership.

4. As such HSS trusts are accountable to:

   i. the general public and in particular local communities. As statutory bodies utilising public funds, trusts are expected to demonstrate good stewardship to the taxpayer

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and an efficient responsive service to the people they serve. They should encourage the involvement of local communities and build up good relationships with their Health and Social Services Councils. Each trust must hold an annual public meeting and issue an annual report.

ii. to purchasers (Boards and GP fundholders). The primary accountability of trusts for the quantity, quality and efficiency of the service they provide will be to their purchasers. The contracting mechanism will provide the means for these to be specified and monitored. In the main therefore the line of accountability for service delivery issues will be initially to the purchaser(s) and from there to the ME if there are strategic implications or the matter is the subject of a Parliamentary Question or Minister's query.

iii. to the ME for the performance of their functions, including the delivery of objectives and targets set out in the Strategic Direction and annual Business Plans. They will also be required to meet their statutory financial obligations and conform with any other specific requirements placed upon them, including those in the Management Plan.

5. The current proposal to amend the 1991 Order will enable Boards to delegate statutory functions to trusts. The new legislation will require each trust involved to develop a scheme specifying how it will discharge these functions in line with Departmental/Board guidance and current good practice. These schemes must be agreed with the appropriate Board and approved by the Management Executive. This mechanism will create a further relationship between certain trusts and Boards in addition, but complementary, to the contractual relationship. Boards will retain a strategic residual responsibility for the functions involved and will be expected to ensure both that the schemes reflect sound and effective working procedures and that they are adhered to by trusts. In turn the Department will retain ultimate legal responsibility for the functions and will wish to ensure that both Boards and trusts are discharging their responsibilities.

Obligations of Trusts

6. Under the 1991 Order, trusts are expected to meet a range of key financial responsibilities:-

   i. break even on an income and expenditure basis taking one year with the next;

   ii. achieve a target return on assets currently 6%;

   iii. stay within the annual External Financing Limit (EFL) set;

   iv. pursue and demonstrate value for money in the services they provide and in the use of the public assets and resources they control.

7. Trusts are also expected to meet all legal obligations, discharge their statutory financial duties and comply with a range of advice, guidance and standards where it is clear that these apply. The ME will establish arrangements to specify where guidance applies to trusts consistent with the principle of maximising operational freedom.

8. All HSS trusts will be expected to contribute to the achievement of corporate objectives of the HPSS and, as appropriate, Government at large. As such they will be required to be committed to:

- the achievement of the Regional Strategy and Boards' Area Strategies;
- delivery of the annual HPSS Management Plan;
- implementation of the Charter for Patients and Clients ;
- work within the framework of relevant central guidance and policies, particularly on:-
    i. education and training;
    ii. capital investment;
    iii. estate issues and environmental issues;
    iv. information and IT;
    v. procurement;
    vi. 'Competing for Quality'.

Strategic Direction and Business Plans

9. It is proposed that there should be 2 essential requirements in the strategic planning process for HSS trusts:-

   i. to produce, submit to the ME and make available publicly, each year, an updated 5-year Strategic Direction, the first year of which represents the detailed Business Plan. The business planning cycle for trusts needs to align broadly with that for Boards. It will therefore be important that the final version of the trust's business plan is submitted at the same time as the Boards' Purchasing Plans are submitted to the ME. It will be necessary for trusts to submit a draft version to the ME in advance once Boards' purchasing prospectuses are available and a reasonable assessment of the contracts likely to be secured is possible.

   ii. to provide the justification for planned capital investment to allow agreement of the annual EFL for each trust. Outline proposals should be linked to the purchaser's longer term plans and contained in the rolling 5-Year Strategic Direction, but full business cases can be made at any time. Interim business case guidance which is currently available will be superseded following the revision of existing Capricode procedures later this year.

10. The main vehicle for the delivery of purchaser requirements will be contracting. The ME will use the business planning process to secure accountability to the Chief Executive, and hence to Ministers, for the use of public funds and assets. Day to day responsibility for this will lie with the Provider Development Directorate, in conjunction with Financial Management Directorate.

11. Business planning is an important management activity which will enable trusts to ensure their long term financial viability and for planning the direction which the trust is taking in a way that is consistent with the key strategic health and social care objectives of the purchasers, as well as providing the basis for the ME to safeguard Ministers' ultimate responsibility over the use of public funds. These Plans will also be the basis on which trusts' overall performance will be assessed by the ME.

12. The Annex sets out details of the purpose of the Strategic Direction and Business Plan together with requirements on capital investment. It is the intention that all HSS trusts would prepare plans in line with the revised requirements set out in this circular. Normally final versions of these submissions should be available following the completion of the contracting round.

13. The Strategic Direction and Business Plan should set out the key management tasks for the trust and identify how longer term strategic objectives will be pursued. The Business Planning guidance already issued to trusts sets out what the ME would expect to see covered by trusts in order to achieve their desired outcomes in terms of meeting purchaser intention, health and social gain activity and service investment, and the resources which the trusts will need to achieve these. The underlying intention is that the accountability needs and the monitoring arrangements should not be onerous, should be based on a broad, but limited, range of indicators and that trusts should be given the maximum possible freedom to manage their own affairs without detailed intervention.

<u>Monitoring</u>

14. In monitoring the performance of trusts the Management Executive will focus on:-

    - performance against targets and objectives in the Business Plan;
    - performance in relation to statutory financial obligations based on detailed financial returns;
    - the contribution, via contracting, to achievement of service priorities;
    - application of funds directly allocated eg for STAR post-graduate medical and dental education and from 1994/95, for the training of junior doctors/dentists;
    - adherence to statutory obligations.

15. In addition to the Strategic Direction, Business Plans and Corporate Monitoring returns, trusts will be expected to participate in and contribute to HPSS information systems such as Korner returns. While the normal accountability lines for service delivery issues will be via purchasers, trusts will still be expected to provide

any information required by the ME in support of Ministers or for Parliamentary purposes.

Openness

16. The Management Executive fully supports the flow of information between purchasers and providers. However, openness is not an accountability tool in itself although it will need to exist at several levels:-

- at the public level, trusts are required to publish their Strategic Direction and summaries of their Business Plan, hold public meetings and present audited accounts and an Annual Report (which should include a report on the extent to which targets in the Strategic Direction and Business Plans have been achieved);

- with purchasers, there should be an equivalence of interests and responsibility in sharing information. Purchasers will be concerned to reassure themselves that contract price and capital bids are reasonable and justified.

17. Confidentiality should be the exception to the rule that information on both sides of the contractual divide should be made available on a mutually beneficial basis. The ME will therefore expect that:-

- providers will comply with relevant ME guidance on contract prices (full costs, no subsidisation etc);

- all contracts and tariffs will be published;

- purchasers will discuss purchasing objectives, resources etc openly with their providers who in turn will discuss proposed developments with purchasers;

- no information relating to other providers/purchasers will be exchangeable other than with their agreement.

Ground Rules for Intervention

18. Intervention by the ME in the affairs of a trust should be exceptional, in line with the principles of maximum delegation. It may be judged necessary in certain circumstances eg:-

- items of concern relating to patient or client care;

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- failure to discharge statutory functions;
- breach of statutory obligations and EC Directives;
- unacceptable financial performance;
- action in breach of the Establishment Order;
- significant variation from agreed objectives and performance targets.

Any such interventions will not preclude relevant actions by the appropriate Board whether acting in its role of purchaser or fulfilling its statutory residual responsibility in respect of the statutory functions delegated to the trust.

<u>Queries</u>

19. Any queries on the terms of this letter should be directed to the Provider Development Directorate, which is the principal point of contact in the Management Executive for Trusts.

Yours faithfully

John G Hunter.

JOHN G HUNTER

Management Executive
Office of the Chief Executive

ANNEX

The Strategic Direction

1. The identification and agreement of strategic objectives, and of a plan for their achievement are essential business planning practice. The Strategic Direction should help trusts to review their operation and consider their longer term response to purchaser requirements and desired changes in the health care delivery systems.

2. Each trust should be required to make available to the ME, and subsequently the general public, a Strategic Direction. This should outline its strategic objectives and indicate the key tasks and investments on which the achievement of the objectives will depend. Outline business cases for key investments should be made available also.

3. The document should be predominantly narrative and should be concise, but it should provide sufficient information to allow the ME to understand the proposed pattern of the trust's services in the future. This is because this information, together with that provided by Boards in relation to purchasing intentions and DMU's plans, will be crucial to the ME overall co-ordination and management of the HPSS.

4. The document should cover the following 5 years. Trusts may wish to look further forward if there are proposed changes in the longer term which are essential to understanding its strategy. The document should be rolled forward annually, with its detailed Business Plan forming the analysis for the first year in each case.

5. The draft Strategic Direction should be submitted in the Autumn of the year before the strategy's commencement. The ME will then discuss and agree with the trusts when their document can be finalised and made available publicly. This agreement will indicate that the ME regards the strategy as a realistic and sensible one for the future development of the Trust. It will not imply that the ME supports the detail of the strategic planning exercise nor will it replace the formal approval required for capital investment.

The Business Plan

6. The detailed, yet integrated, Business Plan should set out the key management tasks for the Trust and identify

how the longer term strategic objectives outlined in the Strategic Direction will be pursued by the Trust in the coming year. It should identify clearly the Trust's desired outcomes and the resources which the Trust will need to achieve these.

7. The plan should draw together the implications for the coming year of the Strategic Plan, the External Financing Limit (EFL), and the contracts established with purchasers. The plan should also contain summary financial and activity information for the subsequent 2 years, in order to ensure consistency with the financial pro-formas.

8. Both the Strategic Direction and Business Plan should be concise. Apart from the information required for the year ahead, they should contain any revisions to outline business cases for proposed investments, and any changes in the Trust's longer term strategy. In support of their Business Plans, trusts should submit a full set of financial pro-formas containing:

   i. actual figures for the previous year;

   ii. forecast figures for the current year ie that in which the plan is being prepared;

   iii. budget figures for the year of the plan; and

   iv. planning figures for the following 2 years.

9. Taken together, the Business Plan and the pro-formas should:

   i. demonstrate that the Trust has planned to meet its financial obligations of breaking even, earning a target return on assets and remaining within its EFL;

   ii. demonstrate that the Trust's plans are based on realistic planning assumptions about, for example, purchasers' intentions, inflation and efficiency gains; and

   iii. provide a detailed forecast of the Trust's activities.

10. Trusts should provide the ME with a draft business plan by the Autumn of the year prior to the plan's commencement. This will be used to determine indicative EFLs against the background of the availability of resources and assumptions on the level of commissioners'

funding. The ME will discuss and agree with the trusts when their plans can be finalised and a summary be made available publicly. In any event they will need to be finalised, together with the pro-formas before the start of the year in question.

Capital Investment

11. Trusts need to provide a rationale for any proposed investment or disposal of capital assets for 2 reasons:

    i. to demonstrate that there are good service and/or financial reasons for the proposal; and

    ii. to demonstrate that the proposal represents a good use of public money.

12. As a matter of good management practice, trusts need to examine the business case for all investments, whether capital or revenue based, and including acquisitions and disposals.

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HEALTH AND WELLBEING 2026

DELIVERING TOGETHER

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FOREWORD

The World Health Organisation defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". That is the health outcome I want to deliver for all our people.

But without new approaches and in the face of ever growing demand - often driven by successful interventions and improving life expectancy - we will increasingly struggle.

Change is quite simply essential to deliver the world class service - free at the point of delivery and based on need - that is our collective commitment.

We must move beyond simply managing illness and instead ensure that our health service supports people to stay well; physically, mentally and emotionally.

In other words, we need to rethink how we deliver our health and social care service.

My predecessor, Simon Hamilton, asked a panel led by the internationally recognised expert, Professor Rafael Bengoa, to help us identify how to tackle the challenges in our Health and Social Care system.

Their report tells us clearly that we need to re-organise how we do things - and that we need to do this in partnership with the people who use the service and those who work in it. Critically, we must prioritise prevention and early intervention to ensure that people stay well. This approach will produce better health and wellbeing outcomes and it will reduce demand on our over stretched acute services. It will also help us tackle what the Expert Panel Report calls "striking health inequalities" in our society.

This document, Health and Wellbeing 2026: Delivering Together, is the outworking of the Expert Panel's recommendations. It sets out a commitment to tackle the issues we face in our Health and Social Care system through decisive political leadership. We are determined to move beyond short-term approaches and crisis management.

This Executive is united as never before in its commitment to take the right, perhaps difficult, decisions. But we know this is the only way to deliver better outcomes for our people.

We are facing into a time of change for our health system but it is change that must happen. This document sets out a direction of travel that I hope all of our society can embrace and support in the challenging but exciting time ahead.

Michelle O'Neill, MLA
Minister of Health

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THE CHALLENGE

My desire for world class health and social care is based on firm foundations - we have a health and social care system staffed with many talented and dedicated people working extremely hard to deliver high quality services to those in need. But increasingly those efforts are frustrated by a system which is clearly under mounting pressure. This is impacting on both those within the system and those it serves. Without radical change there is no doubt the situation will further deteriorate. That is why I am convinced that change is needed now.

Before I set out the case for change, it is important to acknowledge and celebrate where Health and Social Care, in collaboration with wider government, is making a real difference to our health and wellbeing.

Standardised
CIRCULATORY DEATH RATE
in under 75s
decreased by a fifth over the last 5 years

ENGAGEMENT WITH EDUCATION TRAINING OR EMPLOYMENT FOR THOSE AGED 16-21 WHO ARE IN CARE OR HAVE LEFT CARE HAS RISEN 5.7% IN THE PAST YEAR

SMOKING PREVALANCE FELL
from 26% in 2004/05
to 22% in 2014/15

7677
CARERS RECEIVED SUPPORT FROM TRUSTS IN 2015 COMPARED TO
1414
IN 2011

Over **1 in 3** adults (36%) reported that they ate the recommended
5 PORTIONS
of fruit & veg a day (2014/15)
increased by a third over the last 10 years

FAMILY SUPPORT HUBS

In 2015/16, **4522 families with children** were referred to Family Support Hubs, a **72% increase** on the previous year. Of the 5346 children referred to Hubs in 2015/16, **around 18% were children with a disability**

BOWEL CANCER DECREASE

Since **bowel cancer screening** was introduced, the percentage of people diagnosed with early stage disease has increased from **14% to 22%** thereby **improving their life chances**

LOOKED AFTER CHILDREN

achieving Key Stage 1: Level 2 or above

in English
7.5% INCREASE

in Maths
7% INCREASE

INCREASE IN ADOPTIONS

Between 2014/15 and 2015/16, there has been a **24% INCREASE** in the adoptions of Looked After Children

LIFE EXPECTANCY

over the last 5 years life expectancy has increased

1.3 YEARS
for males
(78 years)

1 YEAR
for females
(82.3 years)

Standardised
RESPIRATORY DISEASE DEATH RATE
in under 75s
decreased by a fifth
over the last 5 years

MMR VACCINE

over 95% of children received the MMR Vaccine which means we have not seen the outbreaks of measles that have occurred elsewhere

At the heart of the many successes of the Health and Social Care (HSC) system is the hard work and dedication of all staff, in every grade and role, who are delivering care at higher levels than ever before.

However, while there is much to celebrate, we must recognise the challenges in the current system. The reality is that we increasingly cannot properly meet people's needs with our current structures. In the past, and for a range of reasons, it has not been possible to achieve the whole system transformation at the scale and with the pace we need to meet the evolving health needs of our people. More and more the impact of this is felt on a daily basis and takes its toll on both those who use services and those working in the sector.

Our Health and Social Care System faces a number of significant challenges:

Organisational

In many past reviews, professionals and staff have expressed their frustration at the limitations of our current arrangements and their desire for change, most recently in the Expert Panel report. The 20th century configuration of our services is simply not optimised to meet the needs of 21st century care.

The point has now been reached where maintaining the current delivery models is having increasingly negative impacts on the quality and experience of care for many service users, while constraining the ability of the system itself to transform to meet today's health needs.

While staff work increasingly hard to mitigate these structural issues, the overall impact is experienced by service users and their families every day, in every part of the system. Regrettably, delays in accessing services and unacceptable waiting times for treatment are commonplace. The quality of our service, and the experience of those providing and receiving it, is not as good as it should be.

Modern research shows that outcomes for patients requiring complex or specialist treatment improves where high levels of specialist expertise is available and these teams are able to keep pace with innovation. The current spread of such HSC resources, too often committed to buildings rather than outcomes for patients, is a central challenge we must address.

If we persist with our current models of care, even with the best efforts of all staff and more investment year on year, waiting lists will continue to grow, our expertise will continue to be diluted, and the best possible outcomes for patients will not be realised. This is both unsustainable and unacceptable.

In addition, the way we are organised means that opportunities are being missed to create sustainable employment, drive economic investment, and maximise the contribution of the HSC to the economic goals of the Executive. For example, the life and health sciences sector provides 10% of all of the North's exports. Closer working between the HSC, our world class universities and life and health science organisations and maximising the potential for growth in this high value sector, is fundamentally dependent on centres of clinical excellence with the right level of expertise and the necessary capacity.

Workforce

A further challenge relates to the workforce itself. People who work in health and social care are its greatest strength, working ever harder to provide the care needed by patients and service users. Year on year, investment has been directed to front line services in an effort to meet the ever growing need for treatment and care.

However, if we accept, as a whole range of reviews have, that our services are not best configured for our needs, then it follows that recruiting additional staff alone to prop up outdated service models, is not the answer. We must be able to provide safe and high quality care which keeps up with the fast pace of innovation and health and social care developments. I recognise that staff need the opportunity to develop their skills and expertise in an environment which allows for a greater degree of specialisation, whilst maintaining personalised compassionate care.

It has also become clear that even when resources are made available to recruit additional staff, it has simply not been possible to fill all vacant posts. This in turn puts additional pressure on already hardworking staff and has seen our service become increasingly reliant on short term solutions such as locums and agency staff. This creates additional expense with negative implications for the quality of care. It has become a vicious circle which we must stop.

We must invest in our staff and provide the environment to allow them to do what they do best - provide excellent high quality care. This means providing opportunities to develop their skills and find suitable career paths at all levels. Where necessary, we will increase the numbers we train and consider ways of delivering care more effectively through the development of new roles and skills.

I am determined that we will make the health and social care system an employer of choice in the north of Ireland.

The Needs of a Rapidly Changing and Ageing Population

Our society is getting older: people are living longer, often with long-term health conditions, and we are having fewer children. Estimates indicate that by 2026, for the first time, there will be more over 65s than under 16s.

By 2039, the population aged 65 and over will have increased by 74% compared to the position in 2014. This will mean that one in four people will be aged 65 and over.

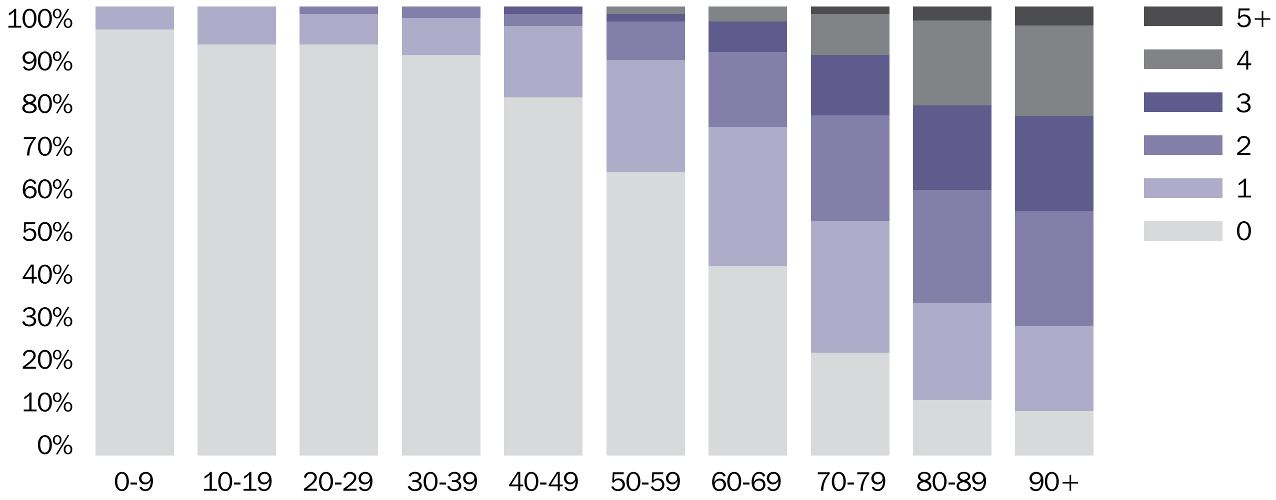
Similarly, the population aged 85 and over will increase by 157% over the same period, which will see their share of the population increase from 1.9 % to 4.4%.

By any analysis, this is a massive success to which our health and social care service has made a significant contribution. That said, it does present a huge and growing challenge in terms of the demands and pressures on health and social care services.


An ageing population - number of older people (65+) per 100 aged 16-64

As much change in the next 8 years as in the previous 40+

Percentage of patients in each age band with the indicated number of morbidities



Developments in how conditions can be treated and managed mean that as we get older we are much more likely to develop and live with one or more long term conditions. The table above demonstrates that as we get older, the likelihood of having more than one condition at the same time increases dramatically, and with that the care and treatment that we require becomes much more complex.

Furthermore, people’s health and social care needs have changed, and their expectations are rightly higher than at any other time before. In the past, for many conditions, where there was an effective treatment available, it often required hospital attendance or an in-patient stay. Increasingly, such treatments are available in the community, or can be provided on a day care basis; which in many instances is more appropriate to the needs of people with longer-term chronic conditions.

People today want to lead full and productive lives, staying independent for longer. In line with wider societal changes, we all expect improved access, choices and control when it comes to public services.

Health Inequalities

Despite people living longer, health inequalities continue to divide our society. The differences in health and wellbeing outcomes between the most and least deprived areas are still very stark, and completely unacceptable.

For example, men in the least deprived areas live 7.5 years longer than men in the most deprived areas. For women, the difference is over four years. In the most deprived areas, 30% of people report a mental health problem - double the rate in least deprived areas. Rates of suicide are also higher, and leave a devastating impact on people, families and those communities.

Birth weight is an important indicator of foetal and neonatal health, and a low birth weight has a strong association with poor health outcomes in infancy, childhood and throughout someone’s life. Between 2010 and 2014, the proportion of babies born at a low birth weight was 44% higher in the most deprived areas than in the least deprived areas.

In 2013/14, the rate of obesity among children in Primary 1 was 71% higher in the most deprived areas than those in the least deprived areas. 42% of Looked After Children (LAC) come from the most deprived areas in the North. Being looked after is associated with poorer socio-economic outcomes in adulthood.

It is clear that economic, social and environmental factors, and experiences early in life, play a major role in determining not just the health outcomes at an individual and community level, but also their social, educational, economic and other outcomes. There is also growing evidence that children who experience adversity in childhood are far more likely to experience health issues in adult life. Specifically, these children are more likely to adopt health harming behaviours during adolescence which can lead to mental health illness and diseases such as cancer, heart disease and diabetes later in life. Adversity in childhood also means that children are more likely to perform poorly in school, more likely to be involved in crime and more likely to experience poverty and disadvantage in adult life.

Our future health and social care system needs to not only treat people who become sick or need support now, but also needs to do much more to ensure that the next generation is more healthy with more equitable life opportunities for all.

Our Opportunity

The problem and the compelling case for change is not in itself new, and has been made repeatedly by experts, staff and patients over many years. The Expert Panel's Report “Systems, not Structures: Changing Health and Social Care” once again reaffirms this. But despite the overwhelming evidence, the opportunity has thus far not been grasped. However, both as Minister and as an Executive we believe there is now no alternative but to transform how we design and deliver health and social care services.

The political summit hosted by the Expert Panel in February 2016 secured a political mandate for the need for change and the principles to underpin it, and I look forward to all parties engaging with and supporting the HSC to make the difficult decisions required to improve our population's health, and build a sustainable health and social care system. This is the time for political leadership.

The advent of a new outcomes based approach in the draft Programme for Government puts an onus on us all to work together, across traditional silos and boundaries to deliver the best outcomes for the people of the North. Now is the time for us to work collectively to deliver a world class health service.

Across this island, the health and social care fabric of both jurisdictions face the same challenges. We have the opportunity to work more collaboratively with colleagues to address those challenges, and deliver services in a way that improves care for our population as a whole. There are many good examples of where this is already working well, such as cancer and cardiac services in the north west or the partnership with Dublin for children's heart surgery. There are many more such opportunities, including the transplantation of organs and rare diseases, and we have developed a programme of work with the Department of Health in the South to identify areas of mutual benefit.

Staff, clinicians and professionals from right across our health and social care system are telling us loud and clear that change is now necessary. If we do not grasp this opportunity change will happen anyway but in a reactive and unplanned way, with more potential for detrimental impacts on those who use and deliver our services.

In addition, the HSC itself is a huge contributor to the economy in many ways, through skills development, spending power and employment practices.

As the single biggest employer in the North, we have a real opportunity and responsibility to make a tangible and positive contribution to the health and wellbeing of our staff, and society as a whole. We will be an employer of choice, leading by example and investing in the wellbeing of our staff. Despite the demand, resource and service pressures being experienced, I am committed to ensuring the wellness dimensions of being an employer of this scale will be better achieved across the HSC.

In the way we operate, we have the opportunity to promote a new way of working with the community and voluntary sectors through the innovative use of social procurement clauses, and commissioning services based on social value rather than simply on the basis of lowest cost.

Working with our world class universities, skilled graduates and world leading companies, we can grow our life and health sciences sector, creating new jobs. This will mean access to cutting edge technology and therapies, and the dual benefit of improving care and economic growth. To do so requires further collaboration between HSC, academia and industry. The HSC can only play its part if it can provide the centres of expertise and excellence that will continue to attract partners, and support the recruitment and retention of experts in their fields.

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THE AMBITION

Health is a human right. I am deeply committed to the principle of universal health care, free at the point of delivery to those in need.

Aligned with the aspirations the Executive set out in the draft Programme for Government, my overarching ambition is for every one of us to **lead long, healthy and active lives**.

Improving the health of our people

Supporting and empowering staff

Improving the quality and experience of care

Ensuring sustainability of our services

Therefore, we want to see a future in which:

- people are supported to keep well in the first place with the information, education and support to make informed choices and take control of their own health and wellbeing;
- when they need care, people have access to safe, high quality care and are treated with dignity, respect and compassion;
- staff are empowered and supported to do what they do best; and
- our services are efficient and sustainable for the future.

All of these aims are of great importance and must be addressed if we are to meet the future needs for our population.

They will underpin a new model of **person-centred care** focussed on prevention, early intervention, supporting independence and wellbeing. This will enable the focus to move from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

We will create the circumstances for people to stay healthy, well, safe and independent in the first place. We will anticipate the needs of individuals for support and care and this new model of person-centre care will intervene early to avoid deterioration.

This model will be designed for and with people and communities rather than by organisations and services. Instead of thinking about buildings and hospitals as the only place to deliver services, we will deliver care and support in the most appropriate setting, ideally in people's homes and communities. In most instances people should only have to go to hospital when they need treatment that can't be provided in their community.

The way we design and deliver services will be focussed on providing continuity of care in an organised way. To do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration.

3

THE CHANGE NEEDED

If we are to support everyone to lead long, healthy, and active lives, we need to change the focus of our services, and how and where those services are delivered. The Expert Panel has clearly said that 'something very different has to happen at the delivery of care level'.

We must:

- **Build capacity in communities and in prevention** to reduce inequalities and ensure the next generation is healthy and well;
- **Provide more support in primary care** to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems;
- **Reform our community and hospital services** so that they are organised to provide care when and where it is needed;
- **Organise ourselves to deliver** by ensuring that the administrative and management structures make it easier for staff to look after the public, patients and clients.

Build capacity in communities and in prevention

We will work with communities to support them to develop their strengths and use their assets to tackle the determinants of health and social wellbeing.

We will support the development of thriving and inclusive communities, through the work of the HSC working closely with Executive colleagues and other providers such as councils, schools, police, housing and transport.

In particular, the HSC will become better at tapping into the innovative ideas and energies in communities themselves, and in the community and voluntary sectors. In all communities, every child and young person should have the best start in life, people should have a decent standard of living, and all citizens should be supported to make healthier and better informed life choices.

We will invest in HSC community development resources to work alongside all communities to enable social inclusion and tackle health inequalities and the underlying contributory factors including poverty, housing, education and crime.

It will take time to realign and grow the community development resource, and as a first step we will review existing capacity and then invest to meet any gaps, including a programme of training.

Alongside this, we will link social care more strongly with improving and safeguarding the wellbeing of individuals, families and communities. We will strengthen the social work profession by fully implementing my Department's Improving and Safeguarding Social Wellbeing Strategy.

To give every child and young person the best start in life, we will further increase the support we provide to children, young people and families from before birth to adulthood. The universal Health Visiting and School Nursing service will enable and support children and young adults to be successful healthy adults through the promotion of health and wellbeing; this will include the full delivery of the Healthy Child, Healthy Future programme. This will support the implementation of the Executive's Public Health Framework "Making Life Better" and its ambition to give every child the best start.

I will work with other Ministers to build on the success of the Early Intervention Transformation Programme and enhance early intervention services and the Family Support Hub network by exploring ways to build on the capacity of the hub model. This would include both better coordination of existing early intervention services and increasing the assessment capacity of the Hubs. This will enable us to respond quickly and flexibly to meet the needs of families early on before the problems they face become more intractable and severe. By increasing our early support to families we will reduce the need for later intervention, such as the need for children to come into care.

For children who are in the care system we will work to improve their life chances. Looked After Children experience much worse health, social, educational, and employment outcomes than other children. We will honour our corporate parenting responsibilities to the fullest extent and will be as ambitious for children in care as we are for our own children.

The range of placement options available to Looked After Children will be expanded. Through service redesign and, if necessary, new legislation we will better meet the individual needs of each child and put in place more effective supports for their caregivers, including kinship carers and families who adopt children from care. By working with the courts we will secure permanence for them more quickly helping their mental and emotional wellbeing, educational attainment and health in particular. Support will also be extended so that they are better prepared for independent living in adult life.

FAMILY SUPPORT HUBS

Family Support Hubs provide an accessible, flexible and responsive point of contact for families in need of support.

As of June 2016, 29 family support hubs were operational, providing full regional coverage across the North.

The engagement of local communities in the planning and commissioning of local services has been a key component to the successful delivery of Family Support Hubs.

In 2015/16 there were 4522 families referred through family support hubs, an increase of 1887 compared with 2014/15.

In 2015/16 a total of 5346 children were referred, 953 of which were children with a disability.

PRACTICE BASED PHARMACISTS

This initiative will see pharmacists working as an integral part of the GP surgery practice team. This means we can use their skills and experience to improve patient outcomes through reviewing their medication and reducing errors.

Practice Based Pharmacists (PBP) can help to alleviate some of the pressures faced by general practice through triaging patients to appropriate services and in some instances undertaking the diagnosis and initiation of treatment and follow-up appointments in patients with long term conditions.This will enable GPs to spend more time with patients with complex needs.

By December 2016, it is anticipated that 54 PBPs will have been placed in GP practices across the North with further PBPs appointed and in place over the period January-May 2017.

Enhancing support in primary care

Primary care is the bedrock of our health and social care system and provides around 95% of the care people need throughout their life. General Practitioners (GPs) and multidisciplinary primary care teams have a key role to play in improving population health and wellbeing, as well as developing care pathways and services to meet the population needs.

Our primary care service is still largely based on GPs working independently with some input from other disciplines. In future, the focus of our system will be increasingly on keeping people healthy and well in the first place. The World Health Organisation defines good health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. In the future we need a model that provides fully integrated multidisciplinary care, not just medical or nursing care.

Our future model of primary care is to be based on multidisciplinary teams embedded around general practice. The teams will work together to keep people well by supporting self management and independence, providing proactive management of high risk patients. They will identify and respond earlier to problems that emerge whether related to health or social circumstances or the conditions in which people live, providing high quality support treatment and care throughout life.

These teams will include GPs, Pharmacists, District Nurses, Health Visitors, Allied Health Professionals and Social Workers, and new roles as they develop, such as Advanced Nurse Practitioners and Physician Associates. There will be capacity and skills to proactively support individuals to address the lifestyle choices that impact upon their health and wellbeing. They will have the right tools and skills to diagnose, treat and coordinate the majority of care for their practice. They know the people they serve, and understand their needs better than anyone.

These teams will work in a more integrated way with all other community services and development work in their area, including Community Pharmacy. Community Pharmacy is an important part of primary care and can help to reduce pressure on other parts of the HSC. We must use them better, especially to support improved public health and engaging in with the public to ensure medicines are being used appropriately.

This model is radically different from what we have at present. It will require significant change in the way staff across the HSC are organised and deployed, and in the way GPs and other members of the new teams work together. This new model will therefore be rolled out incrementally over the next 5 years, learning and addressing gaps in staffing as we proceed. The roll-out of Practice Based Pharmacists will be completed by March 2021. GP surgeries will have named health visitors and named district nurses to work with by the end of March 2017. In addition, the way that core district nursing is delivered will be transformed, and a District Nursing Framework will be published by the end of this year.

We will maximise the potential for developing social prescribing models in the multidisciplinary primary care teams, through the embedding of social workers and building linkages to the range of early support services available to service users, such as Mental Health Hubs and other early help initiatives.

Additional funding for primary care will be focussed on developing these teams, with more funding for mental health interventions in primary care and funding to test the impact that specialist allied health professionals, such as physiotherapists, can have when working alongside the primary care team. Training for the first Advanced Nurse Practitioners for primary care and a new Physician Associate post-graduate degree programme have been developed and will start in early 2017. We will work closely with GPs and other professionals on the roll-out and evaluation of this model.

Together, the enhanced community capacity, the focus on prevention based approaches and the multidisciplinary teams in primary care will provide much greater capability to keep individuals and communities well.

Reforming our community and hospital services

Sometimes, the primary care or community care teams cannot fully meet a patient's needs but it isn't appropriate for them to be admitted to a hospital.

With developments in treatments and technology, we are able to do so much more without the need to admit people to hospital. Therefore in future we want to build on new services and models which are already emerging, and ensure that these are implemented across our health and social care system, working in partnership with those who deliver and use these services.

Acute Care at Home is an example of this type of service. Patients, often frail and elderly, are treated in their own homes by doctors, nurses and other staff. Conditions such as chest infections, urinary tract infections and dehydration can all be safely treated without the need to go to hospital, which can be a worrying and anxious experience for many. Patients have, within their own home environment, the same access to specialist tests as hospital inpatients and receive consultant led assessment and treatment.

We will make Acute Care at Home available to the whole population. We will better integrate it with social care and ensure it is supported by other services, including short stay hospital services, GPs and palliative care. This new model of care will be rolled out to all areas within the next three years.

We are committed to the further development of **Ambulatory Assessment and Treatment Centres**, to provide a more joined up, 1-stop service. Evidence from here and elsewhere shows there are significant benefits to be gained from this approach. Our current model is based on the traditional outpatient model of care where a GP refers a patient to the specialty the GP believes most closely relates to the possible cause of the person's symptoms. But as people live longer and develop more problems, diagnosis and treatment becomes more complex. So the traditional model is no longer fit for purpose.

Over the next 12 months, we will start to design these centres in partnership with clinicians and patients. They will provide simpler and easier access to the healthcare professionals and diagnostic equipment (such as X-Rays, CT scanners) needed to assess and diagnose conditions. Importantly, if a treatment or procedure is needed this will be possible on site with the aim of getting patients safely home the same day.

This avoids multiple outpatient visits and enables earlier diagnosis and appropriate treatment, and is therefore much better for those who use our services, and makes better use of our resources. Staff will have all the facilities they need to make the right diagnosis there and then, and to provide high quality care.

Elective Care Centres will be established to provide a dedicated resource for less complex planned surgery and other procedures. Evidence from elsewhere shows that such centres can reduce waiting times for planned care, and provide a better experience for both patients and staff. The current approach of delivering both planned and unplanned care using the same facilities and the same resources, means that waiting times can be adversely affected when the demand for urgent and emergency care is very high.

By making better use of our existing resources, and organising these in a different way, we will be able to provide larger volumes of activity, to a higher quality and in a more timely manner. The centres will be a resource for the region and the way they operate will be designed around the needs of patients. The number and location of these centres will be developed in partnership with clinicians and patients, and I expect proposals to be brought forward in the next 12 months.

Acute inpatient care will change. By changing the way preventive care, primary, community and less complex elective care is provided, and by looking after people in settings that are more appropriate to their needs, the nature of acute inpatient care will change.

Acute inpatient care will therefore focus on complex planned surgery and emergency care of patients who need an acute inpatient setting, for example, patients who have had a stroke, heart attack, or trauma, and those needing obstetric, neonatal or paediatric services or those with a significant worsening of a long term health condition. Multidisciplinary working will be a key feature of good quality inpatient care.

Across many different services there is very strong evidence that concentrating specialist procedures and services in a smaller number of sites produces significantly better outcomes for patients, as well as a much better and more supportive environment for staff

The role of our hospitals will therefore fundamentally change as they will focus on delivering the highest quality of specialist and acute care. However, not every service will be available in every hospital.

In the past few years we have seen the successful development of region-wide and cross-border **networks for highly specialist services** such as cancer, neonatology or cardiology as well as the development of the first truly all-island service in children’s congenital cardiology. These are delivering innovative, world class services and we will seek to maximise opportunities to expand this approach and deliver more services on an all-island basis, where clinically appropriate to do so.

This is about changing the way that services are delivered, improving safety and quality, and making the best use of the resources we have. The Expert Panel, working with clinicians, has developed criteria which will help us to assess the sustainability and future of how services are provided, and this provides us with a route-map to work in partnership with those who use and deliver our services.

Mental Health

The North has a particular challenge with mental health, having the highest rates of mental illness in these islands. There are many talented and hardworking professionals in the system and the voluntary and community sector, who do excellent work in the services they provide. It is clear that our services need to continue to evolve and improve, building on the Bamford reforms from the last decade.

Mental health is one of my priorities as Minister of Health, and it is an issue that I will champion at every opportunity. I want better specialist mental health services. This would include further support for perinatal mental health and inpatient services for mothers, with potential to address the need that exists across the island. We will expand services in the community and services to deal with the trauma of the past. Underpinning all of this, I am committed to achieving a parity of esteem between mental and physical health to ensure that we are tackling the true impact of mental health on our communities.

Carers

Families and friends take on most of the caring responsibilities for their loved ones and this makes an enormous contribution both to the HSC and to society as a whole. I fully recognise that carers are an equal partner in providing care, and they need our support to be carers. They also need support to enable them to do the things that those without caring responsibilities take for granted such as working, going out socially, having a break or going on holidays. In the case of young carers, they need help and support just to do the things that young people do. I am committed, along with other government departments and their agencies, to providing that support.

We know that the needs of carers are changing, this means the type of support we need to give them is also changing. We need to encourage greater take up of carer's assessments and expand the options for short breaks, as well as enabling the greater use of personalisation and personal budgets where appropriate. We need to ensure carers can access up to date information and crucially consider how we can support carers to live their own lives. The role of carers and how we can better support them will be central to the Review of Adult Care and Support and I encourage everyone to make their views known when we bring proposals forward for consultation in spring 2017.

DELIVERING ACUTE CARE AT HOME

This service enables this vulnerable patient group to retain their independence and dignity and prevents unnecessary and stressful hospital admissions.

It was designed and implemented by East Belfast Integrated Care Partnership (ICP) and subsequently rolled out across Belfast. Similar services are available in some other Trust areas.

In the Belfast area, the average length of stay for Acute Care at Home patients is 6 days compared to 11 days in hospital. Over 1084 referrals have been received for the extended service in the Southern area.

Organising ourselves to deliver

To deliver care in a different way, it is clear that the way we plan and manage health and social care will also need to change. Therefore, in line with the recommendations of the Expert Panel's Report, we need to empower local providers and communities to work in partnership, including health and social care trusts, independent practitioners such as GPs and voluntary providers.

Embracing new models of care has the potential to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and beyond what is traditionally considered to be the health and social care sector.

Working together, they will be expected to plan integrated and continuous local care for the populations they serve. I will set the outcomes we expect them to deliver, and the frameworks within which they need to operate, and hold them to account accordingly. For the first time, they will have the autonomy to make rapid and sustainable changes to improve services and address health inequalities in their area.

Where services are highly specialised, they will be planned and delivered on a region-wide basis. Building on the programme of work currently underway with Department of Health counterparts in Dublin, we will continue to explore opportunities to plan and deliver services on an all-island basis.

The recent consultation on HSC structures supported the need to reduce bureaucracy and put in place a more effective streamlined mechanism for how we plan health and social care services.

Starting now, we will work with the wider HSC system to design the new partnership approaches to the planning and management of HSC services, which moves away from competition towards collaboration, integration and improvement.

PRIMARY PERCUTANEOUS CORONARY INTERVENTION (pPCI)

This service, based in Belfast and in Derry, means that patients having a particular type of heart attack are taken from anywhere across the North straight to a specialised centre which can undertake this life saving procedure on a 24/7 basis.

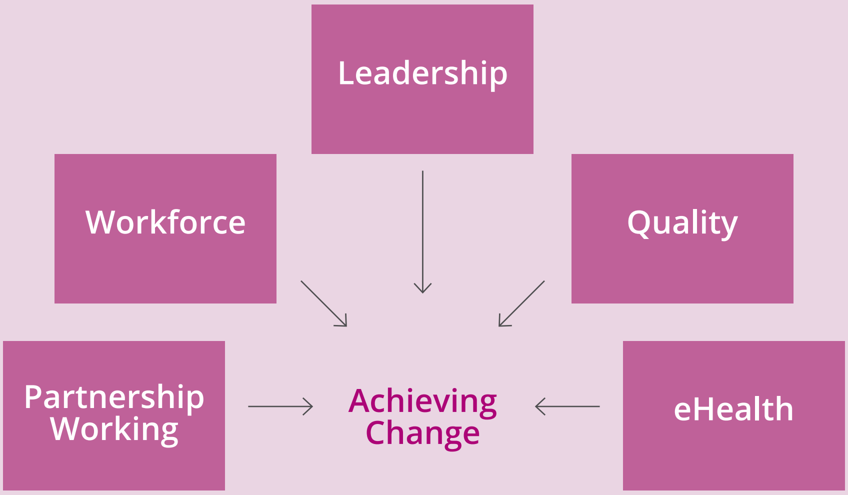
On average a total of 66 pPCI procedures are being carried out per month and from May 2016, Donegal patients have access to the Derry based service.

4

THE APPROACH

How we plan, design, support and implement service transformation is as important as the changes we wish to make.

Only by taking the right approach will these changes be the best ones for our population as a whole, and be sustainable in the long run.



Partnership Working

With people who use and deliver services
Our Health and Social Care system belongs to all of us and we all bring valuable insights to how it can improve. We must work in partnership - patients, service users, families, staff and politicians - in doing so we can co-produce lasting change which benefits us all. Everyone who uses and delivers our health and social care services must be treated with respect, listened to and supported to work as real partners within the HSC system.

Building on the good practice which already exists in the HSC, such as the Mental Health Recovery Colleges, we will work collaboratively in the spirit of openness and trust to deliver agreed outcomes.

When we embark on a change to our system or services, all relevant individuals or groups will be brought together, including those who use and those who deliver our services. A clear terms of reference will be developed collaboratively, ensuring all parties are clear about the task at hand, and how we will work together.

We will adopt creative and innovative ways to maximise involvement. All views and opinions will be received with equal merit. In the past the system has been criticised for delays in bringing forward change, we will support teams to work at pace.

Co-production will empower patients, service users and staff to:

- **design the system** as whole to ensure there is a focus on keeping our population well in the first place and ensuring that when people need support and help they receive safe and high quality care;
- work together to **develop and expand specific pathways of care and HSC services** which are designed around people and their needs, including setting outcomes to measure impact;
- be partners in **the care they receive** with a focus on increased self-management and choice, especially for those with long-term conditions.

A move to this model will not happen overnight. However, I am fully committed to this approach and will support this new way of working across the HSC. In order to start this process in November I will embark on a period of engagement about my proposals for the model of health and care for the future.

I am making a commitment that the design of new and reconfigured services will be taken forward on the basis of co-production and co-design.

We will strengthen the capacity of both those who use our services and those who deliver them to bring about positive change for and by themselves. This includes continued investment in initiatives such as Expert-by-Experience programmes, which provides training and development for users who work with the HSC to improve our services. We will also train staff to support the continued roll-out of the Quality 2020 Attributes Framework.

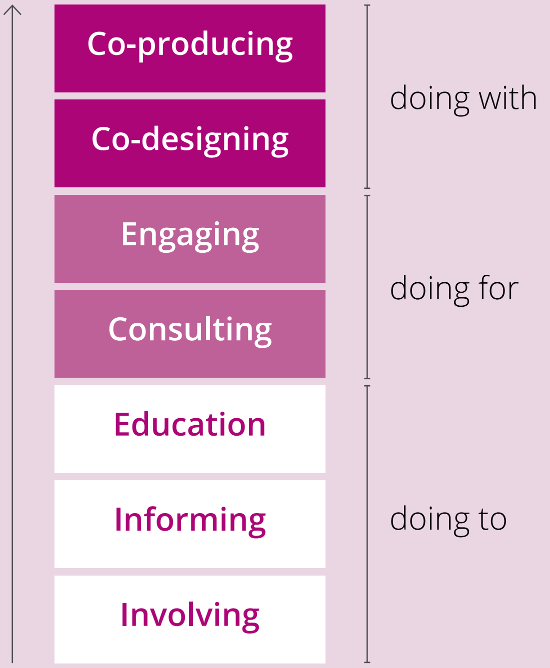
In addition, I intend to maximise the patient voice across our system, and align it much more closely to the quality improvement, and inspection and regulation. I also want to hear the voice of staff particularly those on the ground closest to those who use our services. In early 2017, I will consult and design a new feedback platform open to all those who both use and deliver our services. This will enable users and staff to tell us what matters to them in terms of their health and social care and to raise issues in as timely a manner as possible, so that they can be addressed early before they escalate to a complaint.

Co-production - a new approach to the design and development of mental health services

An example of how co-production can make a big impact on our services is the design and delivery of Mental Health Recovery Colleges. This is an innovative model that assists individuals in their personal and collective journey of recovery. This recovery focussed approach creates opportunities for those with lived experience to contribute as volunteers and in paid roles. These peer educators assist those with mental health problems to discover personal talents and develop life skills which can help them enter the labour market.

A number of people with lived experience have and continue to be developed to become peer educators and are now making a contribution to care delivery. Over 236 sessions of peer education have been delivered.

An alternative ladder of participation



With other providers
Partnership with other providers of care and other service providers is key to improving and safeguarding social, emotional and physical wellbeing. Health and social care has a strong tradition of working with other professions and sectors including the voluntary, community, criminal justice, education, housing and private sectors. These partnerships will be maintained and strengthened to maximise the impact we can make on improving people's health, social wellbeing and quality of life, as well as making the best use of resources.

Improving Quality and Safety

In the design and delivery of health and social care, quality and safety will always be a fundamental priority. The Expert Panel said "any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this".

It is clear to me that, in order to achieve our ambition for health and social care, we need to establish an infrastructure capable of supporting, enabling and driving the improvements we seek, with people at its heart. There needs to be a greater alignment between quality improvement, partnership with those who use our services, and how we regulate those services.

Like many healthcare systems, there has been a gradual increase in improvement capability across our health and social care service. One example is the Regional Mortality and Morbidity Review System, which supports the review of all hospital deaths by multidisciplinary 'frontline' teams to identify learning to improve the quality and safety of care. The system is well embedded in two Trusts at present and will be fully embedded across all Trusts by April 2017. Another example is the Medicines Optimisation Quality Framework which is supporting improvement by scaling up good practices for the appropriate, safe and effective use of medicines across health and social care.

We now need to fully integrate quality improvement into the work of every HSC organisation and provide real support for local and regional improvement work. That will mean improving our capacity to foster local innovation and to implement what works at scale. It also requires us to be able to proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs. Developing the science of improvement can be done at the same time as making improvements.

To deliver a sustainable and world class service into the future will require of all of us to work together very differently. We need an infrastructure that makes this possible.

For that reason, I intend to establish an Improvement Institute that will better align existing resources to enable improvement in our system of care. These include resources currently devoted to patient safety, regulation, evidence gathering, data analytics, information and, critically, those with experience of using our services. My aim is to establish a strong and integrated infrastructure to support improvement wherever it needs to happen across our system of care. This aim will only be achieved with the support and engagement of all leaders across the HSC system.

I have asked my Department to convene a group of local clinicians, professionals and service users with experience in improvement to advise on the design of that infrastructure. This will not be a new HSC organisation but will align existing resources and functions. The design work will be complete by February 2017 and I expect the Institute to begin to test how it will operate by May 2017.

Investing in our Workforce

The Expert Panel has re-affirmed that effective workforce engagement and planning are key enablers to HSC transformation. I believe the far-reaching transformation journey we are about to embark on needs the commitment and engagement of workers across the HSC at every grade if it is to succeed. I am confident that working together we can succeed.

The increasing pressure on services has contributed to difficulties in attracting and retaining experienced staff and the vacancy rate in a range of disciplines continues to grow. These factors have led to an escalation in the costs of maintaining safe service provision through the use of expensive agency and locum staff, as well as longer hospital stays than necessary.

Clearly, this is unsustainable and workforce planning cannot continue to be used simply as an exercise to ensure that existing rotas are filled. It has to be a vehicle for supporting the implementation of a new and sustainable model of care. It has to take account of increasing demand as a result of demographic trends, be informed by robust and accurate workforce information and analysis, and map to the new configuration of services in secondary care and the increased focus on primary care. It also has to address the factors that enhance the attractiveness of key jobs, such as domiciliary care.

However, effective workforce planning is only one aspect of what is needed. We want to ensure that we are harnessing the skills and experience of the 72,000 individuals working in the wider HSC family.

As stated earlier, I want the HSC to be an employer of choice, leading by example and investing in the health and wellbeing of its staff. We will explore ways to build on and consolidate the health and wellbeing services we provide for our staff.

I recognise the fears and anxieties about job security, role and job location that any change process will create. Based on their lived experience, HSC staff at all grades are all too well aware of the unintended day to day impact on their own teams of previous change initiatives. Too many of these experiences to date have not been positive.

I am determined that the unique store of knowledge, commitment and public service ethos that the HSC workforce represents will be listened to, engaged and nurtured at all levels. It is the single most important resource we have to achieve lasting change.

In collaboration with stakeholders, we are committed to ensuring a Workforce Strategy is developed by spring 2017 which will cover all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles and of reskilling and upskilling initiatives. This will require investment but we are convinced that investment in every area of our workforce is critical in delivering this new model of sustainable care.

But it is clear that some action needs to be taken now to address current workforce challenges. Therefore, we will continue to invest in training by expanding GP and nurse training places. I have asked for a number of areas to be looked at in detail, including the appointment of a Nursing and Midwifery Task group which will report within 12 months with recommendations for how we can maximise the contribution nursing and midwifery can make to improved outcomes for the population.

The forthcoming Reform of Adult Social Care and Support will consider the nature, size and skills of the social care workforce needed to deliver social care in the future. I will consider carefully the findings of the Domiciliary Care Workforce Review, which is due to be completed by the end of 2016. I am committed to taking steps to improve the recruitment and retention of this critically important group of staff.

Leadership and Culture

If we are to develop a culture of quality improvement and partnership working, this must be underpinned by a new approach to collective and system leadership. We are fortunate to have some of the most capable, committed and enthusiastic people making up our health and social care workforce. Many leading edge research and reports provide evidence that having continuous learning cultures and team working in health and social care organisations is crucial to ensuring safe high quality care.

Rather than concentrating power at the top, I want all those working in health and social care to feel able to effect change and improvement in care. This means developing leadership at all levels, a truly collective leadership model. I will flatten and remove unnecessary hierarchy, eliminating those policies which inhibit innovation and improvement. If we are to move towards a model of care powered by multidisciplinary teams, we need to empower all teams to deliver care, not micro-manage them. Working in partnership with our staff, I believe this is achievable.

This will require a major programme of cultural change and it will not happen overnight. But we need to start now.

As part of this we need to enhance our clinical leadership. The Expert Panel said that change *"will be more successful if… implemented in a setting which encourages clinical and professional engagement"*. I want to see our structures have more professionals directly engaged in the management and leadership of our services, effecting the change supported by skilled and able managers.

I have recently re-established the Strategic Health Partnership Forum and see this as an important contribution to the development of a new culture of partnership, involvement and listening.

Over the next 6 months, an HSC-wide Leadership Strategy will be developed to support this aim. Resources will be directed over the next 3 years and beyond to develop the right staff and leaders, with the skills, behaviours and values that will be so crucial in developing the compassionate, collaborative and high performing culture we seek.

eHealth and Care

Making better use of technology and data is essential if we are to move to a model focussed on service users, on improving the health and wellbeing of the population and on getting beyond organisational and professional silos. I am determined to realise the potential and opportunities presented by modern information technology to improve outcomes for service users and free up time for front line staff. To do so, co-production must underpin our approach, and we must learn the lessons and build on the experience of current and past HSC IT initiatives.

We will expand the range of information and interaction available to citizens, service users and those providing services both online and through apps. This will include building a new patient portal which will allow secure online access to their own health and care information where service users want this. This new patient portal will be in place for dementia patients next year and rolled out across the North by 2021.

To ensure our staff can focus on supporting individuals, the right information must be available to the right professionals, at the time they need it. Our award-winning approach to sharing information across different IT systems (the Electronic Care Record) has significantly changed the way care is delivered and improved safety. However, we still have too many different systems across the HSC making it difficult to join up data and focus on the service user.

We are currently assessing the best way to achieve a much more consolidated and common patient and user record, with fewer separate IT systems. This will be a major undertaking. We will aim to liberate time for care by equipping our community based workforce with new technology that will increase the time that doctors, nurses, therapists and social workers have to spend with patients. If we can realise a 15-minute increase in care time by reducing bureaucracy this equates to over 1,000 additional care professionals working with service users. These initiatives will also allow more staff in the HSC to work remotely, saving travel to and from hospitals, care centres and offices.

Moving to a more consolidated health record across the North will allow us to make better use of information about our population - designing new ways to intervene early and support people in managing their conditions. A programme of work to improve our use of health analytics, focussed on dementia patients, will start in 2017.

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THE ACTIONS

In this document I have set out my commitment to change but I recognise that much work is needed to develop, design and deliver the building blocks that will enable sustained improvement. I am committed to achieving the change required using a process of co-production.

The task is challenging and will take sustained and incremental effort over the next ten years to achieve real transformation.

But we start now. In the next section I have set out my actions for the next 12 months. These will be taken forward to make a positive and ambitious start towards stabilisation, reconfiguration and transformation.

As I have said, to deliver real and meaningful change will require an extension of the political goodwill and cooperation given to the Expert Panel. Moreover significant investment will be required. I believe this shared investment will not only improve people’s health and wellbeing but have a positive impact on every aspect of their lives.

I fully believe that it is only by working together we can deliver a world class health and social care system.

Stabilisation

1	Develop a comprehensive approach for **addressing waiting lists** which takes account of the ongoing work of the Health and Social Care Board, as well as the recommendations from the Expert Panel.	*January 2017*
2	To improve access and resilience, and support the development of new models of care, make **significant investment in primary care** to ensure there is a multidisciplinary team focussed on the patient and with the right mix of skills. This will be supported by: - increased GP training places; - continued investment in Practice Based Pharmacists; - ensuring every GP practice has a named District Nurse, Health Visitor and Social Worker to work with; - supporting the development of new roles such as Physician Associates and Advanced Nurse Practitioners; and - further roll-out of the AskMyGP system. Bring forward a public consultation on the role of GP Federation and whether they should become HSC bodies.	*March 2017*
3	Bring forward proposals relating to the extension of placement options for **Looked After Children**.	*October 2017*
4	Following the completion and evaluation of a pilot project, roll-out access to the electronic care record (NIECR) to **community pharmacists** and establish a pilot to test access to the record for **independent optometrists.**	*October 2017*
5	Begin development of a new framework to fully realise the potential of **community pharmacy services** to support better health outcomes from medicines and prevent illness.	*November 2016*

Reconfiguration and service change

6	Embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of **service configuration reviews**. These will be clinically led, working in partnership with those that use the services.	*November 2016*
7	As part of this process, my immediate priorities are:	
	• following extensive review and engagement, launch a public consultation on proposals to modernise and transform **Pathology** services designed to improve service and workforce sustainability ensuring a high quality pathology service for the future;	*November 2016*
	• move forward with the implementation of the new **Diabetes** Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups;	*November 2016*
	• launch and commence implementation of the **Paediatric Strategies** (2016-2026) designed to modernise and further improve the standard of treatment and care provided in hospital and community settings, and palliative and end of life care for children and their families; and	*November 2016*
	• launch a public consultation on proposals to develop sustainable **Stroke** services and further improve the standard of treatment and care provided to stroke patients.	*February 2017*
	• following a recent review, launch a public consultation on the configuration of **Imaging** services, taking account of advances in technology, demographics and demands, and looking to both national and international best practice;	*February 2017*
8	Bring forward proposals for the location and service specification for **Elective Care Centres**, and **Assessment and Treatment Centres.**	*October 2017*
9	Develop design for new structures and approaches to support the **reform of planning and administration** of the HSC	*March 2017*
10	Identify current **innovative HSC projects** at the local level and develop a rolling programme and implementation plan to scale up these projects across the region.	*April 2017*

Transformation

11	Embark on a **period of engagement** with staff and service users to build a collective view of how our health and social care services should be configured in the future, and encourage a much wider public debate.	*November 2016*
12	Establish and seek members for a **transformation oversight structure** with membership drawn from within and outwith the HSC.	*November 2016*
13	Consult on proposals for the reform of **adult social care and support**, to consider different approaches to ensuring the long-term sustainability of the adult social care system.	*April 2017*
14	Consult on proposals for and complete design of a **new user feedback platform** open to all those who both use and deliver our services.	*October 2017*
15	Complete the initial design work for the **Improvement Institute.**	*February 2017*
16	Develop a **Workforce Strategy** covering all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles; and upskilling initiatives.	*May 2017*
17	Develop a **HSC-wide Leadership Strategy** to consider a 5 year approach and plan for development of collective leadership behaviours across our system.	*May 2017*
18	Expand the range of information and interaction available to citizens online and development of a **patient portal** for dementia patients.	*October 2017*

Health and Social Care (Reform) Act (Northern Ireland) 2009

The Commissioning Plan Direction (Northern Ireland) 2009

The Department of Health, Social Services and Public Safety[a] in exercise of the powers conferred on it by section 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009[b] hereby directs as follows:

Commencement

1. – This Direction shall come into operation on 23 June 2009.

Interpretation

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

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

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

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

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

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

3. – The commissioning plan to be prepared and published by the Regional Board as required under section 8(3) of the Act shall provide an overview of its commissioning intentions across each of the following areas:

(a) See S.I. 1999/283(N.I. 1) Article 3(6)
(b) 2009 c.1(N.I.)

(a) improving health and well-being;

(b) ensuring safer, better quality services;

(c) improving acute services;

(d) ensuring fully integrated care and support in the community;

(e) improving children's services;

(f) improving mental health services;

(g) improving services for persons with a disability; and

(h) improving productivity.

Costs incurred in commissioning

4. – The commissioning plan shall include details of how the total resources of £2,971m (£2,936m Regional Board resources and £35m Regional Agency resources) for the financial year from 1 April 2009 to 31 March 2010 have been committed to the HSC Trusts or other persons or bodies from whom the Regional Board is to commission health and social care. This information shall be provided separately for each of the five LCGs and for direct, non-LCG commissioned services and shall be in the form set out in the proformas in the Schedule to this Direction**.**

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 23 June 2009.

Sean Donaghy

A Senior Officer of the Department of Health, Social Services and Public Safety