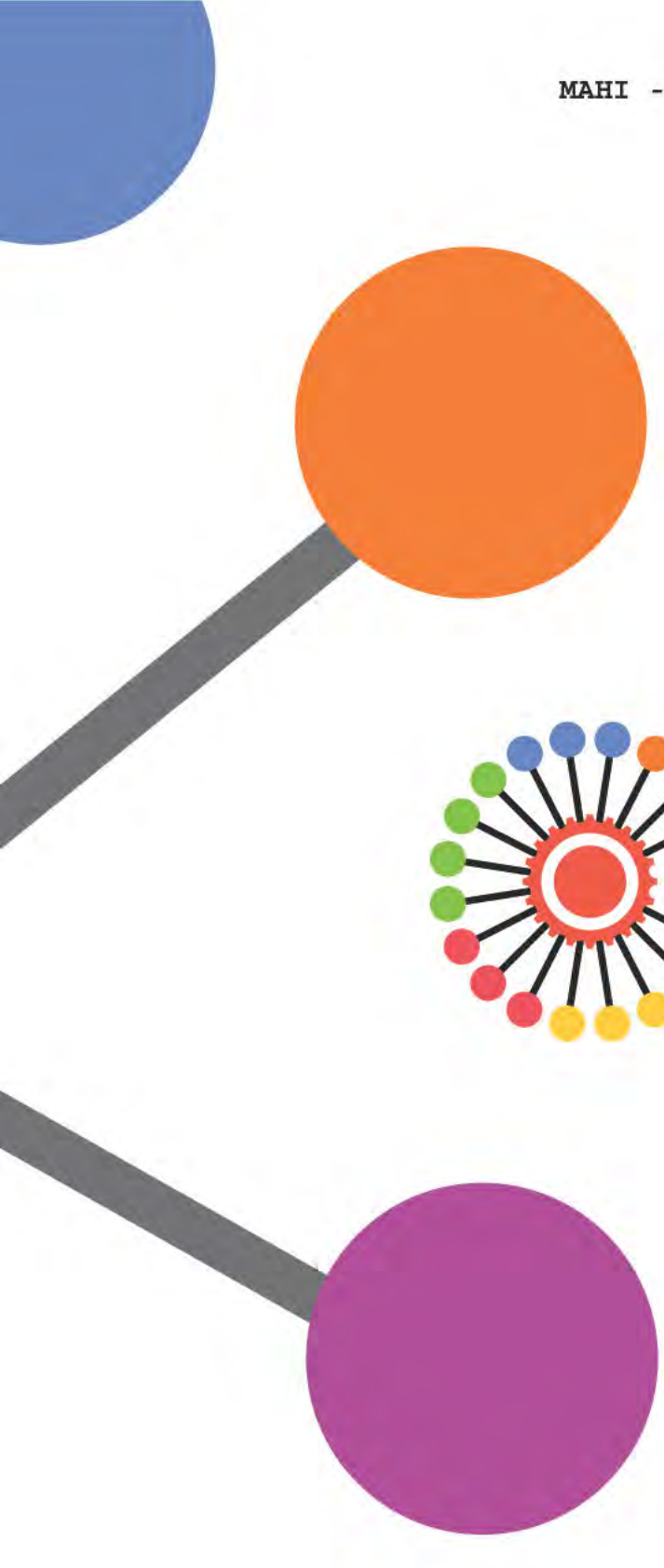

MAKING LIFE BETTER

A WHOLE SYSTEM STRATEGIC FRAMEWORK FOR PUBLIC HEALTH

2013-2023

June 2014

MAKING LIFE BETTER

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THE MAKING LIFE BETTER CHARTER

Our Objective

The Northern Ireland Executive is committed to creating the conditions for individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives.

Our Approach

Our approach to public health focuses on working collaboratively with individuals, communities and partner organisations to address the factors that impact on health and wellbeing in Northern Ireland. We are also committed to ensuring that there are effective mechanisms in place to ensure protection of the community from current and future threats to public health.

Social justice, equity and inclusion

People in different social circumstances experience different levels of health. We will focus on addressing the challenges of disadvantage and inequality that afflict society and work to close the gap in health between those who are least and most disadvantaged.

Engagement and Empowerment

We want individuals and communities to be active in improving their own health. This means that we will work with people to address agreed priorities and build on the assets we have in our communities to improve health. As far as possible we will devolve responsibility and activity to community levels of working. Information about the state of health and wellbeing in Northern Ireland and the ways that health can be improved will be made available to the public.

Collaboration

Our Programme for Government (PFG) 2011/15 sets the broader context for working together. It recognises the inter-relationship between health, disadvantage, inequality, childhood development and education, employment, the social and physical environment, and economic growth.

Building a healthier Northern Ireland will hinge largely on what is done collaboratively, through both policy and practice, to influence these wider factors that impact on lives and choices. Everyone has a role to play. We look to everyone to play their part, including individuals and communities as well as the public, private and third sectors.

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Evidence and Effectiveness

We must use existing resources wisely to have a positive impact on health and wellbeing. We will focus on action which is informed by evidence to help us ensure that public money is spent on actions that will achieve better health and wellbeing for all our people and reduce health inequalities.

Addressing Local Need

We will support joint working at local level between councils, statutory bodies, community and voluntary sectors and others, to optimise opportunities to plan and shape services around the needs of local communities in order to create communities that are healthy, safe, united and thriving.

Our Resources

We will seek to maximise the benefit that we can achieve with our resources and make effective use of the public health budget. We will also promote better use of public resources generally, as well as those of our partners, in order to achieve better health and wellbeing.

We will work collaboratively with partners across Northern Ireland and in other countries to build and share public health capacity to achieve greater impact in public health actions. Where appropriate, we will advocate for changes to national policies in order to achieve local improvements in health and wellbeing.

Rt Hon Peter D. Robinson MLA
First Minister

Martin McGuinness MLA
deputy First Minister

Signed by First and deputy First Ministers on behalf of the Executive

FOREWORD

International evidence demonstrates that improving population health and wellbeing requires the involvement of the whole of Government and all of society, individually and as communities.

We have seen many health improvements as a result of actions in areas such as better housing, safer roads and safer workplaces. Action to address poverty and inequality is also key to the successful delivery of this framework.

Many studies relate health and health inequalities to the conditions in which people are born, grow, live, work and age. There are no doubt challenges ahead in creating the conditions which will enable us all to achieve our full health and wellbeing potential.

A recently published "Review of the social determinants and the health divide in the WHO European Region" states that in countries with the best health and narrowest health inequities the evidence suggests "this is related to a long and sustained period of improvement in the lives people are able to lead – socially cohesive societies, increasingly affluent, with developed welfare states and high quality education and health services."

I welcome the support of my Executive colleagues in this long-term aspiration. We have assets on which to build and which will help set us on a new trajectory. There will be opportunity through local government reform, for example, to strengthen the already significant contribution at local level, working with local communities to create thriving communities and healthy, safe and sustainable places.

As Minister of Health, I am determined to play my part in making life in Northern Ireland better and in giving everyone a fair chance to lead a healthy life. I will continue to progress legislation, strategies and programmes which contribute to better health and tackle health inequalities. I will collaborate with other Ministers to promote a whole of Government approach to health improvement, and to promote greater coherence of action across all sectors and at all levels of delivery. I would like to thank all those who contributed to the development of the framework, either in drafting or through the consultation process. I hope that the energy and expertise shown so far can be maintained as we move forward in implementing the framework over the next ten years.

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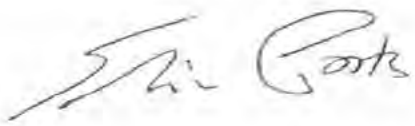
Through collaborative effort and through individual choices and action, I believe that we can make life better in Northern Ireland – for ourselves, our families and our communities.



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

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EXECUTIVE SUMMARY

Part One – Context

1. This ten year public health strategic framework provides direction for policies and actions to improve the health and wellbeing of people in Northern Ireland. The framework builds on the *Investing for Health* Strategy (2002/12) and retains a focus on the broad range of social, economic and environmental factors which influence health and wellbeing. It brings together actions at government level and provides direction for implementation at regional and local level.

2. While in general the health of people in Northern Ireland has been improving over time, health inequalities remain. Too many people still die prematurely or live with conditions they need not have. This situation is not unique to Northern Ireland.

3. In addition to factors such as health behaviours and the provision of health and social care services, population health is to a larger extent affected by economic, social and environmental factors. A number of the priorities outlined in the Programme for Government (PFG) 2011/2015 acknowledge the interrelationship between health, disadvantage, inequality, the social and physical environment, and longer term economic growth.

4. The proposed new framework *Fit and Well – Changing Lives* was consulted on in 2012. A summary of the consultation responses has been published on the DHSSPS website. In addition, the Assembly Health Committee conducted an inquiry into health inequalities, which reported in January 2013 with 9 recommendations. These included the need for a focus on thematic work across government; emphasis on early years interventions and parenting; legislation to support breastfeeding, identification of assets and upskilling for health professionals; funding for projects and increasing spend on ill health prevention. This final framework - "Making Life Better" - builds on "Fit and Well – Changing Lives" and has been re-shaped to take into account the feedback received through the consultation, the Health Committee report and subsequent cross-sectoral discussions.

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Part Two – The Framework

Vision and Aims

5. Through strengthened co-ordination and partnership working in a whole system approach, the framework will seek to create the conditions for individuals and communities to take control of their own lives and move towards a vision for Northern Ireland where **All people are enabled and supported in achieving their full health and wellbeing potential. The aims are to achieve better health and wellbeing for everyone and reduce inequalities in health.**

Values

6. A shared set of values is proposed to underpin action –

Social justice, equity and inclusion	All citizens should have the right to the highest attainable standard of health.
Engagement and empowerment	Individuals and communities should be fully involved in decision making on matters relating to health, and empowered to protect and improve their own health, making best use of assets.
Collaboration	Public policies should contribute to protecting and improving health and wellbeing, and public bodies should work in partnership with local and interest group communities.
Evidence - Informed	Actions should be informed by the best available evidence and should be subject to evaluation.
Addressing Local Need	Action should be focused on individuals, families and communities in their social and economic context

A Thematic Approach

7. The consultation document proposed a **life course approach** to reflect the findings of the *Strategic Review of Health Inequalities in England post 2010* (the Marmot Review), and structured action around five life course stages, with underpinning themes of **sustainable communities** and **building healthy public policy**.

8. Consultation identified a qualified welcome for the life course approach, but also concern that overemphasis on the life course stages detracted from important messages about tackling the underlying social determinants of health that apply across the life course. In addition, the Health Committee's report on health inequalities supported a thematic approach.

9. In light of this the framework has been re-structured around 6 themes:

1. Giving Every Child the Best Start
2. Equipped Throughout Life
3. Empowering Healthy Living
4. Creating the Conditions
5. Empowering Communities
6. Developing Collaboration

10. "Giving Every Child the Best Start" and "Equipped Throughout Life", take account of particular needs across the life course and cover childhood and adulthood, with emphasis given to children and young people, and to supporting individuals' transitions into and through adulthood and older age. "Empowering Healthy Living" addresses support for individual behaviours and choices, including embedding prevention across Health and Social Care services.

11. "Creating the Conditions" and "Empowering Communities" address the wider structural, economic, environmental and social conditions impacting on health at population level, and within local communities. These will align with key government strategies such as those to develop the economy, tackle poverty and promote community relations.

12. "Developing Collaboration" considers strengthening collaboration for health and wellbeing at regional and local levels. This theme identifies three areas of work (in relation to **food, space/environments and places, and social inclusion**) around which a number of partners have been developing collaborative approaches. These areas have been recognised as being of importance in improving health and reducing health inequalities. They have the potential to bring together communities and relevant organisations at local level, supported where necessary at regional level.

Outcomes and Supporting Actions

13. For each of the six themes long-term outcomes have been set with strategic supporting actions and commitments over the current budgetary

period that work towards these. They include actions which are particularly relevant to influencing the determinants of health and wellbeing. It is intended that departmental commitments will be updated on a rolling basis over the period of the framework.

14. The framework is not just about actions and programmes at government level. There are many good examples of joint working underway at a local level that remain relevant. The framework reaffirms and updates the mandate to strengthen collaboration and promote better communication and co-ordination across the system.

The Gradient Approach

15. In order to achieve the aims of better health and wellbeing for everyone and reduced inequalities in health, the overriding approach must be to take account of the need for greater intensity of action for those with greater social, economic and health disadvantage. This applies right across the social gradient, as recognised by Marmot, and requires action to improve universal services as well as more targeted services for those in greater need.

16. There are some groups of the population who are particularly at risk and for whom targeted action is likely to be necessary, regardless of their socioeconomic status. For this reason, later sections of this framework, which set out the actions to be taken across government over the next few years, identify some particularly vulnerable groups. It is important to acknowledge however that this does not represent all that can be done to identify and support those for whom more targeted action may be required. Decisions on targeted action must be taken at a delivery level and take account of identified need.

Part Three - Implementation

17. The framework recognises:

- the key roles of DHSSPS and the wider Health and Social Care system;
- importance of collaboration across government departments; and
- that inter-agency and inter-sectoral partnership working is vital.

It seeks to create a **whole system approach** across the various levels of the system at which work needs to be taken forward.

18. At strategic level the framework illustrates the inter-connectedness of many government policies and programmes. It highlights opportunities to

strengthen these linkages through, for example, consideration of health and health equity in policy making, and governance and monitoring which develops a sense of coherence flowing through to implementation at delivery level.

19. This will require clear lines of communication and accountability, and clarity on how governance and implementation is to work. Connections with other relevant structures, strategies and initiatives need to be managed and maximized.

Structures

20. At strategic level a **Ministerial Committee for Public Health** will be established. Key functions will be to provide strategic leadership, direction and coherence with other key strategic programmes and structures, such as Programme for Government (PFG), NI Economic Strategy and Delivering Social Change, agree shared goals and priorities and oversee implementation on behalf of the Executive. This group will be chaired by the Minister for Health, Social Services and Public Safety and supported and informed by the All Departments Officials Group (ADOG).

21. The **All Departments Officials Group** (ADOG), chaired by the Chief Medical Officer, will comprise senior officials from all departments. It will inform and make recommendations to the Ministerial Committee; co-ordinate collaborative working at departmental level; connect with the Regional Project Board, directing, or supporting action as appropriate; and monitor and report on progress.

22. The **Regional Project Board**, led by the Public Health Agency (PHA) will focus on strengthening collaboration and co-ordination to deliver on shared strategic priorities across sectors at a regional level, and on supporting implementation at a local level. Membership of the group will comprise the Chief Officers of relevant statutory agencies, and include representation from local government, the community and voluntary sector and the private sector.

23. This Group will be informed by and will support **Local Partnerships** of key statutory, private, community and voluntary bodies, based on an agreed geographic coverage. These should be developed from existing local arrangements and include a balance of statutory and non-statutory partners. The initial focus will be to collaborate on the three areas of work outlined under **"Developing Collaboration"** (in relation to **food, space/ environments and places, and social inclusion**).

24. The Partnerships' role will focus on local delivery and will be to identify local opportunities for partnership working based on local need; drive local interventions/services to support those most in need and ensure regional priorities are reflected in local plans.

25. These arrangements should link into and align with local **community planning** arrangements over time. The productive joint working arrangements between the PHA and councils will be maintained and built upon, as well as ensuring strong linkages with others through the new community planning process.

Resources

26. The actions committed to are supported by funding from across Government. This is underpinned by the Executive's commitment through PFG to allocate an increasing percentage of the overall health budget to public health (measured in terms of the PHA budget), with the aim of allocating an additional £10m by 2014/15 compared with the 2011/12 baseline.

27. The framework commits to developing better mechanisms to monitor spend on prevention across the HSC. In addition, it will be important to continue to collaborate with other departments as appropriate, to deliver relevant cross-cutting programmes. Many other sources of funding, including local government and philanthropic organisations, contribute to programmes that will deliver the aims of the framework. Opportunities to pool resources should be explored. In the current financial climate, it is vital that resources are used to optimum effect. This will include careful targeting of resources to meet greatest need with the aim of reducing health inequalities.

Monitoring

28. Overall activity will be reported on annually. The framework also identifies a number of high-level indicators which will serve as proxy measures to monitor progress towards the outcomes, and which will be used to measure progress over time. Many of these will measure the scale of inequalities in addition to overall levels. Recognising the influence of the wider socioeconomic determinants of health, a number of the indicators derive from the strategies of other Departments. It will be important to improve the availability and use of data on an ongoing basis.

PART ONE – CONTEXT

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CHAPTER 1 – INTRODUCTION

1.1 In general, the health of the Northern Ireland population has been improving over time. Social, economic, environmental and health improvements have meant that people are living longer than before – between 1981 and 2010[i] life expectancy has increased here for both men and women by 8 and 6 years respectively. Advances in treatment and care have also meant that chronic conditions can be managed differently to secure better quality of life for longer.

1.2 Unfortunately not everyone has had an equal chance of experiencing good health and wellbeing. Too many still die prematurely or live with conditions that could be prevented. This is particularly the case for those who are disadvantaged, leading to a gap in health between those who live in more affluent circumstances and those whose circumstances are deprived.

1.3 An illustration of this is provided by the "Barcode" [Figure 1] which shows the variation in life expectancy of people in each of Northern Ireland's electoral wards ranked by level of deprivation. (White bars represent those wards where life expectancy is lower than the NI average, black represents those where life expectancy is higher than the NI average, and grey represent wards where life expectancy is similar to the NI average). The general trend is that people are more likely to live longer the more affluent their circumstances, although as illustrated this is not always the case. There are wards towards either end of the scale where life expectancy does not follow the general trend. (Further information about health and health inequalities in Northern Ireland is at Annex A.)

Figure 1: Male Life Expectancy[i] in Electoral Wards by level of deprivation.[ii]

i Life expectancy is calculated using a 3-year rolling average. The year presented relates to the mid-point of the three years.

ii Despite ward-level life expectancy estimates being based on 11 years of data, they are subject to a degree of fluctuation due to the small numbers involved. In addition, it should be noted that small area estimates for life expectancy are normally calculated separately for each gender and there are a number of limitations to the data when estimating overall life expectancy at this level.

1.4 In 2002 the Northern Ireland Executive recognised the importance of the social, economic, physical and cultural environment to health and published a cross-cutting public health strategy, *Investing for Health*[1]. A review of *Investing for Health* (2010)[2] highlighted key areas of success, for example the extent to which local stakeholders had been energized and inspired to work for health improvement, providing a good foundation on which to build. It also found that much of its approach remains relevant, but that the current, more developed evidence base and the changed socio-economic context needed to be reflected in an updated public health strategy.

1.5 *Investing for Health* sought to reduce health inequalities – avoidable differences in health status between different population groups. The last ten years have not seen a noticeable narrowing of the gap in health status between those living in the most deprived areas and the Northern Ireland average. Northern Ireland is not unique in this – health inequalities have widened in many countries across the world.

1.6 A proposed new ten year public health framework, *Fit and Well – Changing Lives 2012-22*[3], was published for consultation from mid-July 2012 to mid-November 2012.

In addition to publication on the Department's website, the Department engaged with a number of network organisations and partnerships to seek the views of key stakeholder sectors and population groups. Including reports by the network organisations, a total of 141 responses were received, with many of these directing the department to additional evidence, views and recommendations.

1.7 There was a general welcome for the framework aims of improving health and reducing inequalities in health, and for a "whole of society" approach across government and other sectors at various levels. Some key sectors, in particular the community and voluntary sector and local government, felt that their contribution was insufficiently recognised and this has been strengthened in the revised framework.

1.8 Respondents generally felt that the document was too long and complex, with too many priorities. It was also the view that, by concentrating on life stages, there was insufficient focus on actions to address the social and economic determinants that are shown to impact most powerfully on health and inequalities across life stages. Feedback also pointed out that there was no recognition of the potential of legislation as a lever for change.

1.9 A summary of the responses to the consultation, with an indication of how these have been reflected in this final version of the framework, is available on the DHSSPS website. One obvious change is the framework's revised title – **"Making Life Better"** – which is intended to reflect that effort is required on a number of fronts, and that health and quality of life are inextricably linked.

1.10 At the same time as the consultation, the NI Assembly Health Committee conducted an inquiry into health inequalities[4] which took evidence from a range of expert witnesses nationally and internationally. The Committee's report called for greater joined up working across Departments, including those not traditionally associated with health matters, and recommended a thematic approach across Departments to tackle inequalities. Recommendations in relation to the importance of early years interventions and for provision of support for parents were made. Identifying all assets that can be used to tackle inequalities and prioritising funding to support collaborative working were also recommended. The Committee called for an increasing share of the overall health and social care budget to be devoted to prevention.

The Committee's report, published in January 2013, and the DHSSPS response are also available on the DHSSPS website.

1.11 Following on from the consultation process, in 2013 two cross-sectoral workshops were held to consider the feedback received on "Fit and Well – Changing Lives" and to explore how this should influence the final framework. The outcomes of all of these processes and subsequent cross-sectoral discussions have informed this revised framework "Making Life Better."

1.12 Importantly, the framework also draws on the updated evidence base and direction provided by a number of key reports and policies, including –

- World Health Organisation Commission on the Social Determinants of Health 2008[5]
- Fair Society, Healthy Lives – Strategic Review of Health Inequalities in England post 2010 (the Marmot Review)[6]
- Health 2020 – European policy framework and strategy, WHO 2012[7]
- Strengthening public health services and capacity: an action plan for Europe[8]

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- Review of social determinants and the health divide in the WHO European Region, WHO, 2013[9]

Impact of Inequalities

- Approximately **one fifth** of the NI population are in relative poverty. In 2011-2012 there were approximately 379,000 people (21% of the population), including almost 95,000 children (22%) in relative poverty[iii].

- Between 2009 and 2011, on average **5,500** premature deaths[iv] per year occurred which accounted for **38%** of all deaths over the same period and an average of **17** potential years of life lost per person.

iii derived from Family Resources Survey NI, DSD

iv deaths of those aged under 75 years

What the Framework Seeks to Achieve

1.13 Through strengthened co-ordination and partnership working in a whole system approach, this framework will seek to create the conditions for individuals and communities to take control of their own lives, and move towards a vision for Northern Ireland where:-

"All people are enabled and supported in achieving their full health and wellbeing potential."

The framework aims to:

"Achieve better health and wellbeing for everyone and reduce inequalities in health."

1.14 The vision and aims make clear that a societal effort is required. Many contributions need to be made at all levels – from government, to regional and local levels – and in many settings, such as communities, workplaces, schools, and homes.

1.15 The framework provides strategic direction for co-ordinated action by identifying themes and outcomes to guide planning and implementation for the next ten years. However, it is also intended to be a "living" document." Short-term commitments are included for the current PFG and budgetary period which will be reviewed and updated on a rolling basis over the ten year period of this framework.

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Northern Ireland at a glance

- Average male life expectancy was now 77.5 years (2009/11), and female life expectancy was 82.0 – an increase of 8 and 6 years respectively since 1980/82.
- In the same period the gender gap in life expectancy decreased by 2 years to 4.4 years.
- The absolute gap in life expectancy between the 10% most and least deprived areas (2009/11) was 10.7 years for males and 7.7 years for females.
- Coronary heart disease, cancer and respiratory disease continue to be the main causes of death for both sexes.
- Northern Ireland has a 25% higher overall prevalence of mental illness than England – 1 in 5 adults here have a mental condition at any one time.
- During 2009/11 the suicide rate in males was 25.1 deaths per 100,000 population and in females 7.4, with the suicide rate in the 10% most deprived areas almost five times that within the 10% least deprived areas.
- In 2011/12 almost a fifth (19%) of adults (18 and above) stated they drank in excess of weekly recommended drinking limits.
- Hospital admission rates due to alcohol-related causes in the most deprived areas were consistently more than **double** the NI rate in 2008-10, and between **five and six times** the admission rate in the least deprived areas throughout the period.
- 61% of adults surveyed in 2011/12 were either overweight or obese (68% of males and 56% of females), and a tenth of both boys and girls aged 2-15 were also assessed as being obese.
- In 2011/12 of those surveyed, 25% of adults were smokers, with a proportion of 30% in the 20% most deprived areas.

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Some estimated costs-

- The impact of the misuse of alcohol on society is estimated at some £900 million each year – almost £250 million of these costs are borne by the Health and Social Care Sector[v].
- Loss to the local economy as a result of obesity is estimated at £400 million, £100m of these costs were direct healthcare costs[vi].
- DHSSPS has estimated the 2011/12 hospital costs of treating diseases, of which smoking could be a contributory factor, as £164 million[vii].

v Social Costs of Alcohol Misuse in Northern Ireland for 2008/09, Research commissioned by Public Health Information and Research branch, DHSSPS

vi The Cost of Overweight and Obesity on the Island of Ireland – Safefood, November 2011

vii Methodology adopted from report by the Tobacco Advisory Group of the Royal College Of Physicians

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CHAPTER 2 – WHAT DETERMINES HEALTH AND WELLBEING

2.1 Health is more than just the absence of disease – it is a state of "complete physical, mental and social wellbeing"[10]. Wellbeing has physical, cognitive, social and emotional dimensions, and is influenced by development across the life course. The World Health Organisation (WHO) defines mental health as a "state of wellbeing in which the individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".[11]

2.2 While genetic make-up plays some part in people's chances of leading long and healthy lives, there are many more factors which interact to influence health and wellbeing at various stages in their lives[12]. This is illustrated in the figure below, which has been developed from earlier work by Dahlgren and Whitehead, 1993[13].

Figure 2: Health Map for the Local Human Habitat

2.3 Health and wellbeing is about so much more than health and social care. A recent American study[14] ranked factors determining the best health outcomes for local populations. According to the study:

- Social and economic issues such as education, employment and violent crime accounted for 40%;
- Health behaviours (alcohol, tobacco and sexual behaviour) accounted for 30%; and
- Clinical services, including quality of and access to health care, accounted for 20%.

In other words health is affected more by economic, social and environmental factors than by anything else.

Health Inequalities

2.4 In 2008 the World Health Organisation (WHO) Commission on the Social Determinants of Health completed a two-year investigation into the social causes of health inequalities. The report concluded that health inequalities cannot be fully explained by variation in income alone. In addition to income, the Report concluded that health inequalities are caused by inequitable distribution of more fundamental social, political and economic forces, the 'social determinants of health' already referred to, much of which is outside of the remit of health ministries.

2.5 The Marmot Review into health inequalities *(Fair Society, Healthy Lives – A Strategic Review of Health Inequalities in England 2010)* presented a substantial body of evidence on health inequalities. The Review's findings reinforce that addressing health inequalities requires co-ordinated action across the social determinants of health. Both this and the 2008 reports affirm that inequalities in health arise because of inequalities in society – "in the conditions in which people are born, grow, live, work and age".

2.6 This evidence has since been supplemented by WHO's publication in 2013 of the "Review of social determinants and the Health Divide in the WHO European Region". The experience of countries in the European Region shows that there are widespread inequities in health between and within societies – there should therefore be two clear aims: *"Improving average health and reducing health inequities by striving to bring the health of less – advantaged people up to the level of the most advantaged".*

Life Course

2.7 Central to the Marmot review is a life course perspective. There is an accumulation of advantage and disadvantage across the life course and each of life's transitions can affect health by moving people onto a more or less advantaged path. The review emphasised that action to reduce health inequalities must start before birth, and be continued through the life of the child, if the close links between early disadvantage and poor outcomes throughout life are to be broken. For this reason "giving every child the best start in life" was the review's highest priority recommendation.

2.8 Health 2020 and the "Review of social determinants and the health divide in the WHO European Region" re-emphasise the life course approach as the recommended way to planning action on the social determinants of health. Whilst the life course approach begins with the important early stages of life – pregnancy and early child development – action is needed at every stage and continues with school, the transition to working life, employment and working conditions and circumstances affecting older people.

Social Gradient

2.9 Studies such as those mentioned above show that there is a social gradient in health. The social gradient in health means that health gets progressively better as the socioeconomic position of people and/or communities improve. This pattern is also evident in the Northern Ireland population (illustrated in Annex A). The social gradient of health exists across the whole population, while the most profound differences in health can be seen between the most and least disadvantaged. To reduce the steepness of the gradient, it is important to act across the whole gradient, and to address the needs of people at the bottom of the social gradient, and those who are most vulnerable, with a view to bringing the health of the least advantaged up. To achieve this, actions are needed that are universal, but implemented with a scale and intensity proportionate to the level of social and health needs. This is known as *proportionate universalism*. It must be acknowledged however that "more of the same" does not always work, and in some cases a different or new approach may be required.

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2.10 It has been argued[15] that health promotion initiatives and improvements in technology and service delivery can increase inequalities - because people in higher social classes are more likely to avail of them. Policies that have achieved overall improvements in key determinants, like living standards and smoking, have often increased inequalities in these major influences on health. It is therefore important to distinguish between the overall level and the social distribution of health determinants and interventions, and to seek to avoid public health interventions increasing inequalities.

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CHAPTER 3 – WIDER CONTEXT

3.1 Government policies and programmes have a significant impact on health and wellbeing. A number of key policies are highlighted in this and later chapters which illustrate the inter-relationships between various government programmes and the ways in which they benefit population health and wellbeing.

Wider Public Policy and a Whole System Approach

3.2 The aims of this Framework and the challenges being addressed are not unique to Northern Ireland. In recent years many governments have increasingly come to realise that they can achieve health, social and economic goals by actively exploring the mutual benefits in sectors such as education, employment, environment, transport and agriculture. Major determinants of ill health can be addressed, and major assets for health can be harnessed by engaging non-health sectors. Collaboration in such a way, alongside engagement of communities and individuals, is a "whole system approach" to health and wellbeing.

3.3 Health 2020 is a joint commitment by the WHO Regional Office for Europe and the 53 European member states to a new common policy framework, which can be adopted and adapted to the different realities within the region. Behind Health 2020 lies the idea that health and wellbeing are essential for human, social and economic development, and of vital concern for the lives of every person, family and community. It reflects a renewed commitment to public health with shared goals to *"significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality".*

3.4 Health 2020 argues strongly that all parts of government need to work together through increased whole-of-government working to recognize risk patterns and identify solutions, share responsibility across policy fields and sectors and act at multiple levels. Health 2020 proposes a set of areas for policy action and for inclusion in strategies for reducing health inequities, to include:-

- action on social determinants across the life course, with the highest priority given to ensuring the best start to life for every child;
- promotion of cohesion and resilience at local level through a whole of society approach;

- addressing links between environmental social and economic factors: and

- focusing on whole of government and whole of society delivery and governance.

3.5 These themes are also reflected in the English White Paper *Healthy Lives, Healthy People – Our Strategy for Public Health in England*[16] published in November 2010. In response to Professor Sir Michael Marmot's Review the White Paper outlined the cross- government framework to enable local government and local communities to be at the heart of improving health and wellbeing and tackling inequalities for their populations. A new integrated public health service – Public Health England – has since been created to strengthen public health across national and local government levels.

3.6 In March 2013, the Republic of Ireland published *Healthy Ireland - Framework for Improved Health and Wellbeing 2013- 2025*[17]. The framework draws on existing policies but proposes new arrangements to ensure effective co-operation and collaboration and to implement evidence- based policies at government, sectoral, community and local levels. A key shift through Healthy Ireland is towards a whole government/ whole society approach.

Northern Ireland Policy context

3.7 The Northern Ireland Executive's *Programme for Government 2011-2015: Building a Better Future*[18] sets out the key goals for government and outlines a number of Executive commitments to achieve its key priority of "a vibrant economy which can transform our society while dealing with the deprivation and poverty which has affected some of our communities for generations".

3.8 PFG recognises the relationship between health, disadvantage, inequality, the social and physical environment, and economic growth. These inter-relationships require that departments work together to produce policies and plans consistent with the five priorities. This framework will be one of the "building blocks" for the achievement of a number of priorities identified in PFG, particularly Priority 2, Creating Opportunities, Tackling Disadvantage and Improving Health and Wellbeing and a key element in efforts to build a "shared and better future for all".

Context for Implementation

Wider public sector

3.9 Effective co-ordination at strategic and delivery levels between this framework and other key government strategies will be vital to ensure maximum impact. Key examples include:–

- *NI Economic Strategy;*
- *Anti-poverty Strategy and Action Plans;*
- *Children and Young People's Strategy and Action Plans;*
- *Delivering Social Change;*
- *Together: Building a United Community; and*
- *Active Ageing Strategy*

3.10 For *Making Life Better* to succeed there is a need for policy coherence and consideration of health and health equity in policy making. Co-ordinated implementation across and beyond government departments and agencies at regional and local levels is also required, ensuring all parts of the system are connected. Efforts must be renewed to strengthen links and maximise resources, particularly during a time of financial constraint coupled with ongoing reform of public administration.

Development of new public health legislation

3.11 A review of the Public Health Act (NI) 1967 has been commissioned to ascertain whether the Act (which deals largely with health protection) still remains fit for purpose. Subject to Executive approval for the review to be carried out, it will put forward proposals for updating the current legislation, in line with reforms carried out in other jurisdictions which reflect an 'all hazards' approach. The 1967 Act is outdated and requires modernisation to enable government to deal effectively with 21st Century threats to public health. A review of the legislation, resulting in an updated statute, will provide an important mechanism for the delivery of a broader strategy for public health.

The Health and Social Care System

3.12 Health is increasingly acknowledged as having a significant influence on the economic aspects of society and on social cohesion. The health care industry is one of the world's largest and most rapidly growing sectors. It is a major employer encompassing a wide range of services, manufacturers and suppliers. At the same time expenditure on health poses a greater challenge than ever before, posing a threat to the long –

term sustainability of the health care system. Chronic disease affects the labour market and productivity at work, and the development of expensive medical technologies and treatments drive up the cost of managing chronic diseases and multiple morbidities. These cost pressures provide a strong economic case for action and investment to promote health and prevent disease.

3.13 The capacity and efficiency of health and social care systems is an important health determinant. The sector plays many roles in improving population health and addressing inequalities in health determinants: a direct leadership role, as a large employer, and as an influencer, mediator and collaborator. Since the recent Health and Social Care Reform in Northern Ireland, public health and wellbeing has been placed firmly at the centre of the system, with greater emphasis on prevention, early intervention, and on addressing health inequalities. It is vitally important that all organisations and individuals within the Health and Social Care system work coherently together to fulfil their respective roles and responsibilities in support of the vision and aims of this framework and related strategies.

3.14 The Department of Health Social Services and Public Safety (DHSSPS) has a statutory responsibility to promote an integrated system of health and social care (HSC) designed to secure improvement in:

- the physical and mental health of people in Northern Ireland;
- the prevention, diagnosis and treatment of illness; and
- the social wellbeing of the people in Northern Ireland

3.15 The department takes this forward both by direct action and through its Arms Length Bodies which make up the sector.

3.16 Under the Health and Social Care (Reform) Act (NI) 2009 (the Act) the Health and Social Care Board (HSCB) supported by 5 Local Commissioning Groups (LCGs) has delegated statutory responsibility for commissioning the range of health and social care services on behalf of the entire population of Northern Ireland. The HSCB has the capacity therefore to greatly influence improvements to population health, and has a statutory duty to co-operate with the PHA in carrying out its commissioning function.

3.17 At sub-regional level there are 5 Health and Social Care Trusts which provide services as commissioned by the HSCB and PHA. The Act places a statutory duty on the PHA and Health and Social Care (HSC) Trusts to work to "improve the health and social well-being of, and reduce health

inequalities between, people in Northern Ireland".

3.18 In addition all the main HSC bodies have a statutory duty of public involvement and consultation – Personal and Public Involvement (PPI). This requires them to involve people at a personal and public level, ensuring everyone, including vulnerable groups, can influence decisions about service design and delivery.

3.19 Key strategic priorities have been identified for the overall Health and Social Care system. These also reflect the Department's specific commitments to the wider PFG:

- to improve and protect health and wellbeing and reduce inequalities, through a focus on prevention, health promotion and earlier intervention;
- to improve the quality of services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services;
- to improve the management of long-term conditions in the community with a view to improving the quality of care provided, and reducing the incidence of acute hospital admissions for patients with one or more long term conditions;
- to improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;
- to improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities; and
- to ensure that the most vulnerable in society, including children and adults at risk of harm, are looked after effectively across all services.

3.20 A number of key policies and strategies also inform service direction including –

- Quality 2020[19], which aims to protect and improve the quality of services and achieve excellence, based on three key components – safety, effectiveness, and patient and client focus;
- Service Frameworks which set out the type of service that patients

and users should expect, and aim to secure better integration of service delivery along the whole pathway of care from prevention of disease/ill health to diagnosis/treatment and rehabilitation, and on to end of life care.

3.21 A further key report, *Transforming Your Care (TYC): A Review of Health and Social Care in Northern Ireland*[20] published in December 2011, set out proposals for the future shape of services across the range of service areas. Both the original review and subsequent consultation and implementation documents include a focus on prevention and earlier interventions as a key part of the model of care closer to home, with helping people to stay healthy and make good health decisions a central goal. TYC is a key element of the wider, holistic approach to tackling inequalities.

Role of Public Health Agency

3.22 The PHA was established to bring renewed focus on public health goals and has the lead role in integrating and supporting health improvement across all parts of the Health and Social Care system. It also has a general responsibility for promoting improved partnership working with local government, other public sector organisations and the voluntary and community sectors to bring about improvements in public health and social wellbeing and for anticipating the new opportunities offered by community planning. The PHA operates at both regional and local levels. The PHA will make a major contribution to the co- ordination of the delivery of the aims of this framework.

Role of the Institute of Public Health

3.23 The Institute of Public Health in Ireland (IPH) was established in 1998 and promotes cooperation for public health on the island of Ireland through:

- strengthening public health intelligence;
- building public health capacity;
- policy and programme development, and evaluation.

The IPH has had a lead role in promoting the application of Health Impact Assessment through the development of practical tools, training, research and facilitating networking opportunities.

Local Government

3.24 There is a key interface between public health, health and social care and the role of local government. Local government will continue to be a natural partner in helping to deliver health improvements and address health inequalities at the community level. The joint working arrangements that exist between the PHA and district councils in support of health and wellbeing improvement, and the commissioning responsibilities of Local Commissioning Groups of the Health and Social Care Board, need to be visible in the proposed new community planning responsibilities of councils. This framework provides a mandate for the joint working arrangements between the PHA and local councils on local delivery, and sets a direction for the public health element of community planning.

3.25 The reform of local government is a priority of the PFG. The Executive's vision for local government is of one that is "strong and dynamic, creating communities that are vibrant, healthy, prosperous, safe, sustainable, and which has the needs of all people at its core". Local government reform will reduce the number of councils from 26 to 11, modernise and streamline public administration, and transfer a number of functions and powers from central government departments to the new councils. It is being managed in line with the 2015 timetable proposed in the Executive's Programme for Government 2011/2015.

3.26 The functions being transferred to councils include planning, aspects of urban regeneration, local economic development and tourism. Councils will also have a new duty to make arrangements for community planning. The integration through community planning of the functions being transferred and councils' existing functions should provide a productive joined up approach which optimises opportunity and makes best use of all the assets available. It will change the way cities, towns and rural areas are planned, and place a sharper focus on sustainable local economic development.

3.27 Community planning will bring councils, statutory bodies and the community and voluntary sector together to develop and implement a shared vision for promoting the wellbeing of an area. Councils will set up a community planning partnership to provide leadership to the process. This will include organisations, central government departments and agencies operating in their area that will work in partnership with them to plan and provide services at the local level, and contribute to PFG objectives at the regional level. Departments will also be required to promote and encourage community planning and have regard to the councils'

community plans in planning the delivery of services.

3.28 The broader range of powers, combined with partnership working with other Departments and agencies operating in their area, means that Councils will be able to better co-ordinate service delivery and avoid duplication, and will lead to more efficient, high quality services. Within the reconfigured, larger Council areas care must be taken not to lose the necessary focus on the most disadvantaged areas.

3.29 Although DHSSPS will not be transferring any functions to local government in 2015, maintaining and strengthening inter-sectoral working between local government and Health and Social Care is key and will provide an important opportunity to maximise the potential for improving the health and wellbeing of communities and tackling health inequalities at the local level.

Community and Voluntary Sector

3.30 Tackling inequalities in health cannot be achieved by statutory agencies alone. This framework will seek to create the conditions for individuals and communities to take control of their own lives, and can only be achieved in full partnership with local communities, communities of interest, volunteers, and the community and voluntary sectors to aid the development of policies and actions that are applicable to the issues faced by communities.

3.31 Community and voluntary organisations play a vital role in enabling and empowering people to improve their health, and in representing and supporting particularly vulnerable interest groups. Development of community capacity and social capital, and drawing on the strengths or assets within communities, will be key to making progress.

3.32 A key government aim is to ensure a vibrant and sustainable voluntary and community sector that can thrive and work closely with Government in the design and delivery of policy and services in the interests of the people of Northern Ireland. This framework fully supports the shared values and principles in the Concordat between the Voluntary and Community sector and the Northern Ireland Government (2011)[21].

> "Working effectively together will help, for example, to develop sustainable, safer communities, ensure a well protected and valued environment, contribute to economic growth, tackle poverty, disadvantage and inequality, and assist in the promotion of health and well being."
>
> *Concordat between the Voluntary and Community Sector and the NI Government 2011*

3.33 Within the health and social care sector, the Health and Social Care Board and PHA have produced "Working in Partnership – Community Development Strategy for Health and Wellbeing 2012 – 2017."[22] This recognises community development as a practice which "assists the process of people acting together to improve their shared conditions, both through their own efforts and through negotiation with public services." The strategy aims to strengthen communities and improve health and social wellbeing by placing an increasing emphasis on community development, prevention and early intervention. It provides guidance and direction on how community development approaches are to be taken forward within health and social care, with an expectation that every HSC organisation incorporates a clear and transparent community development approach into their programmes.

3.34 In the Health and Social Care context, community development also links with mechanisms to improve services and care. The statutory duty of public involvement and consultation – Personal and Public Involvement (PPI)[23] - on Health and Social Care organisations is a central component of the agenda to improve health and social care provision.

3.35 The empowerment of communities, assisted by implementation of community development approaches and PPI, will be key to improving health and reducing inequalities in health. Partnership working with grassroots community and voluntary sector organisations will help release and support the energy within communities, and encourage further development of community capacity to address local needs (see also Chapter 9 – Empowering Communities).

Other Organisations and Partnerships and Business sector

3.36 A variety of partnership arrangements already exist at both regional and local levels in relation to health, or to take forward other government strategies and programmes which impact on health. Both Belfast and Derry are part of the WHO Health Organisation Healthy Cities Network*. Belfast Healthy Cities has recently celebrated 25 years of advocacy and effort on behalf of the city and has a reputation as a key contributor to the Healthy Cities Network. There are many other organisations, including professional bodies, trade unions, advocacy and/or philanthropic organisations, sporting and cultural organisations, and funding bodies, which make important contributions. Appropriate and effective linkages and information sharing with and between such organisations will be beneficial to population health.

3.37 Many partners within the business sector can play a key role. In England this has been recognised through DOH England's collaboration with the sector in promoting "Public Health Responsibility Deals" to promote socially responsible approaches, including for example in relation to consumer information about food. Northern Ireland stands to benefit from these wider relationships and will continue to advocate through relevant networks.

3.38 Retailers, media, sports and leisure businesses can contribute in many ways to promote or support healthy choices. Business in the Community NI is a membership organisation which works to support companies committed to doing business in a way which helps them impact positively on their "People, the Planet and the Place".

* The WHO European Healthy Cities Network consists of cities around the WHO European Region that are committed to health and sustainable development: more than 90 cities and towns from 30 countries. They are also linked through national, regional, metropolitan and thematic Healthy Cities networks. A city joins the WHO European Healthy Cities Network based on criteria that are renewed every five years.

MAKING LIFE BETTER

PART TWO – THE FRAMEWORK

MAKING LIFE BETTER

CHAPTER 4 – VISION, AIMS, VALUES AND THEMES

Vision and Aims

4.1 Through strengthened co-ordination and partnership working in a whole system approach, this framework will seek to create the conditions for individuals and communities to take control of their own lives and move towards a vision for Northern Ireland where –

"All people are enabled and supported in achieving their full health and wellbeing potential."

The aims of the framework are to:

"Achieve better health and wellbeing for everyone and reduce inequalities in health"

Values and Principles

4.2 While values and principles of *Investing for Health* still have merit, the consultation highlighted that some of the concepts did not reflect current thinking or language. The values and principles have been revised to provide a shared set of values to underpin action at strategic and local levels:

Social justice, equity and inclusion	All citizens should have the right to the highest attainable standard of health.
Engagement and empowerment	Individuals and communities should be fully involved in decision making on matters relating to health, and empowered to protect and improve their own health, making best use of assets.
Collaboration	Public policies should contribute to protecting and improving health and wellbeing, and public bodies should work in partnership with local and interest group communities.
Evidence - Informed	Actions should be informed by the best available evidence and should be subject to evaluation.
Addressing Local Need	Action should be focused on individuals, families and communities in their social and economic context.

MAKING LIFE BETTER

4.3 The **"right to health"** has been enshrined in the World Health Organisation (WHO) Constitution[24] and in international and regional human rights treaties, such as the UN Convention on the Rights of the Child, including *General Comment No 15 (2013)*, Convention on the Elimination of all forms of Discrimination Against Women, and Convention on the Rights of Persons with Disabilities[25].

4.4 The right refers to the *"highest attainable standard of physical and mental health"* as a fundamental right of every human being, and means that governments must create conditions in which everyone can be as healthy as possible – such actions range from ensuring the availability, affordability and accessibility of health services to taking public health measures for healthy and safe working conditions, adequate housing and nutritious food and other conditions for protecting and promoting health. Citizens, in turn, need to understand the value of their health and contribute actively to creating better health in society at large.

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, political belief, economic or social condition. (WHO Constitution)"

4.5 At the heart of human rights is the recognition that they are universal, that everybody should be treated equally and with dignity, and that all human rights are interrelated, interdependent and indivisible. Health 2020 asserts that "human rights standards and principles - such as participation, equality, non-discrimination, transparency and accountability - should be integrated into all stages of the health programming process and should guide health policy making."

4.6 Health inequalities result from social inequalities. Reducing health inequalities that are preventable by reasonable means is a matter of fairness and social justice requiring action across society. This aligns with the PFG priority of addressing the challenges of disadvantage and inequality that afflict society, and working to close the gap in health between those who are least and most disadvantaged.

4.7 Promoting equality of opportunity is fundamental to the achievement of the aims of this framework. The social determinants of health affect Section 75 groups differently, for example the social and economic roles performed by men and women significantly affect the health risks to which they are exposed over the life course. Evidence shows that inequalities based on race, disability, age, religion or belief, gender, sexual orientation and gender identity can interact in complex ways with socioeconomic

position in shaping people's health and wellbeing. A key purpose of this framework is to set out a strategic direction and actions that will actively pursue health equity and social inclusion. Tackling the major inequalities in health and wellbeing and their causes will help promote equality of opportunity and good relations.

4.8 The value of community development as a process to empower and bring about changes to individuals, communities and wider society founded on social justice, equality and inclusion is recognised. Adopting an asset-based approach, an aim of this framework is to equip and enable individuals, families and communities to address the issues affecting their health and wellbeing and make healthy choices (see also Chapter 10 – Developing Collaboration)

This approach goes hand in hand with the statutory duty of public involvement and consultation - Personal and Public Involvement (PPI) on Health and Social Care organisations in empowering people to make decisions about services and care.

Themes

4.9 The consultation document *Fit and Well – Changing Lives* proposed a life course approach to reflect the Marmot Review findings, and structured action around five life course stages, with underpinning themes of "sustainable communities" and "building healthy public policy". The document also proposed two strategic priorities – Early Years and Vulnerable People and Communities.

4.10 In the responses to the consultation there was a qualified welcome for the life course approach. There was concern that overemphasis on the life course stages detracted from important messages about tackling the underlying social determinants of health that apply across the life course. In particular, respondents highlighted the need to mitigate the effects of poverty, support people through welfare reform and into employment. In addition the Health Committee's report on health inequalities supported a thematic approach. In the consultation responses, there was general support for making early years a priority, and Giving Every Child the Best Start is retained in the framework as a theme.

4.11 In light of this feedback the Framework has been re-structured around the following themes:

- Giving Every Child the Best Start
- Equipped Throughout Life
- Empowering Healthy Living
- Creating the Conditions
- Empowering Communities
- Developing Collaboration.

4.12 "Giving Every Child the Best Start" and "Equipped throughout Life" take account of the particular needs across the life course and have been broadened to cover childhood and adulthood. They address the key social determinants at each stage. Particular emphasis is given to children and young people, and to supporting individuals' transitions into and through adulthood and older age. "Empowering Healthy Living" addresses support for individual behaviours and choices, and embedding prevention in Health and Social Care services. The next two themes address the wider structural, economic, environmental and social conditions impacting on health - at population level, and within local communities.

4.13 "Developing Collaboration" considers strengthening collaboration for health and wellbeing at regional and local levels. A number of strategic actions are identified, and in addition it identifies three areas of work around which a number of partners have been developing collaborative approaches.

4.14 For each theme, key long-term outcomes have been set. These are outlined in the next series of Chapters along with strategic supporting actions and commitments over the next 2-3 years that work towards these outcomes. These include actions planned either as PFG commitments or business commitments of particular departments; all are relevant to influencing the determinants of health and wellbeing. Progress on these supporting actions will be monitored and, in due course, the actions will be updated in line with PFG and budget periods.

4.15 However this is not just about actions and programmes at government level. It is acknowledged that there are many good examples of joint working underway amongst key partners such as public sector agencies, local government, the community and voluntary sector, local communities and the private sector. The framework reaffirms and updates the mandate to strengthen collaboration at all levels, and promote better communication and co-ordination across the system.

The Gradient Approach

4.16 There was less consensus in the consultation response on the second priority ("Vulnerable People and Communities") with many responses suggesting additional vulnerable population groups. The groups and communities within society who require targeted support vary depending on need and the issue being addressed. Furthermore, the findings from the Marmot and other reviews highlight the social gradient that exists across the entire socioeconomic spectrum. These reviews call for universal action, but with a scale and intensity proportionate to the level of disadvantage – proportionate universalism.

4.17 In order to achieve the aims of better health and wellbeing for everyone, and reduced inequalities in health, the overriding approach must be to take account of the need for greater intensity of action for those with greater social, economic and health disadvantage. This applies right across the social gradient and requires action to improve universal services as well as more targeted services for those in greater need. This is with a view to narrowing the health gap by bringing up the level of health of the groups of people who are worse off.

4.18 There are some groups of the population who are particularly at risk and for whom targeted action is likely to be necessary, regardless of their socioeconomic status. The gradient approach adopts a combination of broad universal measures with strategies targeted at high- risk groups. For this reason, later sections of this framework, which set out the actions to be taken across government over the next few years, identify some particularly vulnerable groups. It is important to acknowledge however that this does not represent all that can be done to identify and support those for whom more targeted action may be required. Decisions on targeted action must be taken at a delivery level and include careful targeting of resources to meet greatest need, with the aim of reducing health inequalities.

CHAPTER 5 – GIVING EVERY CHILD THE BEST START

Key long term outcomes:

1. **Good quality parenting and family support**
2. **Healthy and confident children and young people**
3. **Children and young people skilled for life**

5.1 What happens to children in their earliest years is key to outcomes in adult life. This is supported by a wide range of research evidence from education, health, justice and economic experts[26]. Individuals and communities benefit from the strong attachment and emotional links that are created by good parenting and positive early life experiences. These give children the best start in life and help to prepare children to get the most out of education and social interactions.

1 GOOD QUALITY PARENTING AND FAMILY SUPPORT

5.2 From pregnancy through early childhood, all of the environments in which children live and learn, and the quality of their relationships with adults and care givers, have a significant impact on their cognitive, emotional and social development. The importance of working in partnership with parents and care givers to enable them to encourage a positive home environment, and to provide continuity in their child's early experiences from home to pre-school, is clear.

5.3 Research shows that a shift in emphasis towards co-ordinated support for children in their early years is the most likely route to breaking the cycle of disadvantage and reducing inequalities in health. This is consistent with obligations under the Child Poverty Act 2010. In view of this, and supported by recommendations by the Health Committee for greater focus on early years interventions, this framework places the highest emphasis on the significance of parenting and family support as providing the foundation for realising the potential of children and young people, and for longer term public health and wellbeing.

5.4 The need to shift investment towards early intervention services and programmes for children and families has been recognised more widely across government, for example through two projects underway with funding from the Delivering Social Change

programme to support the development of an additional 10 Family Support Hubs, and a number of targeted parenting programmes over the 2012/13–2014/15 period.

5.5 A collaborative approach is required to bring about the incremental development of universal and targeted programmes to include ante and post natal care and parenting programmes. This progression will need to be co-ordinated to link with a number of relevant strategic programmes such as: Children and Young People's strategy, Delivering Social Change, DE policy and programmes for early years and school age children (such as Learning to Learn: A Framework for Early Years Education and Learning), Families Matter, Child Health Promotion Programme, Maternity and Breastfeeding strategies.

5.6 On behalf of a collective of government departments, it is proposed that DHSSPS will lead the implementation of an Early Intervention Transformation Programme from 2014, subject to funding being approved. It is intended that this Programme will facilitate a systemic change in how services are provided to children and families in Northern Ireland in order to measurably improve outcomes. The emphasis will be on intervening early in a child's life, or at the stage when family difficulties are emerging, so that they can be successfully addressed before problems become entrenched.

5.7 In terms of delivery, the Children and Young People's Strategic Partnership, which brings together key agencies to plan and integrate children's services, in partnership with the Child Development Board established by the PHA to review and advise on evidence, will be key to taking forward this co-ordinated approach. This work reports to and is guided by the Ministerial Sub- committee for Children and Young People.

5.8 A review of the Families Matter Strategy will seek to consolidate and further strengthen efforts to ensure that parents and families continue to receive the information, support, and gain the skills they need to help their children reach their full potential. It will aim to address the barriers that hard to reach families experience in accessing services, address the potential stigma associated with using family support services and raise awareness and uptake of relationship support and family mediation.

5.9 *Bright Start - The Executive's Programme for Affordable and Integrated Childcare (A Strategic Framework and Key First Actions)* sets out the framework, principles and a range of key first actions

to help deliver the establishment of an improved and expanded system of childcare, with a key aim of supporting the development of children and young people, and enabling children and young people from all backgrounds, including the most deprived, to avail of life opportunities.

OUTCOME 1 GOOD QUALITY PARENTING AND FAMILY SUPPORT

Actions and Commitments 2013 – 2015

A Promote and support positive parenting through –

- establishment of Family Support Hubs and systematic expansion of a range of initiatives and evidence based parenting support programmes, *with a particular focus on children in need and children in families in areas of disadvantage and experiencing inter-generational unemployment*
- establishment of a cross-departmental/sectoral Early Intervention Transformation Programme
- roll-out of Family Nurse Partnership programme
- implementation of the PHA/HSCB Hidden Harm Action Plan
- improved safeguarding outcomes for children
- parents and other relatives who can play a role in the lives of children who are in care or on the edge of care
- improved availability of high quality, accessible and affordable childcare through a new Childcare Strategy
- implementation of an infant mental health training plan
- implementation of the Education Works campaign and website

Key Partners
DHSSPS / OFMDFM / HSC / PHA / CYPSP / DSD / SSA / DE / DOJ / DEL Safeguarding Board/ Community and Voluntary sector

OUTCOME 1 GOOD QUALITY PARENTING AND FAMILY SUPPORT Continued

Actions and Commitments 2013 – 2015 Continued

B Ensure appropriate family based financial support to children through –

- effective Child Maintenance arrangements in place
- encouraging and enabling families to take financial responsibility for their children
- providing information and support for separated and separating families

Key Partners
DSD

Healthy and confident children and young people

Family Nurse Partnership

The Family Nurse Partnership programme, an intensive preventive home visiting programme, is being introduced to Northern Ireland. It aims to improve antenatal health, child health and development and parents' economic self-sufficiency. Over the next few years it will be offered to around 500 first time young parents from early pregnancy until their child is 2 years old. The programme can deliver tangible outcomes which have been evidenced through 30 years of research in the US'.

2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE

5.10 An updated programme for 0-19 year olds, known as "Healthy Child – Healthy Future (HCHF): a Framework for the Universal Child Health Promotion Programme in Northern Ireland,"[27] was issued in 2010. The framework is central to securing improvements in child health for all children aged 0-19 years, across a range of issues. The framework sets out a core programme of child health contacts that every family can expect, with access to a universal programme of preventative care and additional services for those with specific needs and risks, e.g. neonatal blood spot screening, childhood immunisations, family health assessment, growth monitoring, infant feeding and family nutrition, routine inquiry etc. HCHF aims to identify and respond to families in need at the earliest opportunity.

15% of women in Northern Ireland smoke throughout pregnancy and reflects the general increase in the number of young women who smoke. The risk of complications for the baby includes premature delivery, low birth-weight and cot death. To aid behavioural change, consistent advice should be given to any woman who is smoking and pregnant. Smoke Free Wombs is an exciting initiative by midwives in the South Eastern HSC Trust to encourage mums-to-be to stop smoking. "Smoke Free Wombs" uses Facebook, a powerful DVD, and cartoon images to try and get the message across that smoking harms the unborn child.

Midwives are asking mums-to-be to sign a pledge to work in partnership with them to give up. Mums-to-be will receive a letter outlining how smoking can harm babies in the womb, and offering the opportunity to meet with the Health Improvement Midwife. Women are provided with consistent information through face-to-face contact, phone support, text message and Facebook. Since this initiative began, data suggests a 52% increase in referral to no smoking programmes and that the "quit" rate has trebled.

5.11 Success in learning at school is rooted in the stimulation and encouragement received at home, in the family and in the community. If parents do not have these skills then it is more likely that children fall behind and disadvantage is passed on. This emphasises the importance of support during early years to aid the transition to more formal learning at school, and of maintaining support involving the family, communities and social networks.

5.12 Growing up is a time in life of considerable health and social needs. Whilst investment in early years is crucial, it needs to be combined with sustained commitment to children and young people throughout their school years. How children progress at school beyond early and into teenage years is clearly important to emotional, cognitive, physical and social development throughout their life. Schools are vitally important settings for personal and social development, and the development of life skills and behaviours which will influence later life chances. Implementation of programmes such as nurture provision, a short term early intervention addressing barriers to effective learning; and iMatter, the Pupil's Emotional Health and Wellbeing Programme in post-primary schools, will make a key contribution to building confidence, empathy, self esteem and resilience, and social skills.

5.13 Adolescence is a critical transitional period that includes biological change and the need to negotiate key development tasks such as increasing independence and normative experimentation. Adolescents and young adults are particularly sensitive to influences such as family, peer group, school, neighbourhood, and developmental changes can either support or challenge young people's health and wellbeing. Promotion of positive social competences and abilities such as self worth, aspiration and connectedness, not only facilitates healthy behaviours but also helps to ensure a healthy and productive future adult population.

5.14 Effective collaboration between the health and education sectors, from early years right through school, is crucial to supporting children and young people's development, in terms of their personal and social development, their educational attainment and future life outcomes.

OUTCOME 2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE

Actions and Commitments 2013 – 2015

A Ensure high quality public health and social care services are provided for all children and young people, from ante natal care onwards to include –

- the full range of health protection, health promotion, surveillance and screening and immunisation programmes
- implementation of the breastfeeding strategy including support programmes for those least likely to breastfeed
- additional and tailored support to those who need it, *for example families with children with a learning or physical disability, young children with speech, language and communication needs, traveller children*
- targeted support for low income, vulnerable pregnant women and young families through the continued promotion and delivery of the Healthy Start scheme

Key Partners
DHSSPS / HSC

OUTCOME 2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE Continued

Actions and Commitments 2013 – 2015 Continued

B Children are cognitively, emotionally and socially ready to benefit from education by the time they start P1 through –

- linking learning and development more effectively through relevant strategies and policies around early intervention and early years, for example implementing 'Learning to Learn – A Framework for Early Years Education and Learning' to strengthen and develop early years education and learning services
- maintaining high quality Sure Start services in designated areas of disadvantage, to support parenting and services for children aged 0-4; and evaluating through a review how effectively the Programme is making a difference to young children and their families, especially the most disadvantaged
- making at least one year of pre-school education available to every family that wants it - *children from socially disadvantaged circumstances likely to experience barriers to learning identified for targeted action*

Key Partners
DE / DHSSPS/ others

C Maximise opportunities for every child and young person to develop confidence, personal resilience and basic skills required for life through for example –

- ensuring all children's and young people's settings (such as schools, colleges and youth organisations) provide environments which support good health and wellbeing through, for example, implementation of anti-bullying policies, promotion of healthy eating and physical activity
- continuing development and implementation of the "iMatter" programme across post-primary schools and special schools
- Delivering Social Change Nurture Units Project – establish 20 new Nurture Units within Primary Schools, to address early emotional and behavioural difficulties among children in Years 1-3 – *children who have missed early nurture experiences, and their parents identified for targeted action*

OUTCOME 2 HEALTHY AND CONFIDENT CHILDREN AND YOUNG PEOPLE Continued

Actions and Commitments 2013 – 2015 Continued

C Continued –

- implementation of Priorities for Youth policy

Key Partners
DE / DHSSPS / PHA / Local government / Community and voluntary sector

D Increase parents and children's awareness of child internet safety

Key Partners
Departments led by OFMDFM / DHSSPS / Safeguarding Board for NI.

E For looked after children and young people ensure –

- greater involvement in the preparation of their care and personal education plans
- improved engagement in special interests, culture and leisure and extra-curriculum activities
- regular school attendance by all children and young people in care

Key Partners
Departments led by OFMDFM / DHSSPS / Safeguarding Board for NI.

F Promote the benefits of play and leisure and increase the opportunities for children and young people to enjoy it

Key Partners
Departments led by OFMDFM/ Local government / DE / DHSSPS / HSC

Rhythm and Rhyme

Libraries, for example, play a key role in early years development though activities such as "Rhythm and Rhyme".

Many Northern Ireland Branch libraries host Rhythm and Rhyme sessions for babies and toddlers accompanied by parents and carers. Each session lasts around 30 minutes and gives the adults and children time to have fun together. The session is led by a member of staff, and carers and children are invited to participate at whatever level they wish. Musical instruments are also used to add a noisy dimension. Rhythm and Rhyme sessions are an excellent opportunity for parents/carers to meet up at the library and discover how much babies and toddlers love songs and rhymes. They are also a great way to help children's talking and listening skills. Good rhymers make good readers.

3 CHILDREN AND YOUNG PEOPLE SKILLED FOR LIFE

5.14 Evidence shows that children who start off well at school are more likely to achieve good qualifications that lead to a job with good income and social status, which in turn affects health and quality of life. Conversely, children growing up in poorer families are less likely to do well at school and in later life outcomes, than those from more affluent backgrounds. As well as affecting educational achievement, children who do not thrive at school are more likely to become disengaged, and try "risky behaviour" such as smoking and drinking at an early age.

5.15 Inequalities in education outcomes are subject to a similar social gradient as those for health. As with health inequalities, reducing education inequalities involves understanding the interaction between the social influences on education, including family background, and the local community context, as well as the school context. Evidence on the most important factors influencing educational attainment suggest that it is families that have the most influence rather than schools, and that closer links between schools, the family, and the local community are needed.

5.16 Sustained commitment to children and young people throughout their years of education will be vital to reducing inequalities in both health and education. Raising standards of educational attainment especially in areas of social need has a positive impact on improving employability and reducing social exclusion.

5.17 Further support for young people is vital in the form of broader skills development for work and training, including management of relationships, advice on continuing education, budgeting and debt management, parenting etc. Without life skills and readiness for work, young people will not be able to make the most of opportunities and take control over their lives.

5.18 Outside the formal education setting, effective youth work provides young people with valuable opportunities to build self esteem, learn new skills, develop new relationships, and helps them to develop as active citizens and members of their communities. While relevant for all young people, youth work can be particularly relevant for those who are at risk of disengaging from society or disaffected at school. "Priorities for Youth" outlines a framework for youth work within education to support young people to mature to reach their potential as valued individuals and responsible citizens.

OUTCOME 3 CHILDREN AND YOUNG PEOPLE SKILLED FOR LIFE

Actions and Commitments 2013 – 2015

A Through implementation of "Every School a Good School" and the Literacy and Numeracy strategy –

- increase the proportion of primary pupils achieving at the expected level in Key Stage Two in both Communication and Using Maths
- address numeracy and literacy issues at transition between primary and post primary school through provision of a professional development programme for teachers of English and Mathematics across Key Stages 2 and 3
- increase the proportion of school leavers achieving at least 5 GCSEs at A* – C or equivalent, including GCSE English and Maths
- increase the proportion of school leavers from disadvantaged backgrounds achieving at least 5 GCSEs at A* – C or equivalent including GCSE English and Maths

Key Partners
DE / Education sector / OFMDFM

OUTCOME 3 CHILDREN AND YOUNG PEOPLE SKILLED FOR LIFE Continued

Actions and Commitments 2013 – 2015 Continued

B Provide young people with an awareness of budget management including the financial implications of parenthood

Key Partners
DE / others

C Provide young people with access to –

- a broad and balanced range of courses, including Essential Skills, that have coherent pathways to HE, FE, training or employment, and that meet the needs of the local economy

Key Partners
DE / DEL / FE / HE

D Identify and intervene early to support children and young people up to age 19 with special or additional educational needs through –

- pilot approaches and building capacity in line with the Review of Special Education Needs (SEN) & Inclusion
- full roll out of Personal Education Plans (PEPs) process for all Looked After Children in school and training
- development of guidance for schools on promoting attendance

Key Partners
DE / DHSSPS / HSC

E Provide 100 Shared Summer Schools for post primary young people to create opportunities as a step towards greater sharing in education

Key Partners
OFMDFM / DE

Active School Travel

Recent research by University College London showed that children in Northern Ireland are the least physically active in the UK. Half of 7 year old children here are not getting the recommended one hour of physical activity each day (recommended through the Chief Medical Officers guidelines for physical activity: Start Active, Stay Active) and this is posing real, long term risks to their health and wellbeing.

To help combat these worrying statistics the Department for Regional Development (DRD) and the DHSSPS/PHA jointly fund an Active School Travel initiative, to be delivered through SUSTRANS, which was launched in October 2013 at St. Joseph's School at Ballyhackamore. This was launched with participation from staff and pupils from both St. Joseph's and Strandtown Primary Schools and aims to encourage more children to walk and cycle to school. The Active School Travel Programme will be delivered to at least 60 schools per year (180 in total) over a three year period to encourage pupils to adopt walking and cycling as their main mode of transport to and from school.

http://www.ucl.ac.uk/news/news-articles/0813/22082013-Half-of-UK-7-year-olds-sedentary-Dezateux

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf)

Key Strategies/ strategic programmes – Families Matter, Co-operating to Safeguard Children, Healthy Child Healthy Future, Breastfeeding strategy – A Great Start 2013 – 2023, Children and Young People's strategy, Child Poverty Action Plan, Delivering Social Change Framework/Signature Programmes, Revised Curriculum, Learning to Learn – A framework for Early Years Education and Learning, iMatter programme, School Improvement policy - Every School a Good School, Raising numeracy and literacy levels – Count, Read: Succeed, Entitlement Framework, A Fitter Future for All, Healthy Food for Healthy Outcomes – Food in Schools policy, Education Works campaign, Bright Start - Childcare strategy, Priorities for Youth, Pathways to Success, Community Family Support Programme, Essential Skills for Living, Hidden Harm Action Plan, Child Maintenance programmes, Play and Leisure Policy statement and Play and Leisure Implementation Plan, Care Matters, Transforming Your Care, Making it Better - A Strategy for Pharmacy in the Community.

CHAPTER 6 – EQUIPPED THROUGHOUT LIFE

Key long term outcomes:

4 **Ready for adult life**

5 **Employment, life-long learning and participation**

6 **Healthy active ageing**

6.1 Initiatives which encourage and engage people at any age in social, cultural, sport and leisure activities impact on both physical and mental health and wellbeing, as well as on such issues as creativity, social inclusion, and good relations. They can also support interaction across generations. In addition to individual and wider societal benefits, there are environmental benefits to be gained. Participation in such interests offers lifelong enjoyment and fulfilment and is an essential part of healthy living.

6.2 Volunteering also benefits individuals, communities and wider society. It helps to connect and support people, and to progress issues or interests. It also helps individuals develop new skills, and utilises the resources of those with skills and expertise to promote the transfer of skills to others. Volunteering has the potential to build capacity, capability and self esteem in the young, and also promote social inclusion and intergenerational activity.

4 READY FOR ADULT LIFE

6.3 As children grow into adults, they face very different opportunities and challenges – some will be moving into further or higher education, others may be leaving education and seeking work for the first time. Within the health system it is also a time of transition from childrens' to adults' services, with the need to become more self reliant. Some will be moving into their own accommodation. It is also a time of developing relationships. The social and economic context of their lives is changing – for many it is a new and different world, exciting and also challenging. It is a time of adjusting to new responsibilities and the transition can involve positive and negative experiences, with increased freedom or independence, but also increased stress.

Ready for Adult Life

Down Community Arts

Based in Downpatrick, Down Community Arts provides a programme called "Healthy Headz" targeted at young people from Ballynahinch, Saintfield, Crossgar and Killyleagh identified through the Youth Service of SEELB as being at risk, marginalised or unattached to existing provision. The programme aims to address areas such as anti-social behaviour, drug and alcohol misuse, mental, sexual and physical health, self-confidence and community ownership.

6.4 While it is generally a time of peak health[28], it is often associated with risk taking behaviour – such as alcohol and drug misuse – with little realisation of the potential impact on future health. Maintaining healthy behaviours and sustaining good physical, sexual and mental health through this period into adulthood is important.

6.5 Young people are the group most likely to be unemployed and to be in low-skilled, low paid jobs. The number and type of jobs available to those with low level skills is increasingly in decline, with jobs growth predominantly in employment which requires higher skills. The evidence points to the importance of providing the opportunities for young people to acquire higher levels of skills and qualifications, and work based learning routes beyond the compulsory education age of 16.

6.6 DEL's "Access to Success" aims to widen participation in higher education by students from groups who are currently under-represented, in particular students from disadvantaged backgrounds and those with disabilities and learning difficulties.

6.7 A key concern relevant to the current economic climate is the high number of young people who are not in employment, education or training (NEETS). This has the potential to impact negatively on longer term outcomes for this group in terms of their future economic status and ultimately their health and wellbeing. DEL leads on the 'Pathways to Success' Strategy which is the Executive's formal strategy for addressing their needs. This has a particular focus on helping those young people who face barriers to participation.

6.8 DEL's Employment Service and a range of other government programmes will also work to address this and the wider issue of unemployment through a range of schemes (including those targeted at particular groups such as young care leavers, people affected by drug/alcohol misuse, etc). In addition, through the new "Building a United Community" a number of planned initiatives, such as the "United Youth Programme" will benefit this group. Other key mainstream DEL provision, such as the Careers Service, will continue to support young people in identifying and progressing towards their career goals.

OUTCOME 4 READY FOR ADULT LIFE

Actions and Commitments 2013 – 2015

A Provide young people with access to –

- careers information advice and guidance as required, to enable them to make effective career/learning choices
- a guarantee of a training place for those in the 16 and 17 year old age group (up to age 24 in special circumstances) who have left school
- opportunities to gain Essential Skills qualifications in literacy, numeracy and ICT from entry level to level 2 that will help young people improve their employability as well as overall quality of life

Key Partners
DEL

B Make tailored health and safety information available to all young people entering work for the first time

Key Partners
DETI / HSE

C Promote employability schemes in public and private sectors targeted at young and long term unemployed

Key Partners
DEL / others

OUTCOME 4 READY FOR ADULT LIFE Continued

Actions and Commitments 2013 – 2015 Continued

D Implement the cross-departmental "Pathways to Success" Strategy for young people not in education, employment or training. (NEETS)

Key Partners
DEL / DE / others

E Development and delivery of the United Youth Programme offering young people employment, work experience, volunteer and leisure opportunities along with a dedicated programme designed to foster good relations and a shared future

Key Partners
DEL / OFMDFM / DE

F PCSPs work collaboratively with local government and relevant partners to intervene early with young people at risk of offending

Key Partners
DOJ / Local government / other local partners

G Take forward relevant outcomes in Care Matters aimed at reducing exclusion and marginalisation –

- maintain appropriate support for young people in and leaving care in higher and further education
- enhance current employability services for each Trust area providing dedicated education and training support
- maintain young people in and leaving care in suitable, affordable and safe accommodation with financial support whilst in higher education/training
- continue to provide fostering services for 18+ in care and provide a point of contact adviser up to age 25

Key Partners
DHSSPS / DEL / HSC

5 EMPLOYMENT, LIFE-LONG LEARNING AND PARTICIPATION

6.9 Adults in Northern Ireland now generally enjoy better health and can expect to live longer than previous generations. However there are still many challenges in respect of health inequalities, including increasing long term damage related to health behaviours such as poor diet, low levels of physical activity, smoking, and alcohol consumption for many.

6.10 As well as physical health it is clear that mental health is a major public health concern in Northern Ireland, necessitating a strong strategic drive to prevent mental illness (where possible) and promote positive mental health and wellbeing in the general population. This will be taken forward through the development of a new cross-departmental strategy to promote positive mental health in the Northern Ireland population. (see Chapter 7)

6.11 Being a parent is a life-changing experience which can be wonderful and challenging at the same time. Good parenting is a key life skill – chapter 5 outlines the importance to both individuals and society as a whole, of giving every child the best start through positive and nurturing early life experiences and through maintaining strong, loving and respectful family relationships as they grow. Supporting and empowering the current generation of parents to shape the next is of vital importance to building a better future for Northern Ireland society. Early intervention initiatives in schools, such as Roots of Empathy[29], also help to build the capacity of the next generation for responsible citizenship and responsive parenting.

6.12 There is a clear link between work and the health of individuals and their families. Being in good employment is protective of health[30]. Conversely, unemployment and poor quality employment contribute to poor health. Employment with a reasonable wage is the best path out of disadvantage and poverty, therefore getting people into such work is of critical importance for reducing health inequalities. However, jobs need to be sustainable and be of sufficient quality, to include not only a decent living wage, but also opportunities for development, the flexibility to enable people to balance work and family life, and protection from working conditions that can damage health.

6.13 In addition to supporting the growth of the labour market and ensuring access to good jobs, there must be support for overcoming the barriers to employment – for example through employability schemes, investing in work experience and qualifications, and in education, childcare and health condition management.

Employment, lifelong learning and participation

CAWT – Travellers

Co-operation and Working Together (CAWT) is the cross border health and social care partnership, comprising the Health Service Executive in the Republic of Ireland and the Southern and Western Health & Social Care Trusts, the Health and Social Care Board and the PHA in Northern Ireland.

The CAWT Social Inclusion Project is focused on reducing health inequalities for specific groups, one of which is travellers who are the most marginalised ethnic minority in Ireland with the worst health indicators. The project includes training programmes for twenty Travellers. One update reported that of the 18 participants who completed the Employment and Skills Training, three were working full time in community development, youth work and HGV driving. Another four were completing work placements in the Southern Trust and HSE DNE areas.

After the EU funding phase, the PHA and Western Local Commissioning Group planned to build on the work done by the project to promote social inclusion for Travellers and to create a steering group with representation from interested agencies, to help build the infrastructure to support work to improve Travellers' health and wellbeing.

6.14 Lifelong or adult learning has the potential to impact on health inequalities by providing skills and qualifications to enhance employment opportunities, and also by improving self esteem and confidence, which have been shown to be associated with healthier behaviours. Evidence which informed the Marmot Review also suggests that adult education increases social capital, which is in turn associated with better health. DEL's Essential Skills for Living Strategy aims to ensure that all working age adults have the opportunity to gain recognised qualifications from Entry Level to Level 2 in Literacy, Numeracy, and Information Communication

Technology (ICT), to help them gain employment as well as promoting greater economic development, social inclusion and cohesion.

6.15 DEL's Skills Strategy *"Success Through Skills – Transforming Futures"* aims to raise the skills level of the whole workforce, raise productivity and increase levels of social inclusion, by enhancing the employability of those currently not in the labour market. DEL and its key providers, such as the Further Education colleges, will provide developmental opportunities to support those who wish to enter the Northern Ireland workforce, as well as those already in work.

6.16 Childcare is a critical enabler to help parents into work, move families out of poverty and help to break the cycle of inter-generational deprivation. Supported by an affordable, flexible and accessible childcare sector, parents can access work, improve their workplace skills and their employability, or continue to be economically active. *Bright Start – The Executive's Programme for Affordable and Integrated Childcare* sets out the framework, principles and a range of key first actions, to move towards the establishment of an improved and expanded system of childcare.

OUTCOME 5 EMPLOYMENT, LIFE-LONG LEARNING AND PARTICIPATION

Actions and Commitments 2013 – 2015

A Contribute to rising levels of employment by supporting the promotion of 25,000 jobs by 2015 as set out in the Northern Ireland Economic Strategy

Key Partners
DETI / DEL

B Provide all citizens as required, with careers information advice and guidance to enable them to make effective career/learning choices

Key Partners
DEL

C Support all citizens who avail of Employment Service programmes and services towards employment

Key Partners
DEL

OUTCOME 5 EMPLOYMENT, LIFE-LONG LEARNING AND PARTICIPATION Continued

Actions and Commitments 2013 – 2015

D Up-skill the working age population by delivering over 200,000 qualifications

Key Partners
DEL / FE

E Provide continued access by adult learners to FE provision including Essential Skills, subject to demand locally, for their economic and/or social benefit

Key Partners
DEL / FE

F Through **"Access to Success"** the NI Strategy for Widening Participation in Higher Education provide support to the most able but least likely people from disadvantaged backgrounds to raise their aspirations, and educational attainment, in order that they can progress to the higher education provision that is right for them, irrespective of their personal or social background (particular focus on people identified as under-represented in higher education)

Key Partners
DEL / DE / HEIs / FECs / and others

G Assist people with mental and physical health and disability related barriers to employment to improve their chances of finding and sustaining employment through the provision of appropriate services and programmes

Key Partners
DEL / DHSSPS / HSC Third sector specialist disability organisations

Employment, lifelong learning and participation

Men's Shed

The 'Men's Shed' concept has gained popularity in Northern Ireland in recent years, as a way to promote social interaction and wellbeing of men.

The Shed is a space for men to come together to work on DIY projects, learn new skills and socialise. It provides a safe, friendly and inclusive

environment where older people can feel more supported and secure in their own community and within their own peer group. Participants can, among other things, work on a meaningful project at their own pace, in their own time and in the company of other men. The primary objective is to use the facility and the support network generated, as a means to advance the health and wellbeing of the participants by encouraging them to become involved in a broader range of programmes targeted at addressing their specific needs.

The Men's Shed is open to men aged 50 years and over. There are Men's Shed in Ballymena and Armagh.

5 HEALTHY ACTIVE AGEING

6.17 Longer life expectancy is a positive outcome to be welcomed. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. Older people can be a valuable resource for their families, communities and the economy. However, for some, old age brings with it a high risk of social isolation and poverty, including fuel poverty, with limited access to affordable, good quality services. Many care for a partner, which can bring physical and psychological burdens, while others living alone can feel isolated. Older people living in rural areas may be particularly vulnerable to social isolation and in need of support and access to services.

6.18 It is important for older people to be able to maintain active independent lives, with access to all the income and benefits to which they are entitled, and opportunities to engage in social and educational activities. There is a need to ensure that future policies, programmes and investment across government are "age friendly" and complementary to each other. Areas such as housing, transport, access to community services, safety, opportunities for lifelong learning and employment can have a major impact on the health and wellbeing of older people. A new cross-cutting strategy is under development to promote and enable "active ageing".

Healthy Active Ageing

Silver Surfer's Day

For a number of years a "Silver Surfer's Day" has been run for the over 50s in local libraries.

Organised by Business in the Community in partnership with the Department of Finance and Personnel and Libraries NI, business volunteers are on hand to help and provide invaluable advice to those wishing to get to grips with technology and surf the internet with free training.

"Silver Surfers" learn how to set up an e-mail account, send e-mails, bank online, access government services through the nidirect website, shop etc. "Silver Surfers' Day" encourages people to go online, addressing barriers, promoting the benefits of accessing the Internet, and seeing the convenience of online public services. Library services are free for everyone, with free computer and internet use for library members.

6.19 To meet the challenges of ageing populations, including older people with disabilities, there needs to be an increased emphasis on health promotion, disease prevention and physical and mental rehabilitation, which incorporates a life-long approach to positive health. Action should focus on:

- advancing health and wellbeing into older age;
- reducing inequalities experienced by older people;
- promoting the inclusion and full involvement of older people in society and their local communities; and
- improving the provision, quality and safety of services and care to address the needs of people as they age.

Me Unlimited

In 2011 a report from the Princess Royal Trust for Carers found that:

- *70% of older carers suffer poor health because of their caring role;*
- *65% have a long-term health problem or disability; and*
- *69% reported that caring has an adverse impact on their mental health.*

A social economy initiative "Me Unlimited", has been commissioned by the PHA to provide tailored personal development programmes to support older carers. The programme aims to build coping, resilience and self-management and self-care skills, encouraging carers to plan for a positive future. Older carers of people with dementia and isolated older male carers have been among those to benefit.

6.20 "Transforming Your Care" promotes the home as the "hub" of care for older people where it is safe and appropriate to do so. This will include developing Integrated Care Partnerships* to support the provision of joined up care and support for frail older people, developing safe, suitable alternatives to statutory residential accommodation and working to address carers' needs.

6.21 Work is already under way in Belfast to establish "age friendly[31]" environments, which can support both older people and those with children, and we wish to encourage the new Councils being established here to commit to the WHO "age friendly" approach. There is a need to consider how the concept can be extended to other communities, including those in more rural areas. This issue is also considered in Chapter 10 in relation to "space and place".

* Integrated Care Partnerships "are multi-sector collaborative networks of health and social care providers that come together to respond innovatively to the assessed care needs of local communities."

OUTCOME 6 HEALTHY ACTIVE AGEING

Actions and Commitments 2013 – 2015

A Improve job outcomes by providing temporary work for those aged 50+ who are unemployed and claiming benefit through the Steps to Work – Step Ahead 50+

Key Partners
DEL

B Promote healthy active ageing, through opportunities to participate including for example through volunteering and opportunities for learning

Key Partners
OFMDFM / DHSSPS / DEL / DCAL/ DSD / HSC other Departments / Volunteer Now / Local government / Community and Voluntary and Business sectors

C Delivery of the cross-cutting Active Ageing Strategy which will promote age friendly environments using the WHO Age Friendly Environments programme

Key Partners
OFMDFM and DOE in association with PHA and Councils

D Promote home as the "hub" of care for frail older people through the outworking of TYC

Key Partners
DHSSPS / HSC / Community and Voluntary Sector

E Take forward public engagement to promote good nutrition.

Key Partners
DHSSPS / PCC / Nutrition Coalition

Key Strategies/ strategic programmes – Essential Skills for Living, Success through Skills – Transforming Futures, Access to Success – an Integrated Regional Strategy for widening Participation in Higher Education, Further Education means Business, Pathways to Success, Build Pathways to Employment, Employment Service programmes, Training for Success / Bridge to Employment / Youth Employment scheme, draft Economic Inactivity strategy, Delivering Social Change Signature Programmes, Community Family Support Programme, NI Economic strategy, Reducing Offending strategy, Care Matters, Join In – Get Involved, Sport Matters, Draft Active Ageing strategy, Transforming Your Care, Making it Better – A Strategy for Pharmacy in the Community, Promoting Good Nutrition – A Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016.

CHAPTER 7 – EMPOWERING HEALTHY LIVING

Key long term outcomes:

7 **Improved health and reduction in harm**

8 **Improved mental health and wellbeing, and reduction in self harm and suicide**

9 **People are better informed about health matters**

10 **Prevention embedded in services**

7 IMPROVED HEALTH AND REDUCTION IN HARM

Healthy Behaviours

7.1 People's behaviours – whether they smoke, how much they drink, what they eat, whether they take regular exercise – are widely recognised as affecting their health and risk of dying prematurely. Recent work by the *Kings' Fund: Clustering of unhealthy behaviours over time (2012)*[32] which looked at the prevalence and co-distribution of risk factors associated with smoking, excessive use of alcohol, poor diet and low levels of physical activity, found that a significant minority of people in western developed countries have three or more risk factors. This trend is more common in some groups than others - several studies have found a consistent socio-demographic gradient in the prevalence of multiple risk factors, with men, younger age groups and those in lower socio economic groups and with lower levels of education being more likely to exhibit multiple lifestyle risks.

7.2 This work argues for a move away from a silo approach to promoting particular healthy behaviours, towards interventions which adopt a more holistic and integrated approach. The "clustering" of lifestyle with medical risk factors is the most important issue related to risk and will require integrated approaches which take account that many people will present with several risk factors at the same time.

7.3 *The House of Commons Health Committee's Health Inequalities inquiry (2009)*[33] highlighted several reasons why the poorest in society are less likely to adopt beneficial health behaviours. These included:

- lack of information;
- lack of material resources to live healthily;
- environments in which they live may make it difficult, for example smoking tends to be more " heavily entrenched in those from lower socio-economic groups which makes positive change harder"; and
- more difficult lives including problems such as low income, lack of employment or personal safety concerns – these may mean that changing health behaviour is unlikely to be a major priority.

7.4 Men and women are prone to different diseases and prevalence of health behaviours. In addition some population groups such as ethnic minorities including travellers, LGB&T, people with disabilities face specific challenges to their health and wellbeing including vulnerability to certain conditions and to broader issues such as social exclusion. Programmes and services at regional and local level should be accessible and address specific needs and risk factors, including those of vulnerable groups.

Health Protection

7.5 Population screening programmes have a key role to play in early detection of disease and a range of programmes are currently available in Northern Ireland. Organised screening programmes are only established on the recommendation of the UK National Screening Committee and according to the best available evidence. Any condition being considered as a screening programme must meet a number of stringent criteria before it is recommended by the Committee.

In Northern Ireland the following screening programmes are in place:

- Abdominal Aortic Aneurysm (AAA) Screening
- Antenatal Screening
- Breast Cancer Screening
- Cervical Cancer Screening
- Bowel Cancer Screening
- Diabetic Retinopathy Screening
- Newborn Screening

Work needs to continue to address any potential inequalities in the uptake and coverage of all screening programmes.

7.6 Vaccination programmes are the best and most effective way to prevent someone becoming sick from various infectious diseases. In Northern Ireland as in the rest of the UK, vaccination policy is informed by the Joint Committee on Vaccination and Immunisation (JCVI), an independent expert advisory committee that advises the four UK Health Ministers. In formulating its advice and recommendations, the Committee's aim is to ensure that the greatest benefit to public health is obtained from the most appropriate vaccination and immunisation strategies. Young babies are most vulnerable to infections and therefore the majority of vaccination programmes are aimed at babies and children. There is also an annual seasonal flu vaccination programme and in 2013 a shingles vaccination programme aimed at those aged between 70 and 79 was introduced.

7.7 Antimicrobial resistance (AMR) has been recognised for many years and efforts have been made to arrest or mitigate the development of resistance by using antibiotics more appropriately and effectively in both humans and animals. However, the threat of AMR is now a priority internationally, across the UK and in Northern Ireland. DHSSPS published the Strategy for Tackling Antimicrobial Resistance in July 2012. Link - **http://www.dhsspsni.gov.uk/star-doc.pdf**

This is in line with the UK 5-year AMR strategy published in September 2013. Actions include improving infection prevention and control to prevent cases of infection occurring in the first place; educating professionals and the public to use antimicrobials appropriately; improving the monitoring and surveillance of resistant organisms, and research. Everyone has their part to play, and coordination of efforts is crucial.

7.8 The Department's role as Lead Government Department for the health and social care consequences arising from emergencies places a responsibility on it to respond at a strategic level and maintain a state of readiness to address and mitigate certain threats and hazards which have the potential to affect Northern Ireland.

7.9 In Northern Ireland four regional statutory bodies have lead roles and responsibilities in relation to food safety, diet and nutrition: the Department of Health, Social Services and Public Safety; the Food

Standards Agency in Northern Ireland, which is a non-ministerial government department; the PHA, and the Food Safety Promotion Board (*'Safefood'*) which is a Northern Ireland-Republic of Ireland implementation body established under the terms of the 1998 Belfast Agreement. Other bodies have a remit in this field, including other government departments and local authorities, who are responsible for certain enforcement functions. In 2012, at the behest of the Health Minister for Northern Ireland, a review was carried out with the aim of ensuring that the lead bodies would work effectively, would complement each other and would provide maximum value for money in respect of the provision of high quality scientific and policy advice relating to food safety, diet and nutrition. The recommendations of the review are being implemented. These include arrangements to strengthen coordination between the four lead bodies concerned.

OUTCOME 7 IMPROVED HEALTH AND REDUCTION IN HARM

Actions and Commitments 2013 – 2015

A Develop and implement strategies, action plans and targeted programmes to –

- reduce the number of people who:
  - smoke;
  - are overweight or obese;
  - drink above the recommended alcohol limits;
  - misuse drugs.
- reduce the number of births to teenage mothers, particularly in disadvantaged areas
- reduce sexually transmitted infections (STIs) including HIV
- increase breastfeeding rates
- improve oral health through a regional caries prevention programme, and programmes to increase dental services utilisation
- reduce preventable hearing and sight loss

OUTCOME 7 IMPROVED HEALTH AND REDUCTION IN HARM Continued

Actions and Commitments 2013 – 2015

A Continued –

- halt the rise in the incidence of skin cancer
- encourage more proactive ill health prevention amongst men

Key Partners
DHSSPS / PHA / DE / DCAL / DSD / other public bodies including local government, community and voluntary sector.

B Achieve and maintain high uptake rates of screening programmes, immunization and vaccination programmes across all areas and target populations, and introduce new vaccination programmes in line with expert advice

Key Partners
DHSSPS / HSCB / PHA / Trusts

C Establish a group to coordinate efforts to tackle antimicrobial resistance in both human and veterinary medicine

Key Partners
DHSSPS / DARD

D Maintain state of readiness for emergencies through management and replenishment of regional stockpile of health countermeasures and any associated vaccination programme

Key Partners
DHSSPS / HSCB / PHA / Trusts / BSO

OUTCOME 7 IMPROVED HEALTH AND REDUCTION IN HARM Continued

Actions and Commitments 2013 – 2015

E Develop and deliver a joint healthcare and criminal justice strategy to improve the health and wellbeing of offenders and reduce the risk of poor health (including mental health problems) leading to offending or reoffending

Key Partners
DHSSPS / DOJ / HSCB / PHA / HSCTs

F Ensure a co-ordinated approach across lead bodies with responsibility for food safety, diet and nutrition

Key Partners
FSA / DHSSPS / PHA / FSPB

8 IMPROVED MENTAL HEALTH AND WELLBEING, AND REDUCTION IN SELF HARM AND SUICIDE

7.10 New policy is under development to set the strategic direction to improve mental health and wellbeing and reduce self harm and suicide. In the meantime, a broad range of programmes and services are in place to promote positive mental health and reduce suicide. These include the Lifeline service, support for community-led initiatives, "gatekeeper" training, education and awareness programmes, and intervention on deliberate self harming. DHSSPS is working with DARD and DCAL on a joint initiative to promote mental health awareness and help-seeking behaviour through rural networks, sporting and cultural organisations. The Health In Mind project delivered by Libraries NI promotes positive mental health and wellbeing through the provision of information, activities, learning and reading resources. The project aims to reduce the stigma attached to mental illness. Departments of Education and Health, Social Services and Public Safety have also worked together to promote mental health awareness through the pupil's emotional health and wellbeing programme ("iMatter"). Progress on all of these areas is reported regularly to a Ministerial Co-ordination Group.

7.11 In the context of an ageing population, dementia is growing as a public health issue. It is intended that the new positive mental health promotion policy will address two main tasks in relation

to dementia: firstly, public health efforts to prevent/ delay dementia as far as possible and to encourage early diagnosis; and secondly, improving the mental wellbeing of people who have dementia.

OUTCOME 8 IMPROVED MENTAL HEALTH AND WELLBEING, REDUCTION IN SELF HARM AND SUICIDE

Actions and Commitments 2013 – 2015

A	Develop new policy to promote positive mental health, reduce self harm and suicide **Key Partners** DHSSPS / other Departments / HSC / Voluntary and Community sector.
B	Increase resilience and improve mental wellbeing in children and young people through implementation of initiatives outlined in theme 1 including eg Family Support, Roots of Empathy, iMatter (pupil's emotional health and wellbeing programme) – *particular focus on children and young people from families at risk* **Key Partners** DE / DHSSPS / PHA
C	Reduce the levels of self harm through roll out of successfully evaluated approaches, *focussing in particular on people who repeatedly self harm, people treated at A&E for injuries due to deliberate self harm* **Key Partners** DHSSPS / PHA / HSC / others
D	As part of the joint healthcare and criminal justice strategy, work to identify and support people with mental ill-health or other vulnerabilities who have offended. *Young people with mental health / communication problems in the juvenile justice system identified for targeted action.* **Key Partners** DoJ / DHSSPS / PHA / HSCB / HSC Trust ***Sport's Support for 'Protect Life,' Suicide Prevention Strategy and Action***

Plan

SportNI, an arms-length body of DCAL, has developed a 'Suicide Awareness through Sport Communications Strategy' with the support of the PHA and Lifeline. This was launched in June 2012. The purpose of the Communications Strategy is to raise awareness of suicide within the sporting community; provide suicide awareness training to sports providers; and encourage sport and sports personalities to support public information campaigns. A range of activities are now being undertaken by sport in support of the Protect Life Strategy.

The 'Suicide Awareness Through Sport Communications Strategy' will continue to be developed and strengthened in line with experience and new ideas emerging from sports organisations, counselling service groups and other stakeholders and partners.

Health in Mind

Health in Mind brings together Libraries NI, Aware Defeat Depression, Action Mental Health, MindWise and CAUSE, who work together and use their expertise to support people to learn more about mental health and how to look after their wellbeing.

Health in Mind is an innovative partnership project which brings together four mental health charities and Libraries NI. By working together and using their expertise in new and fresh ways, it aims to give adults affected by poor mental health, the chance to improve their lives.

Funded by the Big Lottery and Learn Programme until 2015.
For further information: ***www.healthinmindni.net/about/***

9 PEOPLE ARE BETTER INFORMED ABOUT HEALTH MATTERS

"Health Literacy – the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health." – Nairobi, WHO, 2009

7.12 Health literacy means more than being able to read pamphlets; it empowers people to make healthier choices, decide to change their life style and take action. Some published definitions[34] present health literacy as a set of individual capacities that allow the individual to acquire and use new information. Health literacy is dynamic, being influenced by both the individual and the health care system.

7.13 Everyone has a personal responsibility for making decisions which can impact on their own health and wellbeing, but some may need more support than others, for example, when there are conflicting messages. Health and social care professionals including the independent Family Practitioner Services can help and guide people to make appropriate choices - the role of all professionals is not just about treatment when people are ill. It also encompasses supporting people to stay well and live more healthily, including those already living with a condition. This may be through giving them information and support about healthy living and guiding them to any further help they may need. The potential of the front-line workforce needs to be maximised. To this end, DHSSPS is considering the workforce implications and recommendations following England's strategy *"Healthy Lives, Healthy People"* and the associated Public Health Workforce Strategy.

7.14 In many cases it may be that individuals could be supported by a different service either within or outside of the Health and Social Care system, or perhaps by a wider public or community-based service. It will be important that HSC professionals look to build linkages to support services beyond their own specialty, and beyond the HSC to be able to signpost access to appropriate help.

7.15 Improving health literacy aims to influence not only individual lifestyle decisions, and decisions about treatment and self care, but also raise awareness of the determinants of health, and encourage individual and collective actions – at all levels of society - which may lead to a modification of these determinants. Improving health literacy needs to go beyond a narrow concept of health education and individual behaviour, and address the environmental, political and social factors that determine health.

OUTCOME 9 PEOPLE ARE BETTER INFORMED ABOUT HEALTH MATTERS

Actions and Commitments 2013 - 2015

A Empower people to make healthier choices and informed decisions about their health by improving health literacy. This will include –

- providing appropriate and accessible health information (making greater use of modern communication technology) and advice to all, which is evidence informed and tailored to meet specific needs, and which
  - encourages more people to present with early symptoms of health problems to HSC services
  - promotes self-care, and sign-posts to appropriate support through, for example patient education/self management programmes

This should have a specific focus on groups at risk of developing conditions, and those with conditions who are at risk of exacerbating or developing complications. It will be important that appropriate links are made with the work being taken forward through Integrated Care Partnerships as part of TYC.

Key Partners
DHSSPS / PHA / HSC / Local government / Community and Voluntary sectors, others including eg NUS – USI

B Promote healthy active ageing, including further opportunities for more active promotion of health and wellbeing in nursing and care settings

Key Partners
DHSSPS / HSC / others

OUTCOME 9 PEOPLE ARE BETTER INFORMED ABOUT HEALTH MATTERS

Actions and Commitments 2013 - 2015

C Develop and deliver a Community Resuscitation Strategy to focus a drive to increase the number of people, of all ages, trained in Emergency Life Support skills and to coordinate the use of available resources

Key Partners
DHSSPS / PHA / DE / DCAL community and voluntary sector

One-Stop-Shops

In 2009, the PHA to developed a pilot programme of 4 'One Stop Shop' drop in services for children and young people that provide information, education, sign-posting and, where appropriate, referral to specialist services. The programme sought to address a range of issues including but not exclusively: substance misuse; suicide and self harm; mental health and wellbeing; sexual health; relationship issues; resilience; and coping with school/employment.

Following positive evaluation, the PHA has been rolling out a range of 'One-Stop-Shops' across Northern Ireland. There are now eight services as follows:

- *Carrickfergus YMCA – Carrickfergus*
- *FUEL – Enniskillen*
- *Magnet Centre – Newry*
- *FASA – Belfast*
- *FASA – Bangor*
- *Dove House – Londonderry*
- *Opportunity Youth – Ballymena*
- *REACT – Banbridge*

10 PREVENTION EMBEDDED IN SERVICES

7.16 The HSC's role in preventing poor health and promoting healthy living is vital to reduce health inequalities, but also to sustain the HSC into the future. The ethos of supporting individuals, families and communities to maintain and improve their health needs must be fully embedded as a normal way of working right across all organisations, environments and activities within the HSC system. This is not just in day to day interactions with every member of the public, but also as part of commissioning and designing health services. Service Frameworks are a key reference point for commissioning and designing services to secure better integration of service delivery along the whole pathway of care from prevention of disease /ill health to diagnosis / treatment and rehabilitation, and on to end of life.

7.17 Commissioners must ensure that health improvement and addressing health inequalities are embedded within commissioning plans. Healthcare providers must build the promotion of good health into service and pathway design, contracts and service delivery and ensure that it is both integral to the care they provide and the work that they do with their communities. This also includes ensuring that health settings are health promoting for those receiving treatment or care, visiting and for those working there. Health organisations should also consider their contribution to tackling the wider determinants of health through, for example, providing opportunities for volunteering, work experience and employment, or employability schemes, and through maximising the use of social clauses in procurement contracts.

7.18 *"Transforming Your Care: Review of Health and Social Care in Northern Ireland"* set out key proposals for change across a range of service areas, including mental health services, services for older people, acute services and primary care. It also includes a focus on prevention, and earlier interventions, as part of the model of Integrated care closer to home. Key outcomes for TYC include:

- more services will be provided locally with opportunities to access specialist hospitals where needed;
- more people will be cared for at home, where it's safe and appropriate to do so;

- doctors, nurses, social workers and everyone providing care will work together in partnership to help keep people healthy;
- people will get support to stay healthy, make good health decisions or manage their own conditions; and
- investment in new technology will help people stay at home or receive care locally rather than in hospitals.

7.19 HSC efforts must combine integrated planning, commissioning and service delivery including community development and engagement approaches, collaboration, and personal effort.

OUTCOME 10 PREVENTION EMBEDDED IN SERVICES

Actions and Commitments 2013 - 2015

A Increase the emphasis on prevention and early intervention in the commissioning and delivery of Primary, Community, and Secondary Care services including –

- health professionals, particularly within primary care and Emergency departments, trained and encouraged to undertake substance misuse brief interventions and suicide prevention/mental health promotion intervention programmes across NI
- arrangements for Primary and Community sector to deliver accessible sexual health services
- strengthening the focus on improving the mental and physical health and wellbeing of those in contact with mental health services or with a learning disability
- encouraging public health and patient education/self management interventions alongside clinical approaches for people with long term conditions, for example diabetes

Key Partners
DHSSPS / HSCB / PHA / Trusts / GPs

OUTCOME 10 PREVENTION EMBEDDED IN SERVICES Continued

Actions and Commitments 2013 - 2015

B Continue implementation of Integrated Care Partnerships with an initial focus on frail elderly and aspects of long term conditions, namely stroke, diabetes and respiratory conditions and end of life and palliative care in respect of these areas of initial focus

Key Partners
DHSSPS / HSC / other partners inc community and voluntary sector

C Increase the share of the health budget spend on prevention and early intervention and develop mechanisms to monitor this across the HSC, in line with the PFG commitment

Key Partners
DHSSPS / HSCB / PHA / Trusts

CAWT (Co-operation and Working together for Health Gain and Social Wellbeing in Border Areas)

CAWT has been taking forward a GP training scheme. This training provided practical tips in carrying out consultations with a range of minority groups such as Travellers, LGBT, the hearing impaired, those with sight loss etc. The participating GPs commented that the session provided much that they had been unaware of previously in terms of knowledge and attitude.

Key Strategies/ strategic programmes - Protect Life, Tobacco Control Strategy, New Strategic Direction for Alcohol and Drugs, A Fitter Future for All, Teenage Pregnancy and Parenthood strategy, Sexual Health Promotion strategy, Breastfeeding - A Great Start, Strategy for Tackling Antimicrobial Resistance, Sport Matters, Transforming Your Care, Making it Better - A Strategy for Pharmacy in the Community, Long Term Conditions Policy Framework, Strategy for improving the lives of those with disabilities 2012 - 2015, NI Civil Contingencies Framework, UK Influenza Pandemic Preparedness Strategy (DHSSPS as NI lead), Programme for Government Commitment 44 - patient education for people with long term conditions, Programme for Government Commitments 22 – investment in public health and 45 investment to tackle obesity.

MAKING LIFE BETTER

THEME 4

CHAPTER 8 – CREATING THE CONDITIONS

Key long term outcomes:

11 **A decent standard of living**

12 **Making the most of the physical environment**

13 **Safe and healthy homes**

8.1 This theme focuses on the wider economic and environmental determinants that provide the fundamental conditions to support good health and wellbeing. These include the economy, which affects employment and income levels, the wider physical environment and infrastructure, and living conditions.

8.2 This theme is confined to policies and programmes which are within the remit of the NI Executive. Where appropriate DHSSPS and the Executive will advocate for changes to national policies in order to bring about improvements in the health and wellbeing of the Northern Ireland population.

8.3 There is growing recognition of the impact and mutual reliance of public policies on each other and the need therefore for inter - connectedness, reinforcement and cross-cutting collaboration both in policy development and implementation. Creating the conditions for good health and wellbeing will require a "whole system" approach across government and through intersectoral working, which ensures that connections between relevant initiatives are maximised. Chapter 11 considers this issue further, including the option of establishing thematic sub-groups where it may be considered beneficial.

11 A DECENT STANDARD OF LIVING

8.4 The *WHO* asserts that poverty is the single largest determinant of health, and ill health is an obstacle to social and economic development. The Executive has made the economy the top priority in the 2011-2015 PFG with the challenge to re-build the Northern Ireland labour market and rebalance the economy to increase living standards.

8.5 Health is a key factor in productivity, economic development and growth. Both the PFG and the *NI Economic Strategy* acknowledge the inter-relationship between prosperity and population health. Healthier people are more productive and improved health and wellbeing will contribute to positive economic outcomes for both individuals and wider society. At the same time enhancing employability, skills development, incentives and job creation, vital to promoting a vibrant economy, are conducive to improved population health. In addition to efforts to promote employment and prosperity, action is needed to mitigate the impact of poverty and the potential for negative impact of welfare reforms, and to provide more opportunities for work experience and employment. Other commitments on improving benefit uptake and improving budget management skills aim to support individuals and families to maximise their income.

OUTCOME 11 A DECENT STANDARD OF LIVING

Actions and Commitments 2013 – 2015

A Increase employment and prosperity for all by delivering the commitments set out in the Northern Ireland Economic Strategy

Key Partners
All Executive Departments

B Reduce economic inactivity through development and implementation of a strategy for skills, training, incentives and job creation, and careers advice

Key Partners
DEL / DETI / others

C Mitigate the impact of poverty and the potential for negative impact of individual welfare reforms through –

- delivering a range of key targeted actions, by way of the Delivering Social Change Framework, including the Social Investment fund
- reduce the number of births to teenage mothers, particularly in disadvantaged areas

Key Partners
OFMDFM / DSD / DHSSPS / DE / DEL / DETI / DARD / others

OUTCOME 11 A DECENT STANDARD OF LIVING Continued

Actions and Commitments 2013 – 2015

C Continued –

- publishing and implementing a plan for improving uptake of benefits to ensure people have the opportunity to maximise their income levels

Key Partners
DSD

- developing and implementing a new discretionary support service to help people most in need through the provision of immediate financial assistance and encouraging longer term financial independence

Key Partners
DSD / SSA

- developing a financial capability strategy to ensure people have budget management skills

Key Partners
DETI

- developing a co-ordinated strategic approach to address food poverty.

Key Partners
DHSSPS / DSD / FSA / PHA / DARD / other departments / Safefood / Local government / other sectors

D Provide more opportunities for work experience and employment through, for example, maximising the use of social clauses in procurement contracts, and the potential contribution of employability schemes through public and private sector organisations – *this focuses on the unemployed, particularly the young and long term*

Key Partners
Government departments / public agencies inc HSC / Local government etc.

Mitigating the impact of poverty and social isolation in rural communities

MARA (Maximising Access in Rural Areas)

The MARA project is a cross departmental regional project funded by DARD through the Tackling Rural Poverty and Social Isolation Framework and managed by the PHA. Other key organisations involved include DSD (Social Security Agency and Fuel Poverty Unit), DRD, NIHE, DHSSPS and local community and voluntary organisations.

The MARA project aims to improve the health and wellbeing of rural dwellers in Northern Ireland living in or at risk of poverty, and social exclusion by increasing access to services, grants and benefits.

The project proactively targets vulnerable households in identified rural communities using a community development approach. Community lead organisations across a number of designated zones recruit and train enablers to undertake household visits and highlight services available (local and regional) using the local directory of services, a copy of which is left in the household pack following the visit. Target groups include older people, carers, disabled people, lone parents, ethnic minorities, lone adults, farming families and/or low income families.

The MARA project in Phase I targeted the 88 (30%) most deprived rural Super Output Areas (SOAs) in Northern Ireland in 2010/11. A total of 4,135 household visits were completed and over 10,000 onward referrals were made to various departments and agencies e.g. home safety checks, benefit entitlement checks, energy efficiency checks, occupational therapy assessments for disabled facilities grants, community transport and public transport (smart pass).

Evidence from Phase I of the project suggested that visiting people in their own homes and using a "personal touch" encouraged people to avail of services and grants which they would not otherwise have known about or been able to apply for. An independent post project evaluation identified £8.62 leverage for every £1 invested.

Using lessons from Phase 1, the project is now being rolled out into the remaining 70% (198) rurally deprived SOAs in Northern Ireland over 3 years to include approx 12,000 home visits.

12 THE PHYSICAL ENVIRONMENT

8.6 Health and wellbeing is also influenced by the wider physical environment. This includes the direct and indirect effects of chemical, physical and biological hazards on health and wellbeing. It also encompasses aspects of the physical and social environment that influence individuals' health and wellbeing, such as the quality of housing and the neighbourhood environment, urban development, land use, and transport.

8.7 Physical environments can be designed to promote health and wellbeing through providing access to services and opportunities for social interaction. Numerous studies point to the physical and mental health benefits of access to green spaces and better air quality. A range of actions recognise the importance of making the most of the physical environment in promoting healthy and active living. This includes the preparation of a new single strategic planning policy statement, which will reinforce the positive role that planning can play through an approach to the development and use of land that is supportive to the health and wellbeing of people generally.

OUTCOME 12 MAKING THE MOST OF THE PHYSICAL ENVIRONMENT

Actions and Commitments 2013 - 2015

A Protect and promote good health and wellbeing through –

- improving air quality to achieve objectives and targets established to protect health, and alerting those more likely to be affected when levels of air pollution are high
- providing high quality drinking water which is clean and safe, and ensure that waste water is treated in a manner that will not harm the environment and will be if no danger to plant and animal life
- preventing waste and increasing recycling and re-use, through the Northern Ireland Waste Management Strategy
- minimizing the harmful effects of exposure to environmental noise, in line with the Environmental Noise Directive (END) by designating and protecting Quiet Areas

Key Partners
DOE / Local government

OUTCOME 12 MAKING THE MOST OF THE PHYSICAL ENVIRONMENT Continued

Actions and Commitments 2013 - 2015

B Enhance the capacity of our physical infrastructure to protect, support and provide access to healthy and active living and wellbeing through –

- completing work on the current Planning Policy Statement (PPS) programme and publish a single, strategic planning policy document which will, inter alia, address sustainable development and how health and wellbeing considerations are taken into account within the planning system
- formulating and co-ordinating policy for the orderly and consistent use of land with the objective of furthering sustainable development and promoting or improving wellbeing
- producing guidance on urban stewardship and design to promote a positive sense of place encompassing local involvement, distinctiveness, visual quality and potential to encourage social and economic activity which are fundamental to a richer and more fulfilling environment
- promoting "safe by design" approaches
- promoting age friendly environments
- addressing dereliction through the Social Investment Fund to make areas more appealing for investment and for those living there
- ensuring easier access to and sustainable use of publicly owned land including forests for sport and physical recreation
- implementation of an Active Travel Strategy Action Plan, providing increased opportunities for sustainable transport options such as walking and cycling and promotion of a number of demonstration projects

Key Partners
DRD / DOE / OFMDFM / DARD / DCAL / DOJ / DHSSPS / Local government

OUTCOME 12 MAKING THE MOST OF OUR PHYSICAL ENVIRONMENT Continued

Actions and Commitments 2013 - 2015

C Improve transportation infrastructure and services to help achieve a modern, sustainable, safe and fully accessible transport system which actively contributes to social inclusion and everyone's quality of life – this has a particular focus on older people and people with disabilities

Key Partners
DRD

D Produce a Northern Ireland Climate Change Adaptation Programme that will contribute towards building Northern Ireland's resilience to a changing climate.

Key Partners
DOE lead / all other depts. including DHSSPS

E Carry out a cross-departmental review of the implementation of the UK Children's Environment and Health Strategy in NI

Key Partners
DHSSPS / DOE / other depts and agencies

Making the most of our physical environment

Regenerated Lapwing Way Park in Clooney Estate, Londonderry.

A collaboration between the DSD - under its Neighbourhood Renewal programme, Clooney Estate Residents Association, Groundwork NI, Ulster Garden Villages, the Garfield Weston Foundation and the City Council in Londonderry has brought the Lapwing Way park back into full usage for children and families within the Clooney Estate and surrounding areas of the Waterside.

Green spaces are vital in communities to encourage community cohesion and promote healthy lifestyles. Projects like this are also instrumental in renewing civic pride in local communities.

Lapwing Way's regeneration has ensured that this outdoor space, which greatly enhances the physical appearance of the Clooney Estate as a whole,

remains a safe, secure, sustainable and neutral environment for children to play, and a vital space which can be utilised by the entire family and generations to come.

Derry City Council will continue to oversee the planning, designing and delivery of regenerated play spaces under their Parks Development Programme, and the success of the work of Clooney Residents Association at Lapwing Way will be a model for further projects, a good example of the benefit of the collaborative approach in which associations, funding and support agencies worked together for the benefit of the overall community.

13 SAFE AND HEALTHY HOMES

8.8 Housing design, accessible housing and planning that involve communities can improve social cohesion and address some of the most fundamental determinants of health for disadvantaged individuals and communities. Warm secure housing is vital for mental and physical wellbeing. Efforts will continue to deliver affordable homes, reduce levels of homelessness and to tackle Northern Ireland's high rates of fuel poverty.

OUTCOME 13 SAFE AND HEALTHY HOMES

Actions and Commitments 2013 – 2015

A Deliver 8,000 social and affordable homes as set out in the PFG

Key Partners
DSD / NIHE

B Improve the quality of the housing stock through –

- undertaking a review of the statutory fitness standard for homes in all tenures
- reviewing support for repair and improvement in the Private Housing sector with the aim of providing a new scheme to assist homeowners to deal with deterioration in their properties
- addressing dereliction and deprivation
- interventions that help those most in need and/or in fuel poverty

OUTCOME 13 SAFE AND HEALTHY HOMES Continued

Actions and Commitments 2013 – 2015

B Continued –

- improving thermal efficiency of housing stock and ensure full double glazing in all Housing Executive properties
- reviewing policy and associated legislation regulating standards within Housing of Multiple Occupation (HMO) to improve physical and safety standards and occupant behaviour

Key Partners
DSD / NIHE / others

C Deliver practical support through the Supporting People Programme which targets older people, people with disabilities and people with learning disabilities to live independently

Key Partners
DSD / NIHE / DHSSPS / HSC Board / PHA / HSCTs / OFMDFM

D Develop a new strategy to reduce unintentional injuries and deaths resulting from accidents in the home. Children and older people identified for targeted action

Key Partners
DHSSPS / PHA / Local government / Community and Voluntary sectors / NIFRS / HSCTs / HSENI / NIHE

OUTCOME 13 SAFE AND HEALTHY HOMES Continued

Actions and Commitments 2013 – 2015

E Reduce levels of homelessness and mitigate the effects of homelessness by providing support and services to those who are homeless

Key Partners
DSD / DHSSPS / HSC / others

Key Strategies/ strategic programmes - Programme for Government, NI Economic Strategy, Lifetime Opportunities Anti-poverty strategy, Tackling Rural Poverty and Social Isolation, Delivering Social Change Framework, Social Economy strategy, Success through Skills –Transforming futures, Air, Water and Waste Management strategies, Planning Policy, Accessible Transport Strategy, Active Travel Strategy, Local Government Reform programme, Road Safety strategy, Housing and Homelessness strategies, New Strategic Direction on Alcohol and Drugs, Tobacco strategy, Transforming Your Care, (Draft) Active Ageing Strategy, Strategy to improve the lives of those with disabilities 2012 - 2015.

CHAPTER 9 – EMPOWERING COMMUNITIES

Key long term outcomes:

14 **Thriving communities**

15 **Safe communities**

16 **Safe and healthy workplaces**

14 THRIVING COMMUNITIES

9.1 The communities and social networks to which people belong also have a significant impact on health and wellbeing. Support from families, friends and communities is associated with better health. Social capital – the links that connect people within communities - can promote resilience against difficulties and give people a feeling of control over their own lives.

9.2 In recent years there has been a growing recognition of the added value that participation in sport, arts and cultural activities can bring to communities. In addition to direct physical and mental health and wellbeing benefits, sports, arts and culture provide common interest and inspiration which promotes cohesion and good relations. Sports and cultural activities provide a vehicle for building social capital and creating resilient communities, and they provide opportunities for engagement, particularly of vulnerable or hard to reach groups, and for creativity. They can also generate intergenerational and environmental benefits.

9.3 It will be important to work in partnership with communities, local government and other key agencies in seeking ways both to tackle community issues and to build social capital. A number of policies and programmes operate in urban and rural communities to tackle disadvantage – including Delivering Social Change, the Urban Regeneration and Community Development Framework, and the Tackling Rural Poverty and Social Isolation Framework.

Local Government Role

9.4 Local government already makes a vital contribution to creating healthy, safe, sustainable places and thriving communities and this contribution will be further enhanced through the new arrangements

put in place by Local Government Reform. Local decision makers will play a major role in planning and shaping services around many of the physical, environmental, economic and social conditions which affect people's lives. Councils will lead and facilitate the community planning process by effective and genuine engagement with citizens and by building cross sectoral partnerships.

9.5 Local government also has a 'hands on' role in the provision of arts, leisure and community services and has regulatory functions relating to environmental health and health and safety. Its role in good relations, regeneration and planning means that it has a unique "place shaping" role which in itself is critical in creating the right conditions for thriving communities.

Capacity building

9.6 Community development is a practice which assists the process of people acting together to improve their shared conditions both through their own efforts and through negotiation with public services. It is recognised as an effective way to address imbalances in power and work with marginalised people. Its commitment to collective ways of addressing problems can be used to bring about change based on equality and inclusion, and can be used to enable people to improve the quality of their own lives, the communities in which they live and societies of which they are part.

9.7 Community development produces multiple health and wellbeing benefits precisely because it fosters the interconnections of all issues affecting a community as well as building social capital. Building bonds between individuals and communities is known to be a protective factor promoting health and wellbeing and increasing resilience. Community development projects can have dual impact – they can address a health, or social issue, while at the same time the values and processes involved begin to tackle some of the social and political processes which deal with the unequal distribution of the determinants of health. Community development is therefore a natural tool in efforts to reduce health inequalities.

9.8 There are many excellent examples of local people taking the initiative on the issues which are important to them. However there is a need for further community development to enable people to organise and work together.

9.9 The Voluntary and Community Unit (VCU) in the DSD plays a lead role, on behalf of the NI Executive Departments, in supporting a vibrant, effective and efficient Voluntary and Community Sector (VCS), which is well placed to deliver key services to often disadvantaged communities. Much of the work of VCU is geared to supporting the VCS at a regional level across Northern Ireland, or through local councils, thereby enabling the VCS to deliver vital and important services on behalf of government. Key priorities are to promote collaboration, empowering and strengthening communities, increase community participation and ensuring high quality voluntary advice services which are readily available and free at the point of need.

9.10 The Volunteering Strategy acknowledges the contribution that volunteering makes, both in benefits to those who volunteer and to wider communities. Volunteering is a shared experience, it is rewarding and of benefit to the volunteer in building skills, confidence and extending social networks. Volunteering is of benefit to society in contributing to the building of social capital and progressive social change.

9.11 Within Health, the implementation of "Working in Partnership – Community Development Strategy for Health and Wellbeing 2012-2017" will make a vital contribution to this framework. The aim is to strengthen communities and improve health and wellbeing by placing increasing emphasis on community development, prevention and early intervention. This approach will be adopted at a range of levels - with individuals, communities – recognising the different needs of rural and urban communities, and with specific groups in need to ensure the active engagement of those most marginalised.

9.12 The Building Change Trust is resourced through a National Lottery grant of £10 million as an investment for community capacity building and promotion of the voluntary and community sector in Northern Ireland. The Trust supports the sector through the delivery of and learning from a range of programmes including commissioned work, awards programmes and other interventions.

9.13 In order to empower and mobilise local people and communities to address issues for themselves, learning needs to be shared across communities and funders to ensure that benefit from actions can be demonstrated on a consistent basis. This requires a move to a shared understanding of evaluation techniques and tools, with a focus on outcomes. Work already underway through Community

Evaluation Northern Ireland (CENI) will contribute to greater collaboration in this area.

OUTCOME 14 THRIVING COMMUNITIES

Actions and Commitments 2013 – 2015

A Strengthen and promote thriving communities which are welcoming, accessible and safe, and which support social inclusion through –

- the Urban Regeneration and Community Development Policy framework which sets out clear priorities through policy objectives and supporting actions for operational programmes *(includes targeted action for disadvantaged and areas at risk)*

- supporting the development of shared and safely accessible commercial centres in our towns and cities

Key Partners
DSD / NIHE / DOE

- the new duty of community planning which will see councils, statutory bodies and the community and voluntary sectors work together to develop and implement a shared vision for promoting the wellbeing of an area

- delivery of Rural Community Development Support programmes

Key Partners
DOE / Local government / other depts and sectors / DARD / others

B Develop more cohesive and engaged communities by developing volunteering and active citizenship, and empower local people

Key Partners
DSD / DHSSPS

C Through the Social Investment Fund, support communities to Build Pathways to Employment by tackling educational under achievement and barriers to employment; tackling skills deficits and promoting job brokerage, widening access to the labour market, promoting business start up and increasing sustainability through social enterprise – *focus on targeted areas and population groups*

Key Partners
OFMDFM / DEL / DE / DETI / others

OUTCOME 14 THRIVING COMMUNITIES Continued

Actions and Commitments 2013 – 2015 Continued

D Promote healthy and thriving communities at local level, *with a particular focus on disadvantaged areas*, through –

- maximising collaboration to tackle determinants of health
- increasing access to and use of sports, arts and other leisure programmes
- maximising land/green space/woodlands use at local level to promote outdoor activities, allotments etc
- increasing access to public facilities for use by the local community
- supporting investment in social enterprise growth to increase sustainability of social enterprises and the broader community sector
- supporting the growth of the local economy through encouraging people to buy local and use local services and facilities

Key Partners
DHSSPS / DSD / DCAL / DETI / PHA / HSC / Arts Council NI / Sport NI / National Museums and Libraries NI / Local government / Education / community and voluntary sector

E Through the Extended Schools programme, which enables those schools that draw pupils from some of the most disadvantaged areas to provide a range of services and programmes which focus on improving educational outcomes, reducing barriers to learning and providing additional support, to help improve the life chance of disadvantaged children and young people

Key Partners
DE / DCAL / PHA / HSC

F Through the Community Education Initiatives Programme fund community based organisations working with local schools in *areas of social deprivation and under attainment* to help address the high levels of educational under-attainment

Key Partners
DE

OUTCOME 14 THRIVING COMMUNITIES Continued

Actions and Commitments 2013 – 2015 Continued

G Implement the new good relations strategy "Together: Building a United Community" which sets out the strategic framework for improving good relations. *Children and young people, communities of interface areas and areas of contested space identified for targeted action*

Key Partners
All relevant Departments and stakeholders

H Implement support arrangements for the voluntary advice services to help ensure that citizens have access to quality advice which is free at the point of need

Key Partners
DSD

I Ensure that everyone has an opportunity to volunteer and that volunteering is representative of the diversity of the community

Key Partners
DSD / DCAL / DHSSPS / HSC / others

J Maintain provision of Rural Transport Fund Services to enable people in rural areas improved access to work, healthcare and recreational activities

Key Partners
DRD

Measuring Change, an approach for the Voluntary and Community Sector - CENI

The current economic climate, coupled with increasing social need, places an even greater imperative on public funders to show the impact of their investments and for funded projects to evidence the outcomes of their activities.

The Concordat (i) and a recent Public Accounts Committee report on creating effective partnerships (ii) recommend that greater emphasis be given to evaluating and demonstrating the outcomes being delivered by the sector: 'It is important that Government and the Sector work collaboratively to develop output and outcome measures'.

The focus on outcomes is not new and there has been a long history of efforts to grapple with the issue of outcome measurement. However, due to multiple factors this remains difficult.

Community Evaluation NI (CENI) has been working for many years to support the voluntary and community sector to evidence the difference it is making. Measuring Change is an approach which helps organisations and funders to capture outcomes. It enables funders and organisations to capture and use outcomes data to improve delivery, inform planning and make more effective use of resources.

It has been applied in a range of community settings to capture difficult to measure outcomes of programmes.

i Concordat between the Voluntary and Community sector and the NI Government, DSD 2011

ii Public Accounts committee, Report on Creating Effective Partnerships between Government and the Voluntary and Community sector, Jan 2012

15 SAFE COMMUNITIES

9.14 The 2012 Community Safety strategy *Building Safer, Shared and Confident Communities* recognises that addressing crime, disorder and the fear of crime in communities cannot be achieved by the Department of Justice or the justice system alone. Policing and Community Safety Partnerships (PCSPs) at council level provide new opportunities for statutory agencies, local political leaders, voluntary and community groups and local communities to work together to build safer communities.

9.15 Good relations across all communities are also essential to building a prosperous, peaceful and safe society. Key strategic projects within the strategy *'Together: Building a United Community'* focus on housing, regeneration and deprivation, and young people not in education, employment, or training; all have relevance to the aims of this framework.

OUTCOME 15 SAFE COMMUNITIES

Actions and Commitments 2013 – 2015

A PCSPs work collaboratively with the community and relevant agencies at local level and deliver Community Safety programmes so that people feel safer, have reduced fear of crime and increased confidence

Key Partners
DOJ / Local government

B Develop and implement a revised joint Domestic and Sexual Violence and Abuse Strategy to provide victims and witnesses with protection and support, and bring perpetrators to justice

Key Partners
DHSSPS / DOJ / PSNI / Safeguarding Board / other statutory and voluntary sector partners

C Reduce the numbers of people of all ages killed or seriously injured in road collisions through implementation of road traffic collision prevention programmes

Key Partners
DOE / PSNI / other partners

16 SAFE AND HEALTHY WORKPLACES

9.16 A key statutory responsibility for employers is to protect the health and safety of their workforce. Control of risks is important in all work areas but particularly so in some – for example the construction and farming environments. A good working environment, where people are protected and valued, has the potential to increase wellbeing, and there is clear evidence that actively promoting health at work contributes not just to workforce health but also to improved business performance and productivity through, for example, reduction in illness-related absence, increased motivation among staff and improved working atmosphere, leading to more flexibility, better communications and improved use of resources.

9.17 Effective workplace health programmes can make a real difference to the health and wellbeing of employees, businesses and the communities in which people live and work. Support systems to

encourage and maximise the commitment of employers to health and wellbeing and share effective practice will need to be in place.

OUTCOME 16 SAFE AND HEALTHY WORKPLACES

Actions and Commitments 2013 – 2015

A Support more businesses to provide workplace health and wellbeing programmes to secure –

- improved physical and mental wellbeing
- reduction in the number of reportable work related injuries
- prevention, control and management of key occupational health hazards
- awareness raising and advisory campaigns to highlight the dangers of carbon monoxide and promote appropriate management of risk
- appropriate control of risks to the public from harmful organisms encountered in, or associated with workplaces such *as legionella sp, E.coli sp*

Key Partners
DETI / HSE / PHA / Business sector / Local government

B Implement initiatives to improve safety, and reduce casualties and work-related deaths on farms including through –

- the work of the Farm Safety Partnership
- tailored information delivered in rural primary schools
- "Stay Farm Safe" awareness raising campaign

Older farmers and children identified for targeted action

Key Partners
DETI / HSE / DARD / DE / Farm Safety Partnership

Safe and Healthy Workplaces

Credit Union in Londonderry

The PHA-sponsored Healthy Workplace Award 2013 was presented to Derry Credit Union Limited at the Derry/Londonderry Business Awards.

Derry Credit Union Limited has established a health promotion committee made up of staff, management, directors and volunteers.

The committee has organised and delivered more than 150 workshops, activities and events around health and wellbeing. The majority of these activities are offered during the working day and staff rotas are drawn up to accommodate those who wish to participate.

Activities to date have included stress management workshops, healthy eating sessions, taster sessions in yoga and Tai Chi. Staff have also been able to avail of bi-annual cardiac risk assessments and one-to-one consultations with a fitness instructor, and have been given information on foot and eye care, cancer awareness, mental health first aid, and smoking cessation sessions.

In addition, the credit union established a quiet room, a refuge from the hustle and bustle, where staff can listen to calming music and relax. Staff members are also encouraged to get involved in gardening and space has been made available outside the premises to grow vegetables.

Key Strategies/ strategic programmes – Community Safety, Strategic Framework for Reducing Offending, Together – Building a United Community, Urban Regeneration and Community Development Policy Framework, Strengthened Communities and Vibrant Urban areas, People and Place - Neighbourhood Renewal, Areas at Risk programme, Community Asset Transfer framework, Tackling Poverty and Social Isolation, Rural Development Programme, Rural Transport Fund, Delivering Social Change – Social Investment Fund / Build Pathways to Employment, Tackling Domestic and Sexual Violence and Abuse Action Plan, Join In - Get Involved, Sport Matters, Extended Schools and Community Education Initiatives Programme, Transforming Your Care, Workplace Health, (Draft) Active Ageing Strategy, Making It Better - A Strategy for Pharmacy in the Community.

CHAPTER 10 – DEVELOPING COLLABORATION

Key long term outcomes:

17 **A Strategic Approach to Public Health**

18 **Strengthened collaboration for health and wellbeing**

17 A STRATEGIC APPROACH TO PUBLIC HEALTH

10.1 Earlier chapters have outlined the continued need for collaboration on issues that influence health and wellbeing, and the importance of seeking to strengthen this and integrate public health principles more systematically across all parts of society.

There are already a number of strategies and programmes underway which address the wider determinants, which include objectives relating to health and wellbeing, and which engage people and organisations working together to achieve improvements. It will be important to consolidate and build on those connections to ensure maximum benefit for population health. In line with Health 2020, and widely welcomed by the response to the consultation on *"Fit and Well – Changing Lives"*, a key aim of this framework will be to put in place strengthened collaboration for health through a "whole system approach". This will require improved cohesion and communication between all levels of the system, and arrangements to achieve this are covered further in Chapter 11.

10.2 The framework will be delivered in the context of local government reform, which will take place from 1 April 2015. The new Councils will be responsible for Community Planning with a duty to plan for the 'economic, social and environmental well-being' of council districts. This provides an opportunity to redefine and strengthen the way in which the health and social care sector, local government and others work together to improve health and wellbeing and reduce health inequalities. The good working relationships that have been established under Investing for Health form a strong base for this work.

Belfast Strategic Partnership for Health and Wellbeing

The Belfast Strategic Partnership (BSP) was set up in 2011 by the PHA, Belfast City Council and Belfast Health and Social Care Trust to address the significant levels of inequality across the Belfast area.

The Partnership has been set up in order to:

- *Support a citywide collaborative approach across sectors to better address the inequalities and health and wellbeing challenges faced within Belfast; and*

- *Set the strategic direction for health and wellbeing improvement in Belfast, through the development of agreed priorities for the city and the alignment of corporate plans and resources of the key service providers.*

It includes representatives from the following sectors:

- *Statutory sector – Belfast City Council, PHA, Belfast Health and Social Services Trust, Northern Ireland Housing Executive, Police Service of Northern Ireland and the Education sector;*

- *Private sector;*

- *Community and voluntary sector, including representation from the five Belfast Area Partnership Boards and community nominees; and*

- *Local Elected Members.*

Active Belfast *is one of the BSP's key projects. The Active Belfast project aims to promote healthy living and increase physical activity. A range of activities have been set up to encourage a healthier lifestyle for example:*

- ***Community gardens*** *- A community garden is a shared project where people from all age groups, abilities and backgrounds come together to grow their own fruit, flowers and vegetables. Community gardens have been opened at a number of locations around Belfast including Whiterock Leisure Centre, Finlay Park and Knocknagoney Linear Park. Benefits include learning new skills, making friends, improving diet, relieving stress, saving money on groceries, keeping active and getting outdoors.*
- ***Cycling and walking routes****, orienteering opportunities and eco trails*
- ***Outdoor gyms*** *throughout the city to provide access to a free fitness workout.*

Health in All Policies

10.3 The "whole system" governance and implementation arrangements will aim to ensure that health and health equity are considered coherently across ministerial and departmental policy making through a "Health in All Policies" approach.

10.4 The term Health in All Policies (HiAP)[35] describes an approach which emphasises the connections and interactions which work in both directions between health and policies from other sectors. Health Impact Assessment (HIA) is a practical tool used to support HiAP by judging the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups. HIA can inform the decision-making process with the aim of maximising the proposal's positive health effects and minimising its negative health effects. HIA has been promoted to policymakers across Government departments in Northern Ireland with some evidence of use. There have also been examples of HIA at local level, for example in relation to housing programmes. DHSSPS will continue to work with departments and with the IPH, who provide support for HIA, to review and strengthen processes in support of a Health in All Policies approach, and with other sectors such as local government to support wider implementation.

10.5 To safeguard the interests of future generations from the perpetuation of social and economic inequities it will be important to identify the links between environmental, social and economic factors and apply the principles of sustainable development to policies and their implementation.

Research

10.6 Building capacity for research and strengthening the evidence base relating to public health issues will be vital to secure health benefits across all socioeconomic groups. The NI Public Health Research Network and collaborations such as the Centre of Excellence for Public Health and the European Centre for Delivering Social Change will seek to maximise research effort. Evaluation and sharing the learning across government from action taken to address the wider determinants will also be crucial. Such learning will inform future investment.

Legislation

10.7 Legislation in relation to issues such as tobacco control and road safety has been an effective mechanism to secure health improvements and this approach will continue. The Breastfeeding Strategy *"Breastfeeding – A Great Start"* proposes the introduction of legislation to support mothers' breastfeeding their children in public places in Northern Ireland, subject to public consultation, and consideration is being given to introducing minimum unit pricing for alcohol.

10.8 There are examples from other jurisdictions of legislation being used in a broader way to promote and protect public health and the need for similar legislation will also be considered here. A review of the Public Health Act (NI) 1967 has been commissioned to ascertain whether the Act (which deals largely with health protection) still remains fit for purpose. It is proposed that the review will put forward recommendations for updating the current legislation and will examine how to promote a broader strategy for public health.

Supporting the development of the wider Public Health Workforce

10.9 Public health interventions are delivered by people who work in a range of settings, which includes the Health and Social Care sector but also comprises community and voluntary and Local government activity. It is important to recognise that if the aspirations of this framework are to be fulfilled then public health capacity and competency amongst those working towards improving public health across different sectors and from whatever professional background should be supported and developed. For example, nursing will have a key role in the public health outcomes to be delivered. This will encompass all of the existing roles e.g. surveillance, screening, health promotion, but will be much more focused on building community capacity, advocacy, social development and contributing to future policy development.

10.10 Across the UK, a range of initiatives to support professional development and to make public health "everybody's business", have been initiated. These include the UK Public Health Register (UKPHR), the development of the Public Health Skills and Career Framework (PHSCF) and PHORCaST - Link - **http://www.phorcast.org.uk/** - a web based resource to support career development and skills and training for the wider public health workforce.

10.11 In April 2013 the DOH England published a workforce strategy to support England's strategy *"Healthy Lives, Healthy People"*. DHSSPS will examine the actions arising from this strategy including examples of innovation and good practice, and consider how this can be utilised to develop public health capacity and competency in the wider public health workforce in Northern Ireland.

OUTCOME 17 A STRATEGIC APPROACH TO PUBLIC HEALTH

Actions and Commitments 2013 – 2015

A Establish governance, implementation, engagement and monitoring arrangements at strategic, regional and local levels which interconnect to create a whole system approach

Key Partners
DHSSPS and PHA lead / all other relevant partners

B Create the conditions and processes for all departments and other relevant bodies to develop public policies which support improved health and wellbeing and a reduction in health inequalities, including a review of health impact assessment processes

Key Partners
DHSSPS lead / all other relevant partners

C Strengthen collaboration North / South, East / West and internationally, particularly across Europe, on areas of mutual interest

Key Partners
DHSSPS / DOHs in England, Scotland, Wales, ROI / PHA / PHE / IPH / WHO / Healthy Cities organisations

D Maximise the spend on prevention and early intervention through –

- increasing the share of the health budget spend on prevention and early intervention and developing mechanisms to monitor this across the HSC

Key Partners
DHSSPS / HSCB / PHA / Trusts

- securing the reallocation of resources from hospitals into the community envisaged in TYC and the PFG commitment

- monitoring funding contributions of other partners to improving health and tackling health inequalities

Key Partners
DHSSPS / PHA / others

OUTCOME 17 A STRATEGIC APPROACH TO PUBLIC HEALTH Continued

Actions and Commitments 2013 – 2015 Continued

E Promote a planned and co-ordinated approach to research and development (R&D) activity to support improved public health

Key Partners
DHSSPS / DETI / DSD / PHA / others (including universities)

F Consider and implement legislative change to support public health Including in relation to –

- tobacco control
- misuse of alcohol and drugs
- promotion and support of breastfeeding

Key Partners
DHSSPS

- road safety

Key Partner
DOE

G Review the Public Health Act (Northern Ireland) 1967, consult on proposed changes and update as appropriate

Key Partners
DHSSPS

H Assess the actions and recommendations arising from the public health workforce strategy associated with Healthy Lives, Healthy People and consider how good practice and innovation can be utilised to develop public health capacity and competency in the wider public health workforce in Northern Ireland.

Key Partners
DHSSPS / PHA / others

Key Strategies / strategic programmes - Programme for Government, NI Economic Strategy, Lifetime Opportunities Anti-poverty strategy, Tackling Rural Poverty and Social Isolation, Delivering Social Change Framework, Social Economy strategy, Success through Skills –Transforming futures, Air, Water and Waste Management strategies, Planning Policy, Accessible Transport Strategy, Active Travel Strategy, Local Government Reform programme, Road Safety strategy, Housing and Homelessness strategies, New Strategic Direction on Alcohol and Drugs, Tobacco Control strategy, Breastfeeding - A Great Start, Transforming Your Care, Making it Better - A Strategy for Pharmacy in the Community, Making it Better - A Strategy for Pharmacy in the Community, (Draft) Active Ageing Strategy, Strategy to improve the lives of those with disabilities 2012- 2015.

18 STRENGTHENED COLLABORATION FOR HEALTH AND WELLBEING

Asset – Based Approach

10.12 Historically, approaches to the promotion of population health have been based on a "deficit" model. That is, a focus on identifying the problems and needs of populations that require professional resources and high levels of dependence on public services. It is no doubt important and necessary to identify levels of needs and priorities, but this model tends to define communities and individuals in negative terms, without consideration of what is positive and works well in particular populations.

10.13 Recently an asset – based[36] approach to community development has been gaining momentum. This focuses on the factors or resources which enhance the ability of individuals, communities and populations to maintain and sustain health and wellbeing and meet identified needs, rather than a focus on the "deficits" or problems, needs and deficiencies such as deprivation, crime, anti-social behaviour, exclusion, illness and health-damaging behaviours. Assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses. The report "A Glass Half Full - how an asset approach can improve community health and well-being"[37] demonstrates that when practitioners begin with a focus on what communities have (their assets) as opposed to what they don't have (their deficits) a community's ability in addressing its own needs increases, as does its capacity to lever in external support.

10.14 Adopting an asset-based approach, an aim of this framework is to equip and enable individuals, families and communities to address the issues affecting their health and wellbeing and make healthy choices. "People" assets vary across communities; some have stronger support and social networks than others. "Physical" assets also vary across localities. In line with a Health Committee recommendation, it is intended to work collaboratively across government agencies and with other organisations to map assets (both physical and social) which could be used to tackle inequalities in health. This will assist in informing the ongoing implementation of the framework and development of a whole system approach, and may be replicated at other levels of delivery.

Assets may include:

- *the practical skills, capacity and knowledge of local individuals, families and groups;*
- *the passions and interests of local people that give them energy for change;*
- *the networks and connections – known as 'social capital' – in a community, including friendships, neighbourliness and volunteering;*
- *the effectiveness of local community groups and voluntary associations;*
- *the resources of public, private, voluntary and community sector organisations that are available to support a community; and*
- *the physical and economic resources of a place that improve wellbeing.*

(National Institute for Health and Clinical Excellence, 2009)

Local Partnership Action

10.15 The actions outlined in this framework involve a range of government departments and other agencies. Many of the actions are inter-linked and require delivery at local as well as strategic or regional level. Three further areas of work have been identified around which a number of partners have been developing collaborative approaches and which lend themselves particularly to local partnership action.

These are:

- **Food – GROW and EAT;**
- **Space and place – MOVE and MEET; and**
- **Social inclusion – CONNECT FOR A BETTER LIFE.**

10.16 These issues are particularly relevant to current public health challenges and to tackling health inequalities. They inter-relate and overlap. They are included with the aim of building momentum and galvanising communities and relevant organisations at local level, supported where needed by coordination at regional level. Their inclusion provides a focus for collective action over the next three years – the intention is that this work will provide a foundation on which to build in the next wave of actions under this 10 year framework.

(a) Food - GROW AND EAT

Why?

10.17 Food impacts on people's lives on a daily basis in many ways. Eating is essential for survival, but food can be a source of enjoyment and a focus for social engagement. For some it is part of their cultural identity. Good healthy food can be a means to achieve broader goals of improving health and wellbeing, reducing social isolation and increasing civic engagement. It engages individuals and communities in a fundamental way that can cut across socio-economic groups and cultural boundaries.

Food facts from Health Survey NI 2011-12

61% of adults measured were either overweight (37%) or obese (23%)

10% of children aged 2-15 years were assessed as being obese

Rates of obesity tend to rise in association with increasing social disadvantage

86% of respondents said they were aware of the advice to have at least 5 portions of fruit or vegetables each day, but only 33% of respondents met this guideline

87% of respondents in households had enough of the kinds of food that they wanted to eat

Food facts from Health Survey NI 2011-12 continued

A further 12% had enough to eat but not always the kind of food they wanted

7% of respondents in the past year ate less because they felt that there was not enough money to buy food

1% of respondents sometimes did not have enough to eat while 0.4% of respondents often did not have enough to eat

1% of respondents did not eat for a full day because there was not enough money for food; around half of this proportion said that this happened almost every month

10.18 In the current economic climate, food poverty is becoming an increasingly important issue. Food poverty is a complex aspect of poverty that has health and social consequences. It is defined as the "inability to access a nutritionally adequate diet and the related impacts on health, culture and social participation." Households experiencing food poverty consume less nutritionally-balanced diets and suffer from higher rates of diet-related chronic diseases such as heart disease, diet related cancers, and overweight and obesity.

10.19 Currently there is no agreed measure of food poverty across Ireland to inform practice and policy. IPH, using Living Costs and Food Survey data for Northern Ireland, reported that 14.8% of NI households were at risk of food poverty in 2009. Members of the Food Poverty Network, co-chaired by Food Standards Agency in Northern Ireland and Safefood in ROI, have been tasked with developing a food poverty indicator based on routinely available data. This will potentially provide a North/South indicator and allow for comparison.

Food Waste

In the UK 7.2m tonnes of food and drink is thrown away from homes each year.

*NI shoppers could save around £480 per year per household by cutting down on food waste**

* Household Food and Drink Waste in the UK (WRAP 2009)

10.20 Local developmental work should aim to –

- increase access to healthy foods and reduce risk of obesity and malnourishment in a way that promotes dignity, builds health and community and tackles inequalities at a local level for all ages.

This could be taken forward for example through support for initiatives such as community gardens and allotments, community cafes offering free or low cost healthy meals, community farmers' markets, food co-operatives.

Key features of such initiatives could include offering a range of participation opportunities to learn how to grow, cook and choose healthy food; building on existing community assets and linking them, and strengthening capacity and skills.

Community Food Initiative

The Community Food Initiative funded by SafeFood and managed by Healthy Food for All Ireland, aims to support community projects in promoting greater access to affordable and healthy food. Two NI projects are among those receiving funding through the 2013-15 programme.

Incredible Edible Cloughmills

The Incredible Edible Network is a network whose members believe that providing access to healthy, local food can enrich their communities. Typically their work involves setting up community growing plots, reaching out to schools and children and backing local food suppliers. This reflects the movement's drive to provide access to good local food for all through:

- *working together*
- *learning – from field to classroom to kitchen*
- *supporting local growers, retailers and outlets*

Incredible Edible Cloughmills is one such group which seeks to reconnect people and food. It is constantly evolving by putting people at the heart of decision making and action, and aims to improve wellbeing by making 5 actions a reality in its community – connecting, being active, taking notice, learning and giving.

Fareshare

FareShare sources surplus, 'fit for purpose' food and drink from retailers and manufacturers throughout Ireland and redistributes it to local charities feeding hungry and vulnerable people in the community. Food is distributed through ***Community Food Members (CFMs)*** *to disadvantaged groups such as the homeless and vulnerably housed people. This enables these organisations to reinvest funds into other much needed services such as housing advice, training and support. In NI FareShare works in partnership with the Council for the Homeless Northern Ireland with contributions from local retailers and food producers.*

(b) Space and place - MOVE AND MEET

Why?

10.21 The physical and social characteristics of communities and the extent to which they enable and promote healthy behaviours can make a major contribution to improving health and reducing social inequalities in health.

10.22 Many reports note how the quality of both the natural and built environments impact on, for example, mental health and wellbeing, obesity, and health inequalities, and on the development and sustainability of social networks and communities. People with poorer health often live in environments which support unhealthy lifestyles, for example, lacking in green space with limited access to environments for walking or cycling, or for children to play, and more likely to pose a threat to health through higher rates of crime or risks from traffic.

10.23 Much can be done to create safe, health-enabling neighbourhoods and environments for everyone. Physical environments can be designed or maximised to promote health and wellbeing through, for example, providing access to services, green spaces including woodlands and forests, opportunities for being physically active and for safe social interaction. At a broader geographical level opportunities may exist for "joining up" planning and provision of for example transport, walkways, cycle paths, existing infrastructure or services to better connect communities and increase access.

10.24 Active travel – journeys using physical activity, such as walking and cycling – has a role to play in improving and achieving a fairer distribution of health as well as bringing economic benefits to the individual. Making neighbourhoods more "walkable" and making roads more cycle-friendly could make a significant difference to people's levels of physical activity. This would link with DRD's *Building an Active Travel Future for Northern Ireland (2013)* Action Plan which contains measures that will be taken by government departments, local authorities and voluntary bodies to encourage more cycling and walking and less dependency on private cars up to 2015. The establishment of a Cycling Unit in DRD is also aimed at ensuring that cycling provision is a key element in both transport strategy and delivery.

35% of respondents to the 2011/12 Health Survey were classified as meeting the recommended level of physical activity[1], with males (40%) more likely than females (31%).

73% of journeys in Northern Ireland are made by car, 16% are walked whilst a very small proportion of journeys (1%) are cycled (Travel Survey Northern Ireland 2010/12).

Aim

10.25 Work should aim to –

- maximise the use of physical assets to increase access to and use of safe, sustainable, health nurturing spaces and places, and opportunities for social interaction in a way that builds health and community and tackles inequalities at a local level for all ages.

Ways to do this might include for example – maximising and promoting shared use of public and community facilities; public realm schemes; greenways or routes, woodlands and forests for walking, cycling, running etc; green gyms / outdoor gyms; allotments.

Key features of such initiatives could include; incorporating promotion of health and wellbeing, social inclusion and safety in design and use of such spaces and assets; improving links with and capacity between planning, regeneration, public health and community safety; increasing physical activity and improving mental health and wellbeing; promoting age friendly environments.

WHO Healthy Urban Planning and Age-friendly Environments

The WHO International Healthy Cities movement has developed the concept of Healthy Urban Planning focussing on people, and how they use buildings and their surroundings, rather than simply on the urban fabric. An aim is to ensure environments are accessible, and support active participation in the city, for people of all ages. This underpins each phase of the Healthy Cities roll-out. Belfast and Londonderry are part of the Healthy Cities movement.

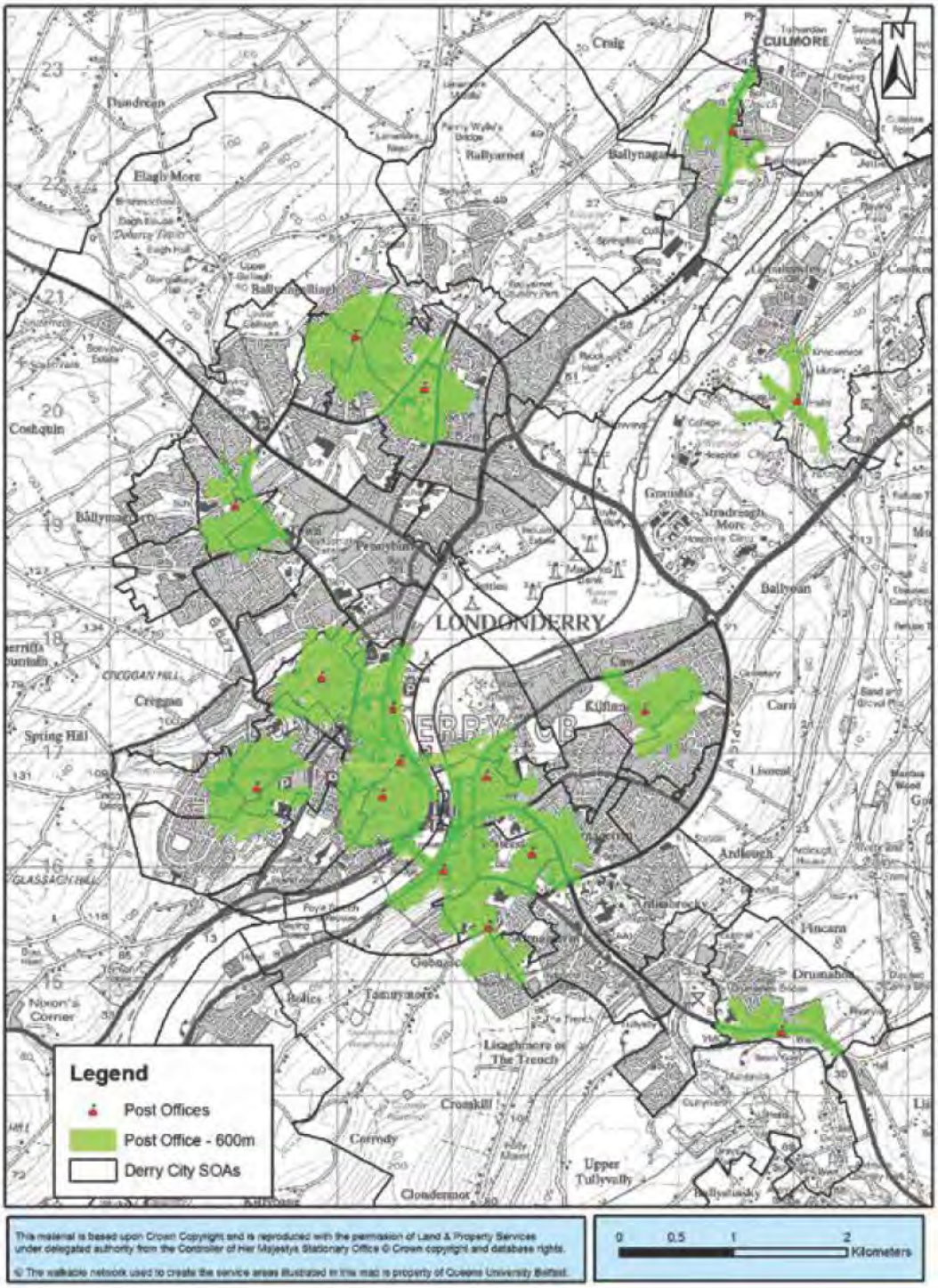
The Age-friendly Environments Programme aims to address the environmental and social factors that contribute to active and healthy ageing. Making cities and communities age-friendly is one of the most effective local policy approaches for responding to demographic ageing. Physical and social environments are key determinants of whether people can remain healthy, independent and autonomous long into their old age. WHO provides guidance and promotes the generation and dissemination of knowledge on how to assess the age-friendliness of a city or community, how to integrate an ageing perspective in urban planning and how to create age-friendly urban environments.

Knowledge Exchange, Spatial Analysis and Healthy Urban Environments

The KESUE project, led by the School of Planning, Architecture and Civil Engineering at Queens University Belfast, aims to maximise the policy impact of research undertaken on walkability, particularly the development of a Real Walkability Network. Initially generated as part of the Physical Activity and Rejuvenation of Connswater (PARC) project, based on a study area of East Belfast, this project has extended the applicability of the developed policy tools to cover the two main cities of Northern Ireland, Belfast and Londonderry, so that the model then covers 37% of the population and some of the most deprived communities in the region. The project has disseminated the use of this model to practitioners to increase the evidence base for interventions in the built environment aimed at promoting physical activity.

The value of the Project is reflected in the large number of public bodies that have been willing to become partners, including Belfast and Derry City Councils, DRD, DHSSPS, PHA and Belfast Healthy Cities.

Accessibility to Post Offices in Londonderry



NIRSA

Comber Greenway

The Comber Greenway is a traffic free walking and cycling route running from Comber to Belfast along the old railway line (which closed in 1950).

Groundwork

Groundwork engages and motivates people to improve their quality of life by investing in people and place through supporting community-led regeneration. Daisy Hill Wood, owned by Newry and Mourne District Council and managed by the Woodland Trust, is a main feature on the hill above Newry city. Originally it was a plant nursery from 1890 to 1990 and most of the current wood has resulted from the planting of exotic species during that period. The aim of the M&S Greener Living Project was to encourage local people to use the wood both as an educational and as a recreational resource.

A local community group – Daisy Hill Nursery Woods Conservation Group was set up. Members of the group met every Saturday from October to March and carried out various practical tasks to make access safer for walkers, to remove invasive species, which prevent trees from regenerating naturally, and to plant native trees and shrubs.

Belfast Health and Social Care Trust

The Belfast Health and Social Care Trust planted nearly 10 hectares of new native woodland at its Knockbracken site in south Belfast and a launch day was held in March 2013 for the Trust staff and patients. The woodland is open to all and additional access has been created to encourage community use.

The Trust had wanted to find a way to make best use of the land available to maximise health and therapeutic benefits for patients, staff, visitors and the local people whilst also providing good quality wildlife habitats. Options were explored and, in partnership with Woodland Trust and with support from Forest Service Woodland Grant Scheme, it was decided to plant almost 20,000 trees. The new community woodland is now an asset for both the Trust and the local community.

(c) Social inclusion – CONNECT FOR A BETTER LIFE

Why?

10.26 In addition to physical places, the communities and social networks to which people belong have a significant impact on health and health inequalities. Social capital can provide a source of resilience against particular risks of poor health, helping people get through economic or other difficulties, and contributing to wellbeing and as a result to other outcomes.

10.27 There are links between poverty and social exclusion, but not everyone who is poor is socially excluded. Many people living in poverty are supported through social, family and community support networks. Not everyone who is socially excluded is poor. Poverty may not be the main issue, for example, for people from minority ethnic groups, people with a disability, or mental health problems, people who are homeless or lesbian, gay, bisexual and transgender people.

10.28 Those living in rural areas may have difficulties in accessing the types of services that other people take for granted and feel isolated. Loneliness and social isolation among older people is also a growing problem. Social networks and social participation act as protective factors against dementia or cognitive decline over the age of 65.

10.29 Exclusion is driven by unequal power relationships, which can be economic, political, social or cultural. Exclusion can operate at individual, household, group or community level. Community involvement can be the key to successful policy and/or action to reverse exclusion.

- The Marmot Review identified that individuals who are socially isolated are between 2 - 5 times more likely to die prematurely than those who have strong social ties.
- Social exclusion can lead to alcohol misuse, poor mental health, lack of physical activity, greater disadvantage, higher levels of social isolation and reduced uptake of services and support.

Aim

10.30 Work in this area should aim to –

- bring together and maximise the resources invested in an area to ensure people of all ages have access to support networks and opportunities to participate, and to build individual and community resilience, capacity and social capital.

This could be taken forward for example through targeted support for particularly vulnerable population groups locally, befriending schemes, schemes to promote access to services and advice, assisted transport, arts and cultural programmes, reading schemes etc.

Key features would include securing the participation of the individuals/groups at risk of exclusion, building individual and community resilience, building on and linking community assets.

Fab Lab

Ashton Community Trust (Belfast) in partnership with the Nerve Centre (Derry/Londonderry) jointly launched the first Fab Labs in Northern Ireland in May 2013. The concept was originally set up in the Massachusetts Institute of Technology to inspire people and entrepreneurs to turn their ideas into new products and prototypes by giving them access to a range of advanced digital manufacturing technologies.

The two Northern Ireland Fab Labs will offer support on a local basis to communities, entrepreneurs, students, artists, small businesses and anyone who wants to create something totally unique through access to manufacturing technology from precision laser cutters and 3D printers to electronic circuit fabrication equipment.

Fab Lab is a prime example of positive social intervention. The project will deliver on a number of levels, for example encouraging greater levels of positive cross-community contact - people from all communities can come together and develop their creative and entrepreneurial skills, as an educational tool helping children and young people to turn their ideas into reality, and by increasing the capacity and employment potential for people living within deprived areas.

Funded by PEACE III managed by Special European Union Programmes Body, the project will also link into and share experiences with the worldwide network of Fab Labs.

Words Alive

The "Words Alive" group is a creative writing group established as a means of encouraging socially isolated people aged 60+ to come together to discuss their shared interest in reading, storytelling and recalling old memories. The members have published their first anthology Pen to Paper in 2012. The group is planning to reach out to other isolated older people by doing readings of their work in nursing and residential homes. The group also plans to secure funding to enable it to engage with the local Polish community.

Keep Warm

The PHA works with partner organisations such as Homeplus, the Welcome Centre, Rosemount House and the Salvation Army to provide protection against cold weather by delivering Keep Warm packs to rough sleepers and homeless people in Belfast.

Ardoyne Library Read Aloud

Ardoyne Library sits at the heart of its community and provides a welcoming space for local people. Following on from a learning initiative, an informal group of mostly senior male users evolved and were offered the chance to try 'Read Aloud' reading from a number of authors and poets over four, weekly sessions.

The common experience of reading is as a solitary activity that takes the reader on a journey based on their own experiences and perceptions of the world. Reading and discussing great literature or poetry in a group context can create a different and unexpected journey of discovery. How someone else interprets a line, a word, or the intent behind a passage can be very different from what an individual reads into it. It can be insightful, thought provoking, and encourages respect for others' opinions.

Read Aloud allows thoughts, connections and understanding to emerge. Group members can choose to join in, or not, and at times the reading will stop to allow discussion about parts of the text – what it might mean – or for reflecting on similar experiences. The effects are subtle and can be profound.

Research is uncovering an intimate connection between reading and wellbeing. The scientific findings indicate that being read to, stimulates thought and memory and encourages the sharing of ideas, feelings, hopes and fears.

Reading for the individual is a therapeutic activity but reading with others is a shared pleasure and rewarding experience for both the reader and the listener. Encouraged by a request from group members, Read Aloud workshops are continuing with the Ardoyne Library Group on a monthly basis.

OUTCOME 18 STRENGTHENED COLLABORATION FOR HEALTH AND WELLBEING

Actions and Commitments 2013 - 2015

A Maximise opportunities to strengthen local collaboration through the joint working arrangements between PHA and local government, and the outworking of local government reform and the new statutory duty of Community Planning process

Key Partners
DHSSPS / DOE / PHA / Local government

B Work collaboratively across government agencies to map assets (physical and people) which could be used to tackle inequalities in health

Key Partners
DHSSPS / DSD / other departments and agencies

C Improve availability and use of data across all levels and sectors for the purposes of identifying priorities, planning action, monitoring trends and evaluating which actions are the most effective

Key Partners
Departments / agencies / Local government / other sectors

D In partnership with relevant departments, agencies, other sectors, local government and communities, develop and implement regional programmes to address health and wellbeing priorities in line with this framework

Key Partners
DHSSPS / PHA lead–partners at regional and local levels

OUTCOME 18 STRENGTHENED COLLABORATION FOR HEALTH AND WELLBEING Continued

Actions and Commitments 2013 - 2015 Continued

E Maximise opportunities for local partnership action working with local communities to –

- establish a network of community led gardens and allotments which promote health and wellbeing
- develop child friendly spaces through a neighbourhood approach to community safety
- promote health and wellbeing of older people in their own homes through a home visitation scheme

Key Partners
PHA to lead with local government, police and community safety partnerships, community and voluntary sector and other partners

Key Strategies / strategic programmes - NI Economic Strategy, Lifetime Opportunities Anti-poverty strategy, Delivering Social Change Framework, Tackling Rural Poverty and Social Isolation, Rural Development Programme, Rural Transport Fund, Local Government Reform programme, Community Safety, Strategic Framework for Reducing Offending, Community Relations – Together, Building a United Community, Urban Regeneration and Community Development Policy Framework, Strengthened Communities and Vibrant Urban areas, planned Community Asset Transfer framework, Social Economy strategy, Build Pathways to Employment, Success through Skills – Transforming futures, Air, Water and Waste Management strategies, Planning Policy, Accessible Transport Strategy, Active Travel Strategy, Road Safety strategy, Housing and Homelessness strategies, New Strategic Direction on Alcohol and Drugs, Tobacco Control strategy, Transforming Your Care, Join In - Get Involved, Sport Matters, Extended Schools, Workplace Health, (Draft) Active Ageing Strategy, A Fitter Future for All.

MAKING LIFE BETTER

PART THREE – GOVERNANCE AND IMPLEMENTATION

CHAPTER 11 – MAKING IT WORK

11.1 Health 2020 argues that, in order to improve population health and wellbeing and reduce health inequalities, all parts of government need to work together to recognise risk patterns and identify solutions, act at various levels, and share responsibility across policy fields and sectors.

11.2 At strategic level this framework emphasises the inter-connectedness of many government policies and programmes, and the mutual benefits and shared goals that can be achieved by working together effectively. It is clear that there are opportunities to strengthen these linkages through governance and monitoring which develops a sense of coherence flowing through to implementation at delivery level.

11.3 The reform of local government will also provide an opportunity to strengthen the already significant contribution at local level to improving health and reducing health inequalities. The productive joint working arrangements between the PHA and councils will be maintained and built upon, as well as ensuring strong linkages with others through the new community planning process.

11.4 A whole system approach is required, with clear lines of communication, accountability and clarity on how governance and implementation is to work. Connections with other relevant strategies and initiatives need to be managed and maximised. Collaboration should be embedded in every aspect of governance and monitoring, and with clear recognition of and relevant linkage with structures and partnerships which will contribute - examples are Children and Young People's Strategic Partnership, and Public Health Local Government Steering Group.

Governance and Implementation

11.5 This chapter outlines the governance and implementation arrangements for "Making Life Better". These arrangements reflect the concerns raised in the Investing for Health Review on disconnect between strategic direction and local implementation. Key roles, responsibilities, monitoring and reporting mechanisms are also outlined. In promoting a thematic whole system approach it may be beneficial to establish additional thematic sub – groups to tackle particular issues. These may be at any level within the proposed structure.

Strategic Level - Ministerial Committee for Public Health

11.6 At strategic level, a Ministerial Committee for Public Health to be chaired by the Minister for Health, Social Services and Public Safety will be established. The key functions will be to provide strategic leadership at government level, provide direction and coherence with other key strategic programmes and structures, such as Delivering Social Change, and oversee implementation on behalf of the Executive. The Ministerial Committee will be supported and informed by the All Departments Officials group (ADOG)

All Departments Officials Group (ADOG) for Public Health

11.7 The ADOG, chaired by the Chief Medical Officer, will comprise senior officials from every department. Its role will be to:

- inform and make recommendations to the Ministerial Committee;
- develop and support a Health in All policies approach to promote coherence;
- co-ordinate collaborative working at departmental level;
- connect with the Regional Project Board, directing, or supporting action as appropriate; and
- monitor and report on progress.

This group will report to the Ministerial Committee. The chair of the Regional Project Board (see below) will be a member of and report to this group.

Regional Project Board for Public Health

11.8 The Regional Project Board, to be chaired by the Chief Executive of the PHA, will focus on strengthening collaboration and co-ordination to deliver on the strategic priorities across sectors at a regional level, and on supporting implementation at a local level.

11.9 Membership of the group will comprise the Chief Officers of relevant statutory agencies. There will also be representation from local government, the community and voluntary sector and the private sector.

11.10 The primary focus of this group will be to drive implementation of agreed priorities through:

- building connections between strategic drivers and local implementation;
- driving forward opportunities for regional initiatives that cut across common themes;
- directing, providing co-ordination for and monitoring the work of local partnerships;
- examination of emerging data, evidence and best practice in terms of addressing health and social wellbeing inequalities; and
- providing advice and recommendations to the ADOG and Ministerial Committee on emerging issues and potential areas for policy and legislative consideration and joint working.

11.11 This Group will be informed by and will support local partnerships. It may also be supported through the establishment as appropriate of thematic sub-groups or time bound working groups on priority themes. The Group will report through the Chair to the ADOG. Individual members will also be required to make effective links into their relevant Department/ organisation in terms of emerging issues and implementation.

11.12 In conjunction with local level partnerships the Regional Board will develop an Implementation Plan, focussed on strengthening co-ordination in relation to the priorities identified in this framework.

Local Level Partnerships

11.13 Local strategic partnerships of key statutory, private, community and voluntary bodies will be established based on an agreed geographic coverage. Each Partnership should in the first instance be developed from existing local arrangements and include a balance of statutory and non-statutory partners. The initial focus will be to collaborate on the three areas of work outlined in Chapter 10.

MAKING LIFE BETTER

11.14 The partnerships' role will focus on local delivery and will be to:

- identify local opportunities for collaboration and partnership working based on local need;
- drive local interventions/services to support those most in need;
- develop and promote new ways of working and models of intervention and test concepts;
- ensure regional priorities are reflected in local plans;
- ensure that local priorities are fed into the strategic process; and
- report to the Regional Project Board (the Chair of the local partnership will be a member of the Regional Project Board).

11.15 These arrangements should link into and align with local Community Planning arrangements over time. New legislation will place a duty on councils to lead the community planning process and on other public bodies to participate. Departments will also be required to promote and encourage community planning and have regard to the councils' community plans in planning the delivery of services.

11.16 Legislation will establish a statutory link between the community plan and the local development plan. This will ensure that issues relating to the general wellbeing of the community will be taken into account in the preparation of a council's local development plan.

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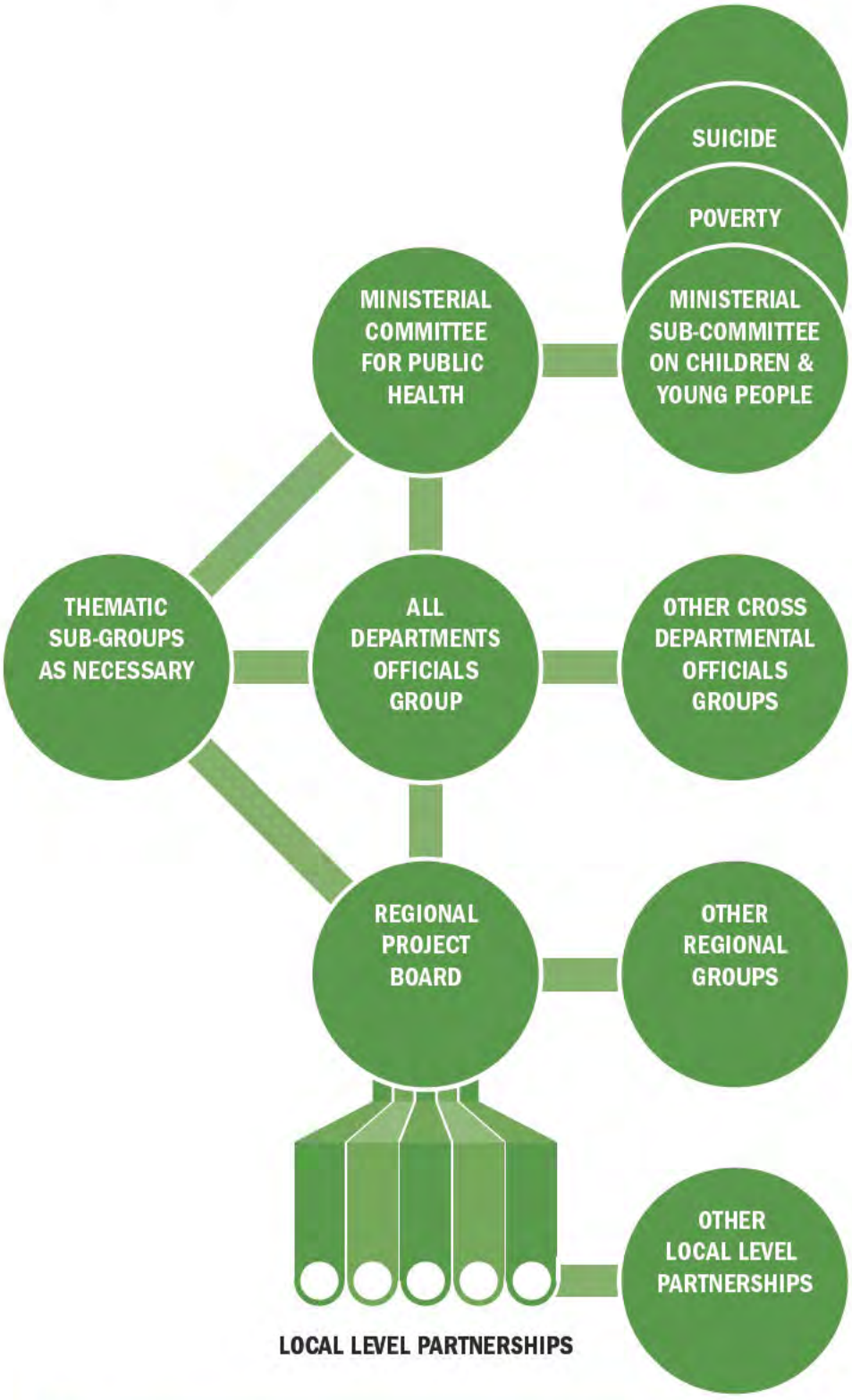
Figure 3: Making Life Better - Governance and Implementation



Local strategic partnerships established on an agreed geographic coverage, and including a balance of statutory and non-statutory partners.

Monitoring Framework

11.17 To support the proposed structures a monitoring framework will be developed to include:

- reports from local partnerships to Regional Project Board;
- reports from Regional Project Board on regional and local activity with advice and recommendations to ADOG;
- reports from ADOG to the Ministerial Committee on strategic issues, key indicator trends, overall activity and provide advice and recommendations; and
- an annual report on overall progress.

11.18 *It is not the intention to duplicate reporting where other mechanisms are already in place, for example, there are already reporting processes for PFG commitments.*

11.19 Through the Data and Research Groups established to support the framework, a set of key indicators has been agreed to facilitate high-level monitoring of progress. The indicators are linked to the framework's themes and will serve as proxy measures to monitor progress towards the outcomes - the indicators with baseline positions are listed in Annex B. This set of indicators may be expanded as work progresses. Data and Research Groups will continue to support the monitoring of progress. Members will also work to secure better record linkage and make recommendations on research and evaluation to inform the framework's implementation and evaluation.

11.20 DHSSPS Information and Analysis Directorate will undertake the role of collating and publishing updates on the key indicators including on those relating to the social determinants. The Health and Social Care Inequalities Monitoring system maintained by DHSSPS and such services as that provided through the Northern Ireland Neighbourhood Information Service (NINIS) will continue to be useful tools supporting policy and service planning and delivery. It will be important to improve the availability and use of data on an ongoing basis across all levels and sectors for the purposes of identifying priorities, planning action, monitoring trends and evaluating which actions are the most effective.

11.21 Effective communication will be required across all levels if the framework is to achieve results. An "Engagement and Communications" strategy will be developed by the Regional Board in collaboration with the All-departments Officials Group to support implementation and monitoring of the framework.

Funding

11.22 Funding from across government is already committed to supporting the strategic actions identified in Chapters 5-10 of this framework. This is underpinned by the Executive's commitment through PFG to allocate an increasing percentage of the overall health budget to public health (measured in terms of the PHA budget), with the aim of allocating an additional £10m by 2014/15 compared with the 2011/12 baseline.

11.23 The framework commits to developing better mechanisms to monitor spend on prevention across the HSC. In addition it will be important to continue to collaborate with other departments, exploring opportunities to pool resources or levering funding as appropriate to deliver relevant cross-cutting programmes such as the MARA project, and Parent Support programmes through Delivering Social Change. Many other sources of funding, including local government and philanthropic organisations, contribute to programmes that will deliver the aims of this framework. In the current financial climate, it is vital that resources are used to optimum effect. This will include careful targeting of resources to meet greatest need with the aim of reducing health inequalities.

Early Action

11.24 Over the next three years:

- the structures outlined above will be put in place and processes developed to ensure a whole system approach;
- the actions committed to in the framework will be advanced;
- local developmental work on the three key areas outlined in Chapter 10 will be taken forward; and
- progress will be monitored and outcomes evaluated.

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All of this will inform the next wave of actions to advance the long-term vision:

"All people are enabled and supported in achieving their full health and wellbeing potential"

and aims:

"Achieve better health and wellbeing for everyone and reduced inequalities in health"

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ANNEXES

ANNEX A - HEALTH AND HEALTH INEQUALITIES

1. The consultation document Fit and Well – Changing Lives set out a detailed analysis of the current health challenges and of the underlying social determinants. It also covered information on health and wellbeing of particular vulnerable groups. This Annex summarises and updates some key data.

2. Northern Ireland currently has a population of around 1.8 million people. This is the fastest growing population in the UK and is projected to rise by 111,000 (6%) by 2020 to around 1.9million.

Figure 4: Number (percentage) of population by age group in 2010 and 2020 (projected)

AGE BAND	2010	2020
0 - 15	382,000 (21%)	398,000 (21%)
16 - 64	1,157,000 (64%)	1,175,000 (62%)
65+	260,000 (14%)	327,000 (17%)
85+	30,000 (1.6%)	44,000 (2.3%)

3. During this period, the age profile of the population is expected to gradually become older. The number of people aged 85 and over is also projected to increase, from 30,000 (1.6% of the total population) to 44,000 (2.3% of the total population). An ageing population is a significant achievement, reflecting advances in health and quality of life. A key challenge will be to enable older people to remain in good health for as long as possible.

4. In addition to these overall trends, there are also significant demographic differences within the region, for example, some localities have higher than NI averages of older people, or young children, which can put disproportionate pressure on local services and communities. These differences make targeting interventions a local rather than a regional matter.

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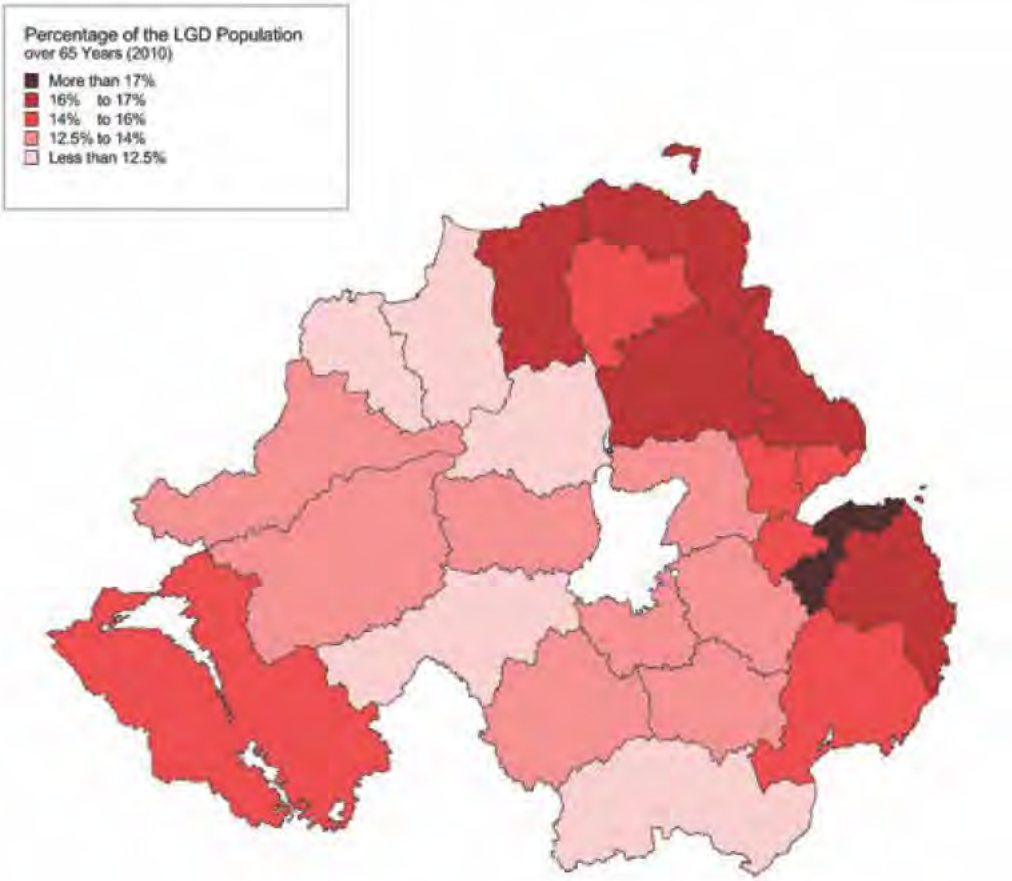
Figure 5: Map of NI population 2010 – % of population aged over 65 years (LGD)



Life Expectancy

5. Since the 1980s life expectancy (used internationally as a measure of population health) has increased steadily for both males and females and is projected to continue to increase. Between 1980/82 and 2009/11[1], male life expectancy has increased by over 8 years, from 69.2 to 77.5, and female life expectancy has increased by over 6 years, from 75.5 to 82.0. During this time, the gender gap has decreased by 2 years, from 6.4 to 4.4 (Figure 6). Healthy life expectancy – the number of years an individual might expect to live in good health – shows similar patterns to overall life expectancy.

1 Life expectancy is calculated using a 3-year rolling average. The year presented relates to the mid-point of the three years.

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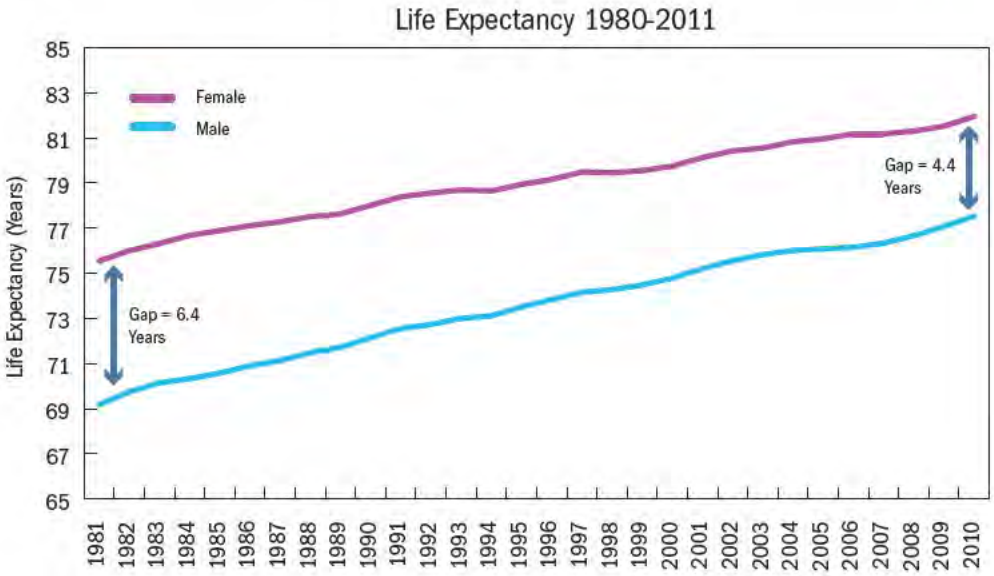
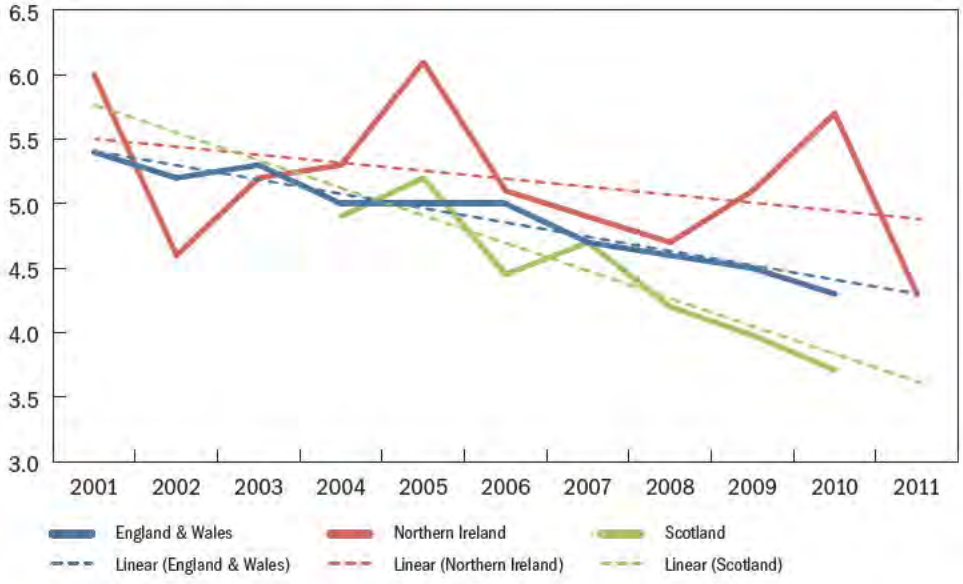
Figure 6: Life Expectancy for men and women in Northern Ireland 1980 – 2011



6. Infant mortality rates are key measures of health outcomes. Infant mortality rates (the number of children dying before their first birthday per 1,000 live births) have fallen across the UK in recent years. Despite sizeable year-on-year fluctuation in the NI rate, it can be seen to be generally improving however at a slower rate than in the rest of the UK (Figure 7).

Figure 7: UK Infant Mortality Rates (2001–2011)



Health Inequalities

7. While there has been general improvement in health, not everyone has been able to avail fully of the benefits of this progress. Evidence shows that inequalities based on race, disability, age, religion or belief, gender, sexual orientation and gender identity can interact in complex ways with socioeconomic position in shaping people's health. Some vulnerable groups and communities, for example people with learning disabilities or travellers, have significantly poorer life expectancy than would be expected based on their socioeconomic status alone. For many of these groups poorer health outcomes are linked to wider social determinants such as access to education and employment.

8. Figures 8 and 9 show that the absolute gap in life expectancy in men between the 10% most and least deprived areas (2009/11) was 10.7 years, while the female life expectancy gap stood at 7.7 years.

Figure 8: Life Expectancy of men in Northern Ireland ranked by deprivation (2009-11)

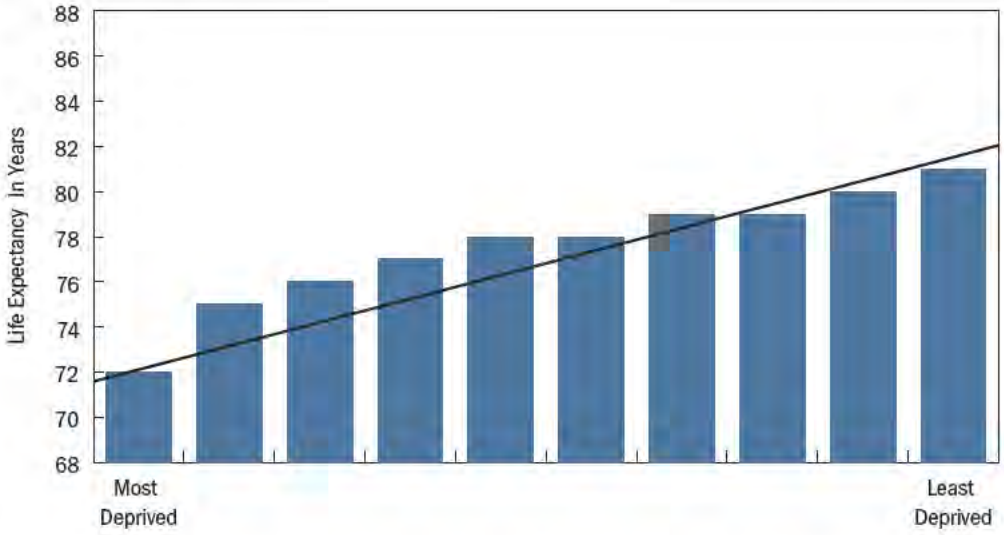


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Figure 9: Life Expectancy of women in Northern Ireland ranked by deprivation (2009/11)

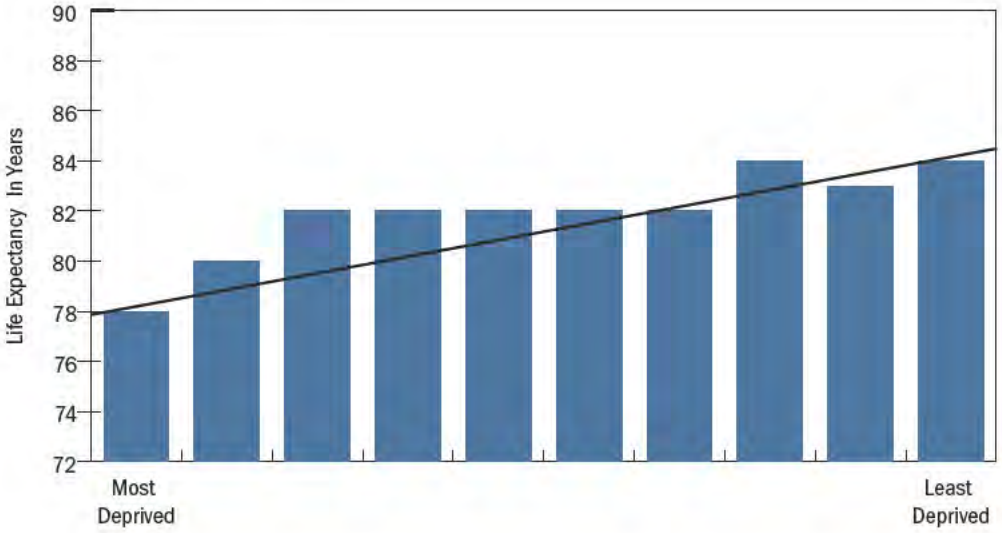

Figure 10: Male Life Expectancy Deprivation Gap: Proportion of Contributing Causes (2008 - 10)

Figure 10 illustrates the decomposition analysis of the gap in life expectancy at 2008 – 10.The size of each sphere represents the proportion of the gap in life expectancy between deprived and non deprived areas attributable to each cause of death. Where appropriate, these causes are further broken down into sub-categories, the sum of which is equal to that cause. Causes contributing less than 0.01 years are not displayed.

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9. Male mortality rates for all overarching causes of death were higher in the 20% most deprived areas of Northern Ireland than in the 20% least deprived areas. In total, male life expectancy in deprived areas of Northern Ireland was 7.6 years less than in the least deprived areas. More than half of this gap is accountable to circulatory diseases and cancer, contributing 2.0 years and 1.8 years respectively. Coronary heart disease is responsible for over 65% of the circulatory disease gap, at 1.3 years. Other notable causes include suicide (0.9 years), respiratory disease (0.7 years), digestive diseases (0.7 years) and accidental deaths (0.6 years).

10. Coronary heart disease (CHD), cancer, and respiratory disease continue to be the main causes of death for both sexes. Many of these deaths occur before 65 years of age and are potentially preventable, since smoking, unhealthy diet, raised blood pressure, diabetes and physical inactivity are major contributors to a large proportion of these conditions.

Figure 11: Death rates from Cancer in people under 75 years in Northern Ireland ranked by deprivation (2007/11)

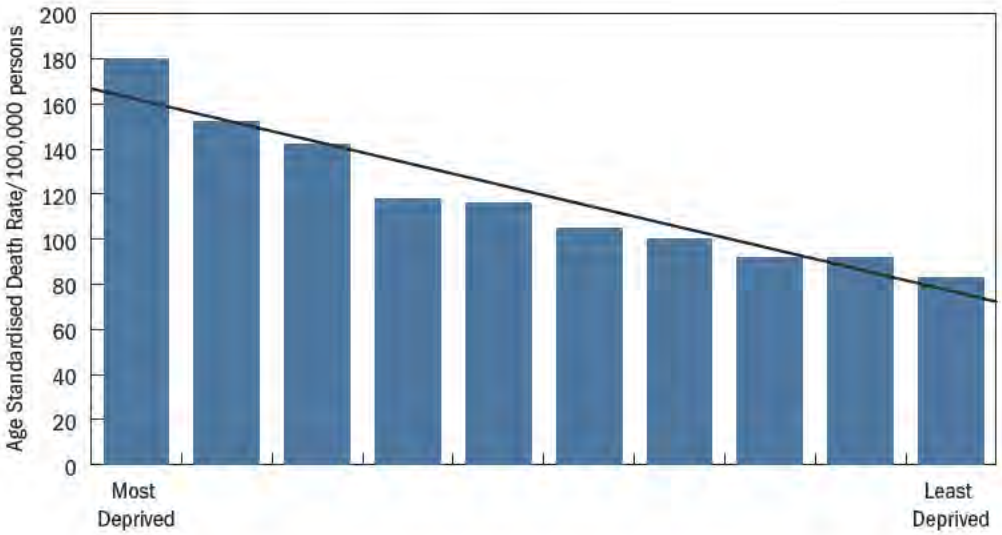

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Figure 12: Death rates from Coronary Heart Disease in people under 75 years in Northern Ireland ranked by deprivation (2007-11)

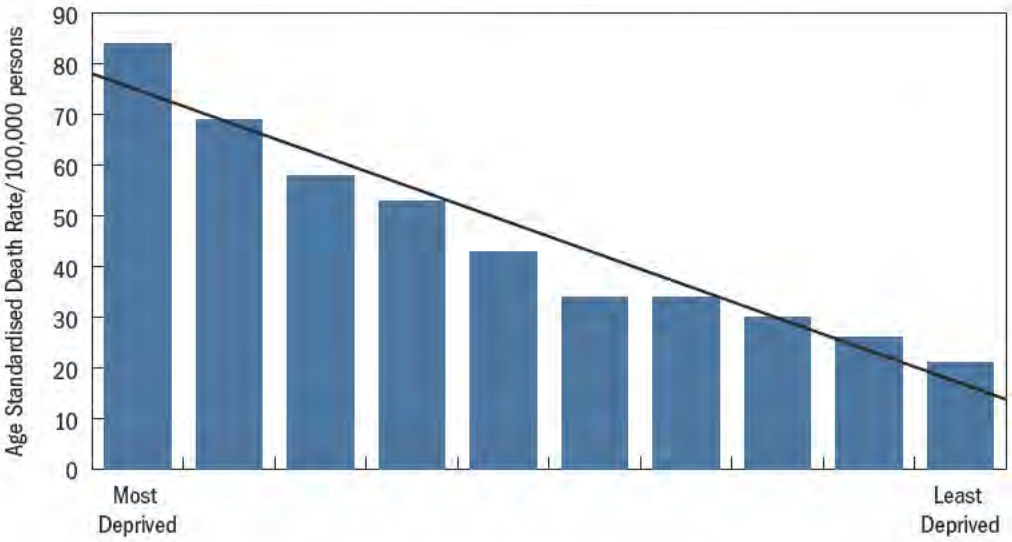
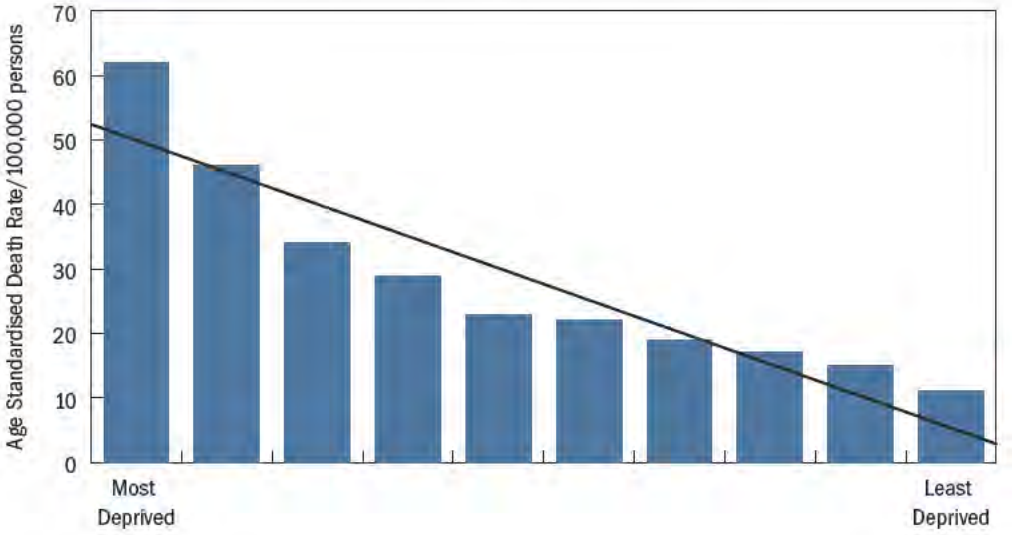


Figure 13: Deaths rates from Respiratory Disease in people under 75 years in Northern Ireland ranked by deprivation (2007-11)



11. Figures 11, 12 and 13, shows there is a notable increase in death rates from cancer, CHD and respiratory disease as level of deprivation increases.

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Mental Health

12. Mental illness is one of the major causes of ill health and disability in Northern Ireland which has 25% higher overall prevalence compared to England. One in five adults in NI has a mental health condition at any one time. Mental ill health is more prevalent in areas of deprivation. People with poor physical health are at a higher risk of experiencing common mental health problems and people with mental health problems, especially those with severe and enduring mental illness, are more likely to have poor physical health.

13. Mental wellbeing is related to, but not the same as, the absence of mental illness. It is possible to have a diagnosed mental illness and still be coping well with life and enjoying a high level of wellbeing. Likewise, someone can have poor mental wellbeing but have no clinically identifiable mental illness. However, in populations where individuals have higher mental wellbeing, fewer people tend to develop mental illness. The Warwick-Edinburgh Mental Wellbeing Scale is a measure of the positive mental health of people over time and has been included in the annual NI Health Survey and, for the first time, in the Young Person's Behaviour and Attitudes Survey. Results from the 2010/2011 and 2011/12 surveys have provided a baseline for monitoring mental wellbeing trends over the coming years (see Annex B).

14. There were 289 deaths by suicide in NI in 2011. During 2009/2011 there was an average annual suicide rate of 16.1 deaths per 100,000 population. The suicide rate in males was 25.1 deaths per 100,000 population, and the suicide rate in females was 7.4 deaths per 100,000 population. During this period, the suicide rate in the 10% most deprived areas was almost five times that within the 10% least deprived areas. A similar picture emerges when examining self-harm admissions to hospital over the same period, with the rate in the 10% most deprived areas over five times that in the 10% least deprived areas.

Wider Determinants

15. A wide range of socio-economic and environmental factors, such as poverty, neighbourhood deprivation, housing conditions, employment, education and physical environment, impact on the level of control people have in their lives and the choices they are in a position to make, and therefore on health and wellbeing and health inequalities.

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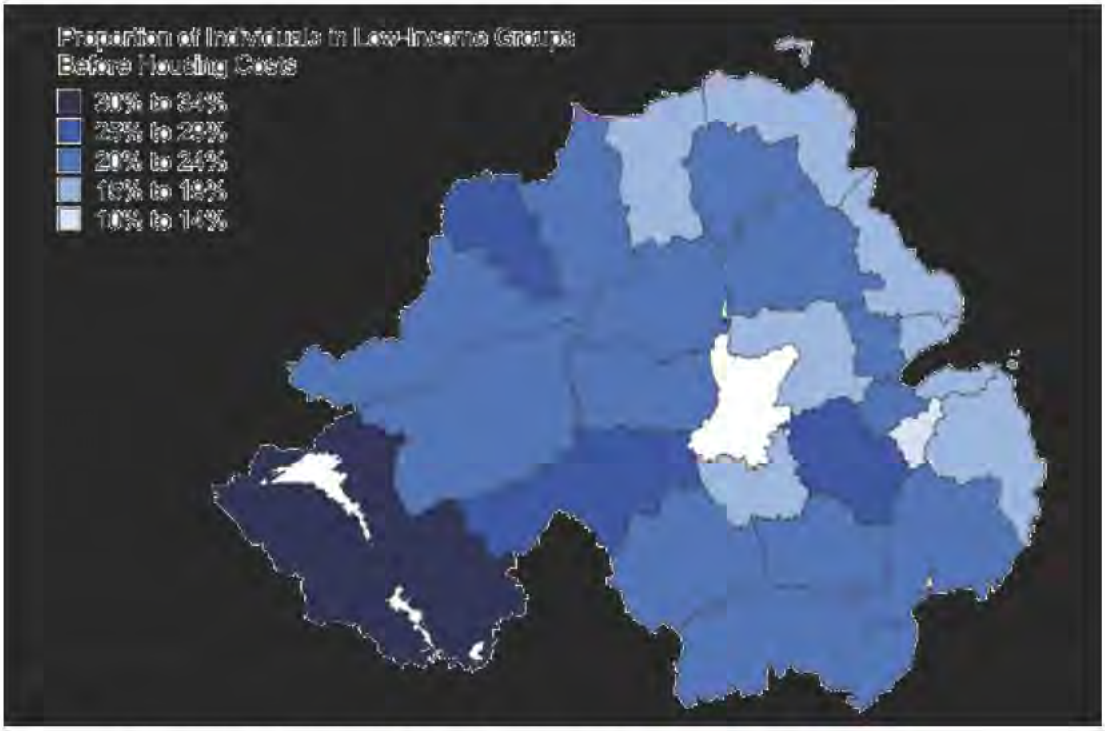
16. Poverty is the greatest risk factor for health and wellbeing, affecting health in many ways, for instance, by creating barriers to buying nutritious food, heating one's home, or participating in activities and social interaction. People living in poverty are less likely to feel in control of their lives and more likely to face damaging stresses. They are also more likely to leave school with few or no qualifications.

In 2011/12, the percentage of individuals in relative poverty (before housing costs) was 21%, broadly similar to that in 2002/03 (20%). The percentage of children in relative poverty in 2011/12 was 23%, compared with 25% in 2002/03.

Figure 14: Percentage of individuals in relative poverty* by Local Government District, 2009/10 -2011/12



* Relative poverty is measured as having income of less than 60% of the UK median.

17. Education impacts on health in many ways – on self-esteem, social skills, training and employment opportunities and income. Inequalities in educational attainment are as stark as those in health and follow a similar social gradient, for example:

In 2011/12, 67.9% of school leavers not entitled to free school meals achieved at least 5 GCSEs at A-C or equivalent including GCSE English and Maths, compared with 34.1% of school leavers entitled with free school meals.*

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"A strong positive relationship exists between education and health outcomes whether measured by death rates (mortality), illness (morbidity), health behaviours or health knowledge."

IPH – Health impacts of education – a review 2008

18. There is a clear link between employment and health. Unemployment has both short and long term effects on health, through lower self esteem, reduced social integration, anxiety and depression. Employment on the other hand is generally protective of health, however insecure work or adverse working conditions can impact negatively. Under-employment, where people are working part-time hours because they cannot find full time jobs, can place a strain on family finances and damage career prospects.

The Northern Ireland economic inactivity rate decreased each year from 30.1% in 2009 to 27.6% in 2012.

Northern Ireland's unemployment rate for 2011 was estimated at 7.3%, an increase of 0.2 percentage points from the figure for 2010 (7.1%) and an increase of 0.6 percentage points from the figure in 2009 (6.7%).

The long-term unemployment rate (1 year and over) increased from 37.6% in 2007 to 46.8% in 2012. During this time, the percentage of 16 to 24 year olds that were not in employment, full-time education or training increased from 15.6% to 22.1%.[2]

19. Good quality, warm, secure housing is also vital to both mental and physical health, with the very young and very old most vulnerable to the impacts of fuel poverty.

In 2011, more than two fifths (42.0%) of homes in Northern Ireland were in fuel poverty. During this time, 3.7% of Social Housing dwellings were classed as non-decent homes.

According to the Northern Ireland Housing Executive, as at 31st March 2013, the social housing waiting list amounts to 41,356 households, of whom around 22,414 are considered to be in housing stress, including 9,878 households deemed to be statutorily homeless.

20. Physical surroundings – the quality of the built and natural environment - buildings, green spaces, roads and walkways - have a significant impact on health and wellbeing, for example, on mental health and levels of obesity. They can also influence social networks and sense of belonging. Wider environmental factors – air and water quality for example – are also important to health.

Between 2007 and 2011, Northern Ireland air quality fluctuated slightly year on year but remains at a high standard.

During this time, Northern Ireland water quality improved year on year and is at a high standard in terms of compliance with regulations for drinking water standards (99.83%).

21. Globalisation and increased movement between countries can impact on the rate and spread of disease or infection. The emergence of novel viruses and continuing risk attached to future occurrences of pandemic influenza necessitates that a state of readiness is maintained to minimise adverse impact to public health.

22. Antimicrobial resistance (AMR) is regarded by WHO as one of the top three global threats to human health. Antimicrobials are medicines used to treat infections caused by bacteria, viruses or fungi, and so comprise antibiotics, antivirals and antifungals. The organisms evolve and survive by developing resistance to the antimicrobials. When that happens antimicrobials are no longer effective; simple infections become untreatable, and many complex medical procedures that depend on antibiotic cover become impossible to perform.

23. Factors such as increased international travel, including medical treatment abroad, an ageing population who are moving between care in hospitals and the community, and the use of antimicrobials in veterinary medicine contribute to the rapid spread of resistant organisms between countries, throughout healthcare systems and between animals and humans.

Impact of the Past

24. It is important to acknowledge that a particular challenge for the health and wellbeing of Northern Ireland society is the need to deal with the consequences of the past. A history of sectarianism, intolerance and violence has left a legacy of hurt and division, and physical and mental scars that must be addressed in building a better and healthier future.

25. The Childhood in Transition Report[38] points to a number of specific factors that influence the present day lives of young people as a result of their direct or indirect exposure to the past conflict and the sectarianism that continues to exist. The legacy of the conflict continues to impact on everyday lives - local research indicates that Northern Ireland has high levels of, (often untreated), Post Traumatic Stress Disorder as a result of the 'Troubles'. Use of anti-depressants has a higher prevalence amongst those living close to peace walls[39], suggesting that people living in these areas have worse than expected mental health.

26. Society here has seen a number of significant milestones in achieving change and research demonstrates that there is strong desire across communities to continue working towards a more shared and positive future.[40]

Health Behaviours and Risk Factors

27. A recently published study[41] reported that the three risk factors that account for the greatest disease burden in the United Kingdom are dietary risks, tobacco smoking, and high blood pressure. In 2010 the leading risk factor for both children under 5 and adults aged 15-49 years was tobacco smoking. Tobacco smoking as a risk factor for children is due to second-hand smoke exposure.

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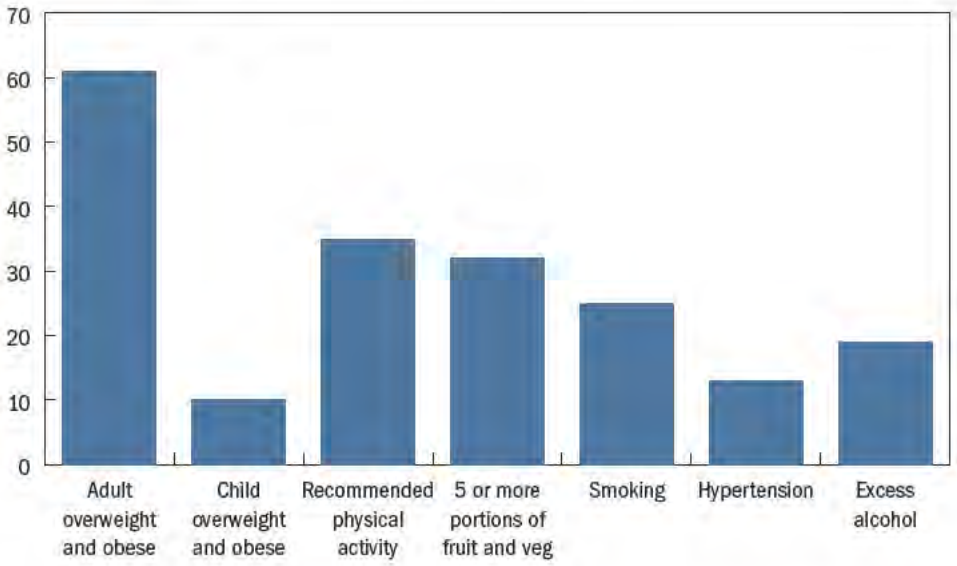
Figure 15: Health Behaviours and Risk Factors in Northern Ireland



* 2011/12 Health Survey, Adult Drinking patterns survey 2011. Adult Drinking patterns survey 2011

1. Data for adults and children's weight, recommended physical activity, eating 5 or more portions of fruit and vegetables, smoking and excess alcohol relate to the Health Survey Northern Ireland 2011/12.
2. Data for hypertension come from the Quality and Outcomes Framework 2013.
3. 2011/12 Health Survey, Adult Drinking patterns survey 2011. Adult Drinking patterns survey 2011
4. In adults, a Body Mass Index of between 25 and 29.9kg/m2 is considered overweight.
5. A Body Mass Index of 30kg/m2 or above is considered obese.
6. The Chief Medical Officer issued guidelines on the amount of physical activity a person should do to achieve a healthy lifestyle. During the fieldwork of the 2010/11 HSNI, the recommended guidelines for adult physical activity were 30 minutes of moderate activity on at least 5 days a week.

28. The Health Survey Northern Ireland 2011/12 reported that a quarter of adults (aged 16 and above) smoked (27% males and 23% females). Similarly, almost a fifth (19%) of adults (aged 18 and above) stated that they drank in excess of the weekly recommended drinking limits[3]. Over three-fifths (61%) of respondents were either overweight (37%) or obese[4] (23%). A higher proportion of males were either obese or overweight (68%) than females (56%). A tenth of both boys and girls aged 2-15 years were also assessed as being obese.

Over a third (35%) of respondents were classified as meeting the recommended level of physical activity[5], with males (40%) more likely than females (31%) to fulfil this. Similarly, almost one-third of respondents (32%) reported consuming the recommended 5 or more portions of fruit

and vegetables per day. Females (36%) were more likely to meet this recommendation than males (26%).

Figures from the 2013 Quality and Outcomes Framework (QOF) reported that there were 245,730 patients in NI with established hypertension which represented 13% of all GP registered patients.

Clustering of risk factors

29. Much of the available information on health behaviours focuses on the prevalence of specific individual risk factors. While this provides a useful insight, often these risk factors occur alongside one another. Recent work by the *Kings' Fund: Clustering of unhealthy behaviours over time (2012)* which looked at the prevalence and co-distribution of risk factors associated with smoking, excessive use of alcohol, poor diet and low levels of physical activity, found for example that:

- a significant minority of people in western developed countries have three or more risk factors:
- multiple risk factors are not randomly distributed across populations but are more common in some groups than others;
- the overall proportion of the population engaging in three or more risk factors is declining, but mainly among those in higher socio-economic and educational groups; and
- several studies have found a consistent socio-demographic gradient in the prevalence of multiple risk factors, with men, younger age groups and those in lower social classes and with lower levels of education being more likely to exhibit multiple lifestyle risks.

30. The Health Survey Northern Ireland 2010/11 looked at lifestyle choices based on five guidelines that can help individuals stay healthy or improve their health:

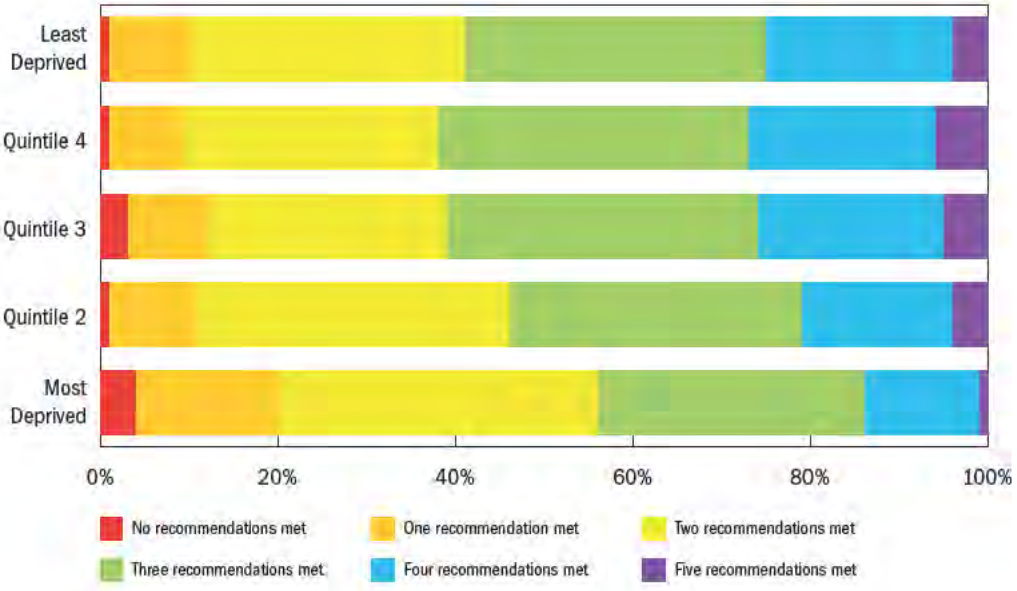
1. Ensuring alcohol intake is within weekly guidelines.
2. Not being overweight or obese by maintaining a Body Mass Index (BMI) of less than 25 kg/m^2.
3. Eating at least five portions of fruit and vegetables a day.

4. Meeting the recommended weekly level of physical activity. In 2010/11 the guidelines recommended exercising for at least 30 minutes 5 days a week. This has since changed to 150 minutes per week.

5. Not smoking cigarettes.

As shown in Figure 13, just over half of respondents (57%) met three or more of the lifestyle choice recommendations (50% of males and 61% of females), while 2% did not meet any of the recommendations. However, respondents in more deprived areas were less likely to meet the lifestyle choice recommendations when compared with those in less deprived areas.

Figure 16: Number of lifestyle choice recommendations met by deprivation quintile in Northern Ireland



Health Survey NI 2010/11

Further Information

31. Baselines for key indicators identified for monitoring progress, are at Annex B.

In addition, reports of the Health and Social Care Inequalities Monitoring System can be found at the link below:
http://www.dhsspsni.gov.uk/index/statistics/health-inequalities.htm

Notes

- It should be noted that figures included in this document may be subject to change in the future due to the revision of small area population estimates produced by the Northern Ireland Statistics and Research Agency (NISRA) and an update to the age standardisation model.

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ANNEX B - KEY INDICATORS AND BASELINES

A set of key high level indicators, to be monitored annually where possible, will help inform the monitoring process.

These include a small number of overarching indicators, and indicators which relate to each of the framework's themes, as follows

Key Overarching Indicators					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Life Expectancy	Differential between NI average and most disadvantaged areas for men and women.	2009 – 2011	In 2009-2011, the differential between the NI average and the 20% most deprived areas was 4.5 years for males and 2.8 years for females.	IAD (NI HSCIMS)	Annual (March)
	Healthy Life Expectancy between NI average and most disadvantaged areas for men and women.	2008/09 – 2010/11	Between 2008/09 and 2010/11, the differential between the NI average and the 20% most deprived areas was 7.2 years for both males and females.	IAD (NI HSCIMS)	Annual (March)
	Disability Free Life Expectancy between NI average and most disadvantaged areas for men and women.	2008/09 – 2010/11	Between 2008/09 and 2010/11, the differential between the NI average and the 20% most deprived areas was 5.4 years for males and 5.0 years for females.	IAD (NI HSCIMS)	Annual (March)
1. Give Every Child the Best Start					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Infant Mortality	Number of children dying before their first birthday per 1,000 live births	2007 - 11	For the period 2007 to 2011, the infant mortality rate was 4.9 per 1000 live births, with a rate of 5.2 within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (December)

1. Give Every Child the Best Start - continued

Indicator	Description	Baseline Period	Baseline	Source	Availability
Smoking During Pregnancy	Proportion of mothers smoking during pregnancy in NI and the most disadvantaged areas	2012	In 2012, 16.5% of expectant mothers in Northern Ireland smoked during their pregnancy, with a rate of 29.6% within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)
Breastfeeding	Proportion of mothers breastfeeding on discharge and differential between NI average and most deprived.	2012	In 2012, 42.3% of mothers discharged were breastfeeding, including those partially breastfeeding and those breastfeeding only. The differential between the NI average and the 20% most deprived areas was 14.6 percentage points.	IAD (NI HSCIMS)	Annual (March)
Educational Attainment	Proportion of primary pupils achieving at the expected levels in Key Stage Two assessment in Communication and Using Mathematics	2012/13	In 2012/13: - 77.1% of pupils achieved at or above the expected level in Communication at KS2 in 2012/13 - 78.5% of pupils achieved at or above the expected level in Using Maths at KS2 in 2012/13 NOTE: 2012/13 data are based on the new Levels of Progression; these results are not directly comparable with Key Stage Assessment outcomes from previous years. The Department of Education also recognises that these new arrangements will need time to embed and has recommended caution in analysing data and benchmarking performance from the first year's implementation.	DE (CCEA)	Annual (December)

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1. Give Every Child the Best Start - continued					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Educational Attainment	Proportion of school leavers achieving at least 5 GCSEs at A*-C or equivalent, including GCSE English and Maths.	2011/12	In 2011/12, 62.0% of school leavers achieved at least 5 GCSEs at A*-C or equivalent, including GCSE English and Maths. The differential between the NI average and the 10% most deprived areas was 21.9 percentage points.	DE (NI School Leavers Survey)	Annual (May)
2. Equipped throughout Life					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Unemployment	Long Term Unemployment Rate: proportion of unemployed that have been unemployed for one year or longer.	2012	The long-term unemployment rate in 2012 was 46.8%.	DFP (Labour Force Survey)	Annual (October)
	Proportion of 16 to 24 year olds who are not in employment, full time education or training (NEETS).	2012	In 2012, 22.1% of 16 to 24 year olds were not in employment, full time education or training.	DFP (Labour Force Survey)	Annual (October)
3. Empowering Healthy Living					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Smoking	Proportion of adults (aged 18 and over) who smoke and proportion in the most deprived areas	2011/12	In 2011/12, of those surveyed in Northern Ireland, 25% were smokers, with a proportion of 39% in the 20% most deprived areas	IAD (Health Survey)	Annual (March)
Alcohol -related Admissions	Standardised rate for alcohol-related admissions in NI and the most disadvantaged areas	2009/10 - 2011/12	For the period 2009/10 to 2011/12, the standard rate for alcohol-related admissions was 618 per 100,000 of the population, with a rate of 1,413 within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)

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3. Empowering Healthy Living - continued

Indicator	Description	Baseline Period	Baseline	Source	Availability
Adults who drink above sensible drinking guidelines	Proportion of adults who drink above the sensible drinking guidelines suggested, and proportion in the most disadvantaged areas.	2011/12	In 2011/12, of those adults surveyed in Northern Ireland, 19% drink above the sensible drinking guidelines suggested, with a proportion of 24% in the 20% most deprived areas.	IAD (Health Survey)	Annual (March)
Teenage Births	The teenage birth rate for mothers under the age of 17 – NI and most deprived areas	2011	In 2011, the teenage birth rate for mothers under the age of 17 was 2.2 per 1,000 females, with a rate of 4.6 per 1,000 females within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)
Adult Obesity	Percentage of adults surveyed classified as obese, and proportion in the most disadvantaged areas.	2011/12	In 2011/12, of those adults surveyed in Northern Ireland, 23% were classified as obese, with a proportion of 25% in the 20% most deprived areas.	IAD (Health Survey)	Annual (March)
Childhood Obesity	Percentage of children surveyed classified as obese.	2011/12	In 2011/12, of those children surveyed in Northern Ireland, 10% were classified as obese.	IAD (Health Survey)	Annual (March)
Mental Health and wellbeing	Mean Warwick-Edinburgh Mental Wellbeing Scale by deprivation quintile	2011/12	The 2011/12 Health Survey results indicate a mean score of 50: Quintile 1 (most deprived) – 48 Quintile 2 – 50 Quintile 3 – 51 Quintile 4 – 51 Quintile 5 – 52	IAD (Health Survey)	Annual (March)
Suicide	Crude suicide Rate in NI and the most disadvantaged areas	2009 – 11	For the period 2009-11, the crude suicide rate in Northern Ireland was 16.1 suicides per 100,000 of the population, with a rate of 30.1 within the 20% most deprived areas.	IAD (NI HSCIMS)	Annual (March)

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3. Empowering Healthy Living - continued					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Blood Pressure/ Hypertension	Number of patients with established hypertension and % of GP registered patients with established hypertension	2013	Figures from the 2013 QOF reported that there were 245,730 patients in NI with established hypertension which represented 13% of all GP registered patients.	IAD (QOF)	Annual (April)
Long term conditions	Number of people with one or more long term condition attending structured patient education/self management programmes	2011/12	An audit of structured patient education/ self management programmes showed that in 2011/12 there were 10,189 attendances at structured patient education/self management programmes in Northern Ireland	IAD (QOF)	Annual (June)
4. Creating the Conditions					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Investment in public health	Amount invested in public health.	2011/12	In 2011/12, the PHA Resource outturn was £77.2 million.	PHA Annual Audited Accounts	Annual (June)
Poverty	Percentage of individuals in low-income groups before housing costs	2009/10 – 2011/12	For the period 2009/10 -2011/12, 21% of the population were in relative poverty (Before Housing Costs).	DSD *(Households Below Average Income Report)*	Annual (February)
Child Poverty	Percentage of children in low-income groups before housing costs.	2009/10 – 2011/12	For the period 2009/10 -2011/12, 23% of children were in relative poverty (Before Housing Costs).	DSD *(Households Below Average Income Report)*	Annual (February)

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4. Creating the Conditions - continued					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Economic Inactivity	Economic Inactivity Rate: proportion of the working-age population that is not in the labour force.	2012	In 2012, the economic inactivity rate in Northern Ireland was 27.6%.	DFP *(Labour Force Survey)*	Annual (October)
Housing Standards	Proportion of social housing dwellings classified as non decent homes.	2011	In 2011, the Non Decency Rate of Social Housing Dwellings was 3.7%.	DSD *(House Condition Survey)*	3 Years
Air Quality	Annual mean concentration level of Nitrogen Dioxide at urban background sites and urban roadside sites.	2011	In 2011, the annual mean concentration level of Nitrogen Dioxide was 22.0 µg/m^3 at urban background sites and 35.2 µg/m^3 at urban roadside sites.	DOE (Nitrogen Dioxide Survey)	Annual (February)
	Annual mean concentration level of particulate matter (PM 10).	2011	In 2011, the annual urban background sites mean concentration level of particulate matter was 21.3 µg/m^3.	DOE (Particulate Matter Survey)	Annual (February)
	Annual mean concentration level of Benzo(a) pyrene at monitored sites.	2011	In 2011, the annual mean concentration level of Benzo(a)pyrene was 0.86 ng/m^3 at Lisburn Dunmurry High School, 0.95 ng/m^3 at Derry Brandywell, and 1.12 ng/m^3 at Ballymena Ballykeel.	DOE (Benzo(a) pyrene Survey)	Annual (February)
	Annual number of ozone breaches (days) at monitored sites.	2011	In 2011, there were 4 ozone breach days at Belfast site, 12 at Lough Navar and 9 at Derry.	DOE (Nitrogen Dioxide Survey)	Annual (February)

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4. Creating the Conditions - continued					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Water Quality	Annual percentage compliance of Water Utility Sector Waste Water Treatment Works.	2011	In 2011, the overall Water Utility Sector WWTW had a 93% compliance with numeric standards.	DOE (WWTW Survey)	Annual (February)
	Annual percentage mean zonal compliance of drinking water quality	2011	In 2011, the mean zonal compliance with Northern Ireland water regulations drinking water standards was 99.83%.	DOE (Drinking Water Quality Survey)	Annual (February)
5. Empowering Communities					
Indicator	**Description**	**Baseline Period**	**Baseline**	**Source**	**Availability**
Social Capital	Proportion of respondents having volunteered in the past year	2012	29% of respondents to the 2013 NI Omnibus Survey stated that they had volunteered in the past year.	DSD (NI Omnibus Survey 2013)	Annual (February)
Road Collisions	Number Killed or Seriously Injured (KSI) casualty numbers per capita	2012	In 2012, there were 843 casualties (killed or seriously injured) as a result of road traffic collisions in Northern Ireland.	PSNI (PSNI Collision Report Form)	Annual (March)

Notes

- It should be noted that figures included in this document may be subject to change in the future due to the revision of small area population estimates produced by the Northern Ireland Statistics and Research Agency (NISRA) and an update to the age standardisation model.
- Health Survey runs annually though topics may not be included every year.

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ANNEX C - GLOSSARY

ADOG	All Departments Officials Group
AMR	Antimicrobial Resistance
BMI	Body Mass Index
BSP	Belfast Strategic Partnership
CAUSE	Regional charity run by carers for carers
CAWT	Co-operation and Working Together
CCEA	Council for the Curriculum Examinations and Assessment
CENI	Community Evaluation Northern Ireland
CFC	Community Food Centres
CFI	Community Food Initiatives
CFM	Community Food Members
CHD	Coronary Heart Disease
CMP	Condition Management Programme
DARD	Department of Agriculture and Rural Development
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DETI	Department of Enterprise, Trade and Investment
DFP	Department of Finance and Personnel
DHSSPS	Department of Health, Social Services and Public Safety
DIY	Do It Yourself
DNE	Dublin North East
DOE	Department of the Environment
DOH	Department of Health
DRD	Department for Regional Development
DSC	Delivering Social Change
DSD	Department for Social Development
END	Environment Noise Directive
EU	European Union
FASA	Forum for Action on Substance Abuse and Suicide Awareness
FE	Further Education
FEC	Further Education College
FUEL	Youth Organisation, Enniskillen
GCSE	General Certificate of Secondary Education
GP	General Practitioner
HEI	Higher Education Institution
HCHF	Healthy Child Healthy Future
HGV	Heavy Goods Vehicle
HIA	Health Impact Assessment
HiAP	Health in All Policies
HMO	Houses in Multiple Occupation
HSC	Health and Social Care

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HSCB	Health and Social Care Board
HSCT	Health and Social Care Trust
HSE	Health and Safety Executive
ICT	Information and computer technology
IDeA	Improvement and Development Agency
INTERREG	an initiative that aims to stimulate cooperation between regions in the European Union
IPH	Institute of Public Health in Ireland
JCVI	Joint Committee on Vaccination and Immunisation
LCG	Local Commissioning Group
LGBT	Lesbian, Gay, Bisexual and Trans-gender
LGD	Local Government District
MARA	Maximising Access (to services, grants and benefits) in Rural Areas
NEETS	Young People not in education, employment or training
NHS	National Health Service
NI HSCIMS	Northern Ireland Health and Social Care Inequalities Monitoring System
NIHE	Northern Ireland Housing Executive
NINIS	Northern Ireland Neighbourhood Information System
NISRA	Northern Ireland Statistics and Research Agency
NUS-USI	National Union of Students-Union of Students of Ireland
OFMdFM	Office of the First Minister and deputy First Minister
PARC	Physical Activity and Rejuvenation of Connswater
PCC	Patient Client Council
PCSP	Policing and Community Safety Partnerships
PEACE III EU	Programme for Peace and Reconciliation in NI and the border region of Ireland, 2007 - 2013
PFG	Programme for Government
PHA	Public Health Agency
PHE	Public Health England
PHORCaST	Public Health Online Resource for Careers, Skills and Training
PHSCF	Public Health Skills and Careers Framework
PPS	Planning Policy Statement
PSNI	Police Service of Northern Ireland
QOF	Quality and Outcomes Framework
REACT	Family Support Services, Banbridge
ROI	Republic of Ireland
SEELB	South Eastern Education and Library Board
SOA	Super Output Areas
SSA	Social Security Agency
SUDS	Sustainable Drainage System
TYC	Transforming Your Care
UKPHR	United Kingdom Public Health Registry

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UNCRC	United Nations Convention on the Rights of the Child
VCS	Voluntary and Community Sector
VCU	Voluntary and Community Unit
WHO	World Health Organisation
WWTW	Waste Water Treatment Works
YMCA	Young Men's Christian Association

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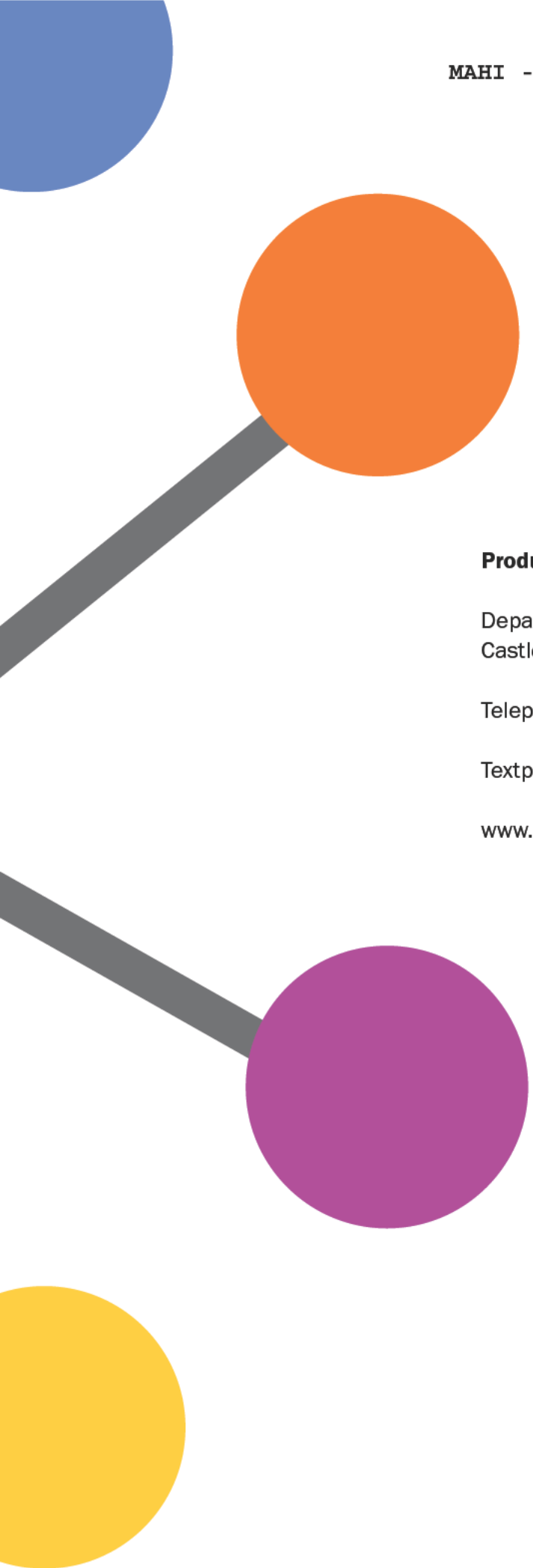

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www.dhsspsni.gov.uk

HSC Hospital Passport

For people with a learning disability in contact with a general hospital

Your Hospital Passport will help to let hospital staff know all about your abilities and needs.

This will help them give you better care when you are in hospital.

Please ensure that your information is up to date.

To staff:

Please read this regional Hospital Passport and make reasonable adjustments *before* you undertake any assessment, examination, treatment or care.

Try to make this passport easily available to all staff involved in care.

HSC Health and Social Care

All about me

MAHI - STM - 120 - 446

My name is

I like to be called

My birthday is (date of birth)

I live at

My telephone number is

I live with

My main carer is

Name

Telephone number

Parental responsibility

(for children under 18 years of age)

Name

Telephone number

My keyworker is

Name

Telephone number

Communication

I communicate by

How best to communicate with me

Support I need to make decisions

My eyesight

My hearing

What I do if I am afraid or worried

How you can support me if I am afraid or worried

Things I do if I am sore or in pain

Medical history

Things I am allergic to

Other conditions I have (for example, epilepsy, diabetes, mental illness, high blood pressure)

Medication

I am on medication **Yes** ☐ **No** ☐

(please bring all your medication to hospital with you)

How I prefer to take my medication (in food, with a drink, as a liquid)

Looking after me

How best to gain my help when examining or caring for me

Support I may need with moving
(in bed, sitting, walking)

Support I may need with eating

Help I need with drinking

How to reduce my risk of choking
(if this applies to me)

Support I may need with my oral or dental care

You can help me with my personal care by

Support I may need with using the toilet

Things that help me have a good sleep

Keeping me safe and happy

Things that I do or use to keep safe

Things I like (what makes me happy, things I like to do, see or talk about)

Things I do not like (what upsets me, things I do not like to do, see or talk about)

If my behaviour becomes difficult for you, please support me by

_____

HSC Public Health Agency

Photosymbols

Public Health Agency
12-22 Linenhall Street, Belfast BT2 8BS,
Tel: 0300 555 0114 (local rate).
www.publichealth.hscni.net

Find us on:

If you need another copy of this passport, please ask the person who gave you this one or go to pha.site/HospitalPassport

Completed by:

Relationship to client:

Date:

06/19

and other people who may find the Hospital Passport useful

Best Practice Guidance
for
Users of the Regional Hospital Passport

June 2020

Prof Michael Brown, Queen's University Belfast
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Dr Laurence Taggart, Ulster University
Dr Freda McCormick, Queen's University Belfast

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Introduction

The Regional Hospital Passport provides essential information for healthcare professionals about your abilities and needs when accessing hospital services to help them plan and provide person-centred care and support.

This guidance has also been prepared to support those who assist in looking after you. This information can be used for all interactions throughout your ‘hospital or healthcare journey’ whether at reception, as an outpatient or as a patient on a ward.

Let healthcare staff know that you have a Regional Hospital Passport and let them see it if they ask for it. If they are not aware of it, let them see it. Healthcare staff have been asked to read your Regional Hospital Passport before any admission, assessment, treatment or care is undertaken to gain an understanding of your abilities, needs and safety requirements. Therefore, it is important that the information being asked for is completed accurately and updated when any changes happen.

Some helpful information is also included.

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Background to the Regional Hospital Passport

The introduction and subsequent implementation of the hospital passport in Northern Ireland came from the recommendations from the Guidelines and Audit Implementation Network (GAIN) 2010 to improve the hospital experience for people with learning disabilities. On further review of the GAIN guidelines by the Regulation and Quality Improvement Authority (RQIA) in 2014, it was highlighted that while all Health and Social Care Trusts were using a hospital passport, there was a lack of standardisation and limited use. Subsequently, RQIA recommended that a regional hospital passport be developed and implemented strategically for routine use across all general hospital services in Northern Ireland. The RQIA 2018 *Guidelines on Caring for People with a Learning Disability in General Hospital Settings* incorporated the actions arising from the recommendations in the original GAIN 2010 guidelines and consistently refer to the use of the Regional Hospital Passport.

Following a pilot study in August 2016 and feedback, the *Regional HSC Hospital Passport* was formally launched by the Public Health Agency in May 2017.

Evaluation reports of the Regional Hospital Passport may be accessed at https://www.publichealth.hscni.net/publications/evaluation-regional-hospital-passport-people-learning-disabilities.

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Some Points to Remember

P resent your Regional Hospital Passport to healthcare staff

A mend and update your Regional Hospital Passport as necessary

S eek help when needed

S afety at all times

P rovide information which may be useful

O ffer information about family and carer support

R outines are important so tell about yours

T ell healthcare staff to keep you informed

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How to complete the Regional Hospital Passport

All about me

⇒ Make sure all information is up to date.

⇒ Telephone numbers for important contacts should be included.

⇒ A mobile phone number can be given.

⇒ A keyworker could also include your social worker, speech therapist, GP. Give their names and contact details.

Communication

Everyone has the ability to communicate, and some people do not use words.

⇒ Tell others how you prefer to communicate.

⇒ What helps you understand information provided to you?

For example, it may be helpful if staff speak slowly, speak loud enough to be heard, write things down, or use pictures and symbols to help you understand what they are saying.

You may be unsure about what happens at a healthcare appointment or be afraid about coming to hospital. Or you may have some difficulty in clearly explaining if you are in pain.

⇒ It is helpful to provide some information about how you might behave if you are afraid, worried or in pain and how staff could help you.

For example, what changes might healthcare staff see if I am afraid or worried? How could staff know if I was in pain?

Medical history

This information should be up to date.

⇒ When thinking about allergies, write down things that may bring you out in a rash or make you feel itchy or sick.

⇒ It is really important to let healthcare staff know if you are taking any medication.

⇒ It is important to bring all your medication to hospital.

⇒ Let it be known how you prefer to take your medication. For example, is it taken in food, with a drink or as a liquid?

Looking after me

⇒ Give information to help staff enable you to be as independent and as involved as possible in decisions about your care when at hospital. This includes information about help you need when you are in bed, sitting or walking.

⇒ Give information about help you need when you are eating, drinking, dressing, using the bathroom or other personal care.

⇒ Let it be known how your food and drink should be prepared, any special diet you are on, and the amounts you usually put in a cup or glass.

⇒ Include information on help which you may need at mealtimes and any choking risks.

⇒ Many people find it difficult to sleep in hospital. Provide any information which will be helpful about what you do before going to bed to help you sleep, as well as the time you normally go to sleep and wake up.

Keeping me safe and happy

You may do things or have things to help you feel safe.

⇒ If you use anything, for example, a walking stick, personal alarm, or other equipment, write this down so that staff know.

⇒ If you like to have any personal things close to you (such as your phone, magazines or special things) also write this down.

Staff want to look after you well when you are in hospital.

⇒ It is useful for them to know about the things you like to do, see or talk about and what makes you happy.

⇒ It is also important for them to know about what upsets you and things you do not like to do, see or talk about.

It can be good for staff to know how to support you if you are nervous or afraid.

⇒ Write down what things help you to be more relaxed.

For example, do you like to be left alone for a short time?

Or maybe you prefer to lie down, sit in a chair, be in a quieter place, have some lights turned off or have someone you know stay with you?

Be very clear about what staff need to do, rather than what they should not do (for example ‘I need you to be quiet now’ instead of ‘stop shouting’).

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If I am admitted to hospital

⇒ Before your hospital stay talk to hospital staff about any concerns e.g. specific equipment you may need.

⇒ For unplanned admissions arrange a meeting to take place as soon as possible after admission.

⇒ Share important information to help make your hospital stay better e.g. communication needs, physical care needs, behaviour when distressed, and make sure these are included in your Regional Hospital Passport.

⇒ Make sure that your Regional Hospital Passport is up to date.

⇒ Ask to see information such as menus, information about the ward.

⇒ Find out the name of the nurse on each shift who will be looking after you.

⇒ Ask to be shown around the ward to find out where the toilets and nurse's station is, and how to call for help.

⇒ Ask for staff to explain any care they are giving you.

⇒ If you need an operation let ward staff know about your needs and behaviours e.g. previous experiences of anaesthesia and surgery.

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Appointments

⇒ Make contact before the appointment to talk about the appointment and address any concerns.

⇒ Tell staff if any extra time or help is needed.

⇒ Tell staff if you would like someone else with you.

⇒ Share important information with staff to help with the appointment e.g. your communication abilities, your physical care needs, how you show distress, and make sure these are included in your Regional Hospital Passport.

⇒ Make sure that your Regional Hospital Passport is up to date.

⇒ Ask, if required, for a quiet waiting area or space to walk around.

⇒ Ask to be kept informed of any delays or changes to care.

⇒ Ask what is going to happen next.

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Learning Disability Services

Belfast Health and Social Care Trust

http://www.belfasttrust.hscni.net/services/1047.htm

Northern Health and Social Care Trust

http://www.northerntrust.hscni.net/services/learning-disability-service-2/

South Eastern Health and Social Care Trust

http://www setrust hscni net/services/2141 htm

Southern Health and Social Care Trust

http://www.southerntrust.hscni.net/services/3168.htm

Western Health and Social Care Trust

https://westerntrust hscni net/service/adult-learning-disability-services/about-learning-disability-services/

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Useful Resources

‘Books Beyond Words’ are picture books which have been developed to aid communication and discussion around topics such as health needs.
https://booksbeyondwords co uk

Carers Trust is a major charity for, with and about carers. They work to improve support, services and recognition for anyone living with the challenges of caring, unpaid, for a family member or friend who is ill, frail, disabled or has mental health or addiction problems. The vision is that unpaid carers count and can access the help they need to live their lives.
www carers org

Carers UK is the voice of carers, and aim to improve their lives by providing advice, information and support and campaigning for change.
www.carersuk.org

Choking awareness
http://helpstopchoking.hscni.net

Easy Health provide accessible information and useful resources related to learning disability and other health issues.
www easyhealth org uk

'Guidelines on Caring for People with a Learning Disability in General Hospital Settings', Guidelines and Audit Implementation Network (GAIN), June 2010
https://rqia org uk/RQIA/files/81/81662c46-b7bb-43a5-9496-a7f2d919c2a3 pdf

'Guidelines on Caring for People with a Learning Disability in General Hospital Settings', Regulation and Quality Improvement Authority, Revised June 2018
www rqia org uk

Makaton is a language programme that gives everyone a helping hand to talk.
https://www.makaton.org

'Making Communication Accessible for All
A Guide for Health & Social Care (HSC) Staff'
www belfasttrust hscni net/pdf/making_communication_accessible_to_all pdf

Mencap is a charity for people with a learning disability and their families and carers. Mencap Northern Ireland campaigns to ensure that people with a learning disability are valued equally, listened to and included.
https://northernireland mencap org uk/

People with learning disabilities – Making reasonable adjustments: The website provides a range of documents with examples of reasonable adjustments, including information relation to cancer screening, constipation, obesity and weight management, health checks, dysphagia, and substance misuse.
https://www gov uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities

Regional HSC Hospital Passport for use throughout Northern Ireland. The document can be completed electronically and printed or printed and completed by hand.
http://www publichealth hscni net

'Working together 2: Easy steps to improve support for people with learning disabilities in hospital'. Guidance for hospitals, families and paid support staff.
https://www ndti org uk/uploads/files/Working_Together_2 pdf

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November 2004

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

HOME ACCIDENT PREVENTION

Strategy & Action Plan 2004 - 2009

Investing for Health

INDEX

Investing for Health

CHAPTER 1
WHY WE NEED A STRATEGY

CHAPTER 1
WHY WE NEED A STRATEGY

Introduction

1.1 Accidents can take place in a wide variety of environments, however, the home is the most likely location. Home accidents are a major cause of death and injury and contribute substantially to potential years of life lost.

1.2 In relation to home accidents, a "home" is categorised as any type of house (including a farm, block of flats or caravan) together with its garden, yard, driveway, path, steps and boundaries. It need not be the home of the injured person. A "home" also includes any permanent or voluntary institution, such as a home for older people or student hall, but not a temporary or non-voluntary institution, such as a hotel, boarding house, hospital, nursing home or prison.

Background

1.3 The Northern Ireland Executive, in its Programme for Government-Making a Difference 2002-2005 under the theme "Working for a Healthier People", gave a commitment to promoting public safety by reducing the number of injuries and deaths caused by accidents at home, at work and on the road.

1.4 The *Investing for Health* Strategy, published in March 2002, provides the framework for the Government's approach to improve health and wellbeing and reduce health inequalities. It identifies the need to reduce accidental injuries and deaths, and gives a commitment to develop a Home Accident Prevention Strategy.

1.5 A draft Strategy and Action Plan, prepared by an Inter-sectoral Working Group, was issued for public consultation in January 2003. Responses to the consultation were received from a number of sources including the housing sector, local councils, the voluntary and community sectors, the Fire Service and those representing the Health & Personal Social Services. The majority of respondents welcomed this initiative and the responses have helped the Working Group to further develop the Strategy.

1.6 Other policies and strategies already underway or planned have relevance to this Strategy and will help to reduce home accidents. Examples of these include the Tobacco Action Plan, Drugs, Alcohol, Physical Activity, and Children and Young People Strategies.

Types of Home Accident

1.7 There are three main categories of home accident:

- **impact accidents** including falls, being hurt by falling objects and general 'bumping into' type accidents;
- **heat accidents** including burns and scalds; and
- **through mouth and foreign body accidents** including accidental poisonings, suffocation,

choking and objects in the eye/ear/nose[1].

THE PROBLEM

1.8 Evidence shows that *accidental deaths* in the home are most commonly caused by falls, fire and flames, and poisoning[2]. The principal causes of *accidental injury* in the home are falls, being struck by or collision with an object, being cut or pierced by an object, burns, scalds and poisoning[3].

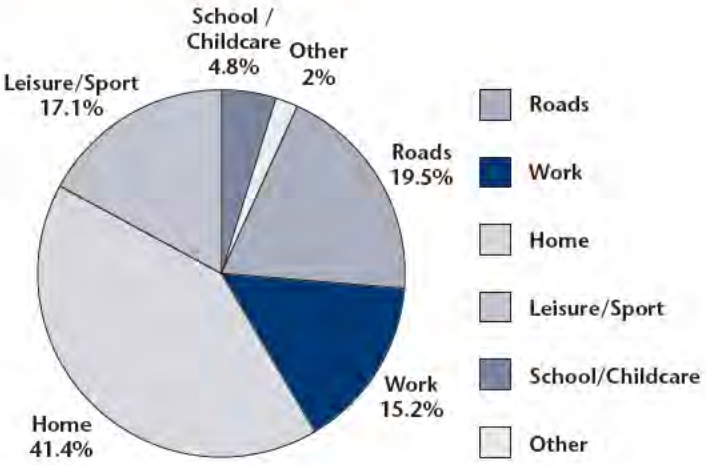
1.9 **Falls** are the predominant cause for admission to hospital for both children and older people. They are also one of the most common reasons given for admission of older people into residential care. A recent Fall Support Programme in North & West Belfast for older people recorded almost two thirds of those assessed had at least one previous fall, and nearly 40% of patients reported a loss of confidence after a fall[4].

1.10 **Fire** related deaths and injuries occur across all ages. Burn injuries can cause life long scars requiring long-term medical treatment usually resulting in years of physical, psychological and occupational therapy.

1.11 **Accidental poisoning** affects all ages. In children it peaks between 1-4 years and is primarily a result of ingesting medicines and household products. Older people are more susceptible through poor management of medication and carbon monoxide poisoning.

1.12 A recent survey[3] of 16 Accident and Emergency (A&E) departments in Northern Ireland found that more accidents occurred inside the home (41.4%) than at work (15.2%) and on the roads (19.5%) put together (Figure 1);

Figure 1. Injury Location



The survey also found that:

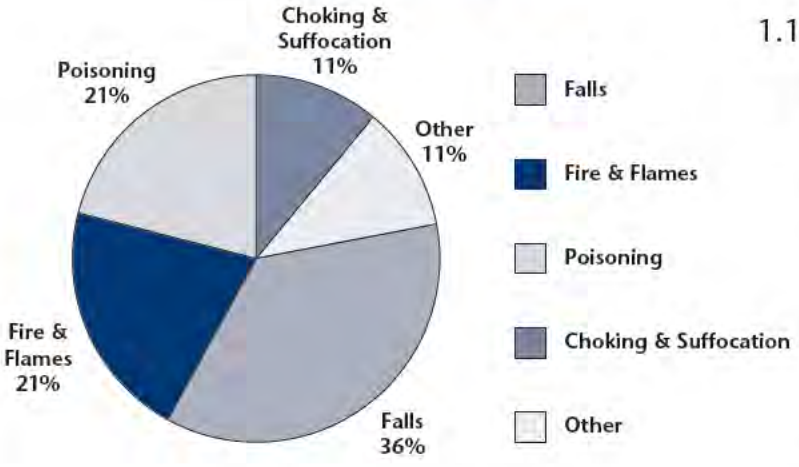
- 66% of home accidents occurred inside the home and 34% occurred directly outside the home i.e. in the garden, yard, driveway, path and steps and boundaries;
- 39.2% of home accidents involved children aged 0-15 years;
- 19.4% occurred in the under-5 years age group;
- 24.3% of home accidents involved adults in the 25-44 age range;
- 11.9% of home accidents involved those aged over 65 years;

- almost half of all home accidents occurred by either a fall on the same level or being struck by an object;
- almost half of those injured as a result of a fall were under 10 years or over 65 years;
- scalds and poisoning caused the most severe injuries in the under-five age group.

1.13 In 2000, 75 deaths (Figure 2) were attributable to accidents in the home – of which:

- 27 were due to falls (15 were people aged 65 and over);
- 16 were due to fire and flames; and
- 16 were due to poisoning[2].

Figure 2. Cause of Deaths from Accidents in the Home



1.14 In 2000-2001, there were 9,042 hospital admissions resulting from injuries received in home accidents[5].

ECONOMIC COSTS OF ACCIDENTS

1.15 The cost of home accidents is high in terms of the number of lives lost and resulting permanent disabilities. It is also high in other ways. It is estimated that there is an average of over 70 deaths and 72,300 injuries per annum (1,300 very serious, 19,000 serious and 52,000 slight). This is equivalent to 1,820 Potential Years of Life Lost (PYLLs) (819 by accidental poisoning, 574 by fire & 427 from falls. 307 PYLLs (17%) affect under 18 year olds). It is also estimated a total of 83,000 working days are lost each year, which equates to £7.6 million in lost productivity. The cost to the Department of Health, Social Services and Public Safety (DHSSPS) and to the economy is estimated to be £78 million and £80 million per annum respectively.

1.16 The benefits of prevention are clear and quantifiable in terms of health and economic costs:

- potential to save lives;
- improved quality of life;
- reduction in the cost of hospital care;
- reduction in the cost of continued community support required after hospital discharge; and
- improved productivity through people's contribution to the economy.

INEQUALITIES

1.17 Home accidents occur in all socio-economic groups and ages, but some types of accidents are linked to those in the lower socio-

economic groups and to particular age groups. Research suggests that:

- the social class gradient is steepest for fire deaths, the risk of fire related death for a child in social class V (unskilled) is 16 times that of children in social class I (professional)[6];
- alcohol is a contributory factor to deaths from accidents, which also show a pronounced socio-economic gradient[7];
- residential areas with higher proportions of lower social class and lower income households have higher accident rates[8];
- those injured by home accidents are more likely to be resident in households where the chief income earners are housewives, unemployed or retired[3];
- home accidents have been identified as a hazard for Travellers[9].

EQUALITY

1.18 Section 75 of the Northern Ireland Act 1998 requires public authorities in carrying out their functions to promote equality of opportunity between persons of different religious belief, political opinion, racial group, age, marital status, sexual orientation, gender, disability and persons with dependants or without. DHSSPS has identified home accident prevention as a new policy requiring Equality Impact Assessment (EQIA). An EQIA was developed and is included as Annex 1.

1.19 The New Targeting Social Need (New TSN) policy aims to tackle poverty and exclusion by targeting the efforts and available resources of public agencies towards the people, groups and areas objectively defined as being in greatest social need. New TSN includes a special focus on tackling the problems of unemployment, but also targets inequalities in health, housing, education and other policy areas. Paragraph 1.17 highlights the link between some types of home accidents and those in the lower socio-economic groups. The development of a Home Accident Prevention Strategy is therefore included in the DHSSPS New TSN Action Plan 2003-2004. Subsequent New TSN Action Plans will monitor and report progress of actions set out in the Strategy to reduce the incidence of home accidents in the lower socio-economic group categories.

1.20 The Human Rights Act 1998 came fully into force in October 2000. It provides additional focus and emphasis to the rights and freedoms of individuals guaranteed under the European Convention on Human Rights. There are some 18 Convention rights and protocols which range from the Right to Life to the Right to Education. The Act requires legislation, wherever enacted, to be interpreted as far as possible in a way which is compatible with the Convention rights; makes it unlawful for a public authority to act incompatibly with the Convention rights; and, if

it does, allows a case to be brought in a court or tribunal against the authority. DHSSPS will ensure that the Home Accident Prevention Strategy is compatible with the Human Rights Act.

1.21 **Chapter 2** describes the aim of the Strategy, **Chapter 3** outlines an Action Plan to support home accident prevention and **Chapter 4** sets out how the Strategy will be taken forward. **Annex 1** outlines the EQIA, **Annex 2** outlines the responsibilities of the organisations with a role to play and **Annex 3** provides useful contacts.

CHAPTER 2
THE STRATEGY'S AIM

CHAPTER 2
THE STRATEGY'S AIM

2.1 The overall aim is:
"To reduce the number of accidental deaths and injuries in the home."

2.2 It is recognised that this aim will take time to achieve and therefore this 5 year Plan represents only the first phase of a long-term strategy to increase people's awareness of the dangers and to highlight ways to prevent home accidents. In addition, the aim will only be realised through an integrated partnership approach including statutory, voluntary and community sectors.

OBJECTIVES OF THE STRATEGY

2.3 The key objectives are:
- to reduce home accidents, particularly in those most at risk;
- to raise awareness of the causes of home accidents and promote effective preventative measures to reduce such accidents;
- to promote and facilitate effective training, skills and knowledge in home accident prevention across all relevant organisations, groups and individuals.

2.4 These objectives will be met through integrated and effective approaches including:
- education and information programmes to promote home safety, and promote a change in public behaviour towards home accident prevention; and
- the use of evidence based practice, models of good practice, and by evaluating home accident prevention initiatives.

OUTCOMES

2.5 If successful, implementation of this strategy will lead to a reduction in the number of home accidents and contribute to the outcome "reduction in preventable deaths and diseases and improvement in wellbeing" set out in the *Northern Ireland Priorities and Budget 2004-2006.*

VALUES AND PRINCIPLES

2.6 The Strategy adopts the values and principles set out in *Investing for Health*. These include:
- health as a fundamental human right;
- actively pursuing equality of opportunity and the promotion of social inclusion;
- reducing social inequalities;
- encouraging community involvement; and
- maximising opportunities for individuals, families and communities to protect and improve their own health.

PRIORITIES

2.7 Improving the health of the entire population and reducing health inequalities are the main aims of *Investing for Health*. Accidents in the home are a major cause of death, and injuries ensuing from home accidents can have a major long-term impact on health. Reducing the number of accidents will save lives and reduce disability.

2.8 While this Strategy is aimed at the

population as a whole, Chapter 1 highlights that there is a strong association between poverty and the likelihood of injury in the home and that particular age groups are more at risk[3]. It will therefore be important to target the socially disadvantaged, children and older people. In addition, those with a disability or from a black and minority ethnic community have particular requirements in accessing information, advice and services and these must also be addressed.

TARGETS

2.9 *Investing for Health* sets two targets relating to accidental death and injuries:

(i) to reduce the death rate from accidents in people of all ages by at least one fifth between 2000 and 2010; and

(ii) to reduce the rate of serious injuries from accidents in people of all ages by at least one tenth between 2000 and 2010.

2.10 The following targets, which have been developed to help achieve the *Investing for Health* targets, will be used to measure the overall aim of the Home Accident Prevention Strategy:

(i) **To reduce the death rate from home accidents for all ages by 15% ie to 3.9 deaths per 100,000 in 2009.**
Baseline: 4.6 deaths per 100,000 in 2001.
Source: General Register Office; Mid Year Population Estimates; Census of Population data.

(ii) **To reduce the number of accidental injuries in the home for all ages resulting in an admission to hospital by 30% to 400.0 per 100,000 in 2009.**
Baseline: 571.3 admissions per 100,000 in 2003.
Source: Korner Return KP22; Mid Year Population Estimates.

(iii) **To reduce the number of home accident injuries for children resulting in an admission to hospital by 20% to 344.0 admissions per 100,000 in 2009.**
Baseline: 430.0 admissions per 100,000 in 2003.
Source: Korner Return KP22; Mid Year Population Estimates.

(iv) **To reduce the number of injuries resulting in an admission to hospital due to poisonings in the home for all ages by 18% to 50.0 admissions per 100,000 in 2009**
Baseline: 61.3 admissions per 100,000 in 2003.
Source: Korner Return KP22; Mid Year Population Estimates.

(v) **To reduce the number of falls in older people resulting in an admission to hospital by 25% to 454.3 admissions per 100,000 in 2009.**
Baseline: 605.7 admissions per 100,000 in 2003.

Source: Korner Return KP22; Mid Year Population Estimates.

(vi) **To reduce the number of injuries from accidental fires for all ages by 10% to 145 injuries in 2009.**
Baseline: 161 injuries in 2002/03.
Source: Fire Authority for Northern Ireland.

TAKING THE STRATEGY FORWARD

2.11 The Strategy comprises a number of actions grouped under four areas, which will ensure its aim and objectives are met.

(a) Policy development

(b) Improving awareness

(c) Improving training

(d) Accident information

2.12 **Chapter 3** sets out for each of these areas, the action to be taken, initial target dates and the main partners.

CHAPTER 3
ACTION PLAN

CHAPTER 3
ACTION PLAN

Policy Development

3.1 Accidents in the home are influenced by behavioural, social factors and environmental hazards, and in some cases, social and economic circumstances. Although much good work is already underway a considerable amount of this effort tends to be fragmented and ad hoc rather than part of comprehensive policies and programmes.

3.2 For example, there are many schemes across Northern Ireland to prevent home accidents including various risk assessment tools in relation to falls in older people and adaptations/equipment for disabled and older people. However, the assessments tend to vary depending on the focus of the profession involved. Some include personal factors which can cause falls such as medication, mobility, footwear or eyesight, while others include environmental factors such as the use of stairs, lighting, trailing flexes etc.. and the presence of grab rails or a second handrail etc. Partnership working across all sectors combining expertise and resources would enable a comprehensive and co-ordinated assessment resulting in more effective home accident intervention.

3.3 Research shows that good home safety visits can reduce home accidents to children by up to 26%[10]. These usually involve a home safety audit and if necessary referral to relevant agencies for small improvements or for safety equipment. The quality and therefore the value of these schemes vary depending on the experience/skills of the key person, their training, the checking tools being used, the use of the information gleaned and available funds.

3.4 It is important to promote Home Accident Prevention from an early age. The Education Sector can make an important contribution towards reducing home accidents in children and young people. For example, during key stage 1, 2 and 3 simple messages can be taught to children who often take the message home and ensure behaviour is modified to safe behaviour. Dramas staged in areas of social disadvantage and targeted at 3-6 year olds and their carers have raised awareness of the causes and prevention of the dangers of household poisons by 76%[11].

3.5 In addition LASER (Learning About Safety by Experiencing Risk) schemes, which are known by a variety of names such as Streetsmart, BeeWise or Streetwise, are interactive interventions on safety related issues that provide an excellent series of scenarios. There is evidence that this sort of experiential learning where children are able to experience risky situations first hand and learn how to deal with them in a controlled and supervised environment is an effective way to raise awareness[12].

3.6 To support home accident prevention the following actions are to be taken forward:

Action 1
The **Department of Health, Social Services and Public Safety (DHSSPS)** will establish a multi-agency Home Accident Prevention Strategy Implementation Group to manage the implementation of the Home Accident Prevention Strategy.
Target date: February 2005

Action 2
The **Home Accident Prevention Strategy Implementation Group** will report progress on implementation of the Strategy to the **Ministerial Group on Public Health (MGPH)**.
Target date: Annually

Action 3
The **Investing for Health Partnerships,** together with **Health and Social Services (HSS) Boards** and **local councils,** will review home accident prevention roles within their areas and develop programmes to reduce injuries and deaths by raising awareness and implementing home accident prevention interventions with particular focus on those most at risk.
Target date: March 2006

Action 4
The Department of Education (DE) will ask the **Council for the Curriculum, Examinations and Assessment (CCEA)** to develop guidance for the teaching of home accident prevention which would be taught to school age children through a range of subject areas in the curriculum.
Target date: September 2005

Action 5
Local councils, in exercising their discretionary powers to promote safety in the home, will have regard to the Home Accident Prevention Strategy and the policies and programmes developed by the Investing for Health Partnerships.
Target date: Ongoing.

Action 6
The **Northern Ireland Housing Executive (NIHE),** in partnership with the **voluntary** and **community sectors** will address home safety issues by identifying tenants at risk and by taking appropriate action to control risk, for example by fitting grab rails/ hand rails (bathrooms/ stairs), poison cabinets in kitchens and hard wired smoke alarms.
Target date: September 2005

Improving Awareness

3.7 Behaviour is the main factor in home accidents and so changing to safe behaviour is crucial to reducing such accidents. While many individuals and organisations have made a real contribution to home accident prevention, much still remains to be done to raise awareness that accidents are linked to behaviour, product design and environment and to change the perception that accidents don't 'just happen'.

3.8 As outlined in paragraph 3.2 adaptations can be made to a home and equipment made available to reduce the risk of accidents e.g. handrails, smoke alarms etc. However, many older

people and people who acquire a disability are not aware of the available help and support.

3.9 Accidental poisoning in children is also preventable. The numbers of poisonings dropped dramatically following the introduction of child resistant closure guidelines. However, the tendency to continue to store poisonous substances under the kitchen sink and the lack of lockable kitchen storage results in many children still being poisoned. Clearly this is an area where behaviour could be changed. In addition, children whose homes are working farms are particularly at risk of home accidents including poisoning and there is a need to develop focused interventions.

3.10 The Northern Ireland Fire Brigade (NIFB) plays a vital role in raising awareness and prevention of fires in the home. It is working with local Home Accident Prevention Groups and local councils to provide smoke alarms in targeted "at risk" areas. The Fire Brigade's "Ban the Pan" campaign is another example of where behaviour has been changed. This campaign raised awareness of the dangers of chip pan fires and resulted in a consumer shift towards thermostatically controlled deep fat fryers.

3.11 If behaviour is to be changed it is important that preventative action should continue through the further development of sustained public information and education initiatives taking account of the priority and vulnerable groups, main causes of accidents and environmental issues such as house layout, design and building regulations.

Action 7
DHSSPS in partnership with the **Health Promotion Agency for Northern Ireland (HPANI), HSS Boards and Trusts, local councils,** and the **voluntary and community sectors** will develop a public information campaign to raise awareness of home accident prevention taking account of the particular needs of those most at risk including those with a disability or from a black and minority ethnic background.
Target date: September 2006

Action 8
The **Department of Enterprise, Trade and Investment (DETI),** through the **Health and Safety Executive for Northern Ireland (HSENI),** will deliver a campaign entitled "Be Aware Kids"which will focus on the safety of children living on or near farm premises.
Target date: March 2007

Action 9
The **NIFB** will continue to deliver 12 fire safety messages to the public, and further develop public information campaigns taking into account the particular needs of vulnerable groups including those with a disability or from a black and minority ethnic background.
Target date: Annually

Action 10
The **NIFB** will develop partnerships with **local Home Accident Prevention Groups** and other community groups to provide active campaigns for community fire safety.
Target date: September 2005

Improving Training

3.12 Those working in a hospital or home setting are well placed to offer advice on the prevention of home accidents e.g. during home assessments and home visits. It is essential that tailored training is made available to all professional staff and volunteers in key roles on a continuous basis. Such training should cover risk assessment, effective interventions, child safety, older people's safety and home safety audit. There is also a need for information on training to be disseminated across all relevant networks.

3.13 *Investing for Health* highlights the role of local communities in reducing health inequalities through the provision of services, information and support within their own localities. Training and support must be made available to ensure they are in a position to identify needs and make an effective contribution towards the prevention of home accidents.

Action 11
DHSSPS in partnership with **HSS Boards and Trusts, HPANI, local councils** and the **voluntary and community sectors** will develop a regionally coordinated programme of home safety training, taking account of the particular needs of vulnerable groups, for all those with a contribution to make.
Target date: September 2006

Accident Information

3.14 Information on accidents is collated by HSS Trusts through a variety of mechanisms. Accident & Emergency (A&E) Departments and Minor Injuries Units use a number of operational systems such as the Northern Ireland Regional Accident & Emergency System (NIRAES), the Patient Administration System (PAS) and other commercially available software packages. Regionally the DHSSPS collects summary information using an aggregated data collection (KP22); information is also available on patients who are admitted to hospital for a period exceeding 24 hours from the Hospital Inpatients System (HIS). However there is a clear need for consistent and detailed information at a regional level, identifying the causes of home accidents and the injuries they result in.

Action 12
DHSSPS in partnership with **HSS Boards and Trusts** will work together to implement modifications to Accident & Emergency (A&E) systems to gather additional Home Accident information.
Target date: April 2006

Action 13
DHSSPS in partnership with the **HSS Boards and Trusts** and the **voluntary sector** will agree a Minimum Data Set for the collection of data relating to Home Accidents, by IT systems in A&E Departments and Minor Injuries Units.
Target dates: Minimum Data Set to be agreed by December 2004
Data Collection to be piloted in at least one Trust by April 2005
Data Collection to be implemented fully by April 2006

Action 14
DHSSPS in partnership with **HSS Boards and Trusts** will develop a central service for the collection, analysis and interpretation, and dissemination of home accident data.
Target date: April 2006

CHAPTER 4
MAKING IT HAPPEN

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MAKING IT HAPPEN

Introduction

4.1 It will take time and partnership working between Government departments, statutory, voluntary and community organisations in a variety of settings to achieve the aim of this Strategy and Action Plan. If the objectives outlined in Chapter 2 are to be met, it is essential that structures are in place to oversee the programme of action. The Action Plan's success will also require sufficient resources and systematic arrangements for monitoring and accountability.

Managing the Action Plan

4.2 The Ministerial Group on Public Health (MGPH) will be responsible for the overall monitoring of the Strategy and Action Plan. A multi-agency Implementation Group will be established to oversee and drive forward the actions outlined in Chapter 3. The Implementation Group will report progress to the MGPH annually. The Strategy will be reviewed after five years.

Research

4.3 The Implementation Group will wish to consider the need for additional research to help monitor and evaluate progress. This could include research on home accidents treated in primary care, interventions to prevent home accidents and subsequent evaluation, interventions specifically aimed at preventing home accidents amongst those most disadvantaged, and drawing comparisons with other countries.

Resources

4.4 The Department of Health, Social Services and Public Safety will make £100,000 available in the first year to implement the Strategy and Action Plan with continued support over the five year lifespan.

Roles and Responsibilities

4.5 The implementation of the Home Accident Prevention Strategy and Action Plan requires input from a variety of organisations, agencies and individuals ranging from Government departments, statutory bodies and the voluntary and community sector, local communities and each person taking responsibility in their own home. **Annex 2** details the roles and responsibilities of the main organisations.

ANNEX 1
EQUALITY IMPACT ASSESSMENT

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EQUALITY IMPACT ASSESSMENT

1. Introduction

Northern Ireland Act 1998

1.1 Section 75 of the Northern Ireland Act 1998 requires the Department of Health, Social Services and Public Safety (DHSSPS) in carrying out its functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity-

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

1.2 In addition, without prejudice to the above obligation, DHSSPS should also, in carrying out its functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

2. Aim of the Strategy and Action Plan

2.1 Accidents in the home are a major cause of death and injury. Chapter 1 of this Strategy and Action Plan sets out the extent of the problem, the types of home accidents, and the health and economic cost implications for the individual and the population.

2.2 The Strategy and Action Plan aims to facilitate a reduction in the number of accidental deaths and injuries in the home by raising awareness of home safety, promoting a change in attitudes and behaviour towards home accident prevention and ensuring that those with a contribution to make are aware, knowledgeable, and skilled to implement effective home accident prevention interventions.

2.3 Action to achieve the aim of the Strategy and Action Plan will include the development of programmes in home accident prevention, raising public awareness of home safety matters through public information campaigns, improvements in the training made available for those with a contribution to make in the promotion of safety in the home and improvements in information relating to home accidents.

2.4 The Strategy and Action Plan has been defined by DHSSPS. It will be implemented by DHSSPS in conjunction with other Government departments, statutory bodies and voluntary and community groups.

2.5 Implementation of the Action Plan should achieve a reduction in the number of accidents occurring in the home, with an outcome reduction in the number of accidental injuries and deaths.

3. Groups affected by the Policy

3.1 The policy will affect the health and wellbeing of the population in general. It will therefore affect all the Groups listed in 1.1.

4. Consideration of Available Data and Research

4.1 **Deaths due to home accidents.** Source: General Register Office - Tables 1 – 3 and Figure 1.

Table 1. Gender

	2001	2000	1999	1998	1997
Male	21	46	81	69	62
Female	18	29	56	22	34

Figure 1. Age and gender, 1997 – 2001

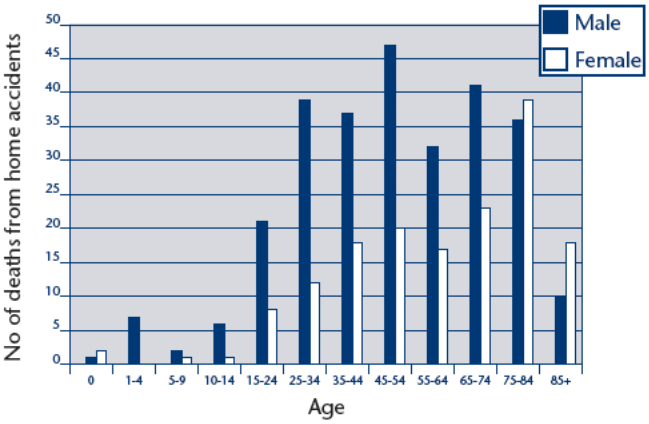


Table 3. Marital status, 1997-2001

Sex	Single	Married	Widowed	Divorced	All
M	44%	35%	13%	8%	100%
F	28%	33%	31%	7%	100%

More males than females have died as a result of home accidents, consistently over the last few years. In almost every age group there are more male deaths due to home accidents. In age groups 1-4 to 45-54, male deaths are more than twice as common as female deaths. In the elderly age groups over 75, more women than men die from home accidents but this reversal of the trend can be explained by the predominance of women in this section of the population (Figure 1).

For men, the number of deaths rises sharply after the 10-14 age group and continues to be high throughout all the remaining age groups. With women, the rise is more gradual but the number of deaths in the 75-84 age group is noticeably higher than all other ages. The number of deaths due to falls among females aged 75-84 was three times the corresponding

Table 2. Age, gender and cause of death, 1997-2001

Cause of Death	Sex	All Ages	0	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Falls	M	100	0	0	0	0	3	7	12	20	15	23	15	5
	F	52	0	0	0	0	1	1	3	4	5	7	22	9
Poisonings	M	64	0	0	0	1	12	16	12	11	7	2	3	0
	F	37	0	0	0	1	3	5	8	5	8	6	1	0
Fires & Burns	M	45	0	3	2	1	2	5	6	7	6	6	5	2
	F	35	1	0	1	0	3	3	2	7	3	4	8	3
Other	M	70	1	4	0	4	4	11	7	9	3	11	13	3
	F	35	1	0	0	0	1	3	5	4	1	6	8	6
Total	**M**	**279**	**1**	**7**	**2**	**6**	**21**	**39**	**37**	**47**	**31**	**42**	**36**	**10**
	F	**159**	**2**	**0**	**1**	**1**	**8**	**12**	**18**	**20**	**17**	**23**	**39**	**18**

figure for the 65-74 age group (Table 2).

Less married people died as a result of a home accident than single, widowed and divorced people which might suggest people living with others or having regular visitors are less at risk of having a serious accident and not being able to contact emergency services.

Information is not collected in relation to deaths on sexual orientation, religion, political opinion, racial group, disability or on persons with or without dependants.

4.2 **Admissions to Northern Ireland Hospitals Staying at least one night as a result of a home accident.**
Source: Korner aggregate return KP22, DHSSPS, 2000 - Tables 4 and 5.

Table 4. Gender

	Male	Female	Total
Falls	1188	2094	3282
Burns	74	47	121
Scalds	16	11	27
Poisoning	601	759	1360
Others	1884	2368	4252
Totals	**3763**	**5279**	**9042**

Table 5. Age

	0-15	16-64	65+	Total
Falls	673	711	1898	3282
Burns	38	57	26	121
Scalds	14	7	6	27
Poisoning	171	1140	49	1360
Others	863	1935	1454	4252
Totals	**1759**	**3850**	**3433**	**9042**

Information is not available in relation to hospital admissions resulting from a home accident on marital status, sexual orientation, religion, political opinion, racial group, disability or on persons with or without dependants.

4.3 **Attendances at Accident and Emergency Departments as a result of a home accident.**
Source: Accident and Emergency Survey 2001.

Figure 2. Age

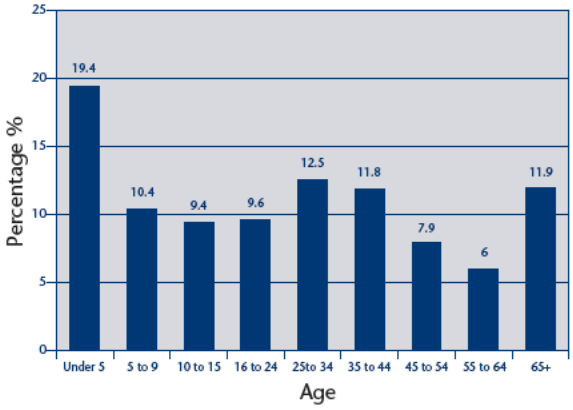
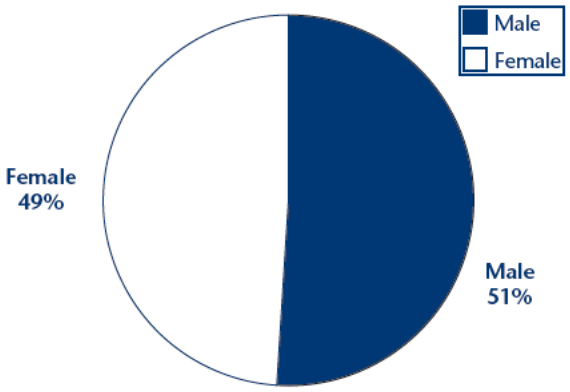


Figure 3. Gender



39% of home accidents involved children aged 0-15 years and 12% of home accidents involved those aged 65 years or over. Information is not available in relation to home accidents treated in Accident & Emergency Departments on marital status, sexual orientation, religion, political opinion, racial group, disability, or on persons with or without dependants.

4.4 **Fatalities from accidental dwelling fires.**
Source: Community Fire Safety Department, Northern Ireland Fire Brigade - Tables 6 and 7.

Table 6. Age

	0-4	5-15	16-64	65+	Total
2000	1	0	7	6	14
2001	3	1	5	5	14

Table 7. Gender

	Male	Female	Total
2000	12	2	14
2001	10	4	14

The figures are too small to be conclusive but appear to show that about 40% of deaths were people aged 65 or over. There were more male than female fatalities in 2000 and 2001 due to accidental dwelling fires.

Information is not available in relation to fatalities from accidental dwelling fires on marital status, sexual orientation, religion, political opinion, racial group, disability, or on persons with or without dependants.

4.5 **Source: A Package for the Future. The report of a seminar looking at ways of improving the health of Travellers. Ginnety, P., Warren, N., Leeson, P. 1993**

Accidents (all types) are highlighted as one of the main causes of high mortality rates in Travellers.

4.6 **Source: Home Accident Surveillance System (HASS) 23rd Annual Report 1999 data.** (UK data including representation from Northern Ireland).

Prevalence of home accidents by age/gender

- More accidents in the older age groups involve females rather than males (largely because females live longer).
- For children under 15, boys have more accidents than girls.
- In boys under-five years of age, the accident rate for burns is more than five times that for boys aged 5-14 years of age.

- The accident rates for falls in girls under-five years and in women over 75 is similar, approximately 6,000 per 100,000 population.
- The accident rate for falls in boys under-five years is 8,000 per 100,000 population, compared to nearly 4,000 per 100,000 population in men aged over 75 years.

4.7 There is limited information available on accidents with regard to Section 75 groups and in particular disability or racial group. However, discussions with the voluntary sector have highlighted the following issues:

Disability
- access to information e.g. limited knowledge of availability/type of equipment for the home to reduce accidents, particularly those people who acquire a disability;
- access to services e.g. length of time waiting for OT assessment, home adaptations, receipt of grant;
- accessibility of information on labelling of equipment, medicines etc.

Racial Group
- accessibility of information relating to home accidents, labelling of equipment, medicines etc;

5. Assessment of Impact

5.1 The policy aims to reduce the number of accidental deaths and injuries in the home.

5.2 Consideration of the data in paragraph 4 indicates that:
- more males than females died from home accidents;
- more males died as a result of a fall in the home than females;
- more males died from an accidental dwelling fire than females;
- more single, widowed and divorced people died as a result of a home accident than married people;
- older people are most at risk from a fatal fall in the home;
- females aged over 75 years were more likely to die from a fall in the home than those females aged 65-74 years;
- females are more likely to be hospitalised as a result of a home accident than males;
- there is a higher prevalence of home accidents in those under-15 years of age, with those under-five years most at risk.

5.3 The information available suggests that of the categories listed in 1.1, the groups most likely to be affected by the Strategy and Action Plan are age, gender and marital status. No information is available on home accidents by religion, dependants, disability, political opinion, ethnic minority or sexual orientation, however, discussion with voluntary organisations suggests that the Strategy will also affect people with a disability and those from a black and ethnic minority background.

5.4 In developing the Strategy and Action Plan the Working Group recognised that age, gender and social disadvantage are associated with home accident rates. Although there is limited information on home accident prevalence here within the Section 75 groups, the Working Group also recognised that people from a black and minority ethnic background and people with a disability have particular requirements in accessing information, advice and services.

5.5 The specific actions contained in the Strategy and Action Plan have been developed with a view to reducing the number of home accidents across the population and it is the Department's view that they should not have an adverse impact on any of the groups. The actions should promote equality of opportunity by ensuring that education initiatives and public information campaigns are developed taking into account the specific needs of vulnerable groups; and that professionals and others with a contribution to make in the prevention of home accidents receive relevant training and are aware of the particular needs of different groups.

6. Monitoring of impact of policy

6.1 An Implementation Group is to be established to take forward the Strategy and Action Plan. This group will advise on a research programme and report progress on an annual basis to the Ministerial Group on Public Health.

ANNEX 2
ROLES AND RESPONSIBILITIES OF ORGANISATIONS

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ROLES AND RESPONSIBILITIES OF ORGANISATIONS

1.1 The **Department of Health, Social Services & Public Safety (DHSSPS)** is responsible for the health and wellbeing of the population and therefore has a key role to play in delivering the aims of the Strategy and Action Plan. The Minister for DHSSPS chairs the Ministerial Group on Public Health (MGPH), which comprises senior officials from all departments. MGPH is responsible for co-ordinating and monitoring the implementation of the Investing for Health Strategy, including the Home Accident Prevention Strategy and Action Plan. Departmental representatives on MGPH will be responsible for monitoring the progress of the bodies for which they are responsible.

1.2 The **Health and Personal Social Services (HPSS)** – has a key role in developing home accident prevention programmes. This involves collaboration between HSS Boards, Trusts and primary care, as well as the voluntary and community sectors. In recognition of the multi-sectoral approach required to effect improvement in health, HSS Boards have established **Investing for Health Partnerships**.

1.3 The **Investing for Health Partnerships** comprise the key voluntary, community and statutory organisations in the local area. Within the statutory sector, **local councils, Housing Executive, Education and Library Boards and HSS Boards & Trusts** will all be included. Beyond these core members, the composition of the Partnerships will be determined locally, and is likely to evolve over time. These multi-sectoral partnerships will ensure that action to improve health is properly co-ordinated and that a long-term cross-sectoral plan is developed to improve the health and wellbeing of the population in line with the *Investing for Health* Strategy.

1.4 **The Health Promotion Agency** – has a regional responsibility for health promotion. It will work closely with DHSSPS, the HPSS and others in developing its contribution in the prevention of home accidents.

1.5 **The Fire Authority for Northern Ireland** – is responsible for creating a safer environment for society by providing an effective fire fighting, rescue and fire safety service, through the NIFB. Its Fire Safety department aims to reduce the number of deaths and serious injuries caused by fire and increase fire awareness education.

1.6 **The Department of Education** – is responsible for securing the place of health education in schools and in the Youth Service. Health education is currently a cross-curricular theme for all pupils up to age 16. The statutory curriculum has been reviewed and proposals have been accepted for a revised curriculum. The position of health education will be given greater focus in the revised curriculum, which is targeted for implementation

from September 2006.

1.7 **Education & Library Boards** - are responsible for ensuring the delivery of health education across all sectors from early years to post-16s and in the youth service from age 8 to age 25.

1.8 **Department of Employment and Learning** funding for Further Education Colleges and Higher Education establishments supports the initial professional education of health and social care professionals. Further and Higher Education establishments also have a responsibility for the continuous professional development of those practising in the health and social care profession.

1.9 **The Health and Safety Executive for Northern Ireland** – is an Executive Non-Departmental Public Body, sponsored by the **Department of Enterprise, Trade and Investment.** It is the lead body responsible for the promotion and enforcement of health and safety at work standards in workplaces, including home-working environments such as farms.

1.10 **The Department of Environment** – is responsible for a range of legislative provisions that are implemented by district councils. The Local Government (Miscellaneous Provisions) (NI) Order 1992 enables councils to promote and contribute to the promotion of safety in the home.

1.11 **Local Councils** – have many statutory functions bearing directly on health, and quality of life. These include, amongst others, environmental health, consumer protection and building control. These functions can specifically impact on the prevention of home accidents.

1.12 **The Northern Ireland Housing Executive (NIHE)** – is the regional housing authority with responsibility to assess housing needs and to ensure that housing programmes are targeted at those individuals and areas in greatest need. NIHE aims to improve housing conditions across tenures and promote high standards of housing design.

1.13 **The Voluntary Sector** – can do much to promote a change in the perception and behaviour in home accident prevention. For example, highlighting the dangers in the home and ways to prevent home accidents. Organisations such as the Royal Society for the Prevention of Accidents and Home Accident Prevention NI have experience in this area and can provide practical help to those seeking advice on home accident prevention.

1.14 **The Community Sector** – Local communities have an important role to play in reducing health inequalities by providing services, support, information and advice within their own localities.

ANNEX 3
USEFUL CONTACTS

ANNEX 3
USEFUL CONTACTS

Government Departments and Agencies

Department of Health, Social Services and Public Safety
Health Promotion Team
Block C4
Castle Buildings
Upper Newtownards Road
BELFAST
BT4 3SQ
Tel: [redacted]
(www.dhsspsni.gov.uk)

Department of Enterprise, Trade and Investment
Netherleigh House
Massey Avenue
BELFAST
BT4 2JP
Tel: [redacted]
(www.detini.gov.uk)

Council for the Curriculum, Examinations and Assessments (CCEA)
Clarendon Dock
29 Clarendon Road
Belfast
BT1 3BG
Tel: [redacted]
(www.ccea.org.uk)

Health Promotion Agency for Northern Ireland
18 Ormeau Avenue
BELFAST
BT2 8HS
Tel: [redacted]
(www.healthpromotionagency.org.uk)

Department of Education
Curriculum & Assessment Branch
Rathgael House
Balloo Road
BANGOR
BT19 7PR
Tel: [redacted]
(www.deni.gov.uk)

Department of the Environment
Clarence Court
10-18 Adelaide Street
BELFAST
BT2 8GB
Tel: [redacted]
(www.doeni.gov.uk)

Health & Safety Executive for Northern Ireland
83 Ladas Drive
BELFAST
BT6 9FR
Tel: [redacted]
(www.hseni.gov.uk)

Health and Social Services Boards

Northern Health & Social Services Board
Health Promotion Service
Homefirst Community Trust
Spruce House
Braid Valley Hospital Site
Cushendall Road
BALLYMENA
BT43 6HL
Tel: [redacted]
(www.nhssb.n-i.nhs.uk)

Southern Health & Social Services Board
Health Promotion Department
Ward 1
St Luke's Hospital
Loughgall Road
ARMAGH
BT61 7HW
Tel: [redacted]
(www.goodhealthinfo.org.uk)

Eastern Health & Social Services Board
Health Promotion Unit
12-22 Linenhall Street
BELFAST
BT2 8BS
Tel: [redacted]
(www.ehssb.n-i.nhs.uk)

Western Health & Social Services Board
Health Promotion Unit
12c Gransha Park
LONDONDERRY
BT47 6WJ
Tel: [redacted]
(www.whssb.org)

Health and Social Services Trusts

Altnagelvin Hospitals HSS Trust
Altnagelvin Area Hospital
Glenshane Road
Londonderry
BT47 1SB
(www.altnagelvin.n-i.nhs.uk)

Armagh and Dungannon HSS Trust
St Luke's Hospital
Loughgall Road
Armagh
BT61 9AR
(www.adhsst.n-i.nhs.uk)

Belfast City Hospital HSS Trust
51 Lisburn Road
Belfast
BT9 7AB
(www.n-i.nhs.uk/trusts/bch)

Causeway HSS Trust
8E Coleraine Road
Ballymoney
BT53 6BP
(www.chsst.n-i.nhs.uk)

Craigavon Area Hospital Group HSS Trust
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ
(www.n-i.nhs.uk/cahgt)

Down Lisburn HSS Trust
Lisburn Health Centre
25 Linenhall Street
Lisburn
BT28 1BH
(www.dlt.n-i.nhs.uk)

Green Park HSS Trust
20 Stockman's Lane
Belfast
BT9 7JB
(www.greenpark.n-i.nhs.uk)

Mater Infirmorum Hospital HSS Trust
Crumlin Road
Belfast
BT14 6AB
(www.n-i.nhs.uk/mater)

Ulster Community and Hospitals
HSS Trust
23-25 Regent Street
Newtownards
BT23 4AD
(www.ucht.n-i.nhs.uk)

Newry and Mourne HSS Trust
5 Downshire Place
Newry
BT34 1DZ
(www.n-i.nhs.uk/trusts/newry)

Northern Ireland Ambulance Service HSS Trust
Ambulance Headquarters
12/22 Linenhall Street
Belfast
BT2 8BS
(www.niamb.co.uk)

Royal Group of Hospitals and Dental Hospital HSS Trust
274 Grosvenor Road
Belfast
BT12 6BP
(www.royalhospitals.org)

Sperrin Lakeland HSS Trust
Strathdene House
Tyrone and Fermanagh Hospital
Omagh
BT79 0NS
(www.sperrin-lakeland.org)

Homefirst Community Unit
The Cottage
5 Greenmount Avenue
Ballymena
Co Antrim
BT43 6DA
(www.homefirst.n-i.nhs.uk)

North and West Belfast HSS Trust
Glendinning House
6 Murray Street
Belfast
BT1 6DP
(www.nwbt.org.uk)

South and East Belfast HSS Trust
Trust Headquarters
Knockbracken Healthcare Park
31 Saintfield Road
Belfast
BT8 8BH
(www.sebt.n-i.nhs.uk)

Craigavon and Banbridge Community HSS Trust
Bannvale House
Moyallen Road
Gilford
BT63 5JX
(www.n-i.nhs.uk/trusts/cbc)

Foyle HSS Trust
Riverview House
Abercorn Road
Londonderry
BT48 6SA
(www.foyletrust.org)

United Hospitals HSS Trust
Antrim Area Hospital
Bush House
Antrim
BT41 2RL
(www.unitedhospitals.org)

Local Councils

Antrim Borough Council
The Steeple
Steeple Hill
Antrim
BT41 1BJ
(www.antrim.gov.uk)

Ards Borough Council
2 Church Street
Newtownards
BT23 4AP
(www.ards-council.gov.uk)

Armagh City & District Council
The Palace Demesne
Armagh
BT60 4EL
(www.armagh.gov.uk)

Ballymena Borough Council
'Ardeevin'
80 Galgorm Road
Ballymena
BT42 1AB
(www.ballymena.gov.uk)

Ballymoney Borough Council
Riada House
14 Charles Street
Ballymoney
BT53 6DZ
(www.ballymoney.gov.uk)

Banbridge District Council
Civic Building
Downshire Road
Banbridge
BT32 3JY
(www.banbridgedc.gov.uk)

Belfast City Council
City Hall
Belfast
BT1 5GS
(www.belfastcity.gov.uk)

Carrickfergus Borough Council
Town Hall
Joymount
Carrickfergus
BT38 7DL
(www.carrickfergus.org)

Castlereagh Borough Council
Civic & Administrative Offices
Bradford Court
Upper Galwally
Belfast
BT8 6RB
(www.castlereagh.gov.uk)

Coleraine Borough Council
Cloonavin
60 Portstewart Road
Coleraine
BT52 1EY
(www.colerainebc.gov.uk)

Cookstown District Council
Burn Road
Cookstown
BT80 8DT
(www.cookstown.gov.uk)

Craigavon Borough Council
Civic Centre
PO Box 66
Lakeview Road
Craigavon
BT64 1AL
(www.craigavon.gov.uk)

Derry City Council
Council Offices
98 Strand Road
Londonderry
BT48 9NN
(www.derrycity.gov.uk)

Down District Council
24 Strangford Road
Downpatrick
BT30 6SR
(www.downdc.gov.uk)

Dungannon & South Tyrone
Borough Council
Circular Road
Dungannon
BT71 6DT
(www.dungannon.gov.uk)

Fermanagh District Council
Town Hall
Enniskillen
Co Fermanagh
BT74 7BA
(www.fermanagh-online.com)

Larne Borough Council
Smiley Buildings
Victoria Road
Larne
BT40 1RU
(www.larne.gov.uk)

Limavady Borough Council
Council Offices
7 Connell Street
Limavady
BT49 0EA
(www.limavady.gov.uk)

Lisburn City Council
Island Civic Centre
The Island
Lisburn
BT27 4RL
(www.lisburn.gov.uk)

Magherafelt District Council
Council Offices
50 Ballyronan Road
Magherafelt
BT45 6EN
(www.magherafelt.gov.uk)

Moyle District Council
Sheskburn House
7 Mary Street
Ballycastle
BT54 6QH
(www.moyle-council.org)

Newry & Mourne District Council
Monaghan Row
Newry
BT35 8DJ
(www.newryandmourne.gov.uk)

Newtownabbey Borough Council
Mossley Mill
Carnmoney Road North
Newtownabbey
BT36 5QA
(www.newtownabbey.gov.uk)

North Down Borough Council
Town Hall
The Castle
Bangor
BT20 4BT
(www.north-down.gov.uk)

Omagh District Council
The Grange
Mountjoy Road
Omagh
BT79 7BL
(www.omagh.gov.uk)

Strabane District Council
Derry Road
Strabane
BT82 8DY
(www.strabanedc.com)

Voluntary Organisations

Royal Society for the Prevention
of Accidents (RoSPA)
Nella House
Dargan Crescent
BELFAST
BT3 9JP
Tel: [redacted]
(www.rospa.com)

Home Accident Prevention
Northern Ireland (HAPNI)
RoSPA Office
Nella House
Dargan Crescent
BELFAST
BT3 9JP
Tel: [redacted]
(www.rospa.com)

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Castle Buildings, Belfast BT4 3SQ

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www.dhsspsni.gov.uk

November 2004

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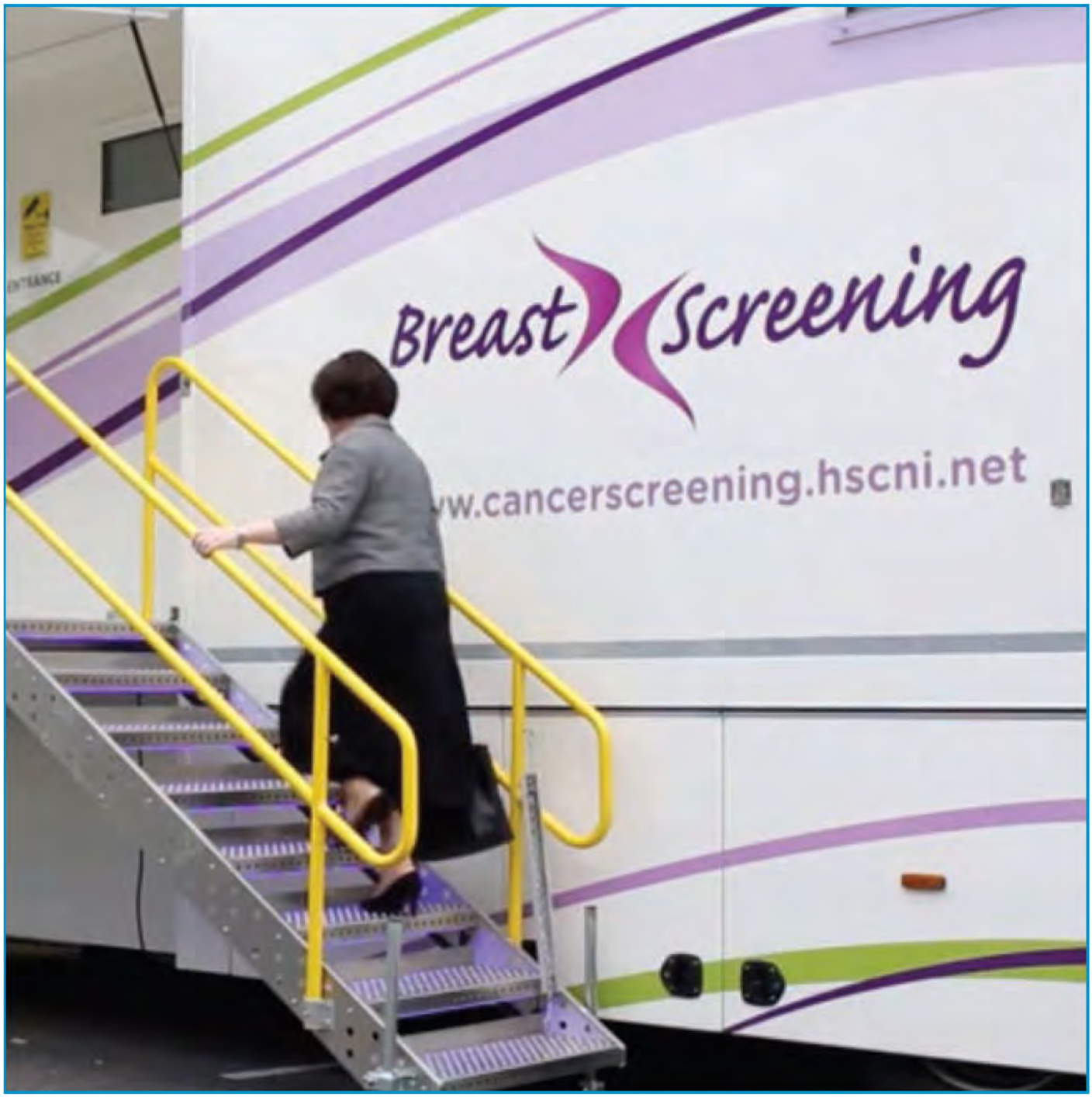
Breast screening

An **easy guide** about a health test for women aged 50 and over



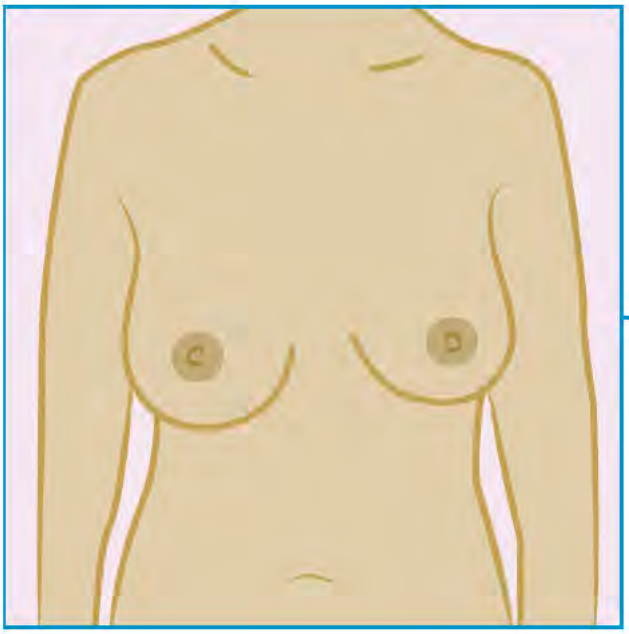
HSC Public Health Agency

Contents: what is in this booklet

Breast screening

This booklet tells you about breast screening. Breast screening is for women aged 50 and older.

This is a free test you can have to check your breasts (boobs).

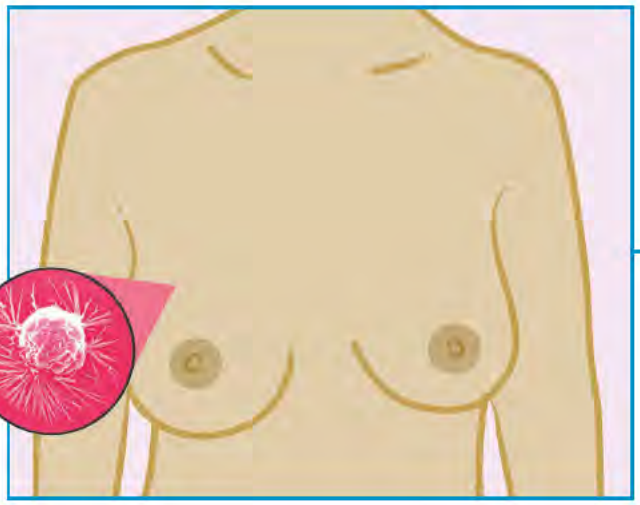


The test checks if your breasts are healthy.

The test can find changes inside your breasts that are too small to see or feel.

These small changes can grow and become cancer.

Breast cancer



Cancer is a very serious illness that you can die from.

Breast cancer starts when cells in the breast begin to grow and get bigger in size. This forms a lump known as a tumour.

Cancer can spread to other parts of the body too.

Breast cancer is the most common cancer in the country.

1 in 10 women get breast cancer.

Your risk of getting breast cancer increases as you get older.

Most breast cancers are found in women aged over 50.

More women now survive breast cancer than in the past.

Your choice

You can choose if you want to have breast screening or not.

There are good points and bad points about breast screening.

Good points

Breast screening is a way of finding breast cancer. It can help find cancers that are too small to see or feel.

Breast screening can save lives. It means more women can have treatment to deal with breast cancer.

Bad points

Screening can mean some women have extra tests and treatment that they may not have needed.

Screening will find most breast cancers but may miss one on rare occasions.

You can talk to someone you feel comfortable with to help you think about the test.

You can talk to a nurse, carer, relative, support worker or your doctor.

You can arrange a visit to your local breast screening unit before the test.

About the test

If you are a woman aged between 50 and 70 we will invite you for breast screening every 3 years.

We will send you a letter.

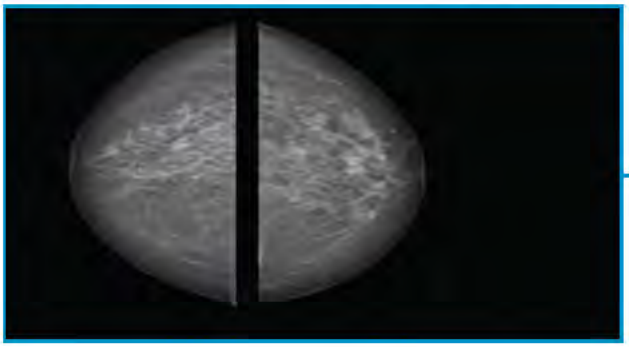
If you need any extra help, or you are in a wheelchair, then you can ask for a special appointment.

If you are aged over 70 you can still have breast screening every 3 years if you ask your local breast screening service.

On the day of the test

If you decide you want to go for breast screening you will need to go to a breast screening unit.

You should bring with you
- your letter and
- hospital passport (if you have one).



You will have images taken of your breasts. These images are called mammograms.

When you arrive at the breast screening unit the staff will check your full name, address and date of birth.

They will explain what will happen and answer any questions you have.

You will need to take off the clothes you are wearing above your waist. This includes your bra, if you wear one.

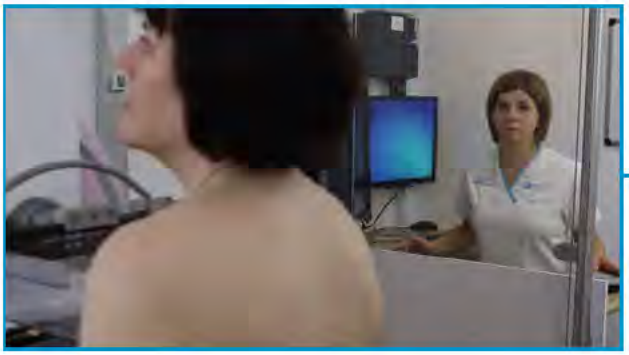
It may be easier to wear a skirt or trousers instead of a dress.

The person doing the test is called a mammographer. This will always be a woman.

She will place your breasts on to the machine one at a time.

The machine will flatten your breast and hold it in place.

You will feel your breast being squeezed.



The x-ray machine may hurt a little bit but this will only be for a few seconds.

You need to keep very still for a few seconds while the images are taken.

We will usually take 2 images of each breast.

The screening test only takes a few minutes.

You will be at the screening centre for about 30 minutes.

Test results

We will send you a letter within 2 weeks with your screening test results.

Most results are normal.

This means you don't get asked to go for screening again for 3 years.

A few women will be asked to go back to the breast screening unit for more checks.

If these extra checks show that you might have cancer, someone will talk to you about what will happen next.

They will answer any questions you have.

Check our breas

If you know how your breasts usually look and feel you are more likely to spot changes that could be a sign of cancer.

Touch your breasts. Can you feel anything unusual?

Look for changes. Is there any change in the shape of your breasts or how they look?

Check anything unusual with your doctor.

It is important to look out for the following:

Lump – you may be able to feel a lump but not see it

A change in t e o k and feel of the skin – this can be a bit like orange peel

A change in the appearance or direction of a nipple

Discharge (liquid) from one or both of your nipples

Redness or rash on the skin or around the nipple

More information

You can phone your local breast screening unit using the number on the appointment letter we sent you.

A carer, relative or friend can phone for you.

You can visit the cancer screening website at **www.nidirect.gov.uk/information-and-services/living-well/early-detection**

This website has the telephone number and address of your local breast screening unit.

You can also talk to your own doctor.

HSC Public Health Agency

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Tel: 0300 555 0114 (local rate).
www.publichealth.hscni.net

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01/23

HEALTH AND SOCIAL CARE BOARD
PUBLIC HEALTH AGENCY

COMMISSIONING PLAN 2010/2011

HSC Health and Social Care Board

HSC Public Health Agency

Contents

SECTION 2 – PRIORITIES FOR ACTION: DETAILED PROPOSALS

Foreword

Legislation enacted on 1 April 2009 created a new Commissioning system with the establishment of a region-wide Health and Social Care Board, including 5 Local Commissioning Groups (LCGs), and a Public Health Agency. In line with Departmental direction and guidance the objectives of the new commissioning arrangements were to:

- Approach the future delivery of Health and Social Care from a region-wide perspective focused on outcomes.
- Ensure local sensitivity through the creation of five Local Commissioning Groups reflective of their areas.
- Give appropriate weight to the public health agenda to ensure that commissioning reflects the drive to reduce health inequalities in our society and works in partnership with others to improve health and wellbeing.

In this regard the legislation signalled a new way forward which would first be expressed in a Commissioning Plan for 2010/11 and beyond. This plan outlines how the Health and Social Care Board and the Public Health Agency are approaching that task. It is our aim that this plan is straightforward and written in a manner which will encourage public engagement and understanding. We wish to show clearly how the commissioning task is to be approached and to signal the decisions necessary to ensure the maintenance of a health and social care system in Northern Ireland which responds to the population it serves.

Commissioning is the process which looks at the needs of the population and plans and secures Health and Social Services to respond to that need.

The Commissioning Plan takes full account of the commissioning direction, financial parameters and Priorities for Action set out by the Minister and DHSSPS. Commissioning has been defined as a " … process which looks at the needs of the population, and plans and secures health and social services to respond to that need within given financial parameters with the objective of improving and protecting the health and social wellbeing of the population

and reducing differences in access to good health and quality of life".

In this regard Commissioning is principally concerned with what is available; it is less concerned with (although not exclusively divorced from) how it is provided. To discharge this responsibility we propose to use the criteria listed below in our planning and decision making to ensure that these processes are linked explicitly to the need for change and for improved clarity of purpose:

- Are decisions rooted in existing policy and targeted to delivering Ministerial objectives and Priorities for Action?
- Do they demonstrate appropriate needs assessment of the population?
- Is there evidence and/or measurement to support these judgements?
- Can we show that the outcomes for the citizen will be improved?
- Is there balance between local provision and the need to ensure safety and sustainability of services to the population?
- Do proposals take account of opportunities for earlier diagnosis and more cost effective intervention?
- Do our proposals ensure an accessible service for the population and address inequalities?
- Do the decisions take account of imminent and future changes in treatment and care?
- Do our proposals contribute to improving health and social wellbeing and reducing health inequalities?
- Are decisions in line with the agreed commissioner quality standards?

The last three years have seen many significant improvements in a wide range of areas, most notably in waiting times for elective treatment and for Accident and Emergency services; in childcare services, improved access to specialist drugs, better access to primary care services, the development of enhanced services which have enabled the shift of care from hospital to community, improvements in chronic disease management through the Quality Outcomes Framework and the continuing growth in community services. The improvements – particularly in waiting times – have been achieved despite a significant growth in demand. This has been achieved by investing in a range of Health and Social Care (HSC) provision and by specific initiatives procured outside that framework.

The future shape of Northern Ireland Health and Social Care system needs to change. Maintaining the status quo is not an option.

Over the same period the HSC system has been faced with the need to make an overall 9% reduction in funding through improved efficiency. Simultaneously it has had to absorb significant increases in demand, perhaps up to 2%. That so much has been done in the face of serious financial constraint and increased demand is a tribute to the professionalism and dedication of Health and Social Care. However, if we are to have a prospect of maintaining the quality of our services and indeed making progress on the many challenges still facing us (such as addressing health inequalities) we need to progress three key areas.

First, we need to understand more fully the nature of demand for services and to identify better ways of dealing with the increases in demand that we have experienced. Our experience to date suggests a number of major avenues through which we can take this work forward:

- The development of groups of General Practitioners co-operating together in the delivery of Primary Care;
- The reshaping of existing patterns of hospital services;
- The promotion of “living at home” strategies in dealing with a range of illnesses including many chronic conditions.

Secondly, we must plan for the future in the knowledge that significant new resources are unlikely to be available. This will mean reviewing how existing services can be reshaped to deliver future demand and needs – even where this confronts us with difficult and potentially unpopular choices.

Finally, we need to give a much greater emphasis to health promotion and disease prevention. For example, research suggests up to 70% of all attendances at general practice are directly related to weight, tobacco use, alcohol consumption, poor sleep or stress. Clearly a different approach to lifestyle and targeted interventions can materially change the population's health status and address inequalities in health. The Public Health Agency will have a key role in developing programmes to drive this agenda forward.

We need to give much greater emphasis to health promotion and disease prevention.

The Commissioning Plan was approved by the Boards of the Health and Social Care Board and the Public Health Agency on 27th of May 2010 and submitted to the Department for consideration. The final Commissioning Plan was approved by the Minister on ( ) and arrangements have now been put in place by the Health and Social Care Board, in partnership with the Public Health Agency, to oversee the delivery of the Commissioning Plan. These include:

- The translation of the Commissioning Plan into objectives within corporate and local commissioning plans that will be the subject of scrutiny through established performance review;

- Detailed service and budget agreements with providers, supported by appropriate performance management regimes to ensure delivery of Priority for Action targets and other objectives;

- Project management arrangements to implement and monitor the financial plan for 2010/11 in line with the financial allocation received from the Department;

- Securing the development of detailed proposals from Local Commissioning Groups and Providers to give effect to the commissioning strategy in this Commissioning Plan for consideration, equality screening, consultation and implementation as appropriate.

The future shape of Northern Ireland Health and Social Care system needs to change. Maintaining the status quo is not an option. Commissioning can and will create that change and this Commissioning Plan for 2010/11 reflects that imperative, acknowledging that final decisions fall to the Minister and the Department in the light of resource availability.

Dr Iain Clements
Chair, Health and Social Care Board

Mr John Compton
Chief Executive, Health and Social Care Board

Ms Mary McMahon
Chair, Public Health Agency

Dr Eddie Rooney, Chief Executive, Public Health Agency

Section One

Summaries and Overviews

1 Strategic Context

This section focuses on some of the environmental factors influencing policy formulation and on the major policy imperatives which define the future direction of travel for service development and redesign.

1.1 Demographic Changes

Northern Ireland is becoming an older society. While the absolute size of our population is estimated to increase over the next ten years, of greater significance to the demand for Health and Social Care is the likelihood that the average age of our population will also continue to increase at a faster rate. Specifically, estimates are that between 2008 and 2020:

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

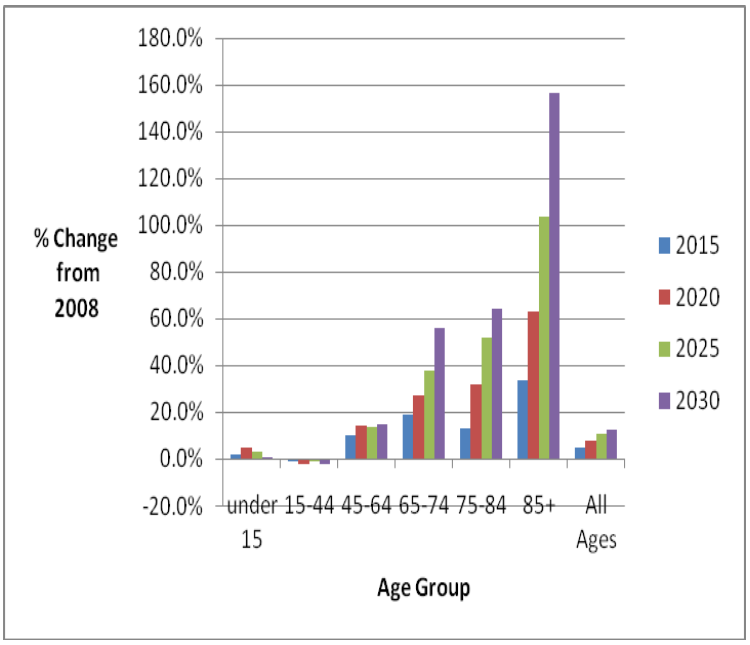


Figure 1: Changing Demography of Northern Ireland - % Change by 2015, 2020 and 2030 by age group.

Older people are major users of our Health and Social Care system. On any given day:

- 800 beds in Northern Ireland are occupied by individuals aged over 70 years;
- Two thirds of acute hospital beds in Northern Ireland are occupied by individuals aged over 65 years;
- 1 in 14 people aged over 65 have a form of dementia, rising to 1 in 6 people over 80 and 1 in 3 over 85 years;
- Of the 21,000 people who receive home help services, 69% are aged 75 years and over;
- 9,485 people aged over 65 are cared for in residential and nursing homes;
- At any given time 1 older person in 8 is very dependent upon health and social services to support them each day.

An important element within this plan is a further shift to supporting people at home.

If systems remain unchanged by 2020 demand placed on our systems by an elderly population mean that hospital admissions will have increased by 17% and beds used by 23%.

Older people tell us that they want care, support and treatment in or close to home (Health & Wellbeing Strategy for Older People 2006-16). Commissioning must therefore continue to reform and modernise the Health and Social Care system, responding to growing demand with an increased emphasis on community based services.

An important element within this plan is to promote older people's health and wellbeing, through a further shift to supporting people at home and giving individuals, their family and local communities' greater control over the range and delivery of services. Major features will be positive health promotion, the active prioritisation of direct payment schemes, the focus on support for carers, the management of people with chronic diseases in their own homes with the help of technology, and the delivery of palliative care in the community.

1.2 Safe and Sustainable Services

The overall aim in commissioning is to ensure that the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. To maintain and to continue to achieve this standard of service will mean a reprofiling of the current pattern of services. To meet best clinical practice some services may have to be delivered on a national, regional or sub regional basis. This is not a new approach and we have demonstrated in the past – for example by consolidating cancer care into the major acute hospitals with strealined access to a regional service – that we can provide evidence based practice standards and achieve improved outcomes for people with cancer.

Frequently these changes are simplistically portrayed as centralisation. The Commissioner will wish to secure local services for local people but simultaneously provide safe, sustainable services for the population at large.

The safety of services provided is paramount and we will progress strategies for reducing infection rates, reducing untoward events across all areas of practice, achieving real improvement in hygiene to improve outcomes and the patient/client experience.

To meet best clinical practice some services may have to be delivered on a national, regional or sub regional basis.

Commissioning is about securing good outcomes and providing safe services. We recognise the importance of patient choice and the need for people to have confidence in how our services are provided. Choice will therefore be a major theme in driving commissioning but this must be realistic and consistent with the delivery of safe, effective care.

1.3 Modern Treatments

Since 1948 the nature of Health and Social Care services has been characterised by the need to respond to new demands, treatments and interventions. For example many surgical procedures previously requiring inpatient stays in hospital now

happen safely on a day case basis allowing patients to return home on the same day as their treatment occurs.

In recent years, we have seen the day case rate as a percentage of total elective work increase in certain key service areas. By March 2011, there is a requirement that all Trusts in Northern Ireland achieve a 75% day case rate across a basket of 24 specified procedures which will see the number of day cases rise even further.

Treatment for cancer has been revolutionised over the past decade with survival rates improving across a range of cancers, although we still fall behind European survival rates in a number of cancers, so further work needs to be done.

Improved survival rates have occurred at a time of significant investment in improving access to cancer services including drug regimes. As survival rates continue to increase the nature of caring for people with cancer will change. More people will be living with cancer as a chronic illness and our services must evolve responsively to these needs.

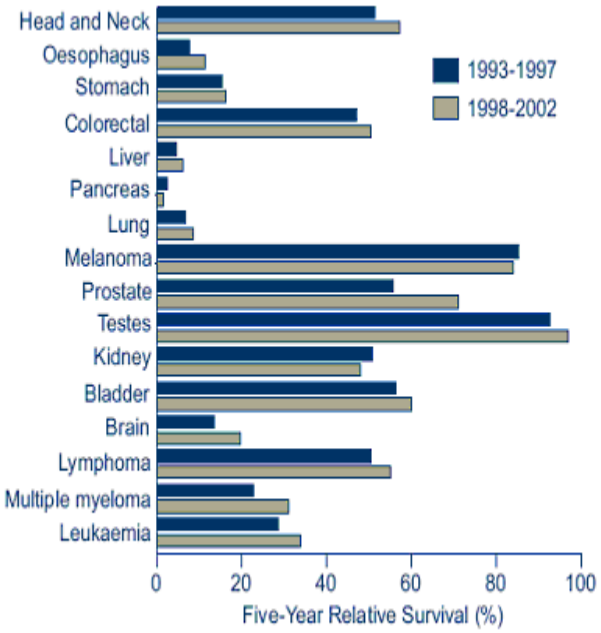


Figure 2: Changes in survival for male patient with cancer by cancer site, 1993 – 2002 (Five year relative survival by sex, cancer site and period of diagnosis. Source NI Cancer registry).

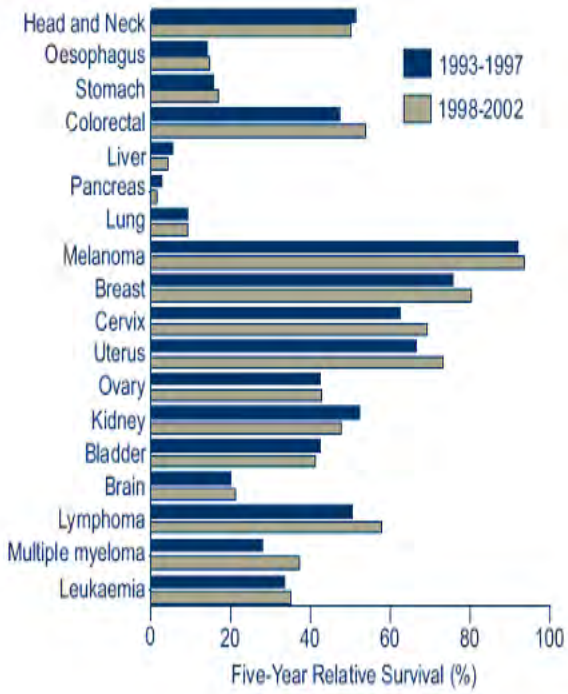


Figure 3: Changes in survival for female patient with cancer by cancer site, 1993 – 2002 (Five year relative survival by sex, cancer site and period of diagnosis. Source NI Cancer registry).

New drugs and treatment techniques for a wide range of healthcare needs are constantly being developed and their efficacy and value assessed by the National Institute for Clinical Excellence.

Traditional support supplied in children's residential care has been revolutionised by a much expanded and more skilled fostering service.

Home based treatment in mental health services has introduced a recovery model of treatment and led to major changes in how hospital care is provided.

Our local population of 1.7m cannot support the full range of modern acute services some of which will have to be commissioned outside Northern Ireland to meet the required standards.

Primary Care has been given the opportunity to provide more care and treatment in the community through locally enhanced services. The decision to introduce and implement these kinds of improvements and innovations is linked to how we use resources. Sometimes this will happen with new funding, or possibly the re-use of funding released by greater efficiency or a decision to change the priority of an existing service.

The introduction of a service can also depend on the availability within Northern Ireland of staff with the appropriate expertise and skills. For example, with a local population of 1.7m it is difficult to support the full range of modern acute services. Some very specialist services for our population will either be commissioned outside Northern Ireland or will be jointly commissioned with other regions.

It will not always be possible to commission immediately every new service that is available.

It is also essential to recognise that it will not always be possible to commission immediately every new service that is available, even where approved by the National Institute for Clinical Excellence. Commissioning in these areas will inevitably make for difficult choices. For example, we will shortly complete a pilot on demand for bariatric surgery. There is no certainty that we will be in a position to commission this service locally and we may opt instead for prevention and support services as alternatives for those with obesity problems. Similarly, there are a number of instances where social care patients have been the subject of transfer to high cost facilities outside Northern Ireland. It will be important to scrutinise these and other similar future cases in order to determine whether appropriate alternatives can be supplied locally.

1.4 Resources

Discussion about money is always controversial. In the public perception, proposed changes or debates about money are frequently assumed to be about savings or perceived cuts. **Where any commissioning decisions are primarily taken to make a saving or service reduction, this will be explicitly stated.**

2010/11 will be the most difficult financial year for Health and Social Care in a generation.

In fact many of the decisions to make change are not driven by money but by a desire to improve quality or effectiveness. Commissioners will not avoid such decisions but will seek to take them in an informed and sensitive manner that reflects the potential implications for individuals and communities. In the end however there are no neutral decisions. Unnecessary

preservation of an existing pattern of service delivery will in all probability mean denial of new developments. Making choices is a reality for any commissioning system. This is vitally important to understand in the financial climate that commissioning is entering. For over a decade Health and Social Care has invested in one year and met the full cost from a growth in funding the following year. The period 2010-13 will not permit such a pattern. It is much more likely that the money currently in the Health and Social Care system is the most that will be available leading to a number of difficult years ahead. Whilst this represents a different climate the Health and Social Care system is likely to continue to spend 38% of the Northern Ireland Block. We will commit nearly £10m[1] every 24 hours to enable the delivery of services to the population of Northern Ireland. Opportunities to develop new services remain but only if there is change and greater efficiency in the current service patterns. It is, however, a fact that 2010/11 will be the most difficult financial year for Health and Social Care in a generation.

[1] *Source: DFP Review of 2010/11 Spending Plans*

Often when there is a debate in regards to resource the problem is presented in terms of unnecessary bureaucracy. While it is important that administration and management costs are tightly controlled and represent value for money, this does not reflect where the real focus needs to be. Within Health and Social Care today we commit 4.1% of the commissioning resource to management costs. We need a properly managed system that is responsibly resourced. Very significant administrative and management savings have been made in the last 3 years. For example a 20% reduction in the resources available to the Health and Social Care Board has been achieved. The real debate about resource is an understanding of the need for change and decisions about what can and cannot be provided. The Plan will not be distracted from this central issue. However, as Commissioners, we fully appreciate that final decisions require to be endorsed by the Minister and the Department of Health, Social Services and Public Safety (DHSSPS).

1.5 Workforce

Successful commissioning needs to have a keen appreciation of the workforce implications of what it wishes to see provided. This

holds true for all types of grades and staff working in the sector. It also requires the Commissioner to have an appreciation of capacity within the delivery system. This interest spreads across both the statutory and independent sector. In 2009/10 £25m was spent on locum doctors and nurses in Northern Ireland to support the existing hospital system. Such expenditure not only represents poor value for money but also impacts on the continuity and therefore the quality of care provided. Commissioning in 2010 and beyond will seek to reshape the hospital sector in a manner which minimises the need for such expenditure. This change is also required to respond to the implementation of the European Working Time Directive and take account of the actual medical workforce availability.

In 2009/10 £25m was spent on locum doctors and nurses in Northern Ireland to support the existing hospital system.

Such a change is driven principally by quality, and the interplay of quality, volume and value for money is at the core of this decision making process. Although there will be a requirement for rapid change it will be done in such a manner as to reflect the need to respond to capacity. Failure to acknowledge this would simply lead to unplanned service change or collapse and inappropriate commissioning which does not take account of responsible risk management.

1.6 Demand

Reference has already been made to demographic change and the effect this has on demand for services:

- In 2008/09 demand grew by 12% in the hospital sector and is on target for a further 9% growth in 2009/10;
- Family and child care services saw demand in the children at most risk grow by 20%;
- In one Trust area additional home care services for older people rose by 20% between 2008 and 2009. For the same Trust there was a 55% increase in the number of older people with complex care needs discharged from hospital over the same period.

Understanding these demand patterns is a central issue for the commissioning system and 2010 will see detailed work and analysis undertaken on both demand for services and on our performance in meeting that demand.

In 2008/09 demand grew by 12% in the hospital sector and is on target for a further 9% growth in 2009/10.

For example, if we were able to improve our performance in hospital length of stay to a level equivalent to the better performing hospitals in the rest of the UK this would substantially reduce the requirement for beds. This in turn would allow us to consider re-investment in community based services and prevention/screening programmes whilst maintaining or even raising quality within the hospital sector. This means planned change within the hospital sector.

At the same time, the creation of Local Commissioning Groups provides us with an opportunity to engage with family practitioners, patients, carers and local care providers to examine both the nature of demand and the potential for local alternatives for appropriate assessment and treatment.

Local Commissioning Groups, in partnership with primary care, will have a key role in the analysis of demand for services and in developing, where appropriate, safe, effective alternative models of care. For example in 2010/11 Local Commissioning Groups will, through partnerships with local stakeholders, explore solutions within primary and community care as alternatives to acute assessment and treatment in a range of acute specialities.

1.7 Developing Better Services

We propose to accelerate the implementation of the final stages of this strategy so that the transition to this model will be substantially completed by 2013.

Written in 2002, this DHSSPS strategy addresses the future shape of hospital provision for Northern Ireland. Although time has moved on its core principles remain. Changes have occurred at Downpatrick, Lagan Valley, Enniskillen, Omagh, South Tyrone and most recently Magherafelt and Whiteabbey. In 2010/11 we propose to accelerate the implementation of the final stages of this strategy so that transition

to this model will be substantially completed by 2013. In addition we will need to address the outcome of the recently announced Review of Maternity Services and the impact this will have on the future pattern of provision later in 2010/11.

The principal driver remains the maintenance of quality of intervention and whilst local services and central delivery will be balanced in the commissioning process, safety, sustainability and outcome will be the key determinants.

The next steps in terms of detailed implementation will follow but it will lead to new roles for local hospitals and the concentration of acute inpatient services on fewer sites. This approach will require change to facilities located in both urban and rural settings. Additionally it will signal new commissioning partnerships with the Republic of Ireland and other facilities in the UK. This will reflect the fact that a population of 1.7m is simply too small to safely sustain some highly specialised services.

1.8 The Bamford Report

The Bamford Report and the 'Protect Life' Strategy set out the vision for the reform and modernisation of Mental Health, Learning Disability and Child and Adolescent Mental Health Services over a fifteen year horizon. Since the publication of the individual reports, further evidence based models of service delivery have emerged and these will be integrated during the implementation of the Bamford recommendations. The Health and Social Care Board and the Public Health Agency have established a number of core task groups to take this work forward and this will be monitored by the Bamford Implementation Taskforce, led by the Health and Social Care Board's Chief Executive. A core theme will be the need to promote mental health and wellbeing and to strengthen community services to promote a recovery based model of care provided predominantly in or close to people's homes. As outlined in "Delivering the Bamford Vision" (DHSSPS, 2009), key themes include:

A core theme (of Bamford) will be the need to strengthen community services to promote a recovery based model of care provided predominantly in or

- Promoting positive health, wellbeing and early intervention;
- Supporting people to lead independent lives;
- Supporting carers;
- Providing better public services to meet people's needs;
- Providing structures and a legislative base to deliver the Bamford Vision.

1.9 Older People

The strategic direction for services for older people has been guided by Priorities for Action in recent years, with the focus being on a continuum of integrated primary and community care services, supporting independence and reducing inappropriate reliance on hospitals and other institutional care. The anticipated Service Framework for Older People's Health and Wellbeing and the NI Dementia Strategy will form the future strategic direction for commissioning, with the agreement of evidence based standards, targets and measurable outcomes. Using this strategic base, commissioning will aim to ensure a balance of provision between disease prevention, health promotion and healthy ageing, and the required network of care and treatment services for those most at risk.

Our focus is on supporting independence and reducing inappropriate reliance on hospitals and other institutional care.

1.10 Children

The theme of improving children's health and wellbeing resonates with the six high level outcomes identified in the Office of the First Minister and Deputy First Minister Strategy "Our Children and Young People – Our Pledge", which refers to actions which demonstrate and evidence to show that children and young people are:

It is important that children are valued, protected and cherished as they are the foundation stone for future generations.

- Healthy;
- Enjoying, learning and achieving;
- Living in safety and with stability;
- Experiencing economic and environmental wellbeing;
- Contributing positively to community and society; and
- Living in a society which respects their rights.

This strategy, combined with other overarching strategic documents issued by the DHSSPS, such as “Care Matters” and “Families Matter” provide the context in which services are being commissioned. There is recognition of the need for development and investment across the continuum of children’s services from prevention/early intervention to adoption/leaving and aftercare. There is an extensive body of evidence which demonstrates the cost benefit analysis of an investment in our children. It is important that children are valued, protected and cherished as they are the foundation stone for future generations. “Care Matters” outlines the corporate role of Health and Social Care to assist those children and young people looked after and care leavers whose health and wellbeing requires to be improved.

1.11 Disability

The Regional Strategy for People with Physical Disabilities and Sensory Impairment will be the strategic framework for services for this client group. The focus will continue to be on promoting health and wellbeing, independence and empowerment and improving the quality and responsiveness of Health and Social Care services for people with disabilities and their carers. The Strategy will adopt a life cycle approach covering all age groups and will promote the importance of partnership working across community and independent sectors.

1.12 Reducing Inequalities and Promoting Health and Social Wellbeing

Relative deprivation in Northern Ireland is assessed by looking at income, employment, education, health, including disability and

early death, local environment, crime and proximity of an area to services such as GP surgeries, hospitals or shops. Individual areas are ranked across Northern Ireland based on these. The 20% of most deprived areas represent nearly 340,000 people.

Populations from deprived areas in Northern Ireland experience:-

- Lower life expectancy than the Northern Ireland average;
- 23% higher rates of emergency admission to hospital;
- 66% higher rates of respiratory mortality;
- 65% higher rates of lung cancer;
- 73% higher rates of suicide;
- Self harm admissions at twice the Northern Ireland average;
- 50% higher rates of smoking related deaths;
- 120% higher rates of alcohol related deaths.

It is clear therefore that we need to do more to narrow the gap in health inequalities and improve the health and wellbeing of our population. This means working to address the determinants of ill health and reduce risk factors, including those associated with poverty and social exclusion. This Commissioning Plan contains specific measures to address this challenging agenda, but it is equally important that health prevention and improvement is actively considered as an integral part of all of our commissioning strategies.

The focus will be on the wider public health agenda, addressing the determinants of health that contribute to and sustain health and social wellbeing inequalities. Inequalities in health arise because of inequalities in society. Addressing inequality therefore requires co-ordinated action across many different sectors and government. The reform and modernisation of the commissioning process can greatly assist this goal. Firstly, by taking a leadership role championing the issue and working collaboratively with other sectors to address the challenge; secondly, by shifting resources and commissioning ‘upstream’ interventions; and thirdly

developing exemplar roles in creating healthy workplaces and by ensuring that the entire health and social care workforce use every interaction with the public to promote health and wellbeing.

We will therefore aim to identify and encourage new models of care that facilitate the transfer of resources to this end. We will also consider the potential value of changes to relevant legislation where this may be a vehicle for promoting change. The aim will be to:

- Make tangible difference to health and wellbeing outcomes;
- Decrease incidence of major causes of ill health;
- Maximise independent living;
- Improve mental health scores of population;
- Reduce health inequalities gap;
- Build sustainable communities and increase social capital and community engagement;
- Impact on the full pathway from community to service.

1.13 Performance Management

The ability to positively impact on health and social inequalities cannot be exclusively addressed by the Health and Social Care Board. Meaningful partnerships and a common agenda need to be developed with our Trusts, our colleagues in local government, housing, education and the environment, and our communities if we are to effectively deliver on improving the health of our population. The Public Health Agency will have a key role in developing programmes to drive this agenda forward in the context of the review of the Investing for Health Strategy and the work that will be developed on a new Investing for Health Strategy for beyond 2012

Strong performance management will be key to achieving an outcome which is positive and publicly understood, and ensures compliance with standards, statutory obligations and Priorities for Action targets set annually by the DHSSPS. In 2010/11 we will

Our first obligation is to ensure safe, sustainable services which respond effectively to the population's needs.

continue to develop the use and publication of a range of high level commissioning milestones as a benchmark of performance. While performance management of our care providers such as Trusts, General Practitioners and other primary care providers will be conducted in a supportive manner, we will be clear our first obligation is to ensure safe, sustainable services which respond effectively to the population's needs and represent value for money.

1.14 Evidence Based Commissioning

Commissioning needs to be carried out within a framework of formal evidenced based guidance about the standards and outcomes we need to achieve. There are two key drivers in developing this approach:

Managed Clinical Networks

Managed Clinical Networks are a way of supporting the provision of high quality, sustainable, safe and effective services to our population. Integration and partnerships with clinical colleagues, either regionally, nationally or with the Republic of Ireland means that in Northern Ireland, despite our small population, we can be assured that our services are delivered to the highest possible standards. We already have some networks in place for paediatric cardiac surgery, adult intensive care, cancer and pathology services, and we will continue to develop these arrangements as appropriate.

Service Frameworks

Service Frameworks are sets of guidance on the highest quality of care and good practice spanning specific conditions or service areas. This guidance encompasses nationally supported evidence based standards, as well as the input of local clinical experts, in the development of recommendations applicable to our local services. Work is currently underway on the implementation of the Service Frameworks for Cardiovascular and Respiratory Services. Other Service Frameworks for Cancer, Mental Health and

Wellbeing, Learning Disability, the Health and Wellbeing of Children and Young People and the Wellbeing of Older People are at various stages of development.

Commissioning will make progress with the implementation of these recommendations. However, there will be a need to balance how and when the recommendations can be fully implemented with affordability, workforce skills and capital investment. Approaches in the near future are therefore likely to focus on standardisation of good practice and reprofiling of care systems in the first instance, rather than assuming that significant additional resources will be available for service development.

2. Ensuring Financial Stability and Effective Use of Resources

The key objective of the Commissioning Plan is to use all available resources to ensure the overall investment in services secures as broad a range as is practicable along with the best possible outcomes for local populations. In developing the Commissioning Plan the Health and Social Care Board, supported by the Public Health Agency, recognises that significant resources are available to support its successful delivery. In 2010/11 this will include access to almost £3,559.4m of the commissioning revenue resources.

To deliver a successful Commissioning Plan requires us to be sensitive to the financial parameters within which commissioning operates. It is vitally important that we provide as much clarity as we can to the public in relation to the financial climate within which commissioning will operate in 2010-13. It is unlikely that the level of growth funds that has characterised the last decade will be available in the period 2010-13.

Opportunities to develop new services remain but will require transformational change in the current service patterns. Absolute growth in resources will be very limited.

Decisions about how we make the best use of the resources at our disposal will be complex, challenging and at times controversial. Such decisions will need to take account of rising demand, existing shortfalls, the financial challenges and quality and service outcomes. Change is therefore an integral part of commissioning. The direction of travel set out in the Commissioning Plan will involve a greater focus on value for money, efficiency and improved outcomes in respect of the health and wellbeing of our local populations. Ensuring value for money will be driven forward through new models and pathways of care with greater use of benchmarking of standards for existing services across Health and Social Care. New accountability arrangements between providers and the Health and Social Care Board will underpin this process. This chapter covers:

- An overview of the existing investment of Health and Social Care Board and Public Health Agency resources;

- An overview of the financial plan for 2010/11 and key financial targets.

2.1 Existing Investment

In 2009/10 the DHSSPS received an overall budget of recurrent resources, £4.3bn. Of this, the Health and Social Care Board and Public Health Agency received £3.1bn for commissioning Health and Social Care on behalf of the 1.7m people resident in Northern Ireland. The balance was used by the DHSSPS to directly fund a range of areas such as prescription drugs costs, general practice costs as well as dentistry and optician services. (During 2010 the responsibility for these services will transfer to the Health and Social Care Board).

Figure 4

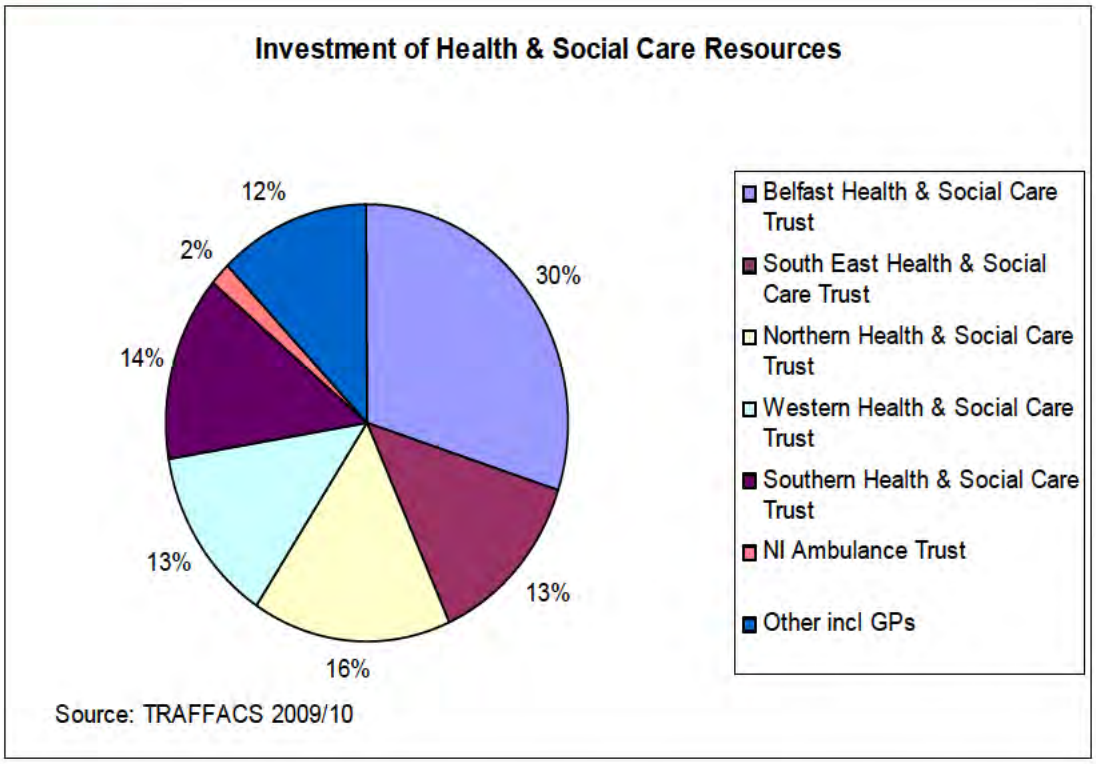
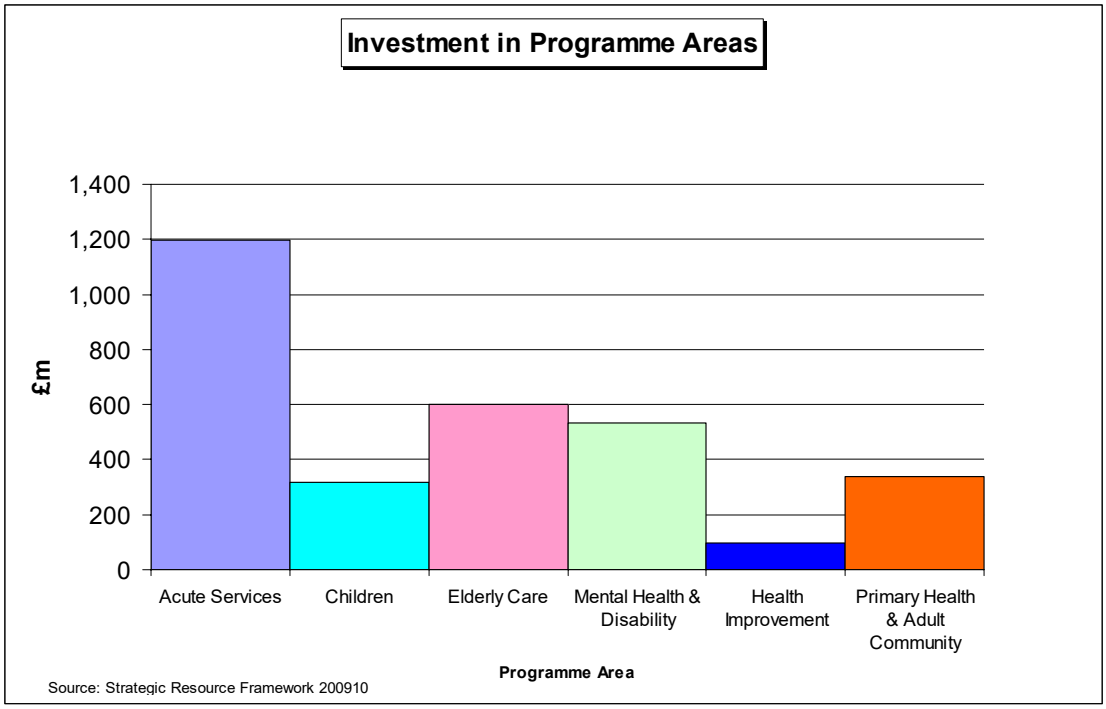


Figure 4 illustrates how commissioning resources are currently allocated across the six Provider Trusts and various other providers of care such as voluntary organisations and General Practitioners.

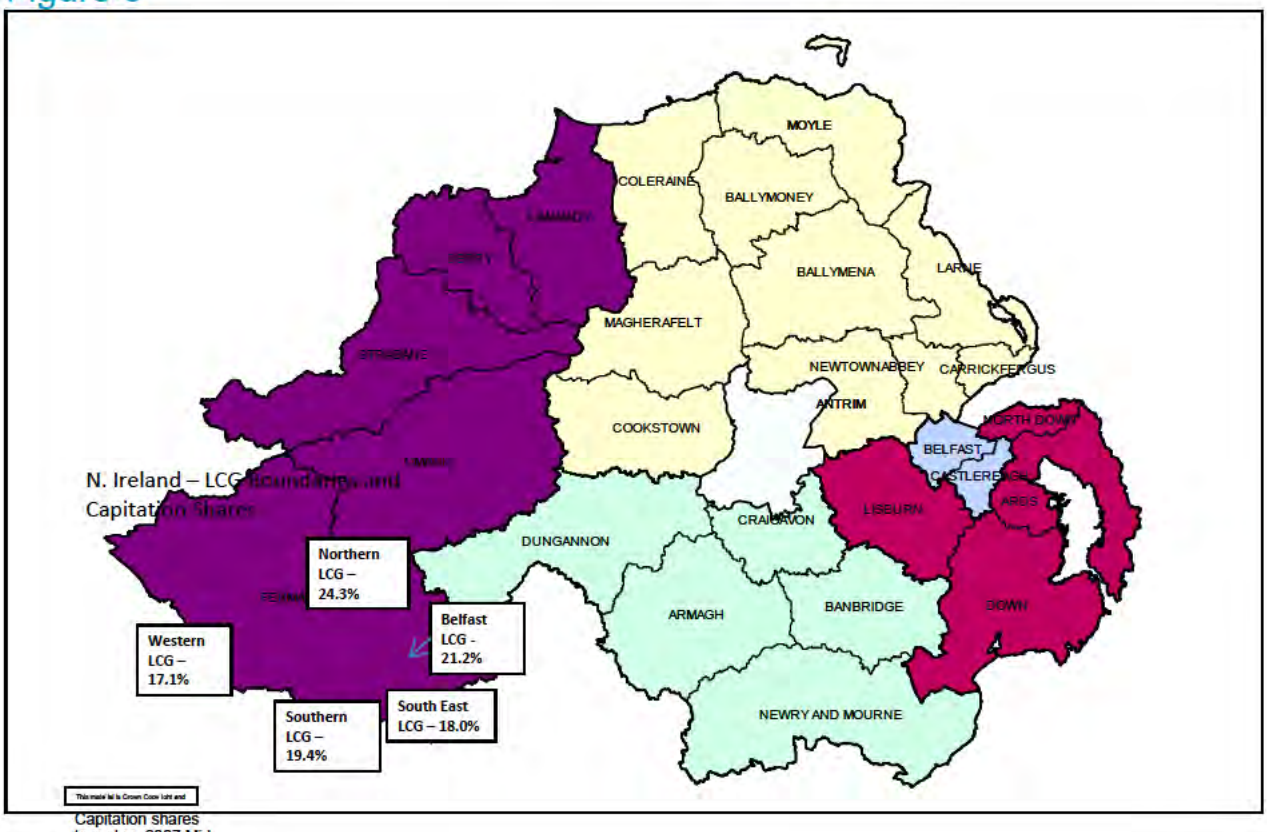
Historically these resources have been invested and managed across Programme of Care areas. These have been broadly mapped in Figure 5 (below) to the Priority for Action areas around which the 2010/11 Commissioning Plan has been developed.

Figure 5



Ensuring these resources are fairly distributed across local populations is a core objective of the commissioning process. Taking account of the diverse needs of local populations is also key. Different population profiles in localities result in the requirement to target resources to reflect the different levels of need; for example, where there are particularly high levels of the very elderly or very young as they are the primary users of health care. It is also the case that where there are high levels of deprivation within population areas this will result in a higher than average need for investment in areas such as social care and health improvement. The Health and Social Care Board uses a validated statistical resource allocation formula to inform its investment decisions made for the population in their localities. This is known as the “capitation formula”. It reflects the different levels of needs across the population for Health and Social Care resources. Figure 6 shows the relevant capitation shares mapped to localities.

Figure 6



Capitation shares based on 2007 Mid Year Estimates

Figure 7

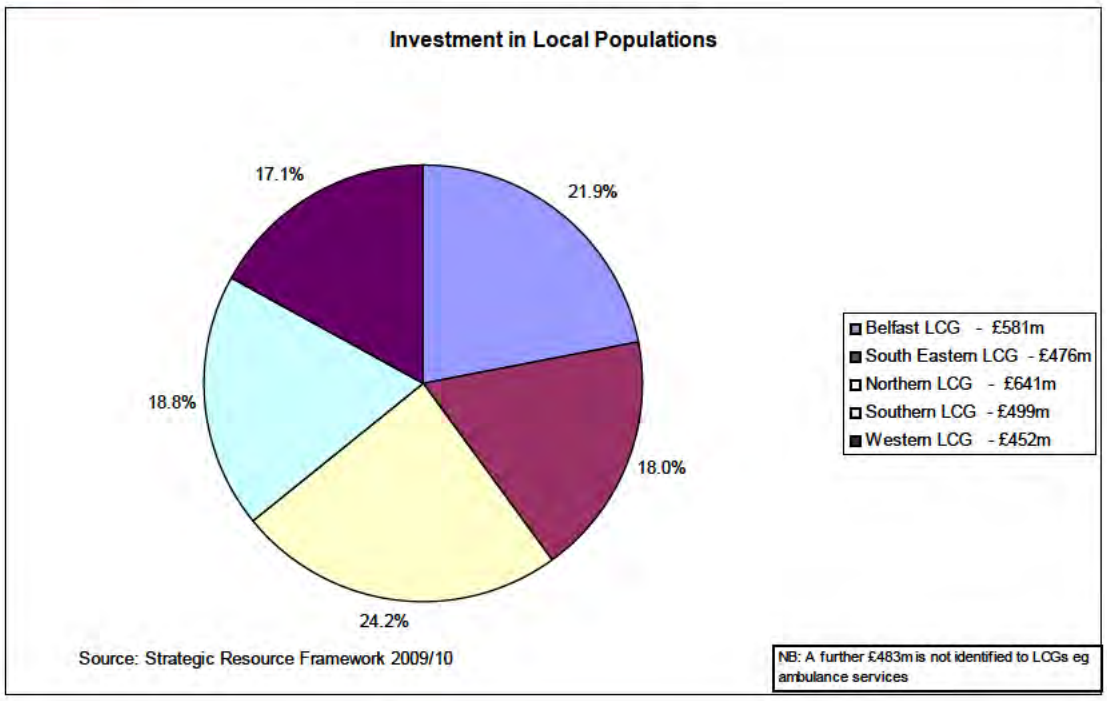


Figure 7 illustrates how existing resources are invested in local populations.

It is important to appreciate that services provided to a population may not always occur in the local geography. Whilst the Health and Social Care Board is committed to local services for local people, it must also ensure that the population has a safe and sustainable service. For example, specialist residential care for children or cardiac surgery will be provided on a province wide basis.

2.2 Overview of Financial Plan 2010/11

The DHSSPS previously published three year resource plans for Health and Social Care spanning 2008/09-2010/11. These were fully approved by the Northern Ireland Executive. These indicated baseline recurrent allocations at the end of the 2009/10 financial year to the Health and Social Care Board and Public Health Agency with plans to allocate around £107m for priority service improvements and developments in 2010/11.

However, the financial climate for 2010/11 has changed since the publication of these original plans. The changes were confirmed when the Northern Ireland budget was ratified by the Executive in April 2010. The key facts for Health and Social Care planning assumptions in 2010 are now threefold:

- Pressures identified at Northern Ireland Block level impacting on all government Departments leading to £105m less for Health and Social Care than was planned within the original three-year 2008/09-2010/11 Comprehensive Spending Review settlement;

- New and emerging inescapable pressures across Health and Social Care which were not included in the original resource plan must be met. For example the cost of continuing to meet waiting time targets;

- Provider Trusts are facing unprecedented challenges in maintaining financial stability and meeting efficiency targets e.g. two Provider Trusts needing temporary financial support

to manage deficits in 2009/10 and enable a recovery plan to be implemented in 2010/11.

The key financial targets for 2010/11 remain financial breakeven and delivery of efficiency savings, therefore the commissioning system will expect all organisations to live within the resources allocated. To achieve this objective the financial aspects of the Commissioning Plan have robustly focused on ensuring there is a source of funds for all expenditure and prioritisation of inescapable funding requirements.

At times there can be a debate about bureaucracy and inefficiency in the Health and Social Care system and the Health and Social Care Board will wish to drive down costs and add to productivity. However, the notion that the financial constraints can be exclusively addressed as a consequence of these issues is not accurate and diverts from the real public debate that will be required on resources and its utilisation.

In order to address the impact of the above and to plan for potential further inescapable pressures emerging across Health and Social Care, the DHSSPS and the Health and Social Care Board/Public Health Agency have undertaken in-depth reviews of the financial position in 2010-11 using the following approach. The outcome of the work is central in shaping the commissioning finance plan for 2010/11.

1. A detailed assessment was undertaken to quantify the scale of funding required to address both the emerging financial pressures and the planning assumptions identified above.

2. Potential sources to address the funding gap were identified, focusing on those sources which will have the least impact on the health and wellbeing of our population.

3. Priority areas for service investment in 2010/11 were identified and resourced in the financial plan.

2.3 Quantification of Funding Pressures

A review of the impact of the emerging 2010/11 HSC financial environment identified total pressures of £275m to £300m

including the third year of the Comprehensive Spending Review. The consequences for the Commissioner are therefore substantial.

Recent pressures at the Northern Ireland Block Level have resulted in the Northern Ireland Assembly advising of further reductions to Departments' 2010/11 baselines. However, not withstanding this, almost £10m will be spent every 24 hours on our health system.

The Commissioning Plan must also reflect the reality of the financial operating position of the Trusts. Rising demand, for example in hospital care, providing care at home or in child care are demonstrable. Inflation and changing cost patterns in such areas as water charges have added to the pressure. Notwithstanding this, as a Commissioner we will want to audit such pressures to ensure that all is being done to manage efficiently in a difficult financial climate.

2.4 Existing Efficiency Savings Targets 2010/11

Within the context of the original financial plan, covering the three-year period 2008/09 to 2010/11, the Health and Social Care system was required to achieve some £260m of recurrent Cash-Releasing Efficiency Savings by the conclusion of 2010/11, as detailed in Table 1.

Table 1

Organisation	Cumulative Cash Release Targets 2008/09 - 2010/11				In-year
	2008/09	2009/10	2010/11		2010/11 Requirement
	2.50%	5.50%	9%		3.50%
	£m	£m	£m		£m
BELFAST	-24.67	-55.62	-91.73		-36.11
NORTHERN	-11.73	-26.46	-43.64		-17.18
SOUTHERN	-9.69	-21.86	-36.05		-14.19
SOUTH EASTERN	-9.95	-22.40	-36.90		-14.50
WESTERN	-9.68	-21.83	-36.01		-14.18
NIAS	-1.24	-2.72	-4.45		-1.73
Total Trusts	-66.97	-150.89	-248.78		-97.89
Health and Social Care Board and Public Health Agency RPA	-0.84	-3.88	-10.90		-7.03
Total per allocation letter	-67.80	-157.77	-259.68		-104.91

Based on these earlier Comprehensive Spending Review plans, the Health and Social Care Board and Trusts are currently required to achieve £104.9m of recurrent cash efficiency savings in 2010/11, before consideration of the additional cash releasing requirements of £105m in 2010/11 arising from the recently announced budget change from the Northern Ireland Executive.

2.5 Trusts' Financial Positions

Trusts have experienced increasing financial difficulties during the course of 2009/10. Indeed, in 2009/10, Trusts found it necessary to initiate in-year Trust Contingency Plans, in order to fulfil their statutory duty to financially break even. In the context of 2010/11, the Health and Social Care system anticipates that it will need to invest in maintaining existing services as well as developing new provision.

2.6 Planned Investments in 2010/11

As with any year, there are a large number of new service proposals to be considered. However, we balance the maintenance and reshape of existing services in parallel with the development of new services as the correct way forward. Consequently the speed of new investment will be carefully controlled.

2.7 Sources to Address Identified Funding Gap

Health and Social Care is being asked to deliver savings of £284m in 2010/11 arising from:

- The third year of the Comprehensive Spending Review efficiency savings as agreed in 2008;
- The additional reductions decided by the Northern Ireland Executive in 2010; and
- The need to cover elective care costs consistent with the Minister's decisions as set out in Priorities for Action.

The consequences of the total final position is that the DHSSPS's commissioning direction of the Health and Social Care Board means that it has to plan for savings of £204m. The sources of funds identified are summarised in Table 2.

Table 2 **Proposed Sources of Funds**

Description	**£m**
Comprehensive Spending Review Year 3: • Trust Payroll; • Strategic Service Redesign and efficiency • Additional Income	 40 15 3
Deferral of funds associated with Maintaining Existing Services	42
Deferral of originally planned Service Developments	58
Family Health Services Pharmacy Control	46
Total	**204**

2.7(i) Comprehensive Spending Review – Year 3

This covers the period 2008-2011 and to deliver these targets a series of actions over 2010/11 (Year 3) will be required, specifically;

- Payroll expenditure control which includes the use of agency, locum and overtime alongside containing recruitment within normal turnover parameters;

- The redesign of services focuses on improved outcomes and efficiency. Despite the complexity of the financial environment these changes are principally driven by the need to respond to organising services to achieve efficient, sustainable quality; whilst

- Additional income will come from regularising such issues as staff meal charges across the province.

2.7(ii) Family Health Services Pharmacy Control

It is anticipated that improved procurement procedures and monitoring mechanisms together with other efficiencies such as working with prescribing pharmacists will allow these savings to be delivered from the Family Health Services budget.

2.7(iii) Maintaining Existing Services and Service Developments

The changing financial scenario has required us to look again at the additional funding we proposed to make available for the maintenance of existing services and to curtail some elements of the new service developments originally planned for 2010/11. This will impact across all service areas. The following describes the broad deferral areas.

In **Mental Health** investment of £9.6m will be deferred. This will impact on plans to increase advocacy services and the number of dementia respite places.

In **Learning Disability** of the £8m in service developments originally identified we will not be able to invest £5m. The majority of respite and autism services as originally planned will now be deferred.

In **Children's Services** we are not investing £1.7m into family and child care services.

In **Physical Disability** the figure is £3.8m. Consequently we will not provide the increased level of respite provision originally planned.

In **Cardiovascular, Stroke Services and Long Term Conditions** we will not be able to progress the scale of community based rehabilitation services, monitoring and specialist support for long term conditions as anticipated. We will also have to defer implementation of some of the recommendations in the Cardiovascular and Respiratory Service Frameworks. All this means a deferral in the order of £12.6m.

In **Acute Services** the deferral figure is £16m. Consequently we will need to defer some additional planned intensive care capacity,

consultant appointments and extra radiotherapy capacity and be prudent about the rate of the expanded use of specialist drugs.

In **Elective Care** £10m less will be invested. We will not therefore be able to ensure that all patients receive surgery as quickly as we would wish. The majority of patients will still benefit from 9 weeks for outpatient waits, 9 weeks for diagnostics and 13 weeks for inpatient treatment. However some inpatients may wait up to 36 weeks in a small number of specialities.

In **Public Health** we are not able to invest in planned developments in interventional services, screening and community infection control initiatives.

The Health and Social Care Board recognises that the deferral of new services is disappointing but it is considered better to focus on the consolidation of existing services. If the financial climate permits the deferral decisions will be reviewed.

2.8 Planned Service Investments in 2010/11

There are major and complex management challenges involved in meeting financial pressures of £204m and these will be carried forward by a Programme Board chaired by the Commissioner. Nonetheless, there will be a range of planned service investments of £117.8m in 2010/11. These are summarised in Table 3.

Table 3

Description	£m
Hospital Drugs	13.85
Long term conditions	0.1
Demographics/Elderly	15.1
Mental Health	2.8
Learning Disability	3.09
Physical Disability	1.22
Acute Services and Complex Needs	2.03
Children's Services	2.36
Public Health Public Health Agency (*inc Tele-health £2.1m)	4.8
* Managing Reform	2.4
* Elective Access	40
* Maintaining Services	30
Total	**117.8**

* Non-recurrent funding in 2010/11

Hospital Drugs - £13.85m

These funds will be used to provide drug therapy for a range of conditions including rheumatoid arthritis, psoriasis, Crohn's disease, HIV, multiple sclerosis, age related macular degeneration, cancer, orphan enzyme conditions, cystic fibrosis, new National Institute for Clinical Excellence approved treatments and high cost blood products.

Long Term Conditions - £0.1m

These funds will be used to fund a British Heart Foundation nurse and a post with Macmillan Cancer regarding palliative care which is match funded.

Elderly and Other Specialist Homecare Services - £15.1m

This funding will meet the growing needs of an ageing population for community care and adult protection. It will provide up to 3,000 additional packages of care to enable older people to remain living at home or to return to home following a stay in hospital.

Mental Health - £2.8m

To fund Mental Health resettlements from hospital, psychological therapies, community infrastructure, personality disorders and substance misuse liaison nurse.

Learning Disability - £3.09m

To fund Learning Disability resettlements from long stay hospital, respite and autism.

Physical Disability - £1.22m

These funds will support wheelchairs and prosthetics services and cover the costs of a process to provide essential replacement of prosthetic equipment.

Acute Services and Complex Needs - £2.03m

This will be used to support renal services, obstetrics, statutory care assessments for autistic children, and stroke services.

Children's Services - £2.36m

This will provide for Family Support Interventions/Packages in the voluntary and community sector, together with funding for Gateway Services and Post Adoption Support.

Public Health Public Health Agency – £4.8m

To support bowel and "Triple A" screening, vaccinations and tele – health, pandemic flu and swine flu immunisation for pregnant women.

Managing Reform - £2.4m

These funds are to fund preserved rights cases, cleaning pressure and activity in the Mater Hospital.

Managing Elective Care - £40m

These funds, in combination with an additional £25m in 2009/10, have been identified to continue to support the maintenance of Elective Access Standards.

Maintaining Existing Services - £30m

This funding is intended to support Trusts in addressing cost pressures arising from areas such as increased utilities costs.

In total therefore, £117.8m will be spent in the year 2010/11 to help maintain existing service delivery and to allow for the development of new services.

It is evident that 2010 and beyond is a very challenging year. It may be that revisions will need to be made in light of the new government's budget. However, it is clear that any further requirements levied would be very challenging with the potential to fundamentally change the current pattern of Health and Social Care provision.

3. Personal and Public Involvement

Personal and Public Involvement is about people and communities influencing the planning, commissioning and delivery of health and social care services. It means actively engaging with those who use our services and the public to discuss: their ideas, our plans; their experiences, our experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services.

Whilst the concept of Personal and Public Involvement is not new, we have made considerable efforts in 2009/10 to further embed Personal and Public Involvement in our everyday work.

For example, under the Health and Social Care Reform Act (NI) 2009, Health and Social Care Organisations were required to have in place Draft Consultation Schemes on Personal and Public Involvement in accordance with Articles 19 and 20 of the legislation. A workshop was held in November 2009 with voluntary and community sector representatives to develop the Draft Consultation Schemes and to collect opinions on how to move Personal and Public Involvement forward. The Draft Consultations Schemes, influenced heavily by the outcome of the workshop, were submitted to the DHSSPS by 31st December 2009 for approval.

Further advice from this workshop was that Health and Social Care Organisations should, in relation to Personal and Public Involvement, find ways to work in a more co-ordinated way. In response to this advice a meeting with the relevant organisations was held in January 2010.

As a result, it was agreed that the Public Health Agency would take a lead role in establishing a regional Personal and Public Involvement Forum and develop a clear work plan for Personal and Public Involvement activities of Health and Social Care Organisations. This Forum will work to promote a whole system approach and reduce unnecessary duplication.

The specific roles for the DHSSPS, Health and Social Care Board, the Public Health Agency and Trusts at a strategic level will be complemented by the unique role of the newly formed Local Commissioning Groups. In preparing their input to this

Commissioning Plan, Local Commissioning Groups engaged with their local populations, including community and voluntary networks, to assist them in the development of their local priorities. The Local Commissioning Groups intend to build on this process throughout 2010/11 and beyond. The Health and Social Care Board, including its Local Commissioning Groups, and the Public Health Agency are committed to working in partnership with the Patient and Client Council, other Health and Social Care Organisations and statutory bodies such as Local Councils, to promote Personal and Public Involvement and identify joint Public Involvement opportunities and reduce duplication.

The Patient and Client Council undertook a major consultation exercise from August to November 2009 to inform the development of the DHSSPS's Priorities for Action 2010/11. As an example of our commitment to work with the Patient and Client Council, we ensured that the recommendations from this consultation exercise have also informed the development of this Commissioning Plan.

We recognise Personal and Public Involvement as an integral process linking human rights and equality, patient and client experience, user involvement and community development. Section 75 of the Northern Ireland Act 1998 provides a legislative framework for the promotion of equality of opportunity and good relations.

The Commissioning Plan, in both its developmental stage and implementation stages, has the potential to impact on Section 75 categories[2] and the categories[3] under Good Relations. It also impacts on the human rights of individuals. In this context, substantial work has been undertaken to ensure that the development of our Personal and Public Involvement consultation schemes were in compliance with the requirements of Section 75 of the Northern Ireland Act (1998), the Human Rights Act (1988) and the Disability Discrimination Act (1995).

[2] ***Covers: religious belief, political opinion, racial group, age or marital status or sexual orientation, gender, disability, dependants***

[3] ***Covers: religious belief, political opinion and racial group.***

Once the Commissioning Plan has been approved by the DHSSPS, consideration will be given to screening/equality impact assessment by the DHSSPS, Health and Social Care Board or Trusts as appropriate and where screening indicates a need for more thorough examination, an equality impact assessment will be considered.

4 Local Commissioning Groups

4.1 Background

Legislation enacted on 1 April 2009 created a new commissioning system with the establishment of a region-wide Health & Social Care Board, including 5 Local Commissioning Groups, and a Public Health Agency. The objectives of the new commissioning arrangements will support local sensitivity with the creation of 5 Local Commissioning Groups reflective of their geography. Local Commissioning Groups are made up of local political representatives and professionals and have a strong role in shaping local services and contributing to the formulation of Board policies.

Local Commissioning Groups are charged with providing local leadership in commissioning health and social care. They are responsible for assessing the needs of the local population, planning to meet those needs and securing delivery of Health and Social Care in line with the Plan. They will do this through wide ranging engagement with local communities, users and carers, and voluntary and statutory partners.

Local Commissioning Group Chairs


Dr G O Neill
Belfast


Dr N Campbell
South Eastern


Dr B O Hare
Western


Mr S McKeagney
Southern


Dr B Hunter,
Northern

Local Commissioning Area	Population	Funding
Belfast	335,000	£581m
South Eastern	340,000	£476m
Southern	348,700	£499m
Western	300,000	£452m
Northern	450,000	£641m

4.2 Local Commissioning Group key responsibilities in 2010/11

All Local Commissioning Groups will specifically have the obligation to ensure resources invested in caring for older people and the primary care component of elective care are properly expended. In addition there is an expectation that they will have a central role in the development of Primary Care Partnerships. As part of this process they will be required to contribute to a greater understanding of demand management. Finally, they will be required, as part of the Health and Social Care Board, to contribute to the full range of decisions it is required to take.

Local Commissioning Groups will, in the course of 2010/11, produce a Local Commissioning Plan providing a profile of their local population, needs assessment and commissioning priorities over the next 12 months.

5 Overarching Themes

5.1 Introduction

This section summarises the key commissioning themes for the future and highlights the main changes which will need to take place if we are to secure safe, sustainable and high quality services for people of Northern Ireland. There are powerful arguments about why we need to make changes in how we commission services and we will need strong processes to drive these forward over the next three years. However, it is essential that these begin to take effect in 2010.

We are faced with the need to generate efficiency savings of 9% while simultaneously addressing the potential impact of financial pressures from the wider environment on the Northern Ireland Block. The net effect of this will be less resources for health and social care. The need to deliver savings and respond to pressures generated by the current financial environment will be challenging. However, it is important that these are seen against the scale of our spending on Health and Social Care services. We will still continue to spend £11m per day on Health and Social Care in Northern Ireland.

5.2 Tackling Health Inequalities

Historically, much of our attention has been focused on specific targets and goals however the Public Health agenda has the potential to make a huge impact on the overall health and wellbeing of the population. The main elements of this agenda are:

Tackling Health Inequalities

Challenging health and social inequalities cannot be exclusively addressed by Health and Social Care organizations but requires meaningful partnerships and a common agenda to be developed with our Trusts, our colleagues in local government, housing, education and the environment and our communities if we are to effectively deliver on improving the health of our population.

Public Health Agency is committed to ensuring the IFH strategy is fully implement and will use the opportunity for developing new

ways of working in collaboration with our partners in local Government to drive this agenda forward. PHA is also committed to exploring new partnership working with other agencies in terms of the wider inequalities agenda in terms of how we share intelligence, agree joint objectives and seek new opportunities for engagement and collaboration

Health Improvement

We also need to give a much greater emphasis to health promotion and disease prevention. For example, research suggests that up to 70% of all attendances at general practice are directly related to weight, tobacco use, alcohol consumption, poor sleep or stress. Clearly a different approach to lifestyle and targeted interventions can materially change the population's health status and address inequalities in health.

Public Health Agency will work across both regional and local domains to promote greater lifestyle choices and addressing the wider determinants of health. This will include directly influencing the joint commissioning plan, the trust delivery plans and the work the Public Health Agency is taking forward with the community and other key stakeholders through Investing For Health Partnerships and joint working arrangements.

Screening Programmes

Population screening is an important public health activity that focuses on the early detection of disease. This allows for earlier interventions contributing to improved outcomes.

5.3 Primary Care Partnerships

In order to support necessary changes in the way in which acute services are provided across Northern Ireland, the Health and Social Care Board will explore the feasibility of Primary Care Partnerships in 2010/11. Demand is an indicator of expressed need and this approach will support the understanding of demand and, as a consequence, enable the redesign of local services through the active involvement of clinical and care professionals, the voluntary sector and service users. The Health and Social Care Board's five Local Commissioning Groups will engage with and support partnerships so that primary and community care

practitioners and staff receive the information and resources required to manage demand through more accessible local services.

Partnerships will be built around local communities numbering around 100,000 and will include GP practices, pharmacists and other providers of health and care based in their area. They will have a key and central relationship with the Local Commissioning Groups and be in a position to provide more local expression of need into the commissioning process. Through assigning indicative budgets covering areas such as prescribing, outpatient care, diagnostics and community services, Partnerships will be afforded the opportunity to reinvest a proportion of savings in local services. They will be clinically led to ensure strong clinical governance and decision making.

Local Commissioning Groups will ensure that, in their formative phase, Primary Care Partnerships are supported with information on referral activity, budget and expenditure reports, quality outcomes and user experience. Partnerships will be ideally placed to exploit the benefits of the GP contracts' Quality and Outcomes Framework in terms of assessing the level of chronic disease in their local communities, with Practitioners overseeing the analysis of this important public health information. By focusing resources on patients with long term conditions and those most at risk of acute complications leading to hospital admission, Primary Care Partnerships will be in a position to improve quality of life through early intervention and a reduced dependence on specialist care. As the budget to support the prescribing of drugs by GPs transfers to the Health and Social Care Board in 2010/11, it will be important to ensure that prescribing activity accurately reflects need and is of the highest quality. Primary Care Partnerships will support local prescribers through the expertise of pharmacists working within the Health and Social Care Board's Medicines Management Team. Efficient and effective prescribing will help to maximise the quality of care provided to patients, particularly those suffering from chronic disease, and reduce the potential impact of budgetary pressures, within prescribing on other essential services. Under the leadership of Local Commissioning Groups, Primary Care Partnerships will be in a position to reinvest savings in developing improved services for local communities including prevention alongside treatment.

In developing this local model it will be important to take account of a wide range of views and the Health and Social Care Board will, through its Local Commissioning Groups, consult with stakeholders. Partnerships will seek approval for investment plans through their 'parent' Local Commissioning Group and their success in delivering change will be subject to evaluation in 2011/12.

5.4 Reshaping Acute Hospital Services

The overall aim in commissioning is to ensure that the people of Northern Ireland have timely access to high quality services and equipment responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively.

To maintain and to continue to achieve this standard of service for our comparatively small population of 1.7m won't be possible unless we change the ways in which we deliver care to people.

Hospital acute services are changing. Commissioning hospital care in a different way does create anxiety but the primary driving force in this is about securing safe, high quality, sustainable services.

As standards for training increase our Medical, Nursing and Allied Health Professions staff are working in an increasingly complex clinical environment. Senior clinical staff need to work in a different way, with access to a significant clinical infrastructure, sub speciality expertise and larger teams of senior colleagues to discuss and to make decisions about the best treatment and care for patients. There are also issues about needing to work in a different way to ensure that staff in training can gain the necessary experience which will best qualify them to provide the highest quality of medical and nursing care. A critical issue in terms of how hospital services are commissioned in the future will be to have a much closer relationship with the training bodies. In this way we can work together to develop approaches about training in systems or networks rather than in institutions to make training better for staff and the patients they care for.

For many years Health and Social Care has tried its best to secure the right clinical staffing profile to maintain acute services but this is becoming increasingly difficult. Many of our services – and not

just those provided in smaller units – are becoming more dependent on the use of locum cover which by its nature must impact on the continuity of care because we cannot attract or retain permanent specialist staff. The drive for change in how we commission and provide acute care is not about money, it is about making sure that all of our population, irrespective of where they live, has access to the same standard of high quality, safe clinical care.

Some of the changes in how we commission hospital care have already happened. Over the last 10 years Northern Ireland has streamlined its care for cancer patients by consolidating services into the major acute hospitals with streamlined access to the regional cancer centre as needed and we are seeing better outcomes for patients as a result. Progress with the 2002 DHSSPS Strategy "Developing Better Services" has also resulted in changes to acute hospital care in Downpatrick, Lisburn, Enniskillen and Omagh.

These approaches will ensure … timely access to the best possible configuration of clinical expertise to meet health needs and improve outcomes consistently across the whole population.

Around 80% of hospital care is made up of diagnostics, outpatients, day care and ambulatory services. Therefore it becomes clear that, irrespective of some of the changes that will have to happen in inpatient care, there remains a very important and key role for smaller local hospitals where much of this activity takes place. We want to maintain, where it is safe, sustainable and appropriate to do so, as much local access for local people as possible. The local hospital has a key role in refining the diagnosis for patients and referring them through the system as appropriate. We want Local Commissioning Groups to work closely with local hospitals to shape the service care pathways so that they are responsive to local need and connect seamlessly to the rest of the hospital network.

The next steps in terms of a detailed programme will follow, but we want to signal in this Commissioning Plan specifically what the changes and developments are likely to involve:

- Investments in the order of £13.85m to offer access to a range of specialist drug therapies;

- Recurrent investment of £25m in local infrastructure to support waiting time targets to reduce the use of the Independent Sector;

- Further developing the role and function of the local hospital network in providing access to diagnostics, outpatients, day and ambulatory care and establishing care pathways through the rest of the hospital system;

- Supporting the changes which have occurred in 2010/11 in Magherafelt and at Whiteabbey by developing their outpatient, diagnostics, rehabilitation and minor injuries capacity and putting in place new services such as bowel screening;

- Redesign the system of Accident and Emergency provision so that people have access to safe and sustainable services in line with their treatment needs;

- Review the current profile of inpatient emergency surgical services to support emerging sub specialisation and appropriate staffing and expertise;

- Avoiding inappropriate duplication of inpatient specialities in each of the Trust sites;

- Ensure that the current profile of paediatric inpatient services provides appropriate staffing and expertise in line with best clinical practice;

- Commission services in line with the recommendations of the Review of Maternity Services;

Enabling people to live at home is a key objective in this Commissioning Plan.

- "Right Sizing" the number of acute medical inpatient beds for our population in line with national standards to release resources for reinvestment in front line services;

- More rigorous adherence to the effective use of resources;

- Developing new clinical partnerships with larger acute providers in the Republic of Ireland and other facilities in the UK as well as continuing with the programme for establishing local Clinical Networks to ensure our services are delivered to the highest possible standards;

We will work closely with individuals and their families when there is a change to services, being sensitive to their concerns.

- Acknowledging that a population of 1.7m may be too small to sustain some highly specialised services, but securing new arrangements which make sure our population gets timely access to these services when they are needed;

- Specifying and addressing the impact these changes will have on emergency transport services;

- Ensuring that the acute service developments arising from the investment of £51m in 2009/10 are fully in place in this financial year.

Making these changes won't be easy. It will require dialogue with the population and involve fundamental strategic shifts in the current pattern of care, but we need to do this to secure good outcomes and provide safe services. We need to be innovative in how we establish networks of different elements of care and how we connect them to populations and to each other to ensure continuity.

These approaches will ensure that the people of Northern Ireland get timely access to the best possible configuration of clinical expertise to meet their health needs and improve outcomes consistently across the whole population. We recognise the importance of patient choice and need

Local Area Coordination for disabled people in two Trust areas which opens up opportunities in people's communities for access to, and involvement in, work, leisure, training and further education. Supported living schemes for older people, disabled people, those with mental health problems and young people leaving care provide housing and support as alternatives to institutional care.

for people to have confidence in how our services are provided. Choice will therefore be a major theme in driving commissioning. It must however recognise that there are limits to the extent of choices available and they must be consistent with the delivery of safe, effective care.

5.5 Living at Home

People do better when they live at home. The outcome of people's care is better when provided as close as practicable to their home. This holds true for older people, children, those with disabilities and those with mental health issues.

Enabling people to live at home is a key objective in this Commissioning Plan. Health and Social Care services need to be designed to promote independence, recovery and rehabilitation and to support individuals to live fulfilling lives.

Strong and effective partnerships with service users, families and carers and communities will be essential in order to provide person centred support to meet people's needs; that is support based on an individual's express wishes. This means looking at the support we give in a different way; based on the concept of recovery rather than long term care and increasing community capacity to create greater opportunities for people to be engaged in employment, education, leisure and social activities.

We will need to re-shape our services in the following ways:

- Promoting self care and self management of long term conditions such as asthma, chronic obstructive pulmonary disease, heart failure and diabetes;

- Providing an agreed support plan for all service users that promotes recovery;

- Involving individuals more in decisions about their care; promoting the use of direct payments and exploring the potential for individual budgets;

- Improving partnerships with the voluntary and community sector to provide community based services;

- Providing more rehabilitation at an earlier stage and reviewing domiciliary care and day care services to support this model;

- Reviewing institutional care and the way in which long term support and care is provided;

- Providing greater support to children and families; supporting parents in their parenting role and helping young people who are leaving care.

There are already many examples of community based services that are promoting the principles outlined above, and most people will agree that such alternatives to institutional care are preferable and that more people should be able to avail of them.

However, there are many challenges in realising this shift in services; not least some people will be concerned that appropriate and adequate support will be available in the community. Local Commissioning Groups, with the Public Health Agency, will have a critical role in working with communities to increase community capacity; help re-design existing community support services and bringing forward plans for their local area.

5.6 Detailed responses to Priorities for Action 2010/11

In the next section, we set out in detail our response to the Priorities for Action for 2010/11 reflecting the Commissioning system's obligation to progress and deliver on the Priorities for Action Targets.

Section Two

Detailed Proposals and Funding

Priorities for Action 2010/11 – Detailed Proposals and Funding

This section sets out in detail the areas identified for action and funding in 2010/11 by the Minister and DHSSPS and the actions the Health and Social Care Board and Public Health Agency propose to take to ensure that targets are met.

The DHSSPS has grouped this year's priorities into a number of broad themes. These are:

1 Keeping adults and children well, improving their health and reducing health inequalities;

2 Ensuring services are safe, sustainable, accessible and patient centred;

3 Integrating primary, community and secondary care services;

4 Helping older people to live independently;

5 Improving children's health and wellbeing;

6 Improving mental health and care for people with disabilities;

7 Ensure financial stability and the effective use of resources.

Priority Area 1:

Improve the Health Status of the Population and Reduce Health Inequalities

6.1.1 Strategic Content

Improving health and wellbeing remains one of the most fundamental ways of improving people's quality of life. The key aim is to maintain and improve the health status of the entire population and to reduce inequalities in health status between population group and geographical areas.

Effective sustained improvements in health and wellbeing can best be achieved by promoting and delivering care at earlier stages in 'life pathway' of people. Shifting the focus 'upstream' towards prevention, health promotion and earlier diagnosis of disease through the provision of appropriate and timely population screening and interventions will positively impact on the health and wellbeing of our population.

In shifting and tailoring this focus, account needs to be taken of differences in the health and wellbeing status in our population. Significant inequalities exist between local geographies and communities and are most often related to levels of deprivation and poverty. Action needs to be taken to improve everyone's health as well as those who are most disadvantaged in order to narrow this gap.

6.1.2 Commissioning Themes

In addition to the Priorities for Action Targets the Health and Social Care Board and the Public Health Agency will progress a number of specific themes related to Keeping Adults and Children Well, Improving Health and Reducing Inequalities:

6.1.2(i) Preventable ill Health

It is estimated that there are some 4,000 premature deaths per annum in Northern Ireland. There are, moreover, unacceptable inequalities in health often associated with socio-economic status and disadvantaged areas. Addressing these issues through the promotion of good health and well being, the prevention of illness and injury, early intervention and good long term care remains a key priority for the Health and Social Care bodies and a major priority as they directly contribute to the process of intelligent

commissioning including needs assessment, engagement and demand management.

Some of the most common characteristics associated with being born into poverty as opposed to more affluent circumstances are:

- You are 40% more likely to die before the age of 75;
- You are 5 times more likely to die of drug or alcohol related diseases;
- You are 3 times more likely to be a parent before you are 20;
- You are twice as likely to die of a smoking related disease or lung cancer;
- You are likely to die 7 years earlier than someone from a less deprived area;
- You are 3 times more likely to take your own life by suicide;
- Poor Mental Health Status – 19% of adults in Northern Ireland have a high GHQ12[4] Score and a 25% higher incidence of Mental Health problems than England and Scotland[5] ;
- In addition, it is recognised that other groups also experience disadvantage eg life expectancy for Travellers if estimated at some ten years less than the most disadvantaged settled communities.

[4] Northern Ireland Health and Social Wellbeing Survey 2005/06

[5] Frieddi I, Parsonage M. Mental health promotion: Building an economic case. Belfast: Northern Ireland Association for Mental Health (NIAMH) 2007.

6.1.2(ii) Health Improvement

The theme of health improvement is also an integral element of other sections of the Commissioning Plan. Delivery must address the up-streaming of interventions designed to tackle inequalities. This will require a broad collaborative approach with other sectors, including local government, education, and local communities.

However in terms of Priorities for Action performance, the primary issues for improving outcomes for adults and children include:

- Implementation of the Investing For Health strategy and the commitment to work in partnership with other partners including local Government on agree priorities targeting life expectancy, wider determinants and lifestyle choices.
- Implementation of the mental health promotion strategy and subsequent review
- Implementation of the Suicide Prevention Strategy (Protect Life) and supporting the review
- Implementation of the Teenage Pregnancy Strategy
- Promotion of good Sexual Health
- Addressing the rise in obesity levels, to include the roll out of the regional review on obesity framework consultation, promotion of breastfeeding, promotion of physical activity and healthy diet and nutrition
- Prevention of accidents in the home, workplace and on the roads
- Implementation of the New Strategic Direction on Alcohol and Drugs, with support services for those with addiction, targeting binge drinking and young people
- Implement the Tobacco Control action plan and development of a new regional strategy – with a focus on manual workers, young people, pregnant women etc
- Promotion of good oral health linked into the wider Health Promotion strategies including obesity, smoking, accident prevention etc.

6.1.2(iii) Service Frameworks

Service frameworks set standards with associated performance indicators, performance levels and timeframes for specific service areas designed to:

- Improve the health and social wellbeing of the population of Northern Ireland;

- Reduce inequalities and promote social inclusion;

- Improve the quality and safety of care;

- Safeguard vulnerable individuals and groups; and

- Improve partnership working with other agencies and sectors.

The Public Health Agency will work with relevant stakeholders to implement the health improvement performance indicators set out in the Cardiovascular and Respiratory Service Frameworks. These are aimed at reducing cardiovascular and respiratory disease. Some apply to both Frameworks and include activity to stop smoking, increase physical activity, encourage healthy eating and reduce consumption of alcohol. Some are Framework specific eg, increasing the percentage of people trained in emergency life support, enhancing social and emotional support to people with chronic respiratory illness and increasing access to maintenance exercise classes.

Implementation will focus on tackling known areas of inequality and link carefully with the emerging joint working arrangements with local councils and existing partnerships. This work will be progressed as part of a planned and coordinated approach with the Health and Social Care Board to framework implementation. A similar approach will be used to implement the health improvement standards in the Cancer Service Framework when it is published.

6.1.2(iv) Population Screening

Population screening is an important public health activity that focuses on the early detection of disease. Screening programmes currently in place in Northern Ireland, and those which are planned for implementation, can be grouped into four categories: cancer, vascular, newborn/child and antenatal, a number of these have already been covered by specific Priorities for Action targets. Quality assurance helps to ensure the benefits of screening are maximised and harm minimised. Structures to support the quality assurance function are well established within the cancer screening programmes. These mirror the arrangements elsewhere in the UK. However, the structures for non-cancer programmes are less well developed. The Public Health Agency will lead on the development of the quality assurance function across Health and Social Care to support these programmes.

6.1.2(v) Health Protection

The Public Health Agency will take the lead in ensuring that a full range of health protection services are provided. This includes the direct provision of services by the Public Health Agency, including its statutory obligations (relating to notifiable diseases etc), working with other organisations such as Environmental Health Departments and Northern Ireland Water and commissioning services in areas such as childhood vaccines, healthcare associated infections and the antenatal infections screening programme. In addition the Public Health Agency together with the Health and Social Care Board, Business Services Organisation and Health and Social Care Trusts will continue to review, test and update emergency plans, taking into account lessons learned from recent incidents and the response to swine flu.

Vaccinations have been cited along with clean water by the World Health Organisation as the biggest contributors to improvement in health over the last 100 years. They are also considered among the most cost-effective health interventions. Northern Ireland now has uptake levels for all vaccinations well above the UK average and the Public Health Agency will seek to build on this position during 2010/11. In particular we will aim to reduce inequalities of MMR vaccine, targeting those in geographic areas with relatively low uptake. We will also aim to further improve uptake of HPV vaccine, improving on the good start that has been established in the first two years of the programme. Any new vaccines will be introduced with the aim of achieving the same high uptake of the established vaccines.

6.1.2(vi) Community and Voluntary Sector

The Public Health Agency is committed to working closely with a wide range of organisations to best enable us to reach out to communities and individuals to improve their health and wellbeing. This will include working with and through the Health and Social Care Trusts, other statutory organisations (and especially developing our partnerships with local government) as well as voluntary and community organisations. The legacy organisations already fund a large number and variety of voluntary and community groups, and the new organisations are committed to building on this expertise. The Public Health Agency and Health and Social Care Board will seek to bring an increased rigor and meaningfulness to managing how we use the budget available to

fund health and wellbeing improvements across the full spectrum of organisations, in order to realise anticipated outcomes.

6.1.2(vii) Primary Care

Family Practitioner Services are a key setting for health promotion. The Public Health Agency is committed to working on existing and future Direct and Local Enhancements opportunities which have long-term health improvement and addressing inequalities at the core. Increased focus will be given to:

- Health Promotion standards in the service frameworks eg smoking cessation , brief intervention on alcohol, and nutrition and physical activity;

- Mental Health promotion and support and referral to other services.

In addition, access to and reducing barriers to services will be encouraged, alongside increasing activity in disadvantaged communities. Practices will also be encouraged to build strong links with access to welfare rights groups as an important means of maximising the income of disadvantaged individuals and communities. The Health and Social Care Board and the Public Health Agency will take the opportunity to review current information systems, their efficacy and ease of using the information captured to chart progress and inform future developments.

There are unique opportunities to develop further partnerships with Community Pharmacies to promote health improvement. The Building Community Pharmacy Partnership initiative has evaluated positively and demonstrated the important role that pharmacists can play in promoting health across a whole range of issues. The Health and Social Care Board and Public Health Agency will wish to build on this progress.

6.1.2(viii) Oral Health and Dental

Despite improvements in the oral health of our population, there remains a strong pattern of inequality in those with good and those with poor oral health.

It is well recognised that many chronic diseases including oral disease share common risk factors such as diet and nutrition, tobacco and alcohol. A collaborative approach needs to be adopted in order to tackle local oral health inequalities.

Dental registration for children under five years are another key indicator of health inequalities. The Public Health Agency and the Health and Social Care Board will work with the Trusts through the Regional Service Level Agreement to encourage families from disadvantaged areas to register with a dentist. This will require working in partnership with other stakeholders such as General Dental Practitioners and Community Groups. In addition, emphasis will be placed on the prevention of disease and promotion of oral health, working with communities, and in particular parents.

6.1.2(ix) Quality Assurance

The Public Health Agency and the Health and Social Care Board are committed to the highest standards of service. Specifically the Public Health Agency has prioritised the need to build effective working links with academic institutions. Research and evaluation are embedded into the development of all programmes. Setting standards for new service areas which can be rigorously evaluated will be essential in order to ensure best use is made of resources. Whenever possible the Public Health Agency will seek to integrate and illuminate knowledge on the nature of inequalities and effective action.

6.1.2(x) Health Intelligence and Communications

Public health priorities across health protection, service development, screening and health and wellbeing improvement all require a wide range of ‘health intelligence’ and ‘health communications’ support.

For example, good quality health and social wellbeing intelligence is a fundamental requirement to:

- Enable rapid response to immediate public health risks and demands;

- Inform and influence public health interventions and measure impact and outcomes; and

- Improve understanding and aid decision making.

Similarly health communications play an essential role in informing, influencing and motivating individual, institutional and public audiences about important health matters.

As a learning organisation the Public Health Agency is committed to the critical examination of what is most effective, including testing and developing new and innovative practice and seeking greater understanding about the nature of health inequalities and the impact of action.

In addition to providing bespoke Health Intelligence support the Public Health Agency will explore partnership arrangements with key Health and Social Care partners and academic institutions in order to optimise the use of existing data sources and the commissioning of new research. We will also undertake to develop an effective and efficient knowledge base which enables flexible, shared access to public health knowledge and helps to influence the strategic agenda of other organisations and interests. We will seek to ensure that the optimum mix of communication tools is applied to help realise the targets addressed throughout this Commissioning Plan.

6.1.2(xi) Reducing Demand on Acute Services

As part of the wider reform and modernisation agenda the Health and Social Care Board and Public Health Agency will support Trusts in ensuring that acute services address the wider primary and secondary prevention agenda. It is in the interest of the Trust to ensure that patients make a speedy recovery and avoid re-admission. Acute settings are also important locations in terms of promoting the health improvement agenda both for staff and patients/clients.

The Health and Social Care Board and Public Health Agency will support the development of an integrated approach across primary, secondary, tertiary and community care so as to maximise the opportunities to avoid unnecessary admissions and improve population health and social wellbeing. This will include

addressing issues such as falls prevention, alcohol abuse services, soft tissue injuries, emotional wellbeing, all which have a major impact on A&E services and acute admissions. In relation to specific areas such as sexually transmitted infections, HIV and other sexually transmitted infections are increasingly presenting as an important public health problem in Northern Ireland, as is the case elsewhere in the UK and Europe. The Public Health Agency will work with partners in the Health and Social Care Board, Trusts, primary care and voluntary sector to meet these needs. Health improvement plans for sexual health will also focus on the opportunities for prevention of sexually transmitted infections.

The Health and Social Care Board and Public Health Agency will exploit partnership opportunities to work with the NI Ambulance Service on the preventative agenda and raising awareness on the impact of issues such as road traffic collisions, attacks on emergency staff/services, community based first responders and so forth. Addressing the causes of demands on trauma and orthopaedic services will have benefit on both the wider community and service pressures; this will include targeting information and support at the most vulnerable communities.

The promotion of good lifestyle choices on diet, nutrition, physical activity, sexual health, smoking and so forth will impact on service demands for Stroke Services, chronic diseases such as diabetes and respiratory disease, and the need for specialist treatment such as HIV drugs.

6.1.2(xii) Improving Mental Health Services

The Health and Social Care Board and Public Health Agency are committed to ensuring that key health improvement priorities including early intervention, prevention and tackling inequalities are integral to the redesign and delivery of mental health services. Because of the Bamford vision and the establishment of a Mental Health and Learning Disability Commissioning Taskforce, working groups for Promoting Mental Health/Suicide Prevention and Drugs and Alcohol will be established. These will sit alongside a number of service groups including adults, learning disability, Child and Adolescent Mental Health Services and Eating Disorders. Within the framework structure there will be significant opportunities to ensure the key health improvement priorities are addressed in each of the working groups and at the overarching Commissioning

Team. A major priority will be promoting personal development and early interventions that are effective, accessible and person centred supported with advocacy for the involvement of clients and carers.

Core to this will be working with organisations in the statutory, community and voluntary sectors that can provide evidence based services such as building resilience, family support and counselling for those in crisis and in need of support. The continued roll out of the Lifeline Contract will be a major investment in terms of ensuring that those in crisis and/or their carers have immediate support when they require it.

Other priority areas will include delivery of the Hidden Harm action plan, review of addiction services, taking forward the recommendations from the Health Committee Inquiry into the Prevention of Suicide and Self Harm, and joint working to provide better services to meet people's needs.

6.1.2(xiii) Workforce Development

Workplace health and wellbeing is gathering momentum as an issue for consideration by employers and management teams. The growing evidence base demonstrates clearly the benefits to organisations of adopting an approach that considers the health and wellbeing of employees in their everyday business. Health and Social Care bodies must advocate this approach and recognise the importance of providing support and accurate advice to workplaces on the subject.

The Investing for Health Strategy identified the potential for our Health and Social Care services to play a major part in promoting health and wellbeing and in addressing inequalities in our population. The modernisation agenda acts as a springboard for wider co-operation and new partnerships. The Health and Social Care Board and Public Health Agency would see future developments building bridges between various health care settings and communities ensuring an integrated and effective contribution to health and wellbeing at regional and local level.

6.1.2(xiv) Domestic Violence and Sexual Violence

Health and Social Care has conjoined the two regional groups on Domestic Violence and Sexual Violence to strengthen the work of both areas. Health and Social Care will ensure the implementation of the revised Sexual Violence and Domestic Violence Action Plan for 2010/11.

Each of the five Trusts/Local Commissioning Group areas, have a multi-agency domestic violence partnership which identifies local needs and proposals for programmes and services to those in need.

6.1.3 Challenges and Constraints

In order to maximise impact and target resources in areas of greatest need a number of communities who experience greatest inequalities have been identified as requiring particular attention in commissioning interventions to bring about change. For example, Travellers, whose life expectancy is some ten years less than the settled community, other targeted groups include children and young people, lesbian, gay, bisexual, transgender, ex prisoners and their families etc.

In broad terms action will be required at the level of the individual, the community, statutory and voluntary sector agencies, and with policy makers. The Public Health Agency and the Health and Social Care Board will develop effective evidence based policies and practice. A unique opportunity presents, given the size and scale of the population, to make a meaningful impact with a long term commitment of Government. There is urgency and speed required on this agenda – inequalities and the impact of inequity on individual's health and wellbeing across the lifespan is stark. Equally, there is a need to address the burgeoning costs of health care and the predicted inability of government to meet this burden if nothing is done to arrest, resize and scale the challenge.

However, many of these challenges are a result of cultural or intergenerational issues and will take the development of partnership arrangements and a considerable time to change before sustainable transformation can emerge.

Locally the change in responsibilities of the new Health and Social Care structures also provide an opportunity for focusing on the prevention agenda. Health and Social Care Trusts are now

charged with a duty to improve health and wellbeing and whilst services will be commissioned via the Health and Social Care Board there is also the opportunity of working closely with Trusts to ensure that the efforts of the Health and Social Care 'family' as a whole are used to greatest effect to bring about change. Commissioning better outcomes for those experiencing the greatest disadvantage is a strong theme in this Commissioning Plan. Specific attention will also be given to:

- Continuing to build on the progress made with partners in developing effective collaborative approaches which address the determinants of health. In particular, work which will integrate approaches including community regeneration, education, health and wellbeing in partnership with communities experiencing disadvantage through the Investing for Health Strategy;

- Changes to the physical environment which promote mental and physical wellbeing;

- Community development approaches to health and wellbeing and service delivery;

- Securing a strategic approach to Early Years Intervention and family support, including implementation of DHSSPS "Families Matter". In addition to the roll out of a variety of early years investment, the establishment of internationally successful and evidence based early intervention models including 'Family Nurse Partnerships' and 'Roots of Empathy' into Northern Ireland will be pursued in 2010/11;

- Improving Breast Feeding support and implementation of co-ordinated action;

- Continuing to build on work in the prison setting to meet the health and wellbeing needs of the prison population;

- Developing and building on integrated planning approaches at local level;

- Strengthen developments with the education sector, in particular using the school as an important setting for health improvement.

6.1.4 Summary of Commissioning Proposals/Responses to Priorities for Action

Priorities for Action Target: Improving Life Expectancy

By March 2011, the Public Health Agency should implement agreed actions contained in its Health Improvement Plan to address inequalities at a regional and local level, including any actions arising from the Investing for Health Review:

Life expectancy is impacted by many factors which include socio-economic status, gender, age, ethnicity, poverty and lifestyle factors. Many are outside the direct remit of health but Health and Social Care will advocate and influence other policy initiatives as well as seek shared goals through inter-sectoral work which will ultimately impact on inequalities. The material and structural barriers which are so important in respect of poverty will also be addressed by Health and Social Care. Health and Social Care are committed to building on social capital as part of the process of addressing root causes through initiatives that tackle issues such as fuel poverty, access to welfare rights and so forth. Health and Social Care will invest in initiatives that build resilience, ensuring that community development programmes empower individuals and groups as well as encouraging their active participation.

Health and Social Care will ensure that the broader range of health improvement strategies, including Investing for Health, Health Promotion Strategies such as Accident Prevention, Suicide Prevention (Protect Life), Mental Health Promotion, Fit Futures, New Strategic Direction and Tobacco control etc will be fully implemented. This approach will be taken in conjunction with the planned brief interventions at primary, community and acute settings and will contribute to improving life expectancy with a particular focus on disadvantaged and vulnerable communities. A key focus must be on early years and ensuring that all children have the best possible start in life and taking forward the strategic drive outlined in the Marmot Review into health inequalities.

In addition the varied individual action plans across the various health improvement agenda will target interventions at a regional,

local and neighbourhood level ensuring cross reference is made with other relevant PfA targets addressed in this plan.

Priorities for Action Target: Smoking

By March 2012, reduce to not more than 22% and 28% respectively the proportion of adults and manual workers who smoke. Consistent with the achievement of these outcomes, by September 2010 the Public Health Agency should take forward its action plan to improve access to smoking cessation services for manual workers. By September 2010, the Public Health Agency should also have in place arrangements for obtaining enforcement activity reports from local government and for analysing and reporting this information (including views on value for money) at least twice yearly to the Department. And by December 2010 the Public Health Agency and Trusts should establish additional support arrangements for pregnant women to help them stop smoking.

Health and Social Care will give a renewed emphasis to reducing levels of smoking, in particular to stopping young people starting smoking and to helping smokers stop. Multi faceted actions including use of media, access to smoking cessation services and working with communities, alongside ensuring robust enforcement of legislation. Health and Social Care bodies will review current interventions and focus on settings which will include enhanced support to women smoking during pregnancy, schools, primary care, ante-natal services, community and voluntary sector partners, employers and working with other statutory agencies to connect with otherwise ‘difficult to reach’ groups with a particular focus on manual workers and developing innovative approaches to engage with, and support, this target group.

Priorities for Action Target: Reducing the Rise in Obesity

By March 2012, reduce to not more than 9% the proportion of children that are obese. Consistent with the achievement of this outcome, the Public Health Agency should throughout 2010/11 ensure timely and effective arrangements are in place in each Trust area to provide targeted support to children identified through the ongoing BMI monitoring process in schools. By February 2011, the Public Health Agency should

produce an integrated action plan to take forward the obesity prevention strategic framework to address overweight and obesity across the whole life course.

Health and Social Care will have in place effective arrangements for the collection and recording of BMI data through the School Nursing Service. This will include a completed evaluation of the various pilot initiatives undertaken by each Trust area to provide support for those children identified through the monitoring process as being obese or at particular risk. (Health and Social Care will be guided by any revised DHSSPS guidance on changes to the Year of Measurement in 2010/2011. Monitoring arrangements are in place within each Local Commissioning Group area to ensure the collection and recording of this data).

Health and Social Care will develop an evidence based integrated approach at a number of levels to address obesity, including the implementation of the strategic obesity framework currently being developed by DHSSPS. This will require a population approach as well as working within the Health and Social Care system to target 'at risk' individuals and groups with information, advice and referral to appropriate services. In the context of Fitter Future for All Frameworks Health and Social Care will work with key stakeholders to promote increased physical activity, improved diet and nutrition and a general sense of wellbeing. Changes to the environment are crucial and the use of Health Impact Assessment and evidence based interventions will be central to future action.

Priorities for Action Target: Reducing the harm related to Alcohol and Drug Misuse

By March 2012, reduce to 29% the proportion of adults who binge drink, reduce to 27% the proportion of young people who report getting drunk, and reduce to 5.5% the proportion of young people taking illegal drugs. Consistent with the achievement of these outcomes, the Public Health Agency should from April 2010 further develop and evaluate the brief intervention pilot designated to support primary care to undertake screening and brief intervention on alcohol misuse. By December 2010, the Public Health Agency should produce

an effective training methodology and determine the feasibility of rolling this out across GP practices. And, from April 2010 the Public Health Agency in partnership with the Health and Social Care Board should, through the implementation of the joint Hidden Harm Action Plan, increase awareness of relevant services and ensure that more young people affected by parental substance misuse are effectively signposted to existing services.

The Health and Social Care bodies will take forward the implementation of the New Strategic Direction on Alcohol and Drugs and build on existing multi-sectoral work and in particular will give increased focus to the implementation and evaluation of:

- Education, Training and Prevention Programmes for GPs , pharmacies, communities and other settings;
- Enhanced collaborative approaches and joint working with communities and local government at a local level;
- Services for Chronic Street Drinkers and outreach services;
- Family support interventions;
- Arrest Referral schemes;
- Alcohol Liaison Services;
- Collaboration with Community Safety Partnerships on wider determinants and anti social concerns.

Health and Social Care will review the outcome from the pilot brief intervention support in a primary care setting and based on the learning examine the opportunity to develop a broader initiative and training programme that could be rolled out on a programmed basis to all GP practices.

Health and Social Care are fully committed to the implementation of the Regional Hidden Harm Action plan to support those children and young people affected by parental substance misuse so that they can avail of the appropriate support service and intervention.

There is also a need for a programme of wider public awareness. There remain major challenges for Health and Social Care to address the growing impact of alcohol misuse on service pressures and demands.

Priorities for Action Target: Suicide

By March 2012, ensure that the suicide rate is reduced below 14.5 deaths per 100,000. Consistent with the achievement of this outcome, by September 2010 the Public Health Agency should ensure that a Deliberate Self Harm Registry pilot is established in the Belfast HSC Trust, and a first draft report produced by March 2011. By September 2010, the Public Health Agency should produce an action plan to implement recommendations arising from Mental Health Promotion/Suicide Prevention Training in Northern Ireland.

Each locality has established multi sector partnerships which oversee the development and delivery of the "Protect Life" and Promoting Mental Health action plans at local level. These partnerships will continue to ensure that local plans are revised regularly and fully implemented in response to locally identified need. All of the plans will be taken forward within the recently established Bamford Taskforce framework and will also take account of regional initiatives such as Life Line and public information campaigns.

Examples of local action includes:

- Building capacity in communities (geographic and / or community of interest) to address suicide prevention and the wider determinants of suicide and mental ill health.
- Community Support for those bereaved through suicide
- Joint working with the Trusts to improve access to services
- Family support for those who self harm
- Liaison with Coroner's office and PSNI to improve communication and early identification of suspected suicides in locality.

Regional actions will include:

- Developing regional co ordination and quality standards for training
- Taking forward model of locality 'Suicide Cluster' plan
- Regional Lifeline telephone helpline and wrap around support services
- Self Harm register and mentoring support (Initially in West now extending to include Belfast)
- Public information campaigns and evaluation of same
- Media monitoring

Health and Social Care bodies will establish the All Ireland Deliberate Self Harm Registry within Belfast Trust area by September 2010, building on the work in the Western Trust and have a draft report by 31 March 2011. Health and Social Care bodies will assess the recommendations of the review of mental health promotion/suicide prevention training and have an action plan in place by 30 September 2010 addressing the priority recommendations.

Priorities for Action Target: Mental Wellbeing

By March 2011, the Public Health Agency should produce an action plan to take forward the relevant regional and local elements contained within the Mental Health and Wellbeing Promotion Strategy

Health and Social Care bodies will support the proposed public consultation on the Draft Emotional Wellbeing Strategy with the final strategy being completed by the early autumn. Health and Social Care bodies will ensure that the process builds on important links with early years and the development of interventions to improve mental health and wellbeing. This will explore the evidence base for the strategy targets and begin the consultation process with key stakeholders for an action plan to deliver the targets. The Public Health Agency and Health and Social Care Board will work with all partners including Trusts to finalise a plan by March 2011.

Priorities for Action Target: Early Years Intervention

By March 2011, the Public Health Agency and Trusts should ensure that the updated child health promotion programme is fully implemented. The impact of the programme will be measured through the Child Health System and the introduction of a new schedule of visits to be undertaken by health visitors.

The Public Health Agency will lead the implementation of the revised Child Health Promotion Programme. Arrangements need to be put in place to use the Child Health System to ensure the uptake of the revised Programme. The Programme will be fully implemented by March 2011.

Priorities for Action Target: Births to Teenage Mothers

By March 2012, the Public Health Agency should ensure that the rate of births to teenage mothers under 17 is reduced to not more than 2.7 births per 1,000. Consistent with the achievement of this outcome, by December 2010 the Public Health Agency should complete a review of the latest evidence of effective intervention for reducing teenage pregnancy, take forward agreed actions to secure further reductions in the rates of teenage pregnancy linked to the Sexual Health Promotion Action Plan.

Each of the five Trust/Local Commissioning Group areas has a multiagency group which identifies local needs and proposals for programmes and services to meet those needs. These plans are brought together regionally, common issues and approaches identified, and these form the sexual health commissioning priorities for the Commissioning Plan.

Achievability of this target is particularly dependant on factors outside health and social services as higher rates of teenage pregnancy are, as identified in the regional 'Sexual Health Promotion Strategy & Action Plan 2008-2013', linked with poor educational attainment, poor physical and mental health, social isolation and poverty.

The Public Health Agency is therefore committed to joint approaches with a wide range of partners. Engagement with and commitment from other sectors such as education, the community and voluntary sector are critical for achieving success.

The Health and Social Care will ensure a review of trends and effective interventions and agree actions that will include key areas such as:

- Programmes to support Looked After Children;
- Sexual health services focused on young people;
- Personal development and training programmes;
- Work with the education sector to support Relationships Sexuality Education.

In respect of Sexually Transmitted Infections (STIs) HIV and other STI's are increasingly presenting as an important public health problem in Northern Ireland, as is the case elsewhere in the UK and Europe.

Between 2000 and 2008

- HIV diagnoses increased by 384%.
- Chlamydia diagnoses increased by 102%.
- Syphilis has become re-established.

The PHA will work with partners in the HSCB, Trusts, Primary Care and Voluntary Sector to meet these needs. Health improvement plans for sexual health will also focus on the opportunities for prevention of STI's and a second workshop will be held to examine trends and the evidence base for effective interventions.

Priorities for Action Target: Bowel Cancer Screening

During 2010/2011, the Public Health Agency, Health and Social Care Board and Trusts should establish on a phased basis a bowel screening programme for those aged 60-69 (to include appropriate arrangements for follow-up treatment).

Health and Social Care bodies will introduce a bowel cancer screening programme for people aged 60-69 in April 2010. The Public Health Agency will be establishing the required quality assurance structures to support this programme and working jointly with the Health and Social Care Board, the Business Services Organisation and relevant Trusts, to ensure that diagnostic and treatment services are provided at the required standards.

Priorities for Action Target: Screening for abdominal aortic aneurysm and ("Triple A")

During 2010/2011, the Public Health Agency should work with the Health and Social Care Board and Trusts to commence preparatory work for the phased introduction of screening arrangements for abdominal aortic aneurysm.

Every effort will be made to support the introduction of this programme.

Priorities for Action Target: Emergency Preparedness

By March 2011, all relevant HSC organisations should review, test and update their emergency plans, including building on the lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments for pandemic flu preparedness.

The relevant Health and Social Care organisations will seek to update their emergency preparedness arrangements in line with this target.

Priorities for Action Target: Business Continuity Planning

By March 2011, each HSC organisation should ensure it has a fully tested and operational business continuity plan in place.

The Health and Social Care Board, Public Health Agency and Business Services Organisation will work together to review legacy arrangements for Emergency Preparedness and Response. This review will be the initial step in a process to develop and test new Public Health Agency, Health and Social Care Board, Business Services Organisation Emergency Preparedness and Response

Interim Arrangements which will include the development of joint protocols and reporting arrangements between the various Health and Social Care bodies including Trusts and the DHSSPS. The review will include implementation of the lessons from the response to recent incidents and the swine flu response. It will also build on regional and national developments and good practice in the area of Emergency Preparedness and Response.

In addressing key health and wellbeing inequalities, the Public Health Agency will refocus £1.25m of programme funds in 2010/2011 as follows:-

Area	**Part Year Effect**	**Full Year Effect**
Interventions with local government partners (other core programme funding also supports this work)	£0.250m	£0.500m
Early Years Intervention Nursing (£100,000 set up and £300,000 for team of 4 in 1 Trust; additional team is £300,00)	£0.100m	£0.400m
Parent Support Officers (to help mainstream initial work in this area)	£0.075m	£0.100m
Roots of Empathy (for phase1)	£0.075m	£0.250m
Non recurrent funding for evidence based campaigns (tobacco / mental health / suicide)	£0.750m	

Priority Area 2:

Ensuring Services are Safe, Sustainable, Accessible and Patient Centred

6.2.1 Strategic Context

The overall aim is to ensure that the people of Northern Ireland have timely access to high quality services responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively.

This aim will provide a strategic and operational approach to how we secure consistency of proven clinical, quality and safety standards across the region to improve outcomes and reduce health inequalities.

There will be challenges to progress. Some of the changes will be controversial and some of our goals will be financially unaffordable in the current environment. Key to the Commissioning role however is to challenge the standards by which we deliver care and make a positive difference to the health and experience of our patients and clients.

The last three years have seen some significant improvements in waiting times for elective treatment and for A & E services, albeit many of our A & E Departments have experienced considerable pressures during 2009/10. These improvements have been achieved despite a growth in demand. We will continue to focus on meeting these needs but at the same time seek to gain a better understanding of the nature of what is driving the demand and how it might be better and more efficiently managed. We recognise the importance of patient choice and engagement and need for people to have confidence in how our services are provided. Choice will be a major theme in driving commissioning though it must be balanced with our commitment to deliver safe, effective and sustainable services.

The approach to commissioning must also address inequalities, ensure equitable access to services and deliver patient treatment in the most appropriate setting.

6.2.2 Commissioning Themes, Challenges and Constraints

6.2.2(i) Evidence Based Commissioning

Consistency of standards across the service by using evidenced based approaches with recognised good practice and proven outcome measures will be driven forward. Service Frameworks and nationally accepted guidance available from the National Institute for Clinical Excellence and NHS Evidence will underpin our approach.

Northern Ireland has a formal relationship with the National Institute for Clinical Excellence in endorsing clinical guidance and appraisals for introduction locally. Whilst we are committed to introducing new technologies and therapies in a timely manner, this will be constrained by the financial environment. We will be more active in using the evidence from the National Institute for Clinical Excellence and NHS Evidence sources to guide us on treatments that are proven not to be effective so that we can reinvest more effectively. We also need to better understand the uptake levels of therapies and the resultant differences in outcomes for our population compared with other regions in the UK. There is some evidence to suggest that we are higher users of some of the high cost drugs and this needs further review. Over the last number of years a number of Service Frameworks for the region have been developed which set out recognised standards for good practice and care to be adopted across the spectrum of provision. Where there is good evidence of proven outcomes we must take steps to ensure these are put in place. Affordability in fully implementing the Service Frameworks will be an issue given the constraints on funding. However, we recognise that Health and Social Care has received substantial funds over the last 2 years for cardiovascular services, respiratory services, cancer and stroke care and not all of these developments have been fully consolidated. In implementing Frameworks, we will give appropriate attention to all elements of the Framework and not just ‘new leading edge’ type developments. The impact on health which can be progressed through management of chronic disease is hugely valuable.

At a broader level, there will be a formal focus identifying evidence of improving clinical outcomes such as mortality and survival rates. Data from Trusts in these areas will be monitored and benchmarked against peer comparators locally and nationally.

6.2.2(ii) Quality and Safety

Our services need to be delivered in an environment which is safe for patients and improves the quality of their experience. It will be essential to focus on minimising risk though robust infection control, high standards of hygiene, reducing adverse incidents, early detection of preventable illness and taking better care of our most vulnerable patients.

In the coming year, the Public Health Agency, in partnership with the Health and Social Care Board, will establish arrangements to ensure that lessons learnt from adverse events are taken forward by Trusts, primary care and other providers.

During this time period, Trusts will have a lead role in implementing quality improvement plans with specific targets for ventilator associated pneumonia, surgical site infection, central line infection, crash call rate, prevention of venous thromboembolism and mental health inpatient care. Trusts will also prepare quality improvement plans to implement World Health Organisation surgical checklists in 80% of cases by March 2011 and promote initiatives in collaboration with the HSC Safety Forum aimed at reducing the incidence of falls and medication errors.

Considerable progress has been made over the last 24 months to ensure a reduction in both the number and rates of Healthcare Associated Infections occurring across Health and Social Care. To date, Healthcare Associated Infections improvement work has focused mainly on secondary care settings. 'Changing the Culture 2010' aims to eliminate the occurrence of preventable Healthcare Associated Infections in all Health and Social Care settings. The Public Health Agency will continue its regional leadership role to ensure ongoing Healthcare Associated Infections reduction during 2010/11. In particular, the Public Health Agency will work to maintain and build on reductions already achieved across secondary care and to address Healthcare Associated Infections associated with and/or occurring in community and primary care settings.

During 2010/11 the Public Health Agency will work in partnership with Trusts, supporting work to deliver clean safe healthcare including work to achieve performance targets for MRSA (Methicillin – resistant Staphylococcus aureus) and Clostridium difficile infections, and full implementation of quality improvement plans. The Public Health Agency will extend the 'cleanyourhands'

hand-washing campaign to include primary, community and independent care settings. The Public Health Agency will establish robust systems for surveillance of surgical site infections in neurosurgery and cardiac surgery. The Public Health Agency will develop a rolling educational programme in respect of Healthcare Associated Infections, including a regional annual symposium to facilitate learning across Health and Social Care. The Health and Social Care Board will lead performance management in respect of Healthcare Associated Infections, supported by the Public Health Agency.

6.2.2(iii) Accessibility

In 2005 the DHSSPS initiated an Elective Care Reform Programme designed to reduce the access times in Northern Ireland for assessment, diagnostics and elective treatment to a level similar to that in the rest of the United Kingdom. The longer term intent is that this should be achieved and maintained through more efficient waiting list management allied to additional investment in Health and Social Care services. It was accepted that, until this investment was fully in place, treatment might also have to be paid for in Independent Sector treatment centres.

The elective access standards applying in 2009/10 were that patients should wait no longer than 9 weeks for assessment, 9 weeks for diagnostics and 13 weeks for treatment. These standards were substantially (though not universally) achieved by March 2010. However, reduced waiting times have triggered substantial increases in demand in many areas. Consequently, we will focus attention on ensuring that waiting times for assessment remain at 9 weeks and that waiting times for treatment are kept as short as resources allow.

6.2.2(iv) Modernising and Reconfiguring Services

Ensuring services are delivered in ways which continue to be of high quality and are safe and effective will be an increasing challenge over the next few years and will result in a reconfiguration of services. To maintain and to continue to achieve this standard of service for our comparatively small population of 1.7m will not be possible unless we change the ways in which we deliver care to people.

As standards for training increase our Medical, Nursing and Allied Health Professions staff are working in an increasingly complex clinical environment. Senior clinical staff need to work in a different way, with access to a significant clinical infrastructure, sub speciality expertise and larger teams of senior colleagues to discuss and to make decisions about the best treatment and care for patients. For staff in training there are also issues about needing to work in a different way to ensure they can gain the necessary experience which will best qualify them to provide the highest quality of medical and nursing care. A critical issue in terms of how hospital services are commissioned in the future will be to have a much closer relationship with the training bodies. In this way we can work together to develop approaches about training in systems or networks rather than in institutions to make training better for staff and the patients they care for.

For many years the Health and Social Care has tried its best to secure the right clinical staffing profile to maintain acute services but this is becoming increasingly difficult. Many of our services – and not just those provided in smaller units – are becoming more dependent on the use of locum cover (which by its nature must impact on the continuity of care) because we cannot attract or retain permanent specialist staff. The drive for change in how we commission and provide acute care is not about money, it is about making sure that all of our population, irrespective of where they live, has access to the same standard of high quality, safe, clinical care.

There has been progress in networking of clinical teams across Northern Ireland and beyond and increasing use of new medical technologies in diagnostics and telemedicine which have helped support safe and effective practice across the country. However, it has to be recognised that even with such innovations and other initiatives, Northern Ireland is a small country with a small population and it simply won't be possible to sustain the current pattern safely for much longer.

For more specialist services, the need for access to expert teams in centres of excellence is a key quality driver for securing the best outcomes for what are often small numbers of complex patients – even within much larger populations than ours. Strategies need to be developed within Northern Ireland as to how we can best secure equality of access to specialist care, taking into account

that it may well not be possible or desirable to try to provide all of this care locally. Different models need to be developed involving formal clinical networks and other innovative relationships with UK services and within the Republic of Ireland.

Some of these changes in how we are commissioning hospital care have already happened. Over the last 10 years Northern Ireland has streamlined its care for cancer patients by consolidating services into the major acute hospitals with streamlined access to the regional cancer centre as needed and we are seeing better outcomes for patients as a result. Progress with the 2002 DHSSPS Strategy 'Developing Better Services' has also resulted in changes to acute hospital care in Downpatrick, Lisburn, Enniskillen and Omagh.

Around 80% of hospital care is made up of diagnostics, outpatients, day care and ambulatory services. Therefore it becomes clear that irrespective of some of the changes what will have to happen in inpatient care, there remains a very important and key role for smaller local hospitals where much of this activity takes place. We want to maintain, where it is safe, sustainable and appropriate to do so, as much local access for local people as possible. The local hospital has a key role in refining the diagnosis for patients and referring them through the system as appropriate. We want Local Commissioning Groups to work closely with local hospitals to shape the service care pathways responsively to local need and to seamlessly connect this to the rest of the hospital network.

The next steps in terms of a detailed programme will follow but we want to signal in this Commissioning Plan specifically what the changes are likely to involve:

- Optimise the role and function of the local hospital network in providing access to diagnostics, outpatients, day and ambulatory care and establishing care pathways through the rest of the hospital system;

- Supporting the changes which have occurred in 2010/11 in Magherafelt and at Whiteabbey by developing their outpatient, diagnostics, rehabilitation and minor injuries capacity and putting in place new services such as bowel screening;

- The concentration of acute inpatient services on fewer sites with the necessary clinical infrastructure to provide safe high quality services with improved patient outcome;

- Changes to the current provision of 24/7 Accident and Emergency Services will improve performance and deliver consistency of care across the region;

- Changes to the current profile of inpatient emergency surgical services to provide for sub-specialisation and appropriate staffing and expertise;

- Avoiding inappropriate duplication of inpatient specialities in each of the Trust sites;

- Changes to the current profile of paediatric inpatient services to provide for appropriate staffing and expertise in line with best clinical practice;

- Changes to maternity services to provide for appropriate staffing and expertise in line with best clinical practice;

- 'Right Sizing' the number of acute medical inpatient beds for our population in line with national standards to release resources for reinvestment in front line services;

- More rigorous adherence to the effective use of resources (demand management);

- Specifying and addressing the impact these changes will have on emergency transport services;

- Taking account of the impact of developments in new technologies and therapies will have on both our capital and staffing infrastructures needs and planning flexible options to accommodate these;

- We also have a substantial agenda in progressing service developments which commenced in 2009/10 but have yet to be consolidated fully.

Making these changes won't be easy. It will require dialogue with the population and involve fundamental strategic shifts in the current pattern of care but we need to do this to secure good outcomes and to provide safe services. We need to be innovative in how we establish networks of different elements of care and how we connect them to populations and each other to ensure continuity.

6.2.2(v) Personal and Public Involvement

Personal and Public Involvement is about people and communities influencing the planning, commissioning and delivery of health and social care services. It means actively engaging with those who use our services and the public to discuss; their ideas, our plans; their experiences, our experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services.

Whilst the concept of Personal and Public Involvement is not new, we have made considerable efforts in 2009/10 to further embed Personal and Public Involvement in our everyday work and a draft Consulting Schemes document has been submitted to the DHSSPS. The Health and Social Care Board and Public Health Agency are committed to working in partnership with the Patient and Client Council, other Health and Social Care Organisations and
statutory bodies such as Local Councils, to promote Personal and Public Involvement and identify joint Public Involvement opportunities and reduce duplication.

6.2.3 PFA Targets

PFA Target: Specialist Drug Therapies for Arthritis

From April 2010, the HSC Board and Trusts should ensure no patient waits longer than nine months to commence specialist drug therapies for the treatment of severe arthritis.

It is anticipated that around 290 additional patients will need to be commenced on treatment during 2010/11. Funding up to a level of £3.150m will be made available to Trusts to support the drug and infrastructure costs to allow these additional patients to commence treatment and maintain the maximum waiting time at nine months. During 2009/10, the number of patients on treatment increased by approximately 500 which was in excess of the estimated growth. Should the recurrent annual costs of this patient group exceed the monies available from 2009/10, it may not be possible to commit the totality of the new monies for additional patients. If this transpires it may not be possible to meet the target.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The service profile will need to support opportunities for patients to be treated locally and funds allocated to Trusts will reflect the usage patterns from each of the Local Commissioning Group areas.

The Regional Medical Services Group has concerns with regard to a differential uptake in usage of these drugs both across Local Commissioning Group areas and in comparison with national peers. During 2010/11 work will be undertaken to confirm this position and the rationale, if any, for same.

PFA Target: Elective Care (Consultant-led)

By March 2011, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks for a first outpatient appointment and 9 weeks for a diagnostic test, the majority of inpatients and daycases treated within 13 weeks and no patient waits longer than 36 weeks for treatment. During 2010/11, Trusts should take steps to ensure review patients

are seen in a more timely fashion; from March 2010, all reviews should be completed within the clinically indicated time.

PFA Target: Diagnostic Reporting

From April 2010, the HSC Board and Trusts should ensure all urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.

It is expected that full implementation of the Northern Ireland Picture Archive and Communication System across all Trusts during 2010/11 will contribute to improved performance in this area and the Health and Social Care Board's Performance Management and Service Improvement Directorate will continue to support Trusts to identify and implement the necessary service reforms.

PFA Target: Elective Care (AHP)

From April 2010, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks from referral to commencement of AHP treatment.

The DHSSPS has identified a total of £40m (£25m recurrent; £15m non recurrent) in funding to assist in the delivery of these targets. It is anticipated that this, allied to £25m in elective investment already allocated to Trusts in 2009/10, should be sufficient to allow these targets to be substantially met, although resource constraints will still present real obstacles to delivery. It is proposed that:

- The levels of demand experienced in 2009/10 will be used as an indicator of where resources should be allocated;
- Providers will be encouraged to implement approved service developments as quickly as possible;
- Short term funding will be prioritised for those providers able to deliver additional assessment and treatment capacity within Health and Social Care;
- Trusts will only be allowed to use the Independent Sector in exceptional circumstances;

- Greater emphasis will be placed on Effective Use of Resources policies to ensure that resources are targeted to service areas with the greatest clinical need.

PFA Target: Fractures

From April 2010, the HSC Board and Trusts should ensure 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.

The ability to achieve this standard is impacted upon by the flows and fluctuations in the number of patients presenting at the fracture units across Northern Ireland on a daily and weekly basis. This has resulted in all Trusts experiencing difficulties in meeting the standard on an ongoing basis. The Health and Social Care Board is working with Trusts to ensure that during periods of pressure arrangements are in place to ensure that the maximum number of patients are treated within 48 hours with priority given to procedures with evidenced based outcomes and a focus on ensuring that no patient waits longer than 7 days.

PFA Target: Cancer

From April 2010, the HSC Board and Trusts should ensure all urgent breast cancer referrals are seen within 14 days, 98% of cancer patients commence treatment within 31 days of the decision to treat, and 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

This target requires additional capacity in oncology and radiotherapy services. Investments already agreed in 2009/10 are expected to be implemented during 2010. These will include an increase in the number of consultant oncologists.

Where investment in cancer drugs is made this will include the appropriate level of infrastructure to provide timely treatment.

Investment in Elective Access Standards will also contribute to the achievement of this target. Investments agreed in 2009/10 include additional radiography and medical physics staff to provide an increase in radiotherapy in BCH Cancer Centre. Every effort will

be made during 2010/11 to optimise the capacity by using extended operating days on the current equipment.

PFA Target: A & E

From April 2010, HSC Board and Trusts should ensure 95% of patients attending any A & E DHSSPS are either treated and discharged home, or admitted within four hours of their arrival in the DHSSPS. No patient should wait longer than 12 hours.

Trusts have indicated difficulties in achieving and maintaining the required level of performance across the current configuration of A&E Departments. This has been reflected in the commissioning statements earlier in this document which recognises the need to review A&E provision across the region. The Health and Social Care Board will continue to engage with Trusts to ensure that the best possible standard of performance is delivered through the implementation of agreed good practice.

PFA Target: Stroke Services

By March 2011, the HSC Board and Trusts should ensure 24/7 access to thrombolysis and that high risk transient ischaemic attacks are assessed and treated within 24 hours. Trusts should also work towards a door to needle time of 60 minutes for thrombolysis by March 2011.

The Health and Social Care Board and the Public Health Agency will work closely with the Trusts to develop these services during 2010/11. Allocations made in 2009/10 will also be consolidated or reprofiled as appropriate to support the service further.

The additional funding of £1.75m will be used to achieve the PFA targets for 24/7 thrombolysis and assessment within 24 hours of high risk TIA's. In view of the reduced funding available in 2010/11, the number of thrombolysis sites in Belfast will be reviewed to take account of this.

PFA Target: Renal Services

From April 2010, the HSC Board and Trusts should ensure all patients should continue to have timely access to dialysis services. From April 2010, at least 60% of patients should receive dialysis via a fistula. By March 2011 the Belfast HSC Trust should deliver a minimum of 50 live donor transplants.

The number of patients needing treatment for end – stage kidney disease grows each year by about 40 cases. These patients are largely treated by hospital haemodialysis (HD), with some patients undertaking home peritoneal dialysis (PD) or home haemodialysis (HHD) and some receiving kidney transplants.

Transplantation is the best treatment in terms of offering increased survival and improved quality of life. It is also cost effective, particularly after the first year.

During 2009 the process to assess patients and their relatives for live kidney donation was strengthened and streamlined. This has resulted in a significant number of potential pairs coming forward as suitable for transplantation. This is very positive for both the individuals and the service. The increased activity will be challenging due to both operational and resource issues.

In order to address the need generated by this approach an increased number of cases will need to be delivered over the next 12-18 months through a specific, time limited arrangement.

By March 2011, it is expected that the PFA Target of 50 live donor transplants could be met by using a combination of enhanced local provision, a level of inreach to the Belfast Trust from a UK NHS Trust and a smaller number of patients being offered transplantation in an NHS Trust in England. Every effort will be made to deliver this target but it presents a significant financial challenge. Early discussions and agreements will need to take place at Commissioner, Trust and Departmental level on the resource issue if we are to achieve the target within the necessary timescale.

All available recurrent and non-recurrent resources for this programme in 2010/11 will be targeted at increasing the transplantation numbers.

It is expected that approximately 35 live donor kidney transplants would be needed each year thereafter in Northern Ireland to meet demand. This would almost balance out the need for growth in hospital haemodialysis places, offer substantially better outcomes for patients and has the potential to reduce future costs in the longer term.

There is already sufficient funded hospital haemodialysis capacity in Northern Ireland to meet the 2010/11 growth in this demand. However the pattern of capacity may not always be in the unit closest to the patient's home. Trusts will be expected to take measures to minimise the need for patient travel in such cases by making available other dialysis treatments such as supported peritoneal dialysis or home haemodialysis as alternative options where clinically suitable, which will be cost neutral.
The demand on haemodialysis capacity will be monitored throughout the year. Where there is opportunity to release substantial goods and services resource these will be re-directed to support the in-year costs of additional live donor transplant programme.

The provision of dialysis via fistula will continue to be developed and opportunities to support the achievement of this target via vascular as well as transplant surgical skills will be pursued and developed in a managed way.

PFA Target: Ambulance Services

From April 2010, the HSC Board and Northern Ireland Ambulance Service (NIAS) should ensure an average of 72.5% of Category A (life-threatening) calls are responded to within eight minutes, increasing to an average of 75% by March 2011 (and not less than 67.5% in any LCG area).

Every effort will be made to ensure that this target continues to be delivered.

PFA Target: Healthcare Associated Infections

In the year to March 2011, the Public Health Agency and Trusts should secure a further reduction of 20% in MRSA and C. difficile infections compared to the position in 2009/10.

The target reductions for each Trust in 2010/11 are based on benchmarking against peer organisations in England. The Public Health Agency will work with Trusts to ensure a further reduction in MRSA and C difficile infections compared to the 2009/10 baseline within the context of the funding available.

PFA Target: Hygiene and Cleanliness

From September 2010, each of the five HSC Trusts should put in place arrangements to routinely review compliance with updated and consolidated regional standards of hygiene and cleanliness. Trust review arrangements should include consideration at Trust Board.

This target will be addressed by Trusts.

PFA Target: Mortality

From September 2010, each of the 5 HSC Trusts should put in place arrangements to routinely review the Trust's standardisation mortality rates, both over time and against comparator organisations in NI and GB. Trust review arrangements should include consideration at Trust Board.

This target will be addressed by Trusts.

PFA Target: Trust Quality Initiatives

From April 2010, the Public Health Public Health Agency and Trusts should continue to ensure satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust – specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash call rate, the prevention of venous thromboembolism and mental health inpatient care. By July 2010, Trusts should submit to the Public Health Agency, for approval and monitoring, quality improvement plans to implement WHO Surgical Checklists in 80% of cases by March 2011, and in collaboration with the HSC Safety Forum promote initiatives aimed at reducing the incidence of falls and medication errors.

The Public Health Agency and the Trusts will work towards full implementation of approved quality improvement plans and achievement of targets as specified.

PFA Target: Patient Experience

Following the adoption of the Patient and Client Experience standards in 2009, Trusts should extend the clinical care areas monitored and increase the range of monitoring tools and ensure appropriate reporting and follow – up, consistent with direction from the Public Health Agency.

This target needs to be addressed by Trusts consistent with the direction of the Public Health Agency.

PFA Target: Patient Involvement

By March 2011, the Public Health Agency in partnership with the HSC Board should: establish a regional Health and Social Care forum, with appropriate Patient Client Council and Public representation, to drive the PPI agenda; develop and implement a regional Health and Social Care Action Plan for PPI including arrangements to promote and evidence active PPI; arrange for the publication of an annual summary of PPI activity across Health and Social Care Organisations.

The Public Health Agency, in partnership with the Health and Social Care Board, will take forward this target as outlined by March 2011.

PFA Target: Service Frameworks

By March 2011, Commissioners and Trusts should have action plans in place to ensure the implementation of agreed standards from the Cancer Framework in accordance with guidance to be issued by the DHSSPS in October 2010.

The Health and Social Care Board and Public Health Agency will seek to have an action plan in place by March 2011.

6.2.4 Summary of Commissioning Proposals in 2010/2011

6.2.4(i) Specialist Drugs (£13.85m)

A total of £13.85m has been allocated regionally in 2010/11 to support the continued introduction of specialist drugs.

Allocation by Local Commissioning Group (LCG) for specialist drugs (FYE)

Belfast	Northern	South Eastern	Southern	Western
£2.943m	£3.363m	£2.492m	£2.681m	£2.371m

The Health and Social Care Board proposes the following use of the funds available. Local Commissioning Groups will be expected to commit their share of resources based on the pattern of usage by their populations by Trust.

6.2.4(ii) High Cost Drugs Inflationary Uplift (£3m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.638m	£0.728m	£0.540m	£0.580m	£0.514m

A total of £3m is required across the region to meet the baseline price uplift associated with the current usage of high cost drugs. Funding will need to be provided to Trusts in a pattern reflective of the Local Commissioning Group service usage.

6.2.4(iii) Treatment of Severe Rheumatoid Arthritis (£3.150m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.669m	£0.765m	£0.567m	£0.610m	£0.539m

PFA Target – By March 2011, the HSC Board and Trusts should ensure no patient waits longer than nine months to commence specialist drug therapies for the treatment of severe arthritis.

It is anticipated that around 290 additional patients will need to start treatment during 2010/11. Funding up to a level of £3.150m will be made available to Trusts to support the drug and infrastructure costs to allow these additional patients to commence treatment and maintain the maximum waiting time at nine months. During 2009/10, the number of patients on treatment increased by approximately 500 which was in excess of the estimated growth. Should the recurrent annual costs of this patient group exceed the monies available from 2009/10, it may not be possible to commit all of the new monies for additional patients. If this transpires it may not be possible to meet the target.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The service profile will need to support opportunities for patients to be treated locally and funds allocated to Trusts will reflect the usage patterns from each of the Local Commissioning Group areas.

The Regional Medical Services Group has concerns with regard to a differential uptake in usage of these drugs both across Local Commissioning Group areas and in comparison with national peers. During 2010/11 work will be undertaken to confirm this position and the rationale, if any, for differences.

6.2.4(iv) Age Related Macular Degeneration (£2.200m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.467m	£0.534m	£0.396m	£0.426m	£0.377m

Services have been established in both the Western and Belfast Trusts to provide treatment for age related macular degeneration for the population of Northern Ireland. Resources have been made available to both Trusts to ensure that timely treatment is provided to preserve the sight of people affected by this condition, in accordance with therapies and regimes approved by the National Institute for Clinical Excellence. The additional funding being made available in 2010/11 will ensure that new patients continue to access this treatment.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The funds allocated to the Western and Belfast Trusts will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(v) Immunoglobulins and Haemophilia Blood Products (£1m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.213m	£0.242m	£0.180m	£0.194m	£0.171m

The Regional Medical Services Group will continue to work with Trusts in order to profile the increased usage of these products by Trust and speciality.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The funds allocated will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(vi) Disease Modifying Therapies for Multiple Sclerosis (£0.100m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.022m	£0.024m	£0.018m	£0.019m	£0.017m

This treatment is provided by the Belfast and Western Trusts for the population of Northern Ireland. The amounts above are required to support the continued maintenance of the 13 week maximum waiting time for these specialist drugs.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The funds allocated to the Belfast and Western Trusts will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(vii) Tobramycin for Cystic Fibrosis (£0.088m)

Allocation by LCG (FYE)

Belfast	Northern	South	Southern	Western

		Eastern		
£0.019m	£0.021m	£0.016m	£0.017m	£0.015m

Northern Ireland has significantly higher survival rates for patients with cystic fibrosis. This service is provided from the Belfast Trust and the funding earmarked for 2010/11 will support the increasing number of patients receiving this drug.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with the Belfast Trust to agree a business case for development of this service. The funds allocated to the Belfast Trust will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(viii) HIV and GUM Drugs (£1.500m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.319m	£0.364m	£0.270m	£0.290m	£0.257m

Over the past two to three years there has been a significant increase in the notifications of patients with HIV in Northern Ireland. Around two thirds of these patients have required the introduction of early treatment for their condition.

The funding earmarked for 2010/11 will fund the full year effect of patients commenced on treatment during 2009/10 and the projected increase in patient numbers during 2010/11.

The Health and Social Care Board and Public Health Agency will seek to direct some of the total funding available to early detection and preventative programmes given the very significant potential health gain that can be achieved.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process to agree business cases for development of this service. The service profile will need to support opportunities for patients to be treated locally. The funds allocated will need to

reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(ix) Orphan Enzyme Therapies (£0.650m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.138m	£0.158m	£0.117m	£0.126m	£0.111m

These funds are to support patients with enzyme deficiencies – estimated at 2 to 3 additional patients per year.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process to agree the patient profile for these resources. Funding to support this will be provided on a capitation basis from each of the Local Commissioning Group areas on a risk sharing basis, irrespective of the area of residence of the patient.

6.2.4(x) Cancer Drugs and Infrastructure (£1m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.212m	£0.243m	£0.180m	£0.194m	£0.171m

A process is in place between the Regional Medical Services Group and the Northern Ireland Cancer Network Haematology and Oncology Drug and Therapeutics Committee to guide the introduction of new cancer drugs.

The Northern Ireland Cancer Network Haematology and Oncology Drug and Therapeutics Committee assesses formal business cases and cross references against the National Institute for Clinical Excellence and Scottish Medicines Consortium guidance before providing a prioritised shortlist of potential drugs for introduction. The current list being reviewed includes a number of drugs which were identified by the Committee in previous years but have not yet been funded recurrently and drugs which have been approved by the National Institute for Clinical Excellence but

for which the Committee has not yet had the opportunity to consider business cases.

In 2010/11 there is £1m available regionally for new cancer drugs. The introduction of new drugs will need to be prioritised within this funding.

The Northern Ireland Cancer Network Haematology and Oncology Drugs and Therapeutics Committee has recently submitted a number of potential proposals for new developments in 2010/11, which are under consideration by the Regional Medical Services Group. The majority have already been approved by the National Institute for Clinical Excellence while a number of the remainder are expected to be approved during 2010. Previously, the Regional Medical Services Group has committed funding to introduce new drug regimes pending an indication that the National Institute for Clinical Excellence approval was expected shortly, only for this approval to be delayed or, on occasion, rescinded. This has meant that these ring fenced resources have not been fully utilised as planned whilst at the same time, other drug pressures have not been supported.

There is balance to be struck between ensuring there is sufficient funding to introduce new drug therapies in accordance with the National Institute for Clinical Excellence whilst trying to ensure a degree of flexibility to allow funding to be reprofiled if a significant delay in approval occurs.

Final decisions have yet to be made on the distribution of funding for cancer drugs and infrastructure in 2010/11.

Over the coming months the Health and Social Care Board and Public Health Agency, via the Regional Medical Services Group, will engage in a process with each of the Trusts to agree business cases for the introduction of the cancer drugs which will be supported in 2010/11 in the cancer centre and the cancer units. The service profile will need to support opportunities for patients to be treated locally where clinically appropriate. The funds allocated will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(xi) Other uses of Anti TNF Drugs (£0.500m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.106m	£0.121m	£0.090m	£0.097m	£0.086m

The use of Anti-TNF therapies has been approved by the National Institute for Clinical Excellence for the treatment of Psoriasis. These therapies have also been approved as short term induction regimes for the treatment of Crohn's disease and for acute exacerbations of ulcerative colitis. A National Institute for Clinical Excellence Multiple Technology Appraisal for infliximab and adalimumab in Crohn's disease was expected to be published in May 2010. This is expected to give approval for maintenance use. The funding earmarked for 2010/11 will allow an increased number of patients to have timely access to these drugs.

Over the coming months the Health and Social Care Board and Public Health Agency, via the Regional Medical Services Group, will engage in a process with each of the Trusts to agree business cases for development of this service. The service profile will need to support opportunities for patients to be treated locally. The funds allocated will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(xii) Introduction of other National Institute for Clinical Excellence approved therapies (£0.663m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.142m	£0.161m	£0.119m	£0.128m	£0.113m

This funding has been earmarked to fund drug regimes likely to be approved by the National Institute for Clinical Excellence during 2010/11. However, due to the pressures to fund cancer treatments that have already been approved by the National Institute for Clinical Excellence, this resource may instead have to be reprofiled to support the latter. This may delay the implementation of future National Institute for Clinical Excellence recommendations/Technical Appraisals in 2010/11.

Over the coming months the Health and Social Care Board and Public Health Agency, via the Regional Medical Services Group will engage in a process to agree the profile of new drugs to be introduced and business cases to support these. The service profile will need to support opportunities for patients to be treated locally. The funds allocated will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(xiii) Renal Services (£0.130m)

Discussions will take place with renal services providers in respect of these funds in the context of reduced demand for dialysis.

6.2.4(xiv) Stroke Services (£1.7m)

Discussions will take place with providers in respect of how services will be developed in line with objectives set out in the Priorities for Action Target.

6.2.4(xv) Support for Ward Sisters/Charge Nurses

The sum of £1.2m will be invested across the five Trusts to allow ward sisters/charge nurses to spend an additional 20% of their time on improving safety, quality and the patient experience.

Priority Area 3:

Integrating Primary, Community and Secondary Care Services

6.3.1 Strategic Context

6.3.1(i) Integrating care services involves removing organisational and professional boundaries, promoting coordination and cooperation, in order to provide 'person-centred' health and social care. The right care, by the right person, in the right place, at the right time: evidence-based care, which is timely and cost-effective.

6.3.1(ii) The Health and Social Care Board and Public Health Agency will continue to develop and support initiatives to build a continuum of responsive, integrated health and social care; balancing health promotion and illness prevention with effective interventions to diagnose and treat illness in the most appropriate setting. Providers will be encouraged to continue to focus on supporting individuals to live independent lives and reduce unnecessary and inappropriate reliance on hospitals or other institutional care. Local Commissioning Groups will play a vital role in consultation with Councils, Trusts, Local Area Partnerships and Voluntary Organisations, to review health and wellbeing needs across their respective localities, working with local communities to seek ways of looking beyond the traditional organisational construct for the delivery of local care.

6.3.1(iii) Commissioners will seek to ensure continued progress in aligning investment with need. The aim of increasing the proportion of care delivered in a community setting will necessitate some redistribution of funding, investment being closely aligned with demand and provision, at the most appropriate point of delivery. Investment in new services will also be linked to rigorous evaluation of delivery and outcomes. In the context of a difficult economic environment, it will be essential to focus on efficiency, value for money and outcome measurement, in order to maximise the benefits for all.

6.3.1(iv) For effective commissioning it is essential that reliable information is available upon which to base commissioning decisions. Integration of care will place an increasing onus upon providers to cooperate in the

collation of reliable information, measuring activity and outcomes, to support the delivery of effective quality care.

6.3.2 Commissioning Themes

Through the vertical integration of Health and Social Care services, Commissioners will seek to enable the removal of traditional primary / secondary care boundaries. The aim is to assist a shift in emphasis through the enhanced local provision of services within the primary care setting, while supporting secondary care providers to focus on specialist secondary care interventions. Supporting the diagnosis, treatment and holistic care of the majority within a local setting ensures that only those who genuinely require secondary care intervention are managed within that domain: improving access and decreasing the unsustainable growth in demand. This will deliver an improvement in the quality of the patient experience, while driving greater overall efficiency in health and social care provision. The Health and Social Care Board and Public Health Agency will require enhanced access to diagnostic services in primary care, supported by clinical decision support tools, so that General Practitioners can efficiently and effectively diagnose more complex conditions, offering a greater range of services to manage increased case complexity, and improving the quality of referrals, with a higher proportion being referred appropriately (requiring intervention that is only available in secondary care).

A significant proportion of secondary care outpatient activity (up to 70%) involves reviewing patients who have already been treated in secondary care. There is evidence that a substantial proportion of these patients could be reviewed and managed in primary care; increasing efficiency and convenience for patients. New models of review are required, to ensure that patients are not required to attend secondary care providers needlessly. Trusts will be encouraged to engage in the development of a new approach to reviewing patients in partnership with primary care.

Delayed discharge of individuals requiring complex support in the community setting causes significant inefficiency. The Health and Social Care Board will seek to engage in partnership, with the Local Commissioning Groups and Trusts, to improve the efficiency of discharge planning. There will also be a requirement for Trusts to improve communication of information into primary and

community care, to accompany patients, ensuring the safe transfer of responsibility of care. This will build upon work undertaken by the Registration and Quality Improvement Authority in this area.

General Practitioners and primary care teams, acting as gatekeepers to health and social care services, are a major determinant of health care utilisation in terms of the care that a patient/client receives and how patient choice is exercised. Linking gatekeeper clinical and financial responsibility has the potential to reconfigure commissioner investment in a way which develops more integrated care whilst raising the standard of care, improving provider efficiency and making services more responsive to patients and clients. The Health and Social Care Board will work with Local Commissioning Groups and healthcare professionals to develop a supportive structure to promote the federation of GP practices to deliver this aim.

Local Commissioning Groups are exploring new and innovative approaches to integrating healthcare and will deliver this on the ground through local partnerships. 'Primary Care Partnerships' will be built around local communities of circa 100k population and will include GP practices, pharmacists and other providers of health and social care based in their area. Through assigning indicative budgets covering areas such as prescribing, outpatient care, diagnostics and community services, partnerships will be afforded the opportunity to reinvest a proportion of savings in local services. They will be clinically led to ensure strong clinical governance and decision-making.

Through Regional Clinical Networks we have seen significant engagement between the range of health care professionals, and organisations, across health and social care, for the benefit of patients. Such cooperation is essential, and should be routine professional activity, across the spectrum of health and social care. Key to improving the quality of care is the agreement of clinical pathways and implementation of agreed standards. Trusts will be encouraged to build on the achievements to date, with increased support to clinicians and practitioners to engage across interfaces, delivering continuing improvement. By encouraging healthy lifestyle choices, health improvement can contribute to reducing demands on primary and community services. With demographic changes and increased life expectancy, the Public Health Agency is keen to ensure that people living longer enjoy

healthier and happier lives. Through targeted health improvement measures, partnership with Local Commissioning Groups and community support, the Public Health Agency will ensure that older people will remain active longer and have less requirements for health and social care interventions; promoting increased independence and improved self management of long-term conditions through healthier choices.

Support will be given in private care settings, such as residential and nursing homes, to ensure the development of a health promotion ethos. Carers providing support to individuals in their own homes will not be overlooked, being considered as a thematic community, prioritised for targeted intervention.

Horizontal integration of health and social care services will be an important development, redefining professional responsibilities, and improving the utilization of all health and social care professionals within the primary care setting. Commissioners envisage a redistribution of the responsibility of elements of care provision, with improved communication and coordination of care. The aim is to provide a genuinely multidisciplinary team approach, with 'person-centred' care, and not care which is organisationally or professionally focused.

6.3.2(i) Demand for services

Trusts have experienced continuing pressure to respond to an ever increasing demand for services. Whilst in the context of delivering significantly improved access to secondary care services, the average growth in demand is estimated at 10% to 12%. This level of growth in demand would be unsustainable in the longer term. To maintain the quality of care, and further improve access to services, it is envisaged that a significant proportion of services will be delivered more appropriately, in primary care and community settings.

6.3.2(ii) General Medical (GP) Services

General Medical Services are a key location to target health improvement initiatives from promotion of immunisation initiatives, targeting emotional wellbeing through to more general health and wellbeing initiatives on diet, exercise, alcohol and smoking. In 2009/10 £43.9m was invested by the Health and Social Care

Board in the General Medical Services Quality and Outcomes Framework (QOF), supporting professionals in General Practice to deliver a range of health promotion and disease prevention activity. £27.3m was invested in Enhanced Services*. The total investment in General Medical Services, for the region in 2009/10 was £236.1m.

**** Services for patients, delivered to a higher specified standard than, and not routinely delivered though the essential/core contract for General Medical Services (GP Services).***

General Medical Services Expenditure 2009/10 (Draft)	
Global Sum/MPIG	£116.1m
Health and Social Care Board Admin	£9.4m
QOF	£43.9m
OOH	£21.7m
Enhanced Services	£27.3m
IT Revenue	£3.2m
Premises	£14.5m
Total General Medical Services	**£236.1m**

Projected General Medical Services Expenditure 2010/11	
Global Sum/MPIG	£114.6m
Health and Social Care Board Admin	£9.4m
QOF	£43.8m
OOH	£21.0m
Enhanced Services	£25.2m
IT Revenue	£4.5m
Premises	£15.7m
Total General Medical Services	**£234.0m**

N.B.: General Medical Services Allocations for 2010/11 not yet finalised

The Health and Social Care Board is committed to working with the Public Health Agency and Local Commissioning Groups to improve existing services and develop new Enhanced Services promoting long-term health improvement and addressing inequalities. The Health and Social Care Board is currently engaged in a review, and regional harmonisation, of Enhanced Services to ensure effectiveness, equality of access, and value for

money. Engagement with professionals, across health and social care is ongoing, to deliver the aims of the Service Frameworks. Integrated primary, community and secondary care services, and the provision of effective Enhanced Services, will be essential for delivery.

A re-focus of existing investment and bids for additional funding are being considered by the Health and Social Care Board, to complement the work undertaken in General Practice in managing chronic illness, through improved integration of care in the delivery of Service Frameworks. For example, in implementation of the Respiratory Framework, the intention is to implement a chronic disease management model, using a self-management approach, and basing services within primary care supported by specialist community input. The focus will be on the avoidance of unnecessary admissions and facilitation of early discharge; with services operating across acute and community interface, to increase effectiveness and efficiency.

The implementation plan has identified investment priorities for Trusts, to establish community multi-disciplinary teams, with a range of professionals such as Nurse Specialists, Physiotherapists and Clinical Psychologists; supported by General Practitioners. Such teams will facilitate a range of activities, including early supported discharge, admissions avoidance, support and training to GP practices, nebuliser and long term oxygen therapy assessments, case management of moderate to severe cases, pulmonary rehabilitation and palliative care. These developments are aimed at an improvement in the quality of life of patients and a reduction in mortality, in an evidence-based and cost effective re-organisation of the delivery of care. “The right care, by the right person, in the right place, at the right time: evidence-based care, which is timely and cost-effective”.

6.3.2(iii) Dental Services

The Health and Social Care Board will continue to work with both independent contractors and Trusts to prevent dental disease. The Health and Social Care Board has a central coordinating role in the Northern Ireland Caries Prevention in Practice trial, the largest primary care based research study into the prevention of tooth decay ever undertaken in the UK. The trial began in November 2009 and recruitment of practices commenced in May

2010. The Health and Social Care Board will also continue to work collaboratively with the Public Health Agency and the Trusts to reduce oral health inequalities through the five Investing for Health funded toothpaste schemes. An evaluation of the schemes undertaken by the Health and Social Care Board in May 2009 found them to be effective and recurrent funding has now been secured.

Registrations with Dental Services for children under-5 are a key indicator for health inequalities and the Public Health Agency will work with communities to encourage more parents to be aware of their own and their children's dental hygiene. The Health and Social Care Board is keen to improve access to dental services across the region, and improve the quality of care provided. The Health and Social Care Board will seek to improve access by new approaches to contracting services, where traditional models of provision have not delivered. To that end, the Health and Social Care Board has invested £17.1m in enhancing access through partnership with the private sector. The Health and Social Care Board entered into a contract with Oasis Dental Care Limited in September 2009 to provide dental services in the areas of Northern Ireland where access was considered problematic. The contract requires that by September 2010, Oasis will have 38 new dentists, working out of 15 practices, in the areas perceived to have the greatest requirement for improved access. To date, two practices have opened in the Western area, and plans remain on the schedule for the remaining 13 practices. To ensure appropriate levels of dental access in the long term, the Health and Social Care Board is working collaboratively with DHSSPS and the British Dental Association on the piloting arrangements for three new dental contracts: one for General Dental Services, one for Orthodontic Services and one for Oral Surgery. In contracting for General Dental Services, there is an aim to shift the emphasis to holistic quality of care, rather than the traditional model, based on 'item of service' payments.

The Health and Social Care Board is committed to improving outcomes and securing best value from the services it commissions. There are currently three centralised out-of-hours dental services in Northern Ireland Health and Social Care, each of which operate in different ways. In 2010-2011 the Health and Social Care Board plans to review these services to ensure that across Northern Ireland out-of-hours dental care is provided in the

most equitable, effective and efficient manner. Specialist Oral Surgery services in Northern Ireland are provided in both the primary and secondary care setting. To maximise efficiency and access to care, it is important that the most complex cases are seen in the most specialised centres and, where possible, that less complicated conditions are treated locally. The Health and Social Care Board will review the provision of Oral Surgery and Maxillofacial Surgery to ensure that the twin goals of efficiency and access are met.

6.3.2(iv) Pharmacy and Medicines Management

There are unique opportunities to develop further partnerships with Community Pharmacies to promote health improvement messages and campaigns. The Building Community Pharmacy Partnership initiative provides one opportunity but other approaches include tackling sexual health, obesity prevention and oral health. Medicines are an important intervention in healthcare. With over 30 million prescription items being dispensed annually costing over £400m, it is important that we optimise the use of medicines to ensure maximum benefits to patients.

The use of medicines can inadvertently lead to adverse incidents with between 5% and 10% of acute admissions to hospitals linked to the use of a medicine. It is important that there are good processes in place to monitor and review medicines and provide support to patients so that their safety is assured.

The cost of medicines used is an important factor to consider. In Northern Ireland we spend £224 per head of population, the next highest administration being Wales at £194 per head of population. The Regional Twenty Year Strategy for Health and Wellbeing “A Healthier Future” recognised that medicines matter and identified the need to “… embrace appropriate Medicines Management services to improve the way medicines are used both by individual patients and by the Health and Social Care”. Much work has been done by practitioners and by legacy HSS Boards, Trusts and DHSSPS in providing direction and support under a range of initiatives. The Pharmaceutical Clinical Effectiveness Programme, led by DHSSPS, has provided a focus on safety and quality to drive efficiency and effectiveness and in so doing has supported the delivery of higher attainment of generic prescribing and dispensing; the implementation of repeat dispensing; adoption of a

methodology to assist in the appropriate selection of therapeutic choices; and the commissioning of Integrated Medicines Management within Health and Social Care Trusts.

In 2010/11, the Health and Social Care Board will implement a programme of medicines governance in primary care. This will build upon the project carried out in the legacy SHSSB and encourage practitioners to report prescribing, dispensing and administration incidents so that lessons can be learned on how to make the management of medicines safer.

6.3.2(v) GP Out-of-Hours Service

The need for integration of health and social care is not confined to normal working hours. The Health and Social Care Board will focus attention on improved integration of unscheduled care and regionalisation of the GP Out-of-Hours Service. The GP Out-of-Hours Service has provided a quality service to patients since its inception. With increasing demand on services, the ability to continue delivering a quality service, within budget, is limited without reorganisation. Regionalisation of the service will deliver efficiencies in service provision, to sustain the delivery of a quality service, and maintain access. In partnership with Local Commissioning Groups, the Health and Social Care Board will seek to improve integration of the service with other forms of community and unscheduled care, building on progress that has already been made, and ensuring equality of access across the region. This will include access to a range of services, for example nursing, dental, pharmacy, mental health and social care. It will also include voluntary and charitable providers. The key is to ensure that GP Out-of-Hours services and unscheduled care are linked with daytime care with significant benefits for essential service such as palliative and ‘end-of-life’ care.

Underpinning this requirement for greater integration of services, development of new care pathways, integration and extension of professional roles, is the need for professional development. The Health and Social Care Board will, in partnership with educational and training agencies, seek to facilitate professional development to support the changing health and social care environment. It is important to ensure that Appraisal, Governance and developments in service delivery are more robustly linked to educational provision.

6.3.3 PFA Targets

PFA Target: Pathway Management

By March 2011, the Health and Social Care Board should establish pilot programmes to evaluate: (i) models of integrated care in community settings which incorporate integration along clinical care pathways and address the wider determinants of health; and (ii) models of unscheduled care in hospital settings which integrate primary care out-of-hours services with ambulance and A&E services.

The Health and Social Care Board will, through Local Commissioning Groups and the development of 'Primary Care Partnerships', establish pilot programmes to evaluate new models of integrated care in community settings. This will build on existing work in developing clinical care pathways, placing a focus on the patient-centred integration of services. The Health and Social Care Board/Local Commissioning Groups and Public Health Agency will work in partnership to address the wider determinants of health, helping a shift in emphasis to prevention. Trusts will be supported to develop improved models of unscheduled care delivery, integrating primary care Out-of-Hours and community unscheduled care services with A&E services, and acute hospital care provision.

PFA Target: Hospital Discharges

From April 2010, the Health and Social Care Board and Trusts should ensure that 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days. All other patients should be discharged within six hours of being declared medically fit.

Timely discharge promotes better patient outcomes and reduces demand on the acute sector, even when the coordination of care and support services is complex. Moreover, timely discharge is frequently the expressed preference of the patients. It requires a discharge ethos to be well embedded across the community-acute interface, in the use of Estimated Dates of Discharge, proactive discharge planning (including the use of existing discharge coordinators) and the focus of all professionals on rehabilitation potential.

At the point of discharge, there must still be the appropriate use of Enhanced Intermediate Care, with the Care Management of patients taking place outside of the ward setting, enabling all involved to make informed and coordinated post-discharge care decisions, eliminating unnecessary delay. The Health and Social Care Board will continue to promote the development and implementation of discharge protocols which are consistent with timely discharge, while facilitating patient choice and the need for carers to be integral to the discharge planning process.

The majority of the necessary elements cited above are established, or are in development, but this activity in development and implementation will need to be sustained. Complementary to this, will be a drive towards greater integration of statutory, independent and voluntary services in the community; stronger partnership with local government, housing, rural development etc. The Health and Social Care Board, through Local Commissioning Groups, will seek to extend the continuum of support, or care services, in place in the local community, facilitating optimal discharge planning and delivery. Such 'whole-systems' working and continuing improvement is at the heart of integrating care, delivering the best outcomes for individuals, and for Health and Social Care across the region.

It is the aim of the Health and Social Care Board to work with Trusts, in order to ensure that 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days. It is also intended that all other patients will be discharged within six hours of being declared medically fit.

PFA Target: Unplanned admissions

By March 2011, the Health and Social Care Board and Trusts should further develop early intervention approaches to support identified patients with severe chronic diseases (e.g. heart disease and respiratory conditions) so that exacerbations of their disease which would otherwise lead to unplanned hospital admissions are reduced by 50%.

In seeking to reduce exacerbations of chronic disease leading to unplanned admissions the Health and Social Care Board will progress parallel approaches to deliver a holistic solution.

In the first instance the Health and Social Care Board will work with general practitioners, through the General Medical Services Contract, seeking to ensure optimal care of all patients through the Quality and Outcomes Framework and Enhanced Services for the management of chronic disease. The Health and Social Care Board will engage general practitioners to review variation in referral rates and unscheduled admissions, in order to optimise effectiveness in the community – based management of such patients.

To ensure an integrated approach across primary and secondary care, the Health and Social Care Board will continue to progress the implementation of current and future Service Frameworks standards in order to optimise the management of chronic illness within the population. Communication at the Primary/Secondary care interface will be examined to ensure effective and timely communication underpinning referral, outpatient attendance and discharge; with an emphasis on ensuring sufficient information and care planning is provided to support patients in the community, and prevent avoidable readmissions.

In order to ensure that resource is focused to provide maximum benefit, the Health and Social Care Board will support clinicians in primary and secondary care in the identification of those patients most likely to benefit from more intensive care management. Research conducted in Northern Ireland, and in England has shown the potential to identify patients with chronic diseases at risk of hospitalisation, at an early stage. PARR (Patient At Risk of Re Hospitalisation) tools have been developed to model risk, and identify patients for intervention in order to prevent hospitalisation rather than react to it. The Health and Social Care Board is exploring approaches taken elsewhere, including those undertaken by the Nuffield Trust in the development of risk modelling for patients in Northern Ireland.

Once patients at risk have been identified evidence is lacking to determine the most effective form of intervention. The Health and Social Care Board/Public Health Agency will seek to evaluate models of intervention across each Health and Social Care Trust in

order to determine effectiveness. The intention will be to monitor deliver delivery of the PfA Target in relation to predicted risk while measuring the relative effectiveness of interventions, in order to optimise care across the region. Work will be undertaken with Local Commissioning Groups / Primary Care Partnerships to develop integrated and coherent interventions across the Primary/Secondary Care interface. Part of this work will involve focus on improved health promotion and outcome focused management of long term conditions, evaluated through measuring the rate of unscheduled admissions to hospital, in absolute terms and relative to the predicted risk. The Health and Social Care Board will expect to see a downturn in rates as a measure of effective care.

PFA Target: Direct Payments

By March 2011, the Health and Social Care Board and Trusts should increase the number of direct payment cases to 1,750.

Considerable progress has been made by Trusts in response to the target for achieving an additional 1,750 clients on Direct Payments between 2008 and March 2011. Commissioners expect Trusts to continue to promote the take up of Direct Payments across all client groups in 2010/11 as a means of ensuring responsive services and value for money.

Trusts are expected, through their Carer Coordinators, to increase the number of carers' assessments offered and the number of completed carers' assessments recorded. In addition the Health and Social Care Board will work with Trusts and relevant independent sector agencies, to ensure that information for carers is up to date and appropriate. Through General Medical Services Quality and Outcomes Framework investment, General Practitioners are encouraged to identify carers and put in place a mechanism for the referral of carers for social services assessment.

PFA Target: Palliative Care

By March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.

Trusts are tasked to progress the development of palliative care teams to provide support and care to palliative and end-of-life patients in the community on a 24/7 basis, with the aim of decreasing the number of inappropriate admissions to hospital. Trusts have been required to put in place service improvement programmes to support these teams; delivered in the context of the Gold Standards Framework, Care Pathway for the Dying and the best standards of multi-professional education. The Health and Social Care Board will seek to facilitate engagement and integration of these services with Family Practitioner Services, both in-hours and Out-of-Hours.

PFA Target: Primary Care Access

From April 2010, the Health and Social Care Board should ensure 70% of patients receive an appointment within two working days with a GP or appropriate practice based primary care practitioner, increasing to 80% from April 2011.

The Health and Social Care Board is committed to ensuring good access to General Practitioner services. The Health and Social Care Board will continue to promote this through implementation of nationally agreed Quality and Outcomes Framework measures of the 'Patient experience of access', and the current Regional Directed Enhanced Service for access.

PFA Target: Medicines Management

By March 2011, the Health and Social Care Board should introduce a Northern Ireland Medicines Formulary.

The Health and Social Care Board will give due consideration to the capacity to achieve this target and in particular build on the excellent work that has been led by the DHSSPS through the pharmaceutical clinical effectiveness programme. In support of this target the Health and Social Care Board will convene a Medicines Management Forum to advise on the safe, effective and efficient use of medicines within Health and Social Care. A key output of this group will be to advise on the development and application of a formulary for Northern Ireland by March 2011

Supplementary Information on PfA Medicines Management Target

A number of products have been identified to develop a formulary in 2010/11:

1/ The Medicines Management Forum will support the corporate governance controls in respect of development and implementation of a formulary. Therefore the establishment of the MMF will be a key output.

2/ A process for developing, reviewing and authorising the content of the formulary. This includes linkage into secondary care to ensure consistency of approach.

3/ Formulary sections - the following will be developed and produced by year end: Gastro-intestinal; Cardiovascular; Central Nervous System; Antimicrobials; Wound Dressings. The delivery of these sections constitutes 60% of products in primary care

4/ Preparatory work to establish the remaining elements of the formulary (respiratory (which will link to the Respiratory Services Framework); endocrine; NSAIDs; dermatology; nutrition).

5/ Implementation plan to include the development of IT infrastructure to support the use of the formulary; and the process for update, review and control of entry onto the formulary.

PFA Target: Greater use of generic drugs

The Health and Social Care Board should ensure the level of dispensing of generic drugs increases to at least 64% by March 2011.

On prescribing, in England and Wales there has been a focus on Better Care, Better Value. These indicators are based upon National Institute for Clinical Excellence guidance and are supported by a clear evidence base. Within the context of a Medicines Management Programme, the Health and Social Care Board will pay due regard to the following targets by March 2011:

- Generic dispensing to increase to 64%;
- Repeat dispensing to increase to 5%.

The Health and Social Care Board will also encourage the alignment of prescribing to Better Care, Better Value, for the following indicators, by March 2011:

- Increase low cost lipid lowering therapy to 60% of total;

- Increase low cost proton pump inhibitors to 80% of total;

- Increase the proportion of low cost Angiotensin Converting Enzyme inhibitors, as a percentage of total use of drugs affecting the rennin-angiotensin system, to 72% of total.

Through the application of these initiatives, it is envisaged that the cost of prescribed medicines will be reduced by some £7m.

Priority Area 4:

Helping Older People to Live Independently

6.4.1 Strategic Context

To date Northern Ireland has not had the advantage of a Regional Strategy for Services for Older People, rather each legacy Board developed their own local strategic statements of intent. Priorities for Action has continued to set the direction of travel for the programme of care, towards the building of a continuum of integrated primary and community care services that focus on people at greatest risk, supporting independence and reducing inappropriate reliance on hospitals and other institutional care.
The launch of the plan to develop a Service Framework for Older People's Health and Wellbeing in January 2010 established a regional process to agree evidence based standards, targets and measurable outcomes for the individual's journey from prevention to ongoing support and care, including where necessary, palliative care.
The strategic direction for commissioners in respect of the needs of people with dementia will be set by the forthcoming NI Dementia Strategy which is expected to be published in mid 2010. The Strategy will reflect the recommendations about dementia included in the Bamford Review report with specific reference to the identification, treatment and care of people with dementia and the provision of better support for carers. A key priority will be improvements in integrated working across primary, secondary and community care.
Commissioning must aim to strike the balance between the need to shift resources towards disease prevention, health promotion and active ageing while also ensuring the delivery of a network of care and treatment services for those at the dependent end of the scale.

6.4.2 Commissioning Themes

Section 1.1 of this Commissioning Plan, 'Demographic Changes', has highlighted already the challenges for Health and Social Care arising from an ageing population. However, it is important to acknowledge the fact that increasing numbers of older people are enjoying active and independent lives for longer. Commissioning needs to build on this positive trend by pursuing a healthy ageing agenda through "Investing for Health" partnerships to address key issues such as isolation, abuse, fuel poverty and the need for improved transport services.

6.4.2(i) Demand for services

Population ageing is a key driver for policy. It is well recognised that the conditions that account for most diseases in the UK are primarily related to old age. Older people are proportionately the main users of acute hospitals and community health and social care services. The greatest concentration of health care costs occurs in the last year of a person's life, whatever the age at death. The DHSSPS Capitation Formula Review Group work shows that the cost per person by age group across all programmes of care rises steeply from an average annual cost of £1,800 in the 60-64 age band to over £11,000 in the 85+ band. An increasing pressure for resources is resulting from the growth in the number of people with dementia. The cost is high in terms of both public and private resources. In Northern Ireland 16,000 people are understood to be living with dementia, 400 of these with early onset dementia. The ageing of the population means that by 2017 the figure is likely to rise to over 20,000 people. Research estimates that the annual average cost of care for someone with dementia ranges from £14,540 for a person with mild dementia living in the community, to £28,527 for someone with severe dementia in the community. The average cost for someone in supported accommodation was estimated to be £31,300. This demonstrates both the human and financial challenge to the commissioning system.

6.4.3 Priorities for Action

The specific standards and targets to be achieved in 2010/11 are:

PFA Target: PSA 4.1: Supporting People at home

From April 2010, the Health and Social Care Board and Trusts should ensure at least 45% of people in care management have their assessed care needs met in a domiciliary setting.

PFA Target: Assessment and treatment of older people

From April 2010, the Health and Social Care Boards and Trusts should ensure older people with continuing care needs wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.

PFA Target: Individualised Care Plans

From December 2010, the Health and Social Care Board and Trusts should ensure any patient receiving a new care package at home is provided with a copy of their individual care plan to enable them to understand the level of care to be

provided and who to contact if difficulties arise with care package arrangements.

In respect of the Priorities for Action targets for 2010/11, the Health and Social Care Board will continue to monitor performance specifically in respect of waiting times for assessment/treatment and hospital discharges. Trust performance against the unplanned admissions target for people with severe chronic diseases will continue to be monitored closely.

Work will be undertaken through the development of the Service Framework for Older People's Health and Wellbeing to identify standards which are evidence-based, and to describe the key performance indicators and benchmarks. As with all Service Frameworks, the process of audit and measurement of the standards will be built in from the start. Likewise, the Northern Ireland Dementia Strategy will represent the main future monitoring framework for dementia provision.

6.4.4 Challenges and Constraints

In 2010/11 the priority for the programme of care for older people will be to continue to reform services to achieve an integrated system which responds flexibly to demand and addresses capacity issues more effectively. The current Health and Social Care Board community care demand/capacity work will analyse variations in charging, costs, demand and application of eligibility criteria. The lessons from best practice elsewhere will be considered for application across NI, particularly the Care Services Efficiency Development programme, or reablement initiative, being implemented in GB and piloting in Southern and Northern Trusts. The emphasis on prevention, detection and early intervention will grow and the role of General Medical Services and the independent sector will be at the forefront of the outcome driven modernisation process. New models of care reflecting innovative practice and the active promotion of Direct Payments and personalised budgets will be significant elements of future commissioning for the care and treatment of older people, as will the provision of support for carers, including formal assessment of their needs. The Carer's Support and Needs Assessment component of Northern Ireland Single Assessment Tool provides an effective, consistent framework for this.

The Trusts, in partnership with primary care, and the independent sector, will be expected to continue to strengthen and streamline discharge planning arrangements and to consolidate the capacity for post-acute rehabilitation in a range of intermediate care settings. The restructuring of existing facilities, resources and

workforce will be crucial to the achievement of the strategic shift away from traditional forms of provision. Individualised care plans for people receiving care at home will be introduced in 2010/11, as an important element in the promotion of self-management.
In previous years the growing needs of an ageing population have been met by a growth in funding. Trusts have already had to increase their spending to meet demand into 2010/11 and an additional £15m is being made available to meet this. The Local Commissioning Groups will have a critical role in how this resource is commissioned within each of their areas.
The Health and Social Care Board will look to the Local Commissioning Groups to adopt a more consistent approach to charging where there are existing variations, aiming for greater equity between different localities. Trusts will also be expected to seek greater value for money in their use of service providers. The Local Commissioning Groups will also have a role in bringing greater consistency to the procurement of community care.
Beyond 2010/11 the main drivers for the strategic development of services for older people will be the forthcoming service framework and the NI Dementia Strategy. The outcome of the demand/capacity work will also influence strongly the priorities for commissioning, as will feedback from effective performance management.

6.4.5 Summary of Commissioning Proposals in 2010/11

The Health and Social Care Board Response/Intent for 2010/11 Based on Funding Intentions or Other Factors (e.g. Restructuring).
The Health and Social Care Board will deploy £15.1m across 5 Trusts to meet the anticipated growth in demand for 2010/11 so that waiting time targets are maintained and to support adult protection.
The Health and Social Care Board expects Trusts to continue to move away from providing care in institutional settings, in particular traditional forms of residential care, and to work with housing agencies and others to develop accommodation which offers a home-based care setting with more flexible and responsive care and support.
The Health and Social Care Board will expect Trusts to plan hospital discharge from the day of admission and to work with carers and other providers to ensure that patients are discharged from hospital as soon as is clinically safe, to appropriate settings, for assessment of their future care requirement.

Priority Area 5:

Improve Children’s Health and Wellbeing

6.5.1 Strategic Context

The theme of improving children's health and wellbeing resonates with the six high level outcomes identified in the Office of the First and Deputy First Minister Strategy – 'Our Children and Young People – Our Pledge'. Achieving the outcomes from this strategy is the underpinning aim for all services to support children and young people in being:

- Healthy;
- Enjoying, learning and achieving;
- Living in safety and with stability;
- Experiencing economic and environmental wellbeing;
- Contributing positively to community and society; and
- Living in society which respects their rights.

This strategy combined with other overarching strategic documents issued by the DHSSPS, namely 'Care Matters' and 'Families Matter' provide the context in which services are being commissioned. The planned Children's Services Framework will also influence future commissioning. There is recognition of the need for development and investment across the continuum of children's services from prevention / early intervention to adoption /leaving and aftercare. There is an extensive body of evidence which demonstrates the cost benefit analysis of an investment in our children. It is important that children are valued, protected and cherished as they are the foundation stone for future generations. "Care Matters" outlines the corporate role of the state to assist those children and young people looked after and care leavers whose health and wellbeing requires to be improved.

6.5.2 Commissioning Themes

6.5.2(i) Demand for Services

In Northern Ireland over 7000 children and young people are referred each year to specialist Child and Adolescent Mental Health Services. The Health and Social Care Board under the auspices of the Bamford Implementation Taskforce has established a Child and Adolescent Mental Health Services task group to take forward service improvement in line with the specific actions outlined in the Bamford Implementation Plan. Birth rates across Northern Ireland as a whole have fluctuated in recent years but show a general upward trend particularly over the past five years. This is illustrated in the following table:

Birth Rate per 1,000 population by Trust for 2000 - 2009

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
BHSCT	12.0	11.9	11.5	12.0	12.4	12.0	12.5	13.4	14.2	14.0
NHSCT	12.5	12.6	12.6	12.3	13.1	12.8	13.0	13.4	14.0	13.1
SEHSCT	12.2	12.4	11.5	12.1	12.4	12.0	12.6	13.4	13.7	13.3
SHSCT	13.7	14.6	14.0	14.0	14.6	14.7	15.0	15.6	16.0	15.9
WHSCT	13.9	13.9	13.6	13.4	12.9	13.4	13.9	13.8	14.4	14.2
NI	**12.8**	**13.0**	**12.6**	**12.7**	**13.0**	**12.9**	**13.4**	**13.9**	**14.4**	**14.0**

Source: NISRA
Notes: Population used is mid-year estimates for each year (2009 figures are provisional – 2009 rate is calculated using the 2008 mid-year estimated population).

6.5.2(ii) Partnership Working

The Health and Social Care Board/Public Health Agency remains committed to working in partnership with service users and a range of stakeholders across the statutory, voluntary, community and independent sectors. These partnerships, which are integral to commissioning include:

- Children and Young People's Committees;

- Hidden Harm Quality Assurance Group;
- Regional Child Protection Committee;
- Child Care Partnerships;
- Investing For Health Partnerships;
- Think Child, Think Parent, Think Family.

There is commitment to bring forward and consolidate work on outcomes based planning and measuring how effective service interventions are with children and their families. There is a need to strengthen the arrangements for children and young people's participation in planning processes and ensure that there are mechanisms in place for feedback on the services available to these children.

6.5.2(iii) Reform and Modernisation

The need to commission services which are fit for purpose has been high on the agenda of the Health and Social Care Board/Public Health Agency which is why there has been and will continue to be in 2010/2011 a focus on reform and modernisation. The Performance Management and Service Improvement Directorate within the Health and Social Care Board has a specific responsibility to take this agenda forward and within children's services the Children's Service Improvement Programme and the Reform Implementation Team have been the vehicles through which prioritisation, demand and capacity, modernisation and productivity have been pursued. This has resulted in multiagency engagement/involvement and the promotion of greater consistency across the Health and Social Care sector. This process will be ongoing in the forthcoming year to consolidate the need for collaborative working and the recognition that more can be achieved for the population.

6.5.2(iv) Family Support

The Children's Services Planning process has effectively brought stakeholders together to plan and provide both local and regional services in line with the strategic direction as spelt out in 'Families Matter'. These services are monitored and require to report on the progress measured against the Children's Strategy High Level Outcomes.

This is the third year of Comprehensive Spending Review funding to a wide range of family support projects and the bulk of the reduced funding available to children's services for 2010/2011 will require to be used to adhere to these contractual arrangements. In the event that some of this funding is mainstreamed in future years the Health and Social Care Board will need to consider the balance of investment between family support and statutory services.

The Childcare Partnerships operating as multiagency partnerships are financed by Department of Education but led by the Health and Social Care Board and this will continue at least for the next year. The primary focus is on early years and family support services in the most deprived areas and the agenda can only be effectively delivered if the partnership arrangements are maintained, if communities continue to contribute and if quality remains as integral to service provision.

It will be important that Local Commissioning Groups are kept apprised of developments commissioned through these multiagency processes but which operate at a local level and will impact on the work of the Local Commissioning Groups.

6.5.2(v) Early Intervention Strategy

The foundations for physical, intellectual and emotional development are primarily established in early childhood. To have an impact on health inequalities ensuring the optimum focus on early interventions is therefore critical. In addition to the roll out of

a variety of early years investment the establishment of internationally successful and evidence based early intervention models including ‘Family Nurse Partnerships’ and ‘Roots of Empathy/Seeds of Empathy’ into Northern Ireland in 2010/2011 will be pursued.

6.5.2(vi) Healthy Child, Healthy Future

The Healthy Child, Healthy Future programme is a universal public health service offered to all children and young people aged 0-19 years. This programme requires a set number of contacts to be made to each family in Northern Ireland to identify the health need(s) through a holistic assessment which includes screening and surveillance, where necessary provide early intervention to ameliorate the potential early negative impact of any physical, social or emotional factors on a child or young person’s health and wellbeing. The Commissioner and Trusts will fully implement the revised Child Health Promotion Programme by 31st March 2011.

We will take into account the Marmot Review of Health Inequalities 2010 which said that reducing health inequalities is a matter of fairness and social justice and the fair distribution of health, wellbeing and sustainability are important social goals.

6.5.2(vii) Long Term Conditions In Childhood

Partnership with parents and children and young people is central to the planning and delivery of children’s services. Parents of children and children with long term conditions e.g diabetes, epilepsy and childhood disability should be supported to manage their child’s condition and help the child self manage whenever possible. A three year Northern Ireland wide project for children and adolescents with diabetes, funded through Inter-Reg IV, is piloting the introduction of Structured Patient Education for all children with diabetes and their families in Northern Ireland.

This will support families and children with diabetes to optimize diabetes control in childhood and prevent or delay the development of complications of diabetes in adulthood. There is a need to ensure children have access to effective interventions in managing their condition.

6.5.2(viii) Pre-pregnancy Care

Evidence is increasing of the importance to pre-pregnancy care for the health of children, particularly for women of child bearing age with long term conditions such as diabetes and epilepsy. A three year Northern Ireland wide project, funded through Inter Reg IV, is piloting pre-pregnancy care for diabetic women of child bearing age in Northern Ireland. This aims to reduce the increased perinatal mortality and congenital malformation rates observed in diabetic pregnancies.

6.5.2(ix) Pregnancy Care

Births have increased in Northern Ireland since 2004. We have endorsed the National Institute for Clinical Excellence guidelines for ante-natal, post –natal and intra-partum care. Trusts need to ensure targeted interventions are available for high risk pregnancies.

6.5.2(x) Child and Adolescent Mental Health Services (Child and Adolescent Mental Health Services)

In response to the growing demand for specialist intervention, legacy Health and Social Care Boards invested over £1.6m over the last two years. This investment was largely focused on developing capacity within existing specialist Child and Adolescent Mental Health Services teams, and in establishing eating disorder and crisis assessment teams. Whilst there has also been some modest investment in the development of wraparound/therapeutic care services for looked after children, there remains a significant gap in earlier intervention services and in the range of available

psychological therapies across the Child and Adolescent Mental Health Services tiers. The Health and Social Care Board has promoted and will continue to apply the Choice and Partnership Approach model in taking forward the modernisation and commissioning agenda.

Currently in Northern Ireland there is a total of 27 regional beds, of which 12 are for adolescents (aged over 14) and 15 for children. This level of provision has historically led to higher levels of admissions of young people to adult mental health wards and Extra Contractual Referrals for those young people with intensive psychiatric/complex care needs. As a result of capital investment from April 2010 the number of beds will rise by 6 to 33 beds regionally, (16 adolescent, 2 Intensive psychiatric care and 15 children's beds).These additional beds should reduce reliance on adult mental health beds and assist in the preventing some Extra Contractual Referrals for intensive psychiatric care. However in order to avoid unnecessary admission and to support earlier discharge there will be a need to develop the scope and range of community child and adolescent mental health services. The Health and Social Care Board in partnership with the Trusts will review the range and scope of tier 4 Child and Adolescent Mental Health Services provision.

6.5.2(xi) Children with Disabilities

Trusts should ensure progress is achieved against the regional Autism and Acquired Brain Injury Action Plans. This necessitates that Trusts develop service capacity across the Children's Mental Health and Disability services and encompasses the child, adolescent and adult age range. A key requirement is to ensure that existing infrastructure and practitioners across the wider range of Children's Mental Health and Disability Services are better able to meet the needs of both children and adults with Autism and Acquired Brain Injury. Trusts must evidence that individuals with Autistic Spectrum Disorder and Acquired Brain Injury are considered within a person centred framework and not restricted

by specific criteria which risk excluding individuals from access to services.

The Health and Social Care Board/Public Health Agency will seek to engage with Trusts in scoping current access criteria to establish regional consistency in the application of such criteria.

Trusts should also ensure that appropriate Transitions services for young people with a disability and their carers are in place and the relevant information around transitions between Children and Adults services is available to service users and their carers including information in relation to carer's assessments and direct payments.

6.5.2(xii) Prevention and Community Engagement

An important theme in community engagement is to avoid crises arising where possible through preventative approaches. Solutions to challenging structural problems require strong service user, carer and community engagement in planning services and new initiatives. Some communities, individuals and families experience multiple social problems. For example they may lack employment, skills and qualifications, are living in poor accommodation, live on a low income, have addiction and substance problems or may be at risk. Health and Social Care services work with some of the most excluded and vulnerable members of society and in working with people with limited capacity must be imaginative in promoting participation, user involvement and person centred approaches. This kind of intervention promotes real empowerment and self help in the community and enables service users and carers to speak for themselves, advocate for service improvements and fully engage with Health and Social Care Board/Public Health Agency in planning new services. User involvement and community based development supports confident active and sustainable communities, capable of meeting their own needs in partnership with Health and Social Care services and others. The Health and Social Care Board/Public Health Agency will continue to employ community development principles in involving service users and carers in planning and developing services.

6.5.3 PFA Targets

The range of targets posed particular challenges as they also reflect the continuum of care covering family support, child protection, looked after children, care leavers and family group conferencing.

In view of the numbers of unallocated cases it has been necessary to put in place robust monitoring processes to be assured that cases of a child protection nature are responded to immediately and that cases are being screened and assessments completed along the pathway in a timely fashion.

The Health and Social Care Board has made recurrent and non recurrent investment in the past year to assist Trusts to respond to an increased number of referrals and will continue to see this as a priority area in the forthcoming year.

It will be important to retain the commitment to the targets as far as this is practically possible as these assist in promoting the outcomes relating to children living with safety and stability and young people experiencing economic and environmental wellbeing.

PFA Target: Children In Care

From April 2010, the Health and Social Care Health and Social Care Board and Trusts should ensure children admitted to residential care have prior to their admission: (i) been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process. For every child taken into care, a plan for permanence and associated timescale should be developed within six months and formally agreed at the first six-monthly Local Advisory Committee review.

PFA Target: Family Support Interventions

By March 2011, the Health and Social Care Health and Social Care Board and Trusts should provide family support interventions to 3000 children and vulnerable families each year. By this date, Trusts should also have updated the Regional Information System with details of family support services which they provide.

PFA Target: Care leavers in education, training or employment

From April 2010, the Health and Social Care Health and Social Care Board and Trusts should ensure that at least 70% of all care leavers aged 19 are in education, training or employment.

PFA Target: Care leavers living with former foster carers or supported families

By March 2011, the Health and Social Care Health and Social Care Board and Trusts should ensure that at least 200 care leavers aged 18+ are living with their former foster carers or supported family.

PFA Target: Looked-after children on the child protection register

By March 2011, the Health and Social Care Health and Social Care Board and Trusts should ensure that the child protection status of all looked-after children on the current register is reviewed in line with Departmental guidance issued in April 2010.

PFA Target: Family group conferencing

During 2010/11, the Health and Social Care Health and Social Care Board and Trusts should ensure that at least 500

children and young people participate in a family group conference.

As regards the targets referring to Family Group Conferencing and Education, Training and Employment opportunities for Care Leavers, some Trusts have stipulated that achievability is dependent on the young person's willingness to be involved and that the economic climate will impact on the careleavers target. The Board will continue to work closely with the Trusts to monitor progress and ensure that the standards are met within the required timescale."

PFA Target: Assessment of children at risk and in need

- **From April 2010, the Health and Social Care Health and Social Care Board and Trusts should ensure the following:**

- **Child protection (allocation of referrals) – all child protection referrals are allocated within 24 hours of receipt of the referral.**

- **Child protection (initial assessment) – all child protection referrals are investigated and an initial assessment completed within 10 working days from the date of the original referral being received.**

- **Child protection (pathway assessment) – following the completion of the initial assessment, a child protection case conference is held within 15 working days of the original referral being received.**

- **Looked-after children (initial assessment) – an initial assessment is completed within 10 working days from the date of the child becoming looked after.**

- **Family support (family support referral) – 90% of family support referrals are allocated to a social worker within 20 working days for initial assessment.**

- **Family support (initial assessment) – all family support referrals are investigated and an initial assessment**

completed within 10 working days from the date the original referral was allocated to the social worker.

- **Family support (pathway assessment) – on completion of the initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days.**

6.5.4 Challenges and Constraints

Within Child and Family Care Services there is a requirement on Trusts to effectively discharge a range of statutory functions and to provide assurances that this is the case. The Health and Social Care Board will wish to strengthen Gateway and Family Intervention Teams to meet demand.

The significant increase in children's names placed on the child protection register reflects the national perspective and the response to high profile situations where children are exposed to serious harm or even death. The Health and Social Care Board/Public Health Agency expect, as will service providers, that there is adherence to procedural requirements and that responses are timely, proportionate and robust.

The needs of looked after children are diverse and complex. They must be informed by meaningful engagement of the children and young people as well as assessment processes which are multi disciplinary and recognise the role to be played by various partners if these children are to recover from previous traumatic experiences, or to form meaningful attachments to appropriate adults and go on to make a positive contribution to the community and society.

The Health and Social Care Board will wish to ensure that previous investment in the development and maintenance of therapeutic fostercare schemes and therapeutic inputs for children in residential care have been utilised and consider which aspects can be regionalised to produce better outcomes. There is a need to consolidate the position and for Trusts regionally to utilise investment in finalising structures. The need for post adoption support services is also recognised and the Health and Social Care Board will work with potential providers to further develop these services in the forthcoming year. Care leavers must

continue to receive support; practical, financial and therapeutic if their needs are to be met. This will allow statutory functions to be discharged whilst also beginning to break the cycle where a significant proportion of care leavers will continue to experience various forms of disadvantage into adulthood which is a further call on public resources.

The former foster care (Go the Extra Mile) scheme has been a positive example of promoting stability for care leavers and leaves Northern Ireland as a forerunner in this regard. The Health and Social Care Board would wish to see this further expanded.

The Health and Social Care Board has established processes for Trusts to report all placements of 16/17 year olds in unregulated accommodation. It is understood standards are to be issued via DHSSPS in relation to such accommodation and Trusts should seek assurance that appropriate safeguarding arrangements are in place and that placements can meet the needs of the young people concerned.

Multi-sectoral discussions have also been ongoing in relation to young homeless and there is a potential for this area to be a significant call on social care services resource if this cohort were to require to be seen as looked after children.

Residential child care is the preferred and necessary placement choice for some young people; there have been some occasions where Trusts have considered their needs can only be met in specialist placements outside Northern Ireland. These have been identified as high cost cases and the Health and Social Care Board has identified recurrent funds to the Trusts for these cases in the expectation that this process and the available funds will be used appropriately with Trusts seeking to remain in budget. It is also the case that the number of young people who experience this level of disruption should be minimised and the Health and Social Care Board will still therefore require to be advised where this is being considered to offer a view on the appropriateness of young people being placed outside the jurisdiction.

Trusts now have a stock of residential care and all Trusts have access to the regional secure unit. The Health and Social Care Board will retain its commitment to the places provided within the regional voluntary children’s home during 2010/11 whilst a

decision is reached in relation to regional provision. It is felt that there is a need for additional differentiation and specialisation in this sector. The Health and Social Care Board would wish to engage further with providers in this regard to determine the specific needs and the potential to work across Trust boundaries to create a more receptive portfolio of provision.

6.5.5 Summary of Commissioning Proposals

2010/11 Investment	
Family Support Interventions / Packages	£1.04
Gateway Services	£1.17m
Adoption Support Services	£0.15m
Children's Services Total	**£2.36m**
2010/11 Investment	
Statutory Carers Assessments for Autistic Children	£0.10m
Out of Hours Cover re Obstetrics	£0.05m
Children with Complex Needs Total	**£0.15m**

Priority Area 6:

Improve Mental Health Services and Services for People with Disabilities

6.6.1 Strategic Direction

The Bamford Report and the 'Protect Life' Strategy set out the vision for the reform and modernisation of Mental Health, Learning Disability and Child and Adolescent Mental Health Services over a fifteen year horizon. Since the publication of the individual report, further evidence based models of service delivery have emerged and these will be integrated during the implementation of the Bamford recommendations. The Health and Social Care Board has established a number of core task groups to take this work forward and this will be monitored by the Bamford Implementation Taskforce, led by the Health and Social Care Board's Chief Executive. A core theme will be the need to strengthen community services to promote a recovery based model of care provided predominately in or close to people's homes. As outlined in 'Delivering the Bamford Vision' (DHSSPS, 2009), key themes include:

1. Promoting positive health, wellbeing and early intervention;

2. Supporting people to lead independent lives;

3. Supporting carers;

4. Providing better public services to meet people's needs;

5. Providing structures and a legislative base to deliver the Bamford Vision.

Additional strategic drivers include the regional 'Protect Life', Suicide Prevention and Promoting Mental Health and Wellbeing strategies and the new Strategic direction for Drugs and Alcohol, which aim to promote mental health and wellbeing and foster resilience within communities.

The strategic direction for Learning Disability service developments and service improvement is set out in the "Equal Lives" report of the Bamford Review. This envisages a similar model of community based care so that no-one remains in hospital unnecessarily and the people with a learning disability can enjoy the maximum quality of life possible, consistent with their needs.

In the absence to date of a regional strategy for Physical Disability/Sensory Impairment, legacy Boards developed local strategies which reflected the aims of promoting independence and empowerment and improving the quality and responsiveness of health and social services for people with disabilities and their carers. Late in 2009, DHSSPS launched the process for developing a Regional Strategy for People with Physical Disabilities and Sensory Impairment and it is anticipated that this will be completed by early Autumn 2010. The Strategy will adopt a life cycle approach covering all age groups and will promote the importance of partnership working across statutory, community and independent sectors.

The focus of Priorities for Action 2009/10 for this programme of care was the continued development of person-centred, seamless community-based services, informed by the views of users and carers. Key priorities were, and continue to be, the avoidance of inappropriate hospital admission, facilitation of early discharge, improved respite and carer support, and the enhancement of provision for those with acquired brain injury and for those who require Wheelchair services.

The latter two areas have recently been the subject of regional review and implementation processes are currently progressing. The targets associated with the action plans for each review are being monitored through the performance management process.

The emphasis now must be upon the reform and modernisation of our existing services. New investment may occur in strategically critical areas (i.e. to deliver Priorities for Action and drive efficiency and effectiveness). The Health and Social Care Board will seek evidence that any new investment is linked to significant reform and service improvement as a condition of approving any new service developments.

The Bamford Implementation Taskforce commenced in January 2009 and is jointly led by the Health and Social Care Board and the Public Health Agency in partnership with Trusts and other stakeholders. At a local level, this process will be led by Local Commissioning Groups.

The Taskforce will be the principal source of advice and guidance regarding service development priorities and will facilitate greater consistency and standardisation of service provision across NI.

The Taskforce will also ensure that service users and carers become partners in the planning and delivery of services regionally.

6.6.1(i) Drivers for Change

There will be a continuing focus on delivering existing, and any new, Priority for Action Targets. Service improvement activity will be focused on those areas where performance is weak or where there is a consensus about the need for whole system reform and modernisation. In particular, attention will concentrate on;

- Consolidation of the stepped care model across all mental health services, in particular Tier 2 and the use of funding provided for the Depression Directly Enhanced Service within primary care;

- A 9 week maximum wait time for all mental health services including within Child and Adolescent Mental Health Services (13 weeks for psychological therapies);

- Continue the process to eliminate hospital delayed discharges;

- Community follow-up within seven days of discharge from; hospital

- Resettlement of the long-stay hospital population;

- Growth in the development of alternatives to hospital admission;

- Promoting the quality of the in-patient experience through the ‘Releasing Time to Care’ initiative;

- Full and consistent implementation of the ‘Card Before You Leave’ scheme;

- Promoting cooperation between Trusts on specific topics of common interest, for example the coordination of access to in-patient resources;

- Maximising the utilisation of existing capacity within community services;

- Support the regional process to scope out the development of peri-natal mental health services;

- Supporting the roll-out of the Beating the Blues project;

- Overseeing the regional Life Line contract;

- Delivery of local Protect Life Action Plans with priority focus on community support;

- Extension of Deliberate Self Harm registry to Belfast Trust;

- Coordination and quality assurance of training under ‘Protect Life” & Promoting Mental Health;

- Evaluation of “One Stop Shops”;

- Continued implementation of New Strategy Direction for Drugs and Alcohol and substitute schemes;

- Increased awareness of, and signposting to, services for children and young people affected by Hidden Harm;

- Development and evaluation of the brief intervention pilot designed to support primary care to undertake screening and brief intervention on alcohol misuse. Production of an effective methodology for training.

- Continue to develop the range of psychological therapies in line with the 2010 strategy and the stepped care approach;

- Begin to develop a Personality Disorder Service in each Trust to be built on as further funding is available;

- Continue to develop Autistic Spectrum Disorder Services to meet the targets for timely diagnosis and intervention and the Autistic Spectrum Disorder Network Action Plan.

6.6.2 General Context including Indicators of Need/Demand

A considerable proportion of the NI population experience problems associated with mental ill-health, learning and/or physical disability. The direct/in-direct costs associated with mental ill health are estimated to be circa £3 billion in NI.

At any one time, 1-in-6 adults will experience a diagnosable mental health problem and a quarter of all primary care consultations will be associated with mental ill health. The Health and Social Care Board will wish to support the efforts of Local Commissioning Groups in developing services embedded within the primary care and at the interface with secondary care.

Around 2-3% of the population have a significant learning disability. In comparison to elsewhere levels of mental ill health and disability are relatively high in NI. For example, the NI Survey of People with Activity Limitations and Disabilities (NISRA July 2007: Bulletin 1) indicates that 18% of all people living in private households in Northern Ireland have some degree of disability. The prevalence rate for adults is 21% and 6% for children.

6.6.3 Commissioning Priorities

6.6.3(i) Mental Health

The promotion of mental health/wellbeing across wider society is a central priority within the Health and Social Care Board/Public Health Agency commissioning intentions. The Health and Social Care Board/Public Health Agency are committed to ensuring that key health and wellbeing priorities including early intervention,

prevention and tackling inequalities are integral to the re-design and delivery of mental health services. There will be significant opportunities to ensure that improving health and wellbeing is addressed in each of the Bamford Implementation Taskforce working groups.

A major priority will be promoting personal development and early interventions that are effective, accessible and person centred, supported with advocacy for the involvement of clients and carers. Core to this will be working with organisations in the statutory, community and voluntary sectors that can provide evidence based services such as building resilience, family support and counselling for those in crisis and in need of support. The continued roll out of the Lifeline Contract will be a major investment in terms of ensuring that those in crisis and/or their carers have immediate support when they require it. Other priority areas will include developing regional co-ordination and quality standards for training, taking forward the recommendations from the Health Committee Inquiry into the Prevention of Suicide and Self Harm, and joint working to provide better services to meet people's needs.

Therefore, local 'Protect Life' and Mental Health Promotion Strategy Action Plans will continue to be supported with existing investment levels during 2010/11. Mental Health promotion, prevention and earlier identification must be better reflected within front line mental health services. Trusts should therefore ensure these themes are fully incorporated as key objectives within all service development proposals.

The continuing increase in Extra Contractual Referrals to specialist services outside Northern Ireland is not sustainable from a financial perspective. A more robust regional approach will be established to assist in the reduction of Extra Contractual Referrals. Clinicians, professionals and managers within Trusts should work collectively together in the context of this regional approach to deliver a significant reduction in Extra Contractual Referrals costs during 2010/2011. Failure to achieve this objective will curtail the release of funding to Trusts for planned new mental health services outlined within this Commissioning Plan. In the first instance an agreed regional process involving Health and Social Care Board and Public Health Agency staff will be identified to oversee all proposed Extra Contractual Referrals. The Health

and Social Care Board/Public Health Agency will take this forward in partnership with Trusts with a view to introducing a new regionally agreed process to be in place by end September 2010. The Health and Social Care Board expects Trusts to work in partnership with their respective Local Commissioning Groups and the wider range of primary care stakeholders, to develop the Stepped Care model. Models should better reflect the provision of specific primary care mental health services (ie. Level 1/2 service provision as per the Stepped Care Model).

The Health and Social Care Board/Public Health Agency will support Trusts to develop and standardise the provision of Crisis Response/Home Treatment services in order to reduce variation between the models and reduce the need for inpatient care. This work will take into consideration the regional principles (published January 2010) which are intended to guide the provision of services to people at risk of suicide or serious self harm.

Efforts will be made to strengthen specialist services. New 'Regional Networks' will be established to oversee the development of Personality Disorder and Forensic Services. These will be established as an integral part of the Bamford Implementation Taskforce. The development of Eating Disorders services should continue in accordance with the regional specification agreed in 2009.

Through the existing regional Child and Adolescent Mental Health Services group efforts will continue to reform and modernise services in each Trust area during 2010/11. Local Drug and Alcohol Co-ordination Teams action plans for the new Strategic Direction for Alcohol and Drugs, the Addressing Young People's Drinking Action Plan and the Hidden Harm Action Plan will be rolled forward. Trusts should continue to implement and support the delivery of specialist substance misuse services including partnership working with key service providers in the independent / voluntary sectors.

Trusts should maintain progress towards existing 'resettlement' plans ie. from 2008/09 & 2009/10 baselines, in terms of the resettlement of mental health clients from long stay hospital based facilities. The Health and Social Care Board will also lead a review of acute psychiatric inpatient services to determine how these

services should be configured to most effectively meet the needs of users across the region.

6.6.3(ii) Learning Disability

The main focus for service delivery and modernisation in 2010-2011 will be to continue to promote inclusion and independence for people with Learning Disability in line with “Equal Lives”.

This will be done by further development and improvement of services to people with a Learning Disability. The services must better support people with a Learning Disability to be able to enjoy housing, training, further education and employment opportunities which all citizens benefit from.

Key to succeeding in this aim is adequate support for parents and carers which recognises that the majority of people in N.I. with a Learning Disability live with family members.

All service plans and improvements must be underpinned by a greater focus during 2010/2011 on recognising and meeting the physical and mental health care needs of people with a Learning Disability. In this regard the full implementation by Trusts of the Directed Enhanced Service for Learning Disability during 2010/2011 is necessary.

Equally as important as specific health screening activity through the Directed Enhanced Service will be the involvement of people with a Learning Disability in all of the other physical and mental health promotion activities of Trusts aimed at improving the health and wellbeing of the general population. New in-patient assessment and treatment services for children and young people from Belfast, South Eastern, Northern and Southern Trusts will be operational during 2010/11 at the Iveagh Unit in Belfast.

Both the long term resettlement and the delayed discharge populations will be reduced in line with the target for 2010/2011 and help progress towards the 2013 target that no one with a Learning Disability should remain unnecessarily in hospital.

The continued growth in the numbers of children with complex needs alongside their Learning Disability will need to be met by

improvements in the transition experienced by young people moving to adult services.

Key to this will be renewed efforts by Trusts to review day support services both in day care settings and in integrated community activities. Additional improvements in services for children and young people with a Learning Disability who have communication difficulties should be delivered by Trusts.

Trusts should ensure progress is achieved against the priorities identified in the Regional Autism Spectrum Disorder Action Plan and Priorities for Action. This necessitates that Trusts should develop service capacity across Child health, Mental Health and Disability Services and encompasses the child, adolescent and adult age range. A key requirement is to standardise the care pathway for children and adults across Child Health, Mental Health and Disability services. Trusts must evidence that individuals with Autistic Spectrum Disorder are considered within a person centred framework and not restricted by specific criteria which risk excluding individuals from access to services. The Health and Social Care Board and Public Health Agency will continue to lead reform and modernisation through the Autism Taskforce.

6.6.3(iii) Physical Disability/Sensory Impairment

In 2010/2011 the priority for the Physical Disability/Sensory Impairment Programme will be to continue to address specific Priorities for Action 2010/2011 targets, to implement the Regional Review Implementation Plans for Acquired Brain Injury and for Wheelchair Services and to seek to address a number of other key areas of need. These include the requirement to consolidate the baseline resource position of the Regional Prosthetics service and the Wheelchair service. Critical to ensuring the appropriate placement of people with severe brain injury following treatment and rehabilitation is the development of suitable long term care options and reduction in the need for Extra Contractual Referrals. This will also improve the operation of the existing care pathway for this client group, releasing treatment and rehabilitation placement currently affected by prolonged discharge delays.

Sensory impairment services will benefit from the intention to complete the implementation of the Challenge and Change inspection report recommendations, to implement the NI

contribution to the UK Vision Strategy 2009-2012 and to procure a regional communication support service for people who are deaf/hard of hearing to ensure equity of provision across NI.

The Trusts will be expected to take forward these priorities whilst also addressing the need to promote strongly the take up of Direct Payments, to take account of, and respond to the needs of carers, and to engage effectively with service users throughout.

Thalidomide: Commissioners and Trusts should also take forward the provision of any assessment required in allocating the additional support for Thalidomide survivors generated by the provision of an extra £1.1m, to be made available by the DHSSPS to the Thalidomide Trust over the next three years.

6.6.4 Priorities for Action – Standards and Targets 2010

The limited availability of Comprehensive Spending Review year 3 funding allocation will constrain the scale and momentum of service developments and limit the ability to deliver the Priorities for Action targets.

The specific standards and targets for Mental Health, Learning Disability and Physical/Sensory Impairment programmes are:

- **Reducing the harm related to Alcohol and Drug Misuse (linked to PSA 1.4, 1.5, 1.6 and 1.7): by March 2012, reduce to 29% the proportion of adults who binge drink, reduce to 27% the proportion of young people who report getting drunk, and reduce to 5.5% the proportion of young people taking illegal drugs. Consistent with the achievement of these outcomes, the Public Health Agency should from April 2010 further develop and evaluate the brief intervention pilot designed to support primary care to undertake screening and brief intervention on alcohol misuse. By December 2010, the Public Health Agency should produce an effective training methodology and determine the feasibility of rolling this out across GP practices. And, from April 2010 the Public Health Agency in partnership with the Health and Social Care Board should, through the**

implementation of the joint Hidden Harm Action Plan, increase awareness of relevant services and ensure that more young people affected by parental substance misuse are effectively signposted to existing services.

- **Suicide (linked to PSA 1.8): by March 2012, ensure that the suicide rate is reduced below 14.5 deaths per 100,000. Consistent with the achievement of this outcome, by September 2010 the Public Health Public Health Agency should ensure that a Deliberate Self Harm Registry pilot is established in the Belfast HSC Trust, and a first draft report produced by March 2011. By September 2010, the Public Health Agency should produce an action plan to implement recommendations arising from Mental Health Promotion / Suicide Prevention Training in Northern Ireland**.

- **Mental Wellbeing (linked to PSA 1.8): by March 2011, the Public Health Public Health Agency should produce an action plan to take forward the relevant regional and local elements contained within the Mental Health and Wellbeing Promotion Strategy.**

- **Unplanned admissions (PSA 6.1): by March 2011, the HSC Health and Social Care Board and Trusts should take steps to reduce the number of admissions to acute mental health hospitals by 10%**

- **Assessment and treatment (PSA 6.3): from April 2010, the HSC Health and Social Care Board and Trust should ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health issues with the exception of psychological therapies for which no patient should wait longer than 13 weeks.**

- **Card before you leave: from April 2010, the HSC Health and Social Care Board and Trusts should ensure that all adults and children who self harm and present for assessment at A&E are offered a follow-up appointment with appropriate mental health services within 24 hours.**

- **Resettlement of Learning Disability patients (PSA 6.4): by March 2011, the HSC Health and Social Care Board and Trusts should resettle 120 long stay patients from Learning Disability hospitals to appropriate places in the community compared to the March 2006 total. (Note: PSA target 6.2 for the resettlement of mental health patients has already been achieved.)**

- **Discharge (both mental health and those with a learning or physical/sensory disability): from April 2010, the HSC Health and Social Care Board and Trusts should ensure that 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. All mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge.**

- **Eating Disorders: further enhancement of a regional approach to eating disorder services recognising the need for specialist provision, and at least a 10% reduction in extra contractual referrals**

- **Respite – Learning Disability (PSA 6.7): during 2010/11, the HSC Health and Social Care Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 125 additional dementia respite packages by March 2011 compared to the March 2008 total.**

  Learning disability respite services will be commissioned across Trusts to achieve the target of an additional 125 packages by 31st March 2011 when compared to the 31st March 2008 baseline. These services will be composed of residential, domiciliary and host family schemes.

- **Respite – dementia: during 2010/11 the HSC Health and Social Care Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 1,200 additional dementia**

respite places by March 2011 compared to the March 2008 total.

The PFA 2010/11 target remains at the level set in PFA 2009/10 . The Health and Social Board is currently working with Trusts to finalise agreed definitions of respite and refine performance reporting to ensure achievement of this target in 2010/11. Trusts invested the additional allocation for this purpose in 2009/10 to progress towards the required level of provision by March 2010 and work will continue in 2010/11 to maximise the delivery of dementia respite within the resources available, and in the context of the forthcoming Regional Dementia Strategy.

- **Respite – physical/sensory disability (PSA 6.5): during 2010/11, the HSC Health and Social Care Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 110 additional respite packages by March 2011 compared to the March 2008 total.**

The PFA 2010/11 target was uplifted by 10 packages over and above the PFA 2009/10 level.The Board is currently working with Trusts to finalise agreed definitions of respite and refine performance reporting to ensure achievement of this target in 2010/11 .Trusts invested the additional allocation for this purpose in 2009/10 to progress towards the required level of provision by March 2010 and work will continue in 2010/11 to maximise the delivery of physical disability respite within the resources available through a range of approaches including partnership with the independent sector and the promotion of Direct Payments .

- **Wheelchairs (PSA 6.6): by March 2011, the HSC Health and Social Care Board and Trusts should ensure a 13-week maximum waiting time for of all wheelchairs, including specialised wheelchairs.**

- **Housing adaptations: from April 2010, the HSC Health and Social Care Board and Trusts should ensure all lifts and ceiling track hoists are installed within 22 weeks of**

the OT assessment and option appraisal as appropriate, and all urgent minor housing adaptations to be completed within 10 working days.

The Health and Social Care Board continue to monitor Trust performance against this target. The Health and Social Care Board the Public Health Agency are currently working closely with Trusts and DHSSPS on a regional group to review provision of housing adaptations in Northern Irealand. This work represents the Health and Social Care element of the wider Inter-Departmental Review of Housing Adaptations. The timescales for reporting recommendations is Autumn 2010. The outcome of this work will have implications for the future response to the PfA target.

- **Autism: from April 2010, the PHA, HSC Health and Social Care Board and Trusts should continue to progress the ASD action plan, ensuring that all children wait no longer than 13 weeks for assessment following referral and a further 13 weeks for commencement of specialised intervention.**

- **Acquired Brain Injury: from April 2010, the HSC Health and Social Care Board and Trusts should ensure a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment.**

- **Domestic violence: during 2010/11, each Trust should ensure that appropriate social services staff has participated in at least 95% for the Multi-Public Health Agency Risk Assessment Conferences (MARAC) held in their area during the year.**

6.6.5 Outcome Measures and /or Other Indicators of Success

While performance will be monitored in respect of the key Priorities for Action target areas, the Bamford Mental Health/Learning Disability Implementation Taskforce will develop a range of key indicators to determine wider progress towards achieving the Bamford vision. This will include not only indicators of service provision but also health and wellbeing focused targets and

benchmarks. The Health and Social Care Board will maximise the potential of the Mental Health and Learning Disability Minimum Dataset to better inform all partners in a benchmarking and activity monitoring process.

In respect of the Physical Disability/Sensory Impairment Priorities for Action targets for 2010/11, the Health and Social Care Board will continue to monitor performance specifically in respect of waiting time for wheelchairs, housing adaptations, respite and acquired brain injury.

In addition, the implementation plans associated with the regional reviews of wheelchair services and acquired brain injury have clear outcomes and milestones and work will continue throughout 2010/11, in partnership with Trusts, service users and relevant independent sector agencies to achieve progress against these.

It is expected that the forthcoming Regional Strategy for People with Physical Disabilities and Sensory Impairment will identify clear indicators of success across a broad range of areas of need, which will be incorporated into future commissioning intentions.

6.6.6 Commissioning Intentions and Associated Funds

The 2010/11 proposed service investments are summarised in the tables below:

2010/11 Proposed Service Development Investments in Mental Health Programme of Care

	Total Investment 2010/11	BHSCT	SEHSCT	NHSCT	SHSCT	WHSCT	Total
	£m	£m	£m	£m	£m	£m	£m
Mental Health							
SHSCT: Resettlement of 12 patients from St Lukes which were due to be resettled in 2009/10 in advance of 2010/11 funding.	**0.274**				0.200		**0.200**
BHSCT : Costs of resettling MH patients from hospital that took place in 08/09 & 09/10 (£147k FYE) in advance of 2010/11 funding.	**0.147**	0.147					**0.147**
SEHSCT : Additional funding to enable the resettling of 16 patients from Downshire hospital. Plans for these resettlements are at an advanced stage.	**0.244**		0.122				**0.122**
NHSCT: Substance Misuse Liaison Nurse	**0.077**			0.077			**0.077**
BHSCT: Agreed funding to top up Trust contract rate with a Voluntary Provider	**0.006**	0.006					**0.006**
Further investment in Psychological therapies.	**1.000**	0.213	0.180	0.243	0.194	0.171	**1.000**
Enhanced Community Services	**0.560**	0.119	0.101	0.136	0.108	0.096	**0.560**
Personality Disorders	**0.500**	0.106	0.090	0.121	0.097	0.086	**0.500**
LCG indicative adj for JCP (In Year only)	**0.000**	0.042	0.035	0.048	0.038	0.034	**0.196**
Total Mental Health	**2.808**	**0.632**	**0.528**	**0.625**	**0.637**	**0.386**	**2.808**

2010/11 Proposed Service Development Investments in Physical Disability Programme of Care

	Total Investment	BHSCT	SEHSCT	NHSCT	SHSCT	WHSCT	Slippage
£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Specialised Wheelchairs	1.143	0.243	0.205	0.278	0.222	0.195	
Prosthic service	0.075	0.016	0.013	0.018	0.015	0.013	
Total Physical Disability	**1.218**	**0.259**	**0.218**	**0.296**	**0.237**	**0.208**	

2010/11 Proposed Service Development Investments in Learning Disability Programme of Care

	Total Investment 2010/11	BHSCT	SEHSCT	NHSCT	SHSCT	WHSCT	Total
	£m	£m	£m	£m	£m	£m	£m
Learning Disability							
BHSCT Costs of Resettlements which occurred in 09/10 which contribute to 2010/11 resettlement target.	**0.327**	0.327					**0.327**
SEHSCT Costs of Resettlements which occurred in 09/10 which contribute to 2010/11 resettlement target.	**0.369**		0.369				**0.369**
WHSCT Costs of resettlements in 2 new ISU's to open, 28th March 2010 and 1st July 2010.	**0.934**					0.934	**0.934**
SHSCT : flexible respite packages to build on 08/09 developments to ensure Trust meets Pfa target for respite.	**0.065**				0.065		**0.065**
12 new resettlements for 2010/11	**0.650**	0.217	0.054	0.325	0.054	0.000	**0.650**
Respite Care	**0.600**	0.128	0.108	0.146	0.116	0.103	**0.600**
Autism	**0.140**	0.030	0.025	0.034	0.027	0.024	**0.140**
Total Learning Disability	**3.085**	**0.701**	**0.556**	**0.505**	**0.262**	**1.061**	**3.085**

6.6.6(i) Constraints

The limited availability Comprehensive Spending Review Year 3 funding allocation will constrain the scale and momentum of service developments and limit the ability to deliver the Priorities for Action targets. However, as already noted, the emphasis for at least the short-to-medium term must be upon the reform/modernisation of existing service infrastructure. While arguments may be placed regarding the relative under-resourcing of mental health/disability services compared to elsewhere, it is incumbent upon all stakeholders to pro-actively evidence added productivity and service improvement within existing resources.

The Health and Social Care Board expects Trusts to continue the process of reform and modernisation of services to achieve efficiencies in process and streamline systems, for example, the LEAN methodology work on wheelchair services. There will also be a continued focus on improving care pathways for specific conditions to enhance the quality of care for patients and clients, for example, within Child and Adolescent Mental Health Service and psychological therapies. The use of personalised budgets and Direct Payments will also be a priority.

In addition to financial constraints, the availability of highly skilled practitioners, in particular, to work within relatively more complex areas of service provision is an ongoing challenge. Workforce plans will need to be developed for services, taking into account the recommendations of the Workforce Report commissioned by the DHSSPS.

Priority Area 7:

Effective Use of Resources

6.7.1 Commissioning Themes

6.7.1(i) Productivity and Efficiency

The current financial context will require all organisations to transform their services, embedding a culture of prevention, earlier intervention and service reform and improvement to meet increasing population needs and demands and the expectations of local communities.

Service users and their carers are increasingly well informed and expect modern, fit for purpose and evidence based care. They have a growing expectation that the services commissioned will result in maximum health gain for the resources deployed. Increasing throughput, streamlining patient and client care pathways, minimising delay and focusing on safety are some of the ways to improve quality of care and a more efficient and productive health and care service.

Value for money and improved outcomes are not competing alternatives – they are one and the same thing. The improvements in outcome measurement and the associated ability to measure productivity are vital instruments for improving performance in Health and Social Care, expressed by better preventative measures and the provision of improved quality of care. Services should be assessed in terms of the outcomes they achieve from the resources available. The achievement of better outcomes is the dominant consideration in assessing effectiveness and efficiency.

While steady improvements in efficiency and productivity have been made by Trusts in recent years, there still remains significant scope to secure further gains. For example, audits carried out across Unscheduled Care during 2007/08 have shown that of the 4362 patients audited, 42% of unscheduled admissions did not require an acute hospital bed on the post admission day, and of the 58% of patients who were appropriately placed, a proportion of these could have had a reduced length of stay. Further implementation of the Unscheduled Care/Elective Reform Programme and the recommendations from the Rolling Audit and Improvement Programme will help to address these and other issues. Similarly, full implementation of the Integrated Elective Access Protocol and the recommendations from Elective Pathway

Review visits will assist Trusts to secure further efficiencies in the elective pathway and deliver improved services for patients. The continuing development of home treatment services will enable Trusts to reduce their reliance on hospital based treatment options, and the application of the service principles contained in the Choice and Partnership Approach will further enhance the capacity of community mental health services. The 'Releasing Time to Care' project will improve patient experience by increasing the availability of therapeutic interventions by trained nursing staff.

6.7.1(ii) Measuring Outcomes

In order to demonstrate improved outcomes, the Health and Social Care Board will require service providers to develop, collect and report on outcome measures for all services. For example:

- agreed elective surgery procedures;
- mortality data;
- cancer 5 year survival;
- readmission rates to acute psychiatric care;
- child protection and family support services;
- waiting times for all services;
- patient and client satisfaction with the care received.

The Health and Social Care Board will work with Trusts to develop a better understanding of the relative costs and benefits of local and regional services to help target expenditure most effectively, reduce unnecessary costs and drive improvements in productivity.

6.7.1(iii) Agreeing a Framework for Delivery

The Health and Social Care Board will work in partnership with Trusts to develop and agree accurate Service and Budget Agreement service volumes across all service areas and these will be closely monitored to ensure agreed productivity is delivered and

to identify early deviation from these to enable appropriate corrective action.

The Health and Social Care Board will support Trusts to improve the productivity and quality gains in care outside hospital by reviewing and rationalising the estate and effectively harnessing technology.

6.7.1(iv) Information and Communications Technology (ICT)

Information and Communications Technology has a major role to play in supporting service delivery and improving productivity and efficiency. The regional Information and Communications Technology strategy aspires to having a person centred electronic care record for every citizen and to ensure that Information and Communications Technology is effectively used to facilitate communication between care professionals. If information is to be communicated and shared electronically, it must be recorded electronically. There is a range of new Information and Communications Technology systems at implementation stage and others at the planning stage. Existing systems such as Patient Administrative System and SOSCARE could be more effectively used and the Health and Social Care Board will assist Trusts in identifying areas where improved use of such systems could improve effectiveness. Data quality and the timelessness of recording data on Information and Communications Technology systems must be improved. The Health and Social Care Board will support initiatives that improve the use of Information and Communications Technology systems and the quality of data recorded in them.

The Health and Social Care Board fully supports additional investment in Information and Communications Technology, however the scope for future increases in the level of investment is limited so new investment must be carefully targeted. This will require an increased focus on benefits identification and benefits realisation. The major areas currently targeted for investment over the next few years are:-

- New integrated Information and Communications Technology systems supporting Social Care, Mental Health, Children's and Community Services;

- Improved systems in the Primary Care area, particularly in those areas that improve communication across the interface between Primary Care and Secondary Care;

- Information and Communications Technology improvements in specific areas of Acute Care;

- A Health and Social Care wide Electronic Care Record system;

- Information and Communications Technology support to improve general administration and support activities;

- Trust Information and Communications Technology infrastructure modernisation.

6.7.1(v) Management Information and Analysis

It is vital that there is a regular flow of rich, timely and quality management information and analysis to support the drive for greater productivity and efficiency. To date much work has been carried out between the Health and Social Care Board and the Business Services Organisation on developing a greater and more timely flow of data from core Health and Social Care information systems such as Patient Administrative System, SOSCARE, Mental Health and Learning Disability systems, and latterly the Theatre Management System. This data is accessed via the regional data warehouse and is the primary source for much of the required productivity and efficiency analysis. However in parallel with these developments, there needs to be an equal focus on data quality improvement, covering:

- A much greater focus on administrative and clerical processes to produce higher quality and more timely data inputs into these core operational systems;

- Richer and more timely coding; and

- Greater standardisation of how these systems are used across the Health and Social Care e.g. Patient Administrative System Technical Guidance.

This work is vital in order to produce better quality source data and needs to be driven by the information and service improvement elements within the Health and Social Care Board working together with Trust colleagues.

6.7.2 PFA Targets

PFA Target: Hospital productivity

Each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.

PFA Target: Daycase rate

Each Trust should secure improvements in daycase rates for a defined range of procedures in accordance with Departmental targets for March 2011.

PFA Target: Pre-operative length of stay

Each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2011.

PFA Target: Cancelled operations

From April 2010, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.

Service redesign, based on a more sophisticated understanding of capacity is a key component of the reform and modernisation agenda and the Health and Social Care Board will continue to work closely with local Trusts, to progress this work in 2010/11. In particular Trusts will be expected to focus on the following key areas:

- Reduced length of stay – Trusts should review and improve admission and discharge processes, and be able to evidence a reduction in the average number of bed days patients spend in hospital settings;

- Pathways of Care – Trusts should deliver effective integrated pathways of care that reduce unnecessary steps in the process, improve the patient and client experience and lead to better outcomes;

- Care in the right place – Trusts should demonstrate a commitment to intervening earlier in the patient and client pathway that reduces inappropriate demand for beds and other care packages. This should include a focus on delayed discharges, early and safe discharge to community care and a more focused approach to the management of specialist services including referrals to services outside Northern Ireland;

- Implementing evidence – There is evidence from local audits that further efficiencies can be gained through streamlining the patient pathway. Trusts have been asked to produce Unscheduled Care Action Plans to identify how they will implement recommendations following recent audits, and monitoring and support to Trusts will be embedded in the Health and Social Care Board's work plan for emergency care during 2010/11;

- Clinical decision-making and engagement – Trusts should demonstrate that they have systems in place to provide effective access to appropriate clinical opinions to facilitate good patient flows and that Clinicians are fully involved in service improvement processes;

- New to review ratios – Trusts should benchmark ratios with high performing services elsewhere and should ensure that all review appointments are clinically appropriate. Consideration should be given to developing new ways of working and alternative models of service delivery;

- Day surgery, treatment and care – Trusts should work, in partnership with primary care and others, to increase the range and volume of procedures and services that are carried out without the need for unnecessary overnight stays;

- Short stay surgery and early discharge – Trusts should work to reduce post operative length of stay by improving discharge processes and identifying suitable short stay beds

(i.e. 24hrs stay beds) for elective procedures. They should also seek to better integrate community services that can in-reach to hospital care and promote earlier discharge;

- Day of admission surgery – Trusts should put in place protocols to ensure that admission on the day of surgery is the default position for all clinically appropriate patients;

- Cancelled Operations: Trusts will put in place protocols to ensure that all patients will have appropriate pre operative assessment and ensure that no more than 2% of operations will be cancelled for non clinical reasons;

- Theatre utilisation – Trusts should produce consultant level data detailing theatre utilisation rates and use this data to benchmark against peer groups;

- Did Not Attends – Trusts should continue to monitor Did Not Attends across all services and establish the causes for the non-attendance, and develop plans to address these;

- Can Not Attends – Trusts should monitor the level of both clinical and non-clinical cancellations across all services. Trusts should ensure that their booking process complies with IEAP guidance;

- Service Provision – Trusts will need to be cognisant of the Effective Use of Resources Review and the potential impact on service provision. Consideration should be given to reviewing the clinical benefit and rationale for undertaking certain surgical procedures.

These should not be regarded as separate projects but as means to work with clinical teams to modernise and review the complete care pathway. It is important that Clinicians see and understand the benefits of measuring outcomes in their day to day work, and this should be linked to the principles of good clinical practice. The Health and Social Care Board will adopt a whole systems approach and will work with Trusts to ensure that proposed productivity and demand management changes are balanced across the region.

Underpinning all these processes is the need for organisations to engage with their staff and their representatives to inspire, motivate and engage them in taking forward these service improvements.

PFA Target: Absenteeism

Each Trust should reduce its level of absenteeism to no more than 5.2% in the year to March 2011.

The need to ensure an effective productive workforce within a changing healthcare environment will require a clear workforce strategy which will include the use of more effective workforce planning techniques. In the past workforce planning has tended to be based around a centralised model focusing on the development of the commissioning of training places in the education sector. There has been recent investment in Human Resources, Nursing and Allied Health Professions capacity to undertake Strategic Workforce Planning using the “Six Step Model” developed by Skills for Health and the National Workforce Project.

This model can be effectively used in both local service delivery planning but also at a Commissioning level. The forthcoming financial challenges provide a stimulus for greater levels of cooperation and collaboration between workforce planners both at Trust and Commissioning level to identify the workforce implications of the changes that are required of the workforce not only on dealing with commissioning intentions but also the productivity agenda. An important tool in ensuring more effective planning is access to meaningful performance information.

The engagement of the Trust workforce planning network in a prioritised plan of work will be an important step in developing workforce plans in a manner which will enable the development of a workforce that can be deployed both numerically and with appropriate skills to provide safe and effective healthcare.

PFA Target: Staff health and wellbeing

All HSC organisations should put in place organisational health and wellbeing strategies including being pro-active in improving the quality of and speeding up access to occupational health services, and strengthen Health and

Social Care Board accountability for the management of sickness and absence.

Work is underway not only in some Trusts but also in Review of Public Administration Phase 2 organisations to ensure the development of a strategic approach to improving the health and wellbeing of the workforce. The importance of ensuring the health and wellbeing through the optimum use of people and other resources is an important human resource approach at a time when the workforce is being asked to improve productivity and potential responding to an increasing patient and client safety agenda. This will have to address the issues of the effective deployment of resources, skill mix reviews and the need to ensure access targets are achieved.

SCHEDULES

Health and Social Care Board Commissioning Plan

FP1

PLANNED INCOME AND EXPENDITURE COMMITMENTS
2010/11

Income/Expenditure	HSCB		PHA		TOTALS	
	IYE £K	FYE £K	IYE £K	FYE £K	IYE £K	FYE £K
RECURRING INCOME						
1.0 Recurring departmental allocation	3,582,829	3,559,392	70,418	68,097	3,653,247	3,627,489
2.0 Other Income					0	0
TOTAL INCOME	3,582,829	3,559,392	70,418	68,097	3,653,247	3,627,489
RECURRING COMMITMENTS						
3.0 Direct commissioning by Board & Agency	34,942	34,440	11425	11424	46,367	45,864
Local Commissioning Group analysis:						
4.1 Belfast	609,657	599,747	9230	8784	618,887	608,531
4.2 Northern	667,365	657,191	10621	10111	677,986	667,302
4.3 Southern	532,640	525,108	7635	7228	540,275	532,336
4.4 South Eastern	493,874	485,646	7115	6737	500,989	492,383
4.5 Western	468,513	462,185	8304	7945	476,817	470,130
Management & administration:						
5.1 Board / PHA	26,872	27,345	14179	13959	41,051	41,304
5.2 BSO	19,271	19,271	294	294	19,565	19,565
5.3 LCGs					0	0
5.4 other					0	0
6.0 Patient & Client Council					0	0
7.0 FHS	655,390	655,390	1615	1615	657,005	657,005
Reserves: (specify)						0
8.1 Central Pressures	8,196	11,960			8,196	11,960
8.2 Elective Care	48,450	33,450			48,450	33,450
8.3 DIS - IT revenue/licences	17,659	17,659			17,659	17,659
Other expenditure: (specify)						0
9.1 CSR bridging		30,000			0	30,000
9.2 AFC/Incremental drift					0	0
TOTAL RECURRING COMMITMENTS	3,582,829	3,559,392	70,418	68,097	3,653,247	3,627,489

10.0 **SURPLUS / (DEFICIT)**	0	0	0	0	0	0

Commissioning Plan

RECURRING EXPENDITURE COMMITMENTS BY LCG AND TRUST- HSCB FP2

	Belfast IYE £k	Northern IYE £k	Southern IYE £k	South Eastern IYE £k	Western IYE £k	NIAS IYE £k	other IYE £k	Total IYE £k		
Belfast LCG	538334	941	156	41513	100	10946	17667	609657	778617	-250
Northern LCG	132429	494871	3191	5770	6652	13390	11062	667365	858877	-250
Southern LCG	73493	1487	426816	9627	3108	9464	8645	532640	684231	0
South Eastern LCG	123119	730	1058	350499	82	8649	9737	493874	637024	0
Western LCG	40616	1282	1143	2018	401079	11160	11215	468513	614379	0
Direct Commissioning				7356				7356		
Totals	907991	499311	432364	416783	411021	53609	58326	2779405		

Totals for Board and each LCG must reconcile to lines 3 and 4.1 to 4.5 of FP1

Commissioning Plan

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RECURRING EXPENDITURE COMMITMENTS BY LCG AND TRUST- HSCB FP2

	Belfast FYE £k	Northern FYE £k	Southern FYE £k	South Eastern FYE £k	Western FYE £k	NIAS FYE £k	other FYE £k	Total FYE £k	
Belfast LCG	528586	941	156	41408	100	10946	17610	599747	773669
Northern LCG	129842	487361	3191	5754	6499	13390	11154	657191	852858
Southern LCG	68055	471	426167	9152	3108	9464	8691	525108	680139
South Eastern LCG	121768	730	1058	343668	82	8649	9691	485646	632738
Western LCG	39111	1282	1143	2013	396231	11160	11245	462185	610789
Direct				7356					
Totals	887362	490785	431715	409351	406020	53609	58391	2729877	

Totals for Board and each LCG must reconcile to lines 3 and 4.1 to 4.5 of FP1

RECURRING EXPENDITURE COMMITMENTS BY LCG AND TRUST- PHA FP2

	Belfast IYE £k	Northern IYE £k	Southern IYE £k	South Eastern IYE £k	Western IYE £k	NIAS IYE £k	other IYE £k	Total IYE £k
Belfast LCG	1670	33	0	0	0	0	7527	9230
Northern LCG	210	3145	892	0	0	0	6374	10621
Southern LCG	156	36	2437	0	0	0	5006	7635
South Eastern LCG	782	34	0	477	0	0	5822	7115
Western LCG	148	32	626	0	2178	0	5320	8304
Direct Commissioning	5457	563	315	591	469		4025	11420
Totals	8423	3843	4270	1068	2647	0	34074	54325

Totals for Board and each LCG must reconcile to lines 3 and 4.1 to 4.5 of FP1

RECURRING EXPENDITURE COMMITMENTS BY LCG AND TRUST- PHA FP2

	Belfast FYE £k	Northern FYE £k	Southern FYE £k	South Eastern FYE £k	Western FYE £k	NIAS FYE £k	other FYE £k	Total FYE £k
Belfast LCG	1670	33	0	0	0	0	7081	8784
Northern LCG	210	3145	892	0	0	0	5864	10111
Southern LCG	156	36	2437	0	0	0	4599	7228
South Eastern LCG	782	34	0	477	0	0	5444	6737
Western LCG	148	32	626	0	2178	0	4961	7945
Direct	5457	563	315	591	469		4025	11420
Totals	8423	3843	4270	1068	2647	0	31974	52225

Totals for Board and each LCG must reconcile to lines 3 and 4.1 to 4.5 of FP1

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG: All LCGS

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	17921	9523	8278	7867	7887	1038	9632	62146
Non-pay (line 233)	5033	2774	2449	2277	2301	309	950	16093
SCAPE (line 241)	10971	5833	4885	4415	4733	751	629	32217
Children & Young People (line 242)	2940	3987	3063	2998	2610	0	0	15598
TOTAL	36865	22117	18675	17557	17531	2098	11211	126054

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG: Belfast LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	10690	19	3	833	2	214	2154	13915
Non-pay (line 233)	2990	5	1	239	1	63	230	3529
SCAPE (line 241)	6623	13	3	481	3	160	133	7416
Children & Young People (line 242)	2940							2940
TOTAL	23243	37	7	1553	6	437	2517	27800

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG: South Eastern LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	2464	16	26	6697	1	172	1704	11080
Non-pay (line 233)	695	4	6	1940	0	50	165	2860
SCAPE (line 241)	1491	14	26	3747	0	135	114	5527
Children & Young People (line 242)				2998				2998
TOTAL	4650	34	58	15382	1	357	1983	22465

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG: Northern LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	2618	9452	62	113	125	257	2220	14847
Non-pay (line 233)	741	2755	18	33	38	77	192	3854
SCAPE (line 241)	1564	5781	37	61	65	182	153	7843
Children & Young People (line 242)		3987						3987
TOTAL	4923	21975	117	207	228	516	2565	30531

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG: Southern LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	1375	9	8162	184	63	187	1754	11734
Non-pay (line 233)	386	3	2417	53	18	54	146	3077
SCAPE (line 241)	844	5	4798	104	42	145	123	6061
Children & Young People (line 242)			3063					3063
TOTAL	2605	17	18440	341	123	386	2023	23935

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG: Western LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	774	27	25	40	7696	208	1800	10570
Non-pay (line 233)	221	7	7	12	2244	65	217	2773
SCAPE (line 241)	449	20	21	22	4623	129	107	5371
Children & Young People (line 242)					2610			2610
TOTAL	1444	54	53	74	17173	402	2124	21324

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ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG: All LCGS

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health	590	577	599	615	352	0	74	2807
Learning Disability	701	505	262	556	1061	0	0	3085
Stroke	0	0	0	0	0	0	1751	1751
Acute (incl renal)	130	0	0	0	0	0	0	130
Children with complex needs	21	24	70	18	17	0	0	150
Children	272	65	52	168	46	0	666	1269
Physical Disability	259	296	236	219	209	0	0	1219
Long-term Conditions - palliative are	0	0	0	0	50	0	0	50
Long-term Conditions - chronic disease	0	0	45	0	0	0	0	45
Demographics	3188	3642	2904	2698	2568	0	0	15000
Hospital & Specialist Drugs	5976	551	372	312	327	0	6318	13856
Child Protection Gateway Teams	234	267	213	198	188	0	0	1100
Adult protection arrangements	47	2	2	47	2	0	0	100
IT services reduction to revenue	0	0	0	0	0	0	-201	-201
Managing Reform	0	0	0	0	0	0	0	0
TOTAL	11418	5929	4755	4831	4820	0	8608	40361

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ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG: Belfast LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health	590						16	606
Learning Disability	701							701
Stroke							372	372
Acute (incl renal)	28							28
Children with complex needs	21							21
Children	272							272
Physical Disability	259							259
Long-term Conditions - palliative are								0
Long-term Conditions - chronic disease								0
Demographics	3188							3188
Hospital & Specialist Drugs	1518			76			1343	2937
Child Protection Gateway Teams	234							234
Adult protection arrangements	47							47
IT services reduction to revenue							-43	-43
Managing Reform								0
TOTAL	6858	0	0	76	0	0	1688	8622

ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG: South Eastern LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health				615			13	628
Learning Disability				556				556
Stroke							315	315
Acute (incl renal)	23							23
Children with complex needs				18				18
Children				168				168
Physical Disability				219				219
Long-term Conditions - palliative are								0
Long-term Conditions - chronic disease								0
Demographics				2698				2698
Hospital & Specialist Drugs	1262			236			1136	2634
Child Protection Gateway Teams				198				198
Adult protection arrangements				47				47
IT services reduction to revenue							-36	-36
Managing Reform								0
TOTAL	1285	0	0	4755	0	0	1428	7468

ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG: Northern LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health		577					18	595
Learning Disability		505						505
Stroke							425	425
Acute (incl renal)	32							32
Children with complex needs		24						24
Children		65					370	435
Physical Disability		296						296
Long-term Conditions - palliative are								0
Long-term Conditions - chronic disease								0
Demographics		3642						3642
Hospital & Specialist Drugs	1345	547			2		1534	3428
Child Protection Gateway Teams		267						267
Adult protection arrangements		2						2
IT services reduction to revenue							-49	-49
Managing Reform								0
TOTAL	1377	5925	0	0	2	0	2298	9602

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ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG: Southern LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health			599				14	613
Learning Disability			262					262
Stroke							339	339
Acute (incl renal)	25							25
Children with complex needs			70					70
Children			52				142	194
Physical Disability			236					236
Long-term Conditions - palliative are								0
Long-term Conditions - chronic disease			45					45
Demographics			2904					2904
Hospital & Specialist Drugs	1107		372				1224	2703
Child Protection Gateway Teams			213					213
Adult protection arrangements			2					2
IT services reduction to revenue							-39	-39
Managing Reform								0
TOTAL	1132	0	4755	0	0	0	1680	7567

ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG: Western LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health					352		13	365
Learning Disability					1061			1061
Stroke							300	300
Acute (incl renal)	22							22
Children with complex needs					17			17
Children					46		154	200
Physical Disability					209			209
Long-term Conditions - palliative are					50			50
Long-term Conditions - chronic disease								0
Demographics					2568			2568
Hospital & Specialist Drugs	744	4			325		1081	2154
Child Protection Gateway Teams					188			188
Adult protection arrangements					2			2
IT services reduction to revenue							-34	-34
Managing Reform								0
TOTAL	766	4	0	0	4818	0	1514	7102

GLOSSARY

8 Glossary of Terms

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Quality Outcomes Framework – a system under which the effectiveness of schemes and measures to improve health is measured against a set of agreed targets.

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Chronic conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and need regular treatment and medication.

Palliative Care – services for people who are terminally ill and who suffer from conditions such as advanced cancer.

National Institute for Clinical Excellence – an expert organisation based in London that guides health care organisations across the UK on the effectiveness of new treatments, new drugs and other innovations.

Bariatric Surgery – a new type of hospital operation that enables some chronically obese people to reduce their weight by extensive surgery on their abdomen and digestive organs.

Northern Ireland Block – the total amount of financial support given to Northern Ireland by the Treasury in London.

Locum doctors – doctors whose work is based upon short term or temporary contracts.

Local Commissioning Groups – committees of the regional Health and Social Care Board that are comprised of GPs, professional health and social care staff such as dentists and social workers and community and elected representatives. Their role is to help the Board arrange or commission health and social care services at local level.

The Bamford Report – a major study commissioned by the Department of Health in Northern Ireland to provide a long term strategic plan for the development of mental health services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Evidence Based Commissioning – the provision of health and social care services based upon proven evidence of their value.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff.

Board Membership

Health and Social Care Board Membership

Dr Ian Clements – Chair
Mr John Compton – Chief Executive
Non Executive Directors
Mr Robert Gilmore
Mrs Elizabeth Kerr
Mr Stephen Leach
Dr Melissa McCullough
Mr Brendan McKeever
Mr John Mone
Dr Robert Thompson
Executive Directors
Ms Fionnuala McAndrew, Director of Social Services
Mr Paul Cummings, Director of Finance
Mr Dean Sullivan, Director of Commissioning
Mr Michael Bloomfield, Acting Director, Performance Management and Service Improvement

Public Health Agency Board Membership

Ms Mary McMahon – Chair
Dr Eddie Rooney – Chief Executive
Non Executive Directors
Ms Julie Erskine
Dr Jeremy Harbinson
Ms Miriam Karp
Mr Thomas Mahaffy
Councillor Cathal Mullaghan
Councillor Stephen Nicholl
Mr Ronnie Orr
Executive Directors
Dr Carolyn Harper, Executive Medical Director/Director of Public Health
Mr Ed McClean, Director of Operations
Mrs Mary Hinds, Director of Nursing and Allied Health Professions

Local Commissioning Groups

Belfast Local Commissioning Group

Dr George O'Neill (Chair)
Mr Iain Deboys, Commissioning Lead
Cllr. Tim Attwood
Ms Gerry Bleakney
Dr Grainne Bonner
Mr Gerry Burns
Ms Pat Cullen
Dr Jenny Gingles
Alderman Michael Henderson
Cllr. Mervyn Jones
Dr Terry Maguire
Ms Joyce McKee
Mr Danni Power
Alderman Gerry Rice
Ms Catriona Rooney
Mrs Irene Sloan
Dr Alan Stout
Mr Mike Townsend

Western Local Commissioning Group

Dr Brendan O'Hare (Chair)
Mr Paul Cavanagh, Commissioning Lead
Dr Kieran Deeny
Dr Eugene Deeny
Cllr. Mark H Durkan
Mrs Jenny Irvine
Cllr. Robert Irvine
Dr Jackie McCall
Dr Martin McCloskey
Mr Seamus McErlean
Mrs Clare McGartland
Ms Loretto McManus
Mr Eamon O'Kane
Mr Martin Quinn
Mr Graham Robinson
Cllr. Bernice Swift

Northern Local Commissioning Group

Dr Brian Hunter (Chair)
Mrs Bride Harkin, Commissioning Lead
Cllr. David Barbour
Dr Iain Buchanan
Mrs Linda Clements
Cllr. Adrian Cochrane-Watson
Mr Brendan Ford
Mrs Molly Kane
Mr Kevin Keenan
Dr Fiona Kennedy
Dr Una Lernihan
Mr Laurence O'Kane
Dr Terry McGowan
Cllr. Louise Marsden
Cllr. Thomas Nicholl
Ms Sharon Sinclair
Dr Turlough Tracey

South Eastern Local Commissioning Group

Dr Nigel Campbell (Chair)
Mr Paul Turley, Commissioning Lead
Cllr. Dermot Curran
Dr Paul Darragh
Mr John Duffy
Cllr. Andrew Ewing
Dr Colin Fitzpatrick
Mr David Herron
Dr Garth Logan
Ms Louise McCormick
Ms Joyce McKee
Dr Paul McGarrity
Ms Heather Tennyson
Cllr. William Ward
Ms Deirdre Webb

Southern Local Commissioning Group

Mr Sheelin McKeagney (Chair)
Mrs Lyn Donnelly, Commissioning Lead
Mrs Beverly Allen
Dr Walter Boyd
Cllr. Vincent Currie
Dr Sean Digney
Dr Brid Farrell
Mr Gerry Maguire
Mr Paul Maguire
Dr Keith MCCollum
Mr Miceal McCoy
Mrs Claire McGartland
Cllr. Sean McGuigan
Cllr. Sylvia McRoberts
Mr Kieran McShane
Dr Tom O'Leary
Cllr. Dr Philip Weir

HEALTH AND SOCIAL CARE BOARD
PUBLIC HEALTH AGENCY

COMMISSIONING PLAN 2012/13

13 September 2012

Health and Social Care Board

Public Health Agency

Contents Page

Foreword

Legislation enacted in 2009 created a new commissioning system in Northern Ireland with the establishment of a region-wide Health and Social Care Board (including five Local Commissioning Groups (LCGs) and a Public Health Agency).

The Health and Social Care Board is required by statute to prepare and publish each year a Commissioning Plan setting out the health and social care services to be commissioned and the associated costs of delivery.

It is the responsibility of the HSCB, in cooperation with the Public Health Agency, to assess health and care need, to identify ways in which this need might be met and to directly commission or otherwise put in place services and systems for the appropriate delivery of health and social care gain. In carrying out this responsibility, it is important that the HSCB engages with a wide range of stakeholders such as the public in general, patients and clients, their relatives and carers, health and social care professionals, Trusts and other providers of health and care. It is our aim to ensure that services are appropriate and equitably distributed in line with service user expectations and that those services we commission are the subject of regular and ongoing performance appraisal and quality improvement.

It is within this context that the HSCB prepares the annual Commissioning Plan in partnership with the Public Health Agency. The Board and Agency take forward the regional commissioning agenda through a series of integrated, multi-disciplinary service teams. The HSCB's commissioning processes are underpinned by the five LCGs which are committees of the HSCB and are responsible for ensuring that the health and social care needs of local populations across NI are addressed. (Each of the LCGs has produced its own local plan for 2012/13 which is appended to and should be read in conjunction with this document.) The HSCB has also established a network of Primary Care Partnerships to work in partnership with LCGs to effect change in primary care, and support the integration of primary, community and secondary care.

The HSCB is accountable to the Department and the Minister for the achievement of Ministerial priorities, standards and targets and for ensuring that services are commissioned in accordance with statutory obligations, standards, departmental policy and strategy guidance and guidelines as well as agreed service frameworks. Where a major change

is proposed to an existing service, the change will require the endorsement of the Minister and the Department. Other decisions will be taken by the Board with support from the Agency as part of routine commissioning business, consistent with the respective roles and responsibilities of each organisation.

This is the third Commissioning Plan to be produced by the Health and Social Care Board and Public Health Agency. The Plan takes full account of the financial parameters set by the Executive and DHSSPS, and is consistent with the direction and priorities set out in the Minister's Commissioning Direction for 2012/13.

While the capital budget is not within the responsibilities of the HSCB and is therefore not referenced directly in this Plan, clearly a number of the commissioning proposals set out in the Plan will have implications for the capital budget in terms of equipment and estate.

Purpose

The Commissioning Plan provides details of how the services being commissioned by the HSCB align with the Executive's Programme for Government, the Economic Strategy and the Investment Strategy; the Minister's vision and priorities for Health and Social Care; extant statutory obligations, including Equality duties under the Northern Ireland Act 1998(b), Personal and Public Involvement (PPI), the standards, policies and strategies set by the Department and Departmental Guidance and Guidelines.

The Commissioning Plan aims to provide a clear roadmap for the development of health and social care services for the population of Northern Ireland. The Plan builds upon the work in previous years and also is fully consistent with and supportive of the long-term direction set out within *Transforming Your Care* and in the Quality 2020 Strategy. While the primary focus of the Plan is on the 2012/13 financial year, many of the changes signalled will be implemented over a much longer timescale, up to and beyond 2015.

This Plan sets out the level of service that the population of NI can expect to receive, and the changes that are necessary to existing services to secure this.

The Plan supports the Minister's clearly stated desire to improve the quality of health and social care for clients and patients and their carers, with a strong focus on outcomes, specifically:

1. Improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion and earlier intervention.
2. Improve the quality of services and outcomes for patients, clients and carers.
3. Develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community.
4. Improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector.
5. Improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities.
6. Ensure that the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services.

The Plan is driven primarily by the desire to secure improvements in the above areas – rather than by money – although inevitably the scale and pace of change is limited by the availability of resources within health and social care in 2012/13 and beyond.

The Plan also reflects how the HSCB and PHA will support the Minister's policy objective of providing more services in the community, in or close to people's homes, in particular through the necessary redesign of service provision.

This objective will create opportunities to shift resourcing into community services including social care services to help avoid the causes of delayed discharges. The Plan sets out in section 6 the actions to minimise unnecessary hospital admissions and facilitation of timely discharge across a range of patient and client groups.

Transforming Your Care

Transforming Your Care: A Review of Health and Social Care was published by the Minister in December 2011. *Transforming Your Care* describes a future vision for health and social care in Northern Ireland, one in which services are designed around the needs of the individual and delivered as locally as possible.

There are a total of 99 recommendations resulting from comprehensive engagement and consultation with a wide range of stakeholders, and analysis of the current provision of care. Together these represent a fundamental change in how we deliver services with overarching focus being on quality of care and care provided as close to home as practical.

As noted above, this Commissioning Plan is fully consistent with and supportive of the long-term direction set out within *Transforming Your Care.*

Planning Context

The budget for Health and Social Care in 2012/13 is £3,994m. This represents an increase of £58m (1.5%) on the previous year's budget, but falls well short of the additional inescapable financial pressures in 2012/13 of £273m, leaving a deficit of £215m.

To address this deficit, a range of actions will be taken, including securing further improvements in efficiency and effectiveness in the delivery of services by Trusts. The HSCB will work with Trusts and other partners to ensure that the required savings in 2012/13 are delivered in a way which does not undermine the delivery of high quality, accessible health and social care services. While inevitably some elements of savings will have to be secured through one-off, opportunistic measures, as far as possible we will ensure that savings are delivered through genuine productivity improvements rather than service cuts, consistent with the longer term strategic direction for service delivery as set out in *Transforming Your Care.*

This Commissioning Plan specifies *what* services are to be provided for the local population including associated commissioner requirements and expectations. Details of *how* these services will be provided – consistent with Ministerial priorities, commissioner requirements and available resources – will be set out in the individual Trust Delivery Plans 2012/13 (to be completed in June 2012).

The focus of this Commissioning Plan and the subsequent Trust Delivery Plans is on the year 2012/13. While implementation of key strategic reforms will be progressed in 2012/13, a number of reforms signalled in *Transforming Your Care* will take several years to fully implement. Details of the nature and timing of these longer term changes for 2012/13 and beyond will be provided in five local economy Population Plans 2012-15. Each of these Population Plans will be led by the relevant Local Commissioning Group with significant contribution

from the local Trust, working in partnership as part of a 'local economy'. The Population Plans are to be completed by June 2012.

The Population Plans will bring together in a single document for each of the five local economies both the 'what' and the 'how' in terms of the arrangements for ensuring safe, high quality accessible health and social care services. The Population Plans will set out the changes to how services are to be provided within each local area consistent with the vision set out in *Transforming Your Care*, and with the commissioner requirements and expectations set out in this document.

The table below summarises the various health and social care plans to be produced in the coming months.

Plan	Produced in Response To	Focus	Planning Period	Lead Organisation	Date for completion
Commissioning Plan/ Local Commissioning Plans	Minister's Commissioning Direction	*What* services are to be provided	2012/13	HSCB/ LCGs/PHA	April 2012
Trust Delivery Plans	Commissioning Plan/ Local Commissioning Plans	*How* services are to be provided	2012/13	Trusts	May 2012
Population Plans	Transforming Your Care; Commissioning Plan/ Local Commissioning Plans	What and how services are to be provided	2012-15	LCGs/Trusts	June 2012

Key Achievements in 2011/12

During 2011/12, substantial progress was made across the range of HSCB/PHA commissioning priorities. Some particular achievements are highlighted below:

- The Bowel Cancer Screening Programme was fully rolled out to all Trust areas in Northern Ireland from January 2012.
- In 2011/12, Trusts increased the take-on rate for NICE-approved specialist therapies for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. At the end of March 2012, no patient was waiting longer than six months to commence therapy for the agreed conditions.
- In 2011/12 the HSCB concluded a comprehensive capacity planning exercise in relation to all aspects of elective care services/outpatient assessment, outpatient reviews and inpatient / day case treatment. This has provided a robust foundation for the

identification of the core capacity to be delivered by Trusts and areas where capacity is shorter than demand.

- In 2011/12, as part of a wider programme of elective care reform, improvement and investment, waiting times for plastic surgery outpatients were reduced from 108 weeks to 36 weeks. More generally, the HSCB has secured significant reductions in elective care waiting times across Trusts and specialties.
- In 2011/12 the HSCB secured significant improvement in waiting times for endoscopic services. By the end of March 2012 all patients were being seen within 13 weeks or less compared to the position at the beginning of the year with patients waiting up to 36 weeks.
- During 2010/11 and 2011/12, a total of over 100 patients have received a live kidney transplant. Recent data suggest that Northern Ireland offers a higher level of access to this service than any other region in the UK.
- In 2011/12 the HSCB secured significant improvement in the waiting time for specialist drug treatment for wet age related macular degeneration.
- During 2011/12 all patients with MS have commenced appropriate NICE recommended therapies or therapies approved under the UK Risk Sharing Scheme for disease modifying treatments for MS within 13 weeks.
- In 2011/12 the PHA launched a multimedia campaign “Act Fast” to raise public awareness of the early signs and symptoms of stroke.
- During 2011/12 the HSCB / PHA worked with Trusts to ensure that patients with stroke and transient ischaemic attack (TIA) have access to treatment and care that meets national quality standards and is consistent with the recommendations of the review of stroke services in Northern Ireland.
- During 2011/12, all Trusts have continued to ensure that patients with acquired brain injury commence specialised treatment within 13 weeks.
- During 2011/12 the HSCB re-established a regional group to promote direct payments and other forms of self-directed support which will give service users and carers greater control and wider choice.
- At the end of March 2012, some 6,300 children in vulnerable families had received family support intervention. This significantly

exceeds the March 2012 target to ensure that 3,000 children in vulnerable families were receiving such support.

- During 2011/12 the HSCB in partnership with key stakeholders established a Regional Fostering and Adoption Taskforce to progress a range of initiatives to improve the consistency and quality of fostering and adoption services across the region.

Key Commissioning Priorities in 2012/13

The commissioning agenda for 2012/13 is both significant and complex. A consistent focus throughout the Plan is on securing improvements both in the quality of care provided and in individual patient's experience of that care. In many cases these improvements will be delivered during 2012/13, for example, further improvements in patient waiting times. Other improvements, particularly those linked to *Transforming Your Care*, will take longer to effect. Within this context, the HSCB will ensure particular focus on the following issues during 2012/13:

(i) Improve A&E Performance

Waiting times for A&E services in NI are unacceptable, falling well below the Minister's minimum standards, namely that 95% of patients should be seen and treated within four hours, and no one should wait longer than 12 hours. The failure to provide routinely accessible, high quality emergency care services is impacting on patients, on staff and on wider public confidence in the health and social care system. At best long emergency department waiting times result in a negative experience for patients and their families; at worst long waiting times can impact materially on the quality and safety of the care provided.

In response, the Board and PHA have established an A&E Improvement Action Group to work with Trusts to secure a major improvement in performance by June 2012; from July, there are to be no 12-hour breaches and performance against the 4-hour target is also expected to improve materially.

(ii) Maintain Momentum with Elective Care

During the first six months of 2011/12 there was a considerable increase in waiting times for elective care (outpatients, diagnostics and planned treatments). This deterioration in performance was directly related to wider uncertainty with the HSC financial position during this period and the resulting inability to commission additional activity.

Since September 2011, very significant progress has been made, with improved elective care waiting times for patients across the five Local Commissioning Group areas, and for regional services.

The HSCB is committed to maintaining this momentum into 2012/13, securing further reductions in maximum waiting times for patient assessment and treatment. This improvement will be through a combination of ensuring Trusts deliver their core, funded capacity, together with investment in additional in-house or Independent Sector activity where this is required to meet patient demand.During2012/13the HSCB will make targeted recurrent investments, with a particular focus on those regional services for which there is no readily available Independent Sector solution when additional activity is required.

(iii) Co-ordinate Implementation of Transforming Your Care

The *Transforming Your Care* report forms one element of the DHSSPS whole system plan. It has been agreed that the HSCB take forward the implementation of recommendations in *Transforming Your Care* for which it has operational responsibility. A 'Transformation Programme Board' has been established within the HSCB to lead the delivery of those recommendations. This comprises members from the HSCB, HSC Trusts, Business Services Organisation, Public Health Agency and Local Commissioning Groups.

In 2012/13 the key milestones and deliverables are:

- 5 local Population Plans, by June 2012;
- A strategic implementation plan will be produced which consolidates the 5 local population plans and identifies a series of work-streams, and projects, to progress the implementation of the transformational change; and the
- Establishment of the 17 Integrated Care Partnerships.

A key role for commissioning in 2012/13 and beyond will be to help to support the delivery of the *Transforming Your Care* process. In this regard arrangements have been established – both in terms of structures and processes – to ensure that *Transforming Your Care* is incorporated into routine commissioning business. A good example of this is the incorporation into detailed commissioner service specifications of the relevant Transforming Your Care recommendations, ensuring that there is a single commissioning agenda to be taken forward with HSC Trusts and other provider organisations.

(iv) Establish Integrated Care Partnerships

Transforming Your Care has proposed the establishment of 17 Integrated Care Partnerships (ICPs). It is envisaged that these will be based on the existing Primary Care Partnership (PCPs) configurations but move beyond the scope of PCPs to embed vertical integration, improving coordination between hospital, primary and community care, and driving significant transformational change which could in future include:

- **'Risk stratification'** of patients who have a chronic illness – identifying patients at risk of readmission to hospital with flare-ups of their chronic illness and providing 'intensive care' in the community
- **Integrated Care Planning:** using a common IT platform populated from existing GP and hospital systems (including lab results) viewable by GPs, community nurses and hospital specialists. The anticipated rollout of the NI Electronic Care Record in 2012/13 will facilitate this objective
- **Clinical information sharing:** viewing the clinical record from multiple settings and learning from past experience through multidisciplinary case conferences involving consultants, nurses, social workers and GPs
- **Performance feedback:** driving up clinical performance and patient experience across the integrated partnerships

Under the auspices of the Transformation Programme Board, the five LCGs will signal, in their local population plans, their intention to work with Trusts and other stakeholders to establish ICPs in 2012/13.

Over-riding principles

Even in the current difficult financial environment we have the opportunity to secure an excellent health and social care service for the population. In doing so, we must ensure that the still significant resources available are targeted towards providing care and support for those patients and clients most in need, and ensuring that these services are delivered efficiently and effectively consistent with best available evidence.

We are committed to securing value for money through commissioning, ensuring that we achieve maximum benefit from all available resources. As stated in last year's Commissioning Plan, there are no neutral

decisions: every decision will have consequences and opportunity costs for patients and clients.

In our commissioning of health and social care services shall be guided by the following principles:

- Protect the most vulnerable and disadvantaged
- Promote equality of opportunity and human rights
- Secure transformational improvement to the health and wellbeing of the population through both a reduction in health inequalities and a general improvement in health outcomes for all
- Ensure commissioned services are evidence-based, safe and of high quality, and deliver improved outcomes for patients and clients
- Avoid false choices – patients and clients rightly expect their health and social care services to have a positive experience *and* a good outcome and our commissioning will reflect this
- Commission compassionately, ensuring that the individual and collective needs and expectations of patients and clients are at the centre of our thinking in all of our decision making
- Secure value for money, maximise efficiency and effectiveness in service delivery and drive out waste
- Ensure meaningful involvement of clinicians in primary, community and secondary care in the commissioning processes
- Ensure meaningful involvement of patients and clients in our commissioning processes
- Ensure that our primary focus is first and foremost on the needs of patients, clients and populations, as well as encouraging and enabling service providers and practitioners
- Support people to live as independently as possible and with dignity
- Provide services as locally as possible, where this can be done safely, sustainably and cost-effectively
- Maintain reasonable waiting times for all of the services we commission, consistent with the prioritised needs of patients and clients
- Facilitate a working environment that enables the committed workforce to do their job sensitively and effectively.

In all of our commissioning activities we will be open, accessible and straightforward. Where we propose changes to existing services, or decide not to commission a new service, we shall do so transparently with a clear rationale for our decision. Where a commissioning decision is taken primarily to make a saving or service reduction, this will be explicitly stated.

While we fully recognise that our primary and direct line of accountability is to the Minister, as a public body we shall seek to continue to work openly and effectively with the Assembly Health Committee and other elected representatives.

The People's Priorities

As noted above, our key principles include the effective involvement of clinicians, patients and clients and others at all stages in the commissioning process. In this regard, we have sought to reflect throughout this Commissioning Plan the People's Priorities for 2012/13 identified by the Patient Client Council, namely:

1. Timely access to important hospital services such as A&E and improving the standards of care e.g. hospital cleanliness
2. Supporting the elderly to live independently through sustainable domiciliary care
3. Reducing waiting times for outpatient assessment, treatment and diagnostic services to acceptable levels
4. Shorter waiting times for diagnostics and treatment for cancer
5. Improving the quality of Mental Health and Learning Disability services including implementation of the Bamford Review
6. Increase the number of specialist staff e.g. nurse specialists
7. Quicker access to GPs and better consultation times
8. Improving child care, child protection and other support services for the very young
9. Reducing the costs of Administration and Management
10. Improving quality generally across the full range of HSC services

Making the changes

This Commissioning Plan was approved by the boards of the Health and Social Care Board and the Public Health Agency in June 2012 and submitted to the Department for consideration. The final Commissioning Plan was approved by the Minister in September 2012 and arrangements have now been put in place by the Health and Social Care Board, in partnership with the Public Health Agency, to oversee its delivery.

These arrangements include:

- The translation of the Commissioning Plan into objectives within corporate and local commissioning plans that will be the subject of scrutiny through established performance review
- The agreement of detailed service and budget agreements with providers, including appropriate incentives and sanctions, supported by appropriate performance management regimes
- The development of detailed proposals from Local Commissioning Groups and Providers to give effect to the commissioning strategy in this Commissioning Plan for consideration, equality screening, consultation and implementation as appropriate.

In addition to the above arrangements, and consistent with their criticality to the integrity of the health and social care system in 2012/13 and beyond, we shall establish programme management arrangements on a regional basis to ensure the delivery of the key strategic reforms signalled in *Transforming Your Care* and in this Commissioning Plan. External support will be secured to help ensure that reform is implemented quickly, effectively, consistently and sustainably.

Within this plan it is fully recognised that the shape of health and social care service will need to change in order to adapt to an ever changing, and increasingly difficult environment. We have sought to put in place arrangements that will deal specifically with these complex issues, while acknowledging that all final decisions will require endorsement by the Minister and the Department.

As the Commissioning Plan is implemented we are committed to assessing potential effects on particular populations – including those identified under Section 75 of the Northern Ireland Act 1998 –in a rigorous way, through the conduct of equality and human rights screening and if necessary further equality impact assessments.

Through this activity we believe that we can increase the probability that decisions will better promote equality of access and outcomes.

We recognise however that in some instances an assessment of equality and human rights implications can be limited by lack of local data or evidence including the lack of disaggregated data. Data collection will therefore continue be a key consideration, as are our organisational efforts – at regional and local levels – to embed equality and human rights in our commissioning activity; promote personal and public involvement and engagement; work in partnership with community, voluntary and other public sectors and increase the capacity of staff to use all the relevant evidence in decision making processes.

Our regular monitoring of progress on the implementation of the Commissioning Plan will inform us of how well we are doing this.

Dr Ian Clements
Chair, Health and Social Care Board

Ms Mary McMahon
Chair, Public Health Agency

Mr John Compton
Chief Executive,
Health and Social Care Board

Dr Eddie Rooney,
Chief Executive,
Public Health Agency

Section One

Context and Key Themes

1 Strategic Context

This section sets out the key environmental factors influencing policy formulation and the major policy imperatives which define the future direction of travel for service development and redesign.

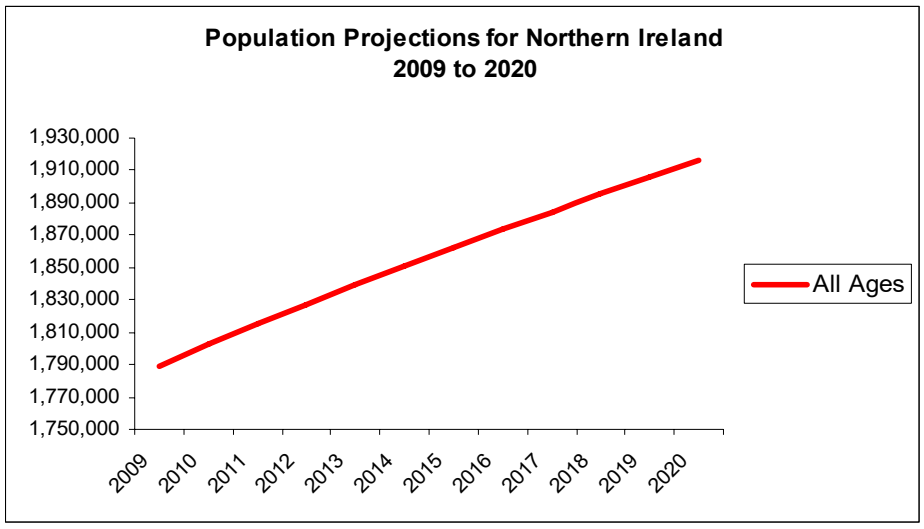
1.1 Demography

Northern Ireland has the fastest growing population in the UK. Currently there are approximately 1.8m people in the province, a figure which is expected to rise to 1.937m by 2022. From a health and social care perspective, possibly the most significant aspect of this increase is the rising number of older people.

Up to 2022 the number of people aged 65 years and over is estimated to increase to 348,000. This is 18% of the total population compared with 15% now. The area of highest growth is in the west of the province whilst the area projected to have the highest number in this age bracket is the South Eastern locality. In Northern Ireland life expectancy increased between 1998-2000 and 2008-2010from 74.5 years to 77 years for men and from 79.6 years to 81.4 years for women.

Figure 1

Population Projections



Projected Total Population Change by LCG Area 2009-2020

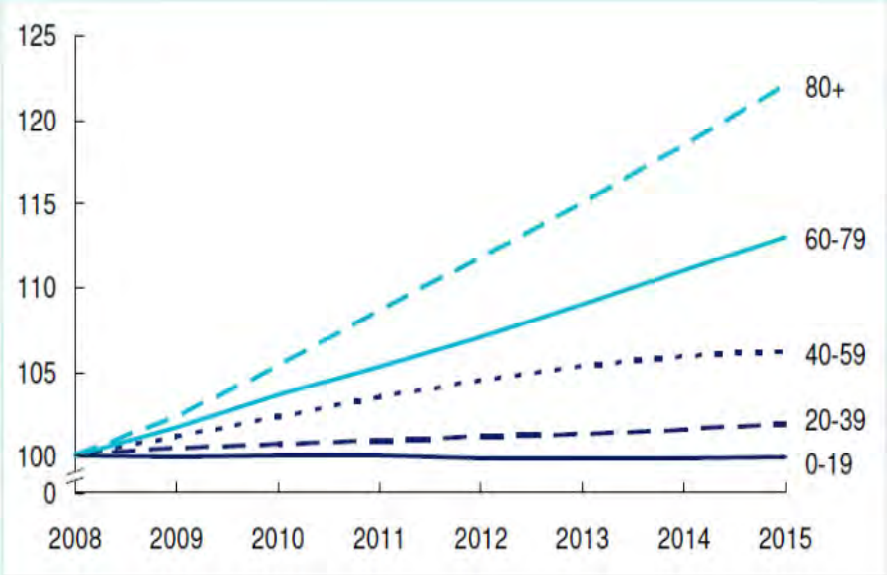
- Belfast ***+2%***
- South Eastern ***+6%***
- Northern ***+7%***
- Southern ***+15%***
- Western ***+6%***

Source: 2008 Based Population Projections, NISRA

By 2014 there will be approximately 50,000 more people in N.Ireland than there are today and more than half of these will be over 65 years old.

Figure 2

Projected Growth of 85+



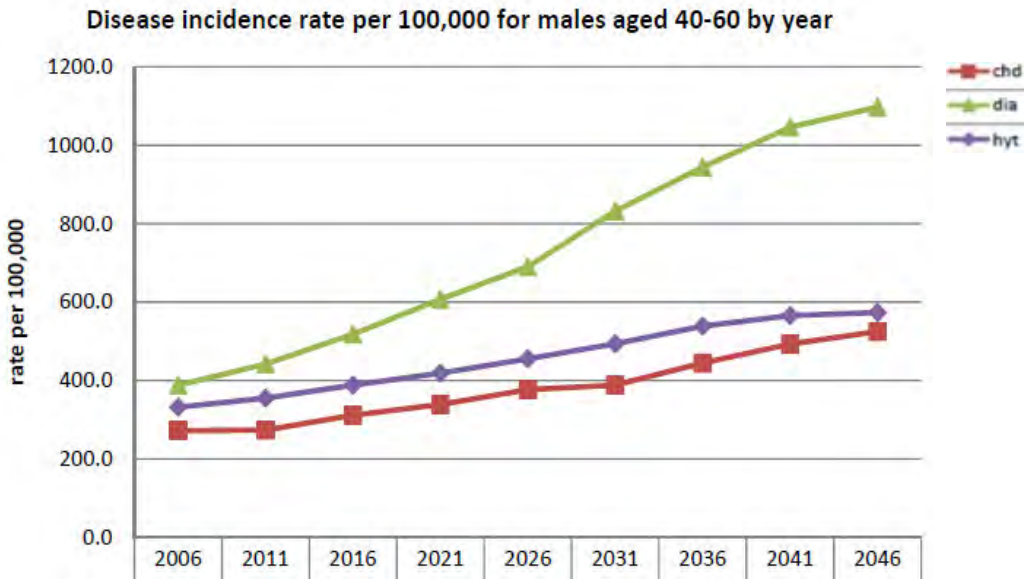
Source: 2008 Based Population Projections, NISRA

Advancements in modern treatments should be celebrated, but the implications on health and social care provision need to be recognised and planned for accordingly. In addition to an ever increasing older population, health and social care is also required to respond effectively to the growing incidence rate of chronic conditions such as hypertension, diabetes, asthma and obesity.

The incidence rate (new cases) is influenced in part by lifestyle choices and government and personal action is required to make healthy choices easier. In addition, the prevalence rate (total number of cases) is influenced by survival rates. Early diagnosis and modern treatments reduce mortality and increase the need for services to manage chronic conditions in the long term; increasingly, this includes people with cancer.

Figure 3 following will show the estimated growth of the incidence rates for Coronary Heart Disease (CHD), Diabetes and Hypertension for males aged 40 to 60.

Figure 3



Source: National Heart Forum: Obesity Trends for Adults. Analysis from the Health Survey for England, (2010)

The preference for the location of services differs depending on the type of care required. An Omnibus survey (2011), found that over 80% of those surveyed would prefer long term care to be closer to home. Alternatively for short term episodes of care, the Patient Client Council found that people are prepared to travel to get the right treatment quickly. Health and social care services will be required to adapt to new ways of working in order to provide services of the highest quality consistent with the needs and expectations of patients and clients.

1.2 Quality 2020

In November 2011, *Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland* was published. The overall vision of the strategy is "To be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care."

Quality 2020 defines quality as having 3 key components:

- **Safety** – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them
- **Effectiveness** – the degree to which each patient and client receives the right care (according to scientific knowledge and

evidence-based assessment), at the right time in the right place, with the best outcome

- **Patient and Client Focus** – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

In order to achieve this ambitious target, the document describes five strategic objectives:

1. Transforming the Culture - Create a new and dynamic culture that is even more willing to embrace change, innovation and new thinking that can contribute to a safer and more effective service.

2. Strengthening the Workforce - Equip the workforce with the skills and knowledge they will require, building on existing and emerging HR strategies, to deliver the highest quality.

3. Measuring the Improvement –Confirm improvement through more reliable and accurate means to measure, value and report on quality improvement and outcomes.

4. Raising the Standards –Introduce robust standards of excellence particularly involving service users, carers and families in the development, monitoring and reviewing of standards.

5. Integrating the Care - Fully integrate services across all sectoral and professional boundaries to benefit patients, clients and families.

It is within this 10-year strategic context that the Commissioning Plan for 2012/13 and beyond seeks to be one of the key enablers of delivering the vision of high quality HSC services.

1.3 Programme for Government 2011-15

On 12 March 2012, the First Minister and deputy First Minister published the Programme for Government 2011-2015. The programme contains a number of key areas to be progressed in health and social care over the coming period. The commitments and associated outcomes are shown in the table below. The HSCB and PHA are committed to supporting the delivery of these objectives over the next three years. Monitoring and reporting on the commitments will be a requirement on the DHSSPS, HSCB and PHA. Commissioning will have an important role in achieving the commitments.

	Milestones / Outputs		
Commitment	**2012/13**	**2013/14**	**2014/15**
Allocate an increasing percentage of the overall health budget to public health	Strengthen the cross-sectoral / cross-departmental drive on improving health and mental wellbeing and reducing health inequalities	The HSC will have in place, all the arrangements necessary to extend bowel cancer screening to everyone aged60-74 from1st April 2014	Invest an additional £10min public health (increase based on 2011/12spend)
Invest £7.2 million in programmes to tackle obesity	Invest £2 million in tackling obesity through support of Obesity Prevention Framework	Invest £2.4 million in tackling obesity	Invest £2.8 million in tackling obesity
Introduce a package of measures aimed at Improving Safeguarding Outcomes for Children and Vulnerable Adults	Develop strategic Plan for Adult Safeguarding in Northern Ireland and produce a joint Domestic and Sexual Violence and Abuse Strategy	Open new Sexual Assault Referral Centre at Antrim Area Hospital	Develop an updated interdepartmental Child Safeguarding Policy Framework
Improve patient and client outcomes and access to new treatments and services	Enhance access to life-enhancing drugs	Improve quality of life for the children of teenage mothers from disadvantaged backgrounds by rolling out the Family Nurse Partnership Programme	Improve access to diagnostic and interventional cardiology services to reduce mortality and morbidity arising from myocardial infarction (heart attack)
Reconfigure, reform and modernise the delivery of Health and Social Care services to improve the quality of patient care	Development of clear implementation and Population plans to ensure delivery of the new model of care as set out in the Transforming Your Care report	By 2013/14 reduce the number of days patients stay in acute hospitals unnecessarily (excess bed days) by 10% compared with 2011/12	Secure a shift from hospital based services to community based services together within appropriate shift in the share of funding in line with the recommendations of TYC
Enrol people who have a long-term (chronic)condition, and who want to be enrolled, in a dedicated chronic condition management programme	Identify and evaluate the current baseline of patient education and self-management support programmes that are currently in place in each Trust area	Develop and secure range of quality assured education, information and support programmes to help people manage their long term conditions effectively	Offer people access to Appropriate education, information and support programmes

1.4 Health and Social Care Resources

The annual revenue budget for Health and Social Care in 2012/13 is just under £4bn, almost 40% of the total NI block funding. Despite the significant scale of this investment there are very real and increasing pressures on resources across all areas of Health and Social Care. These include demographic funding pressures arising from a growing elderly population, increasing numbers with chronic health conditions and the cost of new technologies and drugs.

Given the scale of competing demand, debate about how resources are deployed is often controversial and difficult. In this context, it is vitally important to ensure that the financial climate that we have entered is understood. Living within available resources and ensuring financial stability will be a key challenge for the HSC system. Financial plans for the next three years show that emerging inescapable funding requirements far exceed the anticipated levels of additional income available to Health and Social Care.

In response to this challenge the HSCB has developed a robust financial framework with the objective of maintaining quality performance while ensuring financial stability across the HSC through strong financial planning, management and accountability.

At the same time there is still clear evidence that there are significant opportunities to improve productivity, efficiency and effectiveness while maintaining and improving quality, patient and client outcomes. A further key objective is to ensure resources are being used to their maximum potential. Challenging productivity targets have been set for all HSC organisations for 2012/13 and for the remainder of the Spending Review period. It will be important to ensure health and social care outcomes for local populations are sustained as these stretching productivity targets are delivered.

Longer term reform of the HSC is required if resources are to be fully maximised. The long term model is set out in *Transforming Your Care*. The managed change it proposes will ensure resources are safeguarded from the potential impact of unplanned change. The final outcome will provide a reformed system where resources can be used to best effect. The future model will involve a definite shift from current hospital spend and its reinvestment into primary, community and social care services. This will be phased in throughout the period of the review.

In 2012/13 the Commissioning Plan provides the context for the HSC system to live within available resources and at the same time maintain the integrity of the service, while initiating the transition to effect the long term reforms planned for in *Transforming Your Care* that are so urgently required. Ensuring equal weight is given to the finance agenda, quality agenda and productivity agenda will be of central importance.

1.5 Transforming Your Care

In June 2011, the Minister announced the need for a review of HSC services. The key objectives of the Review were to:

- Undertake a strategic assessment across all aspects of health and social care services;
- Undertake appropriate consultation and engagement on the way ahead;
- Make recommendations to the Minister on the future configuration and delivery of services; and
- Set out a specific implementation plan for the changes that need to be made in health and social care.

The Minister's vision for the Review of Health and Social Care in Northern Ireland was to drive up the quality of care for clients and patients, improving outcomes and enhancing the patient and client experience. In addition he emphasised the need to improve productivity and make sure that every penny is spent effectively. The Minister further emphasised the importance of promoting greater involvement of frontline professionals in decision making and service development and the crucial role which more powerful local commissioning and charity and voluntary sector providing services could play in driving change and innovation.

Transforming Your Care: *A Review of Health and Social Care*– was published by the Minister on 13 December 2011 and sets out proposals for the future health and social care services in Northern Ireland. The full report can be accesses online through the following link:

http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

Transforming Your Care describes a compelling case for change and proposes a model which puts the individual at the centre with health and

social care services becoming increasingly accessible in local areas. This will result in a significant shift from provision of services in hospitals to the provision of services in the community, where it is safe and effective to do this.

Transforming Your Care proposes the establishment of 17 Integrated Care Partnerships. These Partnerships will join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent and voluntary sector. Each Local Commissioning Group will play a central role in determining the needs of its local population and will work closely with the Integrated Care Partnership in planning and delivering integrated services. In future more of the services that currently require a hospital visit will be available locally – Local Commissioning Groups and Integrated Care Partnerships will be integral to making this happen.

Transforming Your Care also highlighted the difficulties with maintaining the current complex model of emergency services, and the resultant need for significant change to how these services are provided. The Review also signalled the need for change to the way in which planned care is delivered, with shorter lengths of stay for inpatients, more patients receiving treatment in day-case or outpatient settings, and improved access to diagnostics such as CT and MRI scanning. These and other changes will be progressed in the context of moving to a hospital system made up of five to seven major acute hospital networks across Northern Ireland.

There are a total of 99 recommendations resulting from comprehensive engagement and consultation with a wide range of stakeholders, and analysis of the current provision of care. Together these represent a fundamental change in how we deliver services with overarching focus being on quality of care and care provided as close to home as practicable.

Integrated Care Partnerships

General Medical Practitioners (GPs) and primary health care teams, acting as gatekeepers to health and social care services, are significant players in determining the model of care that a patient receives and in how patient choice is exercised. Improving the coordination of health and care provision has the potential to raise the standard of patient care, improve provider efficiency and make the services that they provide more responsive to patients.

The concept of clinically led Primary Care Partnerships (PCPs) was developed in 2010 with the purpose of exploring new and innovative approaches to enabling the effective commissioning of health and social care, particularly where integrating care and designing and delivering services around patient need is concerned.

A PCP is a networked group of service providers who are not in themselves commissioners, but rather work to make service improvements across a care pathway. Activity is guided by and informs the decisions of LCGs in taking forward more effective and locally informed commissioning. PCP services required coordination between clinical and care professionals working across a specific care pathway (e.g. stroke care). They can analyse demand and secure progressive improvement of local services.

In 2011/12 the five Local Commissioning Groups (LCGs) developed the concept through fifteen pathfinder pilots, addressing issues as diverse as dermatological care, the prescribing of oral nutritional supplements, access to urgent ultrasound diagnostics, diabetic care and mental health.

An independent evaluation by the Beeches Management Centre concluded that PCPs have the potential to substantively deliver on key corporate objectives:

- Improving clinical quality
- Improving access and patient experience
- Reducing overall costs

One of the key enablers identified in *Transforming Your Care* is the establishment of Integrated Care Partnerships (ICPs). It is anticipated there will be 17 ICPs across the five health economies. GP practices will work together as federations of practices, enabling consistently high quality care for their patients. ICPs will join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent and voluntary sector. The ICP, working with the LCG, will have a central role in determining the needs of local population and planning and delivering integrated services. Key roles for ICPs are expected to include:

- **'Risk stratification'** of patients who have a chronic illness – identifying patients at risk of readmission to hospital with flare-ups of their chronic illness and providing 'intensive care' in the community
- **Integrated Care Planning:** using a common IT platform populated from existing GP and hospital systems (including lab results) viewable by GPs, community nurses and hospital specialists. The anticipated rollout of the NI Electronic Care Record in 2012/13 will facilitate this objective
- **Clinical information sharing:** viewing the clinical record from multiple settings and learning from past experience through multidisciplinary case conferences involving consultants, nurses, social workers and GPs
- **Performance feedback:** driving up clinical performance and patient experience across the integrated partnerships.

Acute Reconfiguration

Through comprehensive engagement with the public, *Transforming Your Care* found that the vast majority of people would prefer services delivered closer to home. Therefore, in the future HSC model, more of the services that currently require a hospital visit will be available locally. Local Commissioning Groups and ICPs will be integral to making this happen.

Transforming Your Care also pointed to the complex range and number of emergency services and cited evidence suggesting the current model is not fit for purpose. The example is given of the ongoing failure to deliver acceptable A&E waiting times. The DHSSPS has recommended that the Royal Victoria Hospital becomes a regional trauma centre which will work closely with local hospitals as part of an emergency care network.

For planned care there will be need to be improvements through shorter lengths of stay for inpatients, more patients receiving treatment in day case or outpatient settings, the required access to diagnostics and bringing access times into acceptable limits.

These and other service transformations will be in the context of moving over time to a hospital system made up of five to seven major acute hospital networks across Northern Ireland.

Transitional Funding

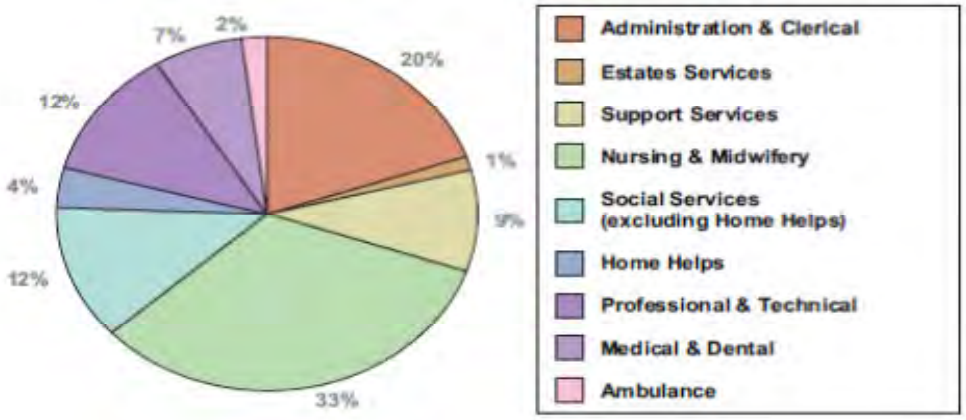
This transformation will not be straightforward - described recently by the Minister, in presenting to the Health Committee of the NI Assembly, as a 'major undertaking in the coming months'. It will require fundamental changes in the way services are delivered, including an estimated shift of £83 million from current hospital spend and its reinvestment into primary, community and social care services. To support this, *Transforming Your Care* estimated £70million of transitional funding will be required for implementation – approximately £25 million in the first year; £25 million in the second year; and £20million in the third year.

1.6 Workforce

At March 2011, the HSC employed around 78,000people either full-time or part-time. This accounts for just over 10% of the overall Northern Ireland workforce. The role of the workforce in the delivery of health and social care cannot be overstated. As *Transforming Your Care* is implemented during the coming years it is anticipated that a transition from acute to community services will be facilitated by a similar transition in workforce.

Figure 4 shows the overall split of the workforce by occupational family or profession. The largest Occupational Family, representing a third of the HSC workforce or 17,515, was Nursing, Midwifery and Health Visiting, followed by Administration & Clerical at 20%. Medical and Dental staff accounted for just 7% of all HSC staff or 3,636.

Figure 4



Source: DHSSPSNI Workforce Census2011

The role of commissioning is fundamental to supporting this transition.

Any decisions to make changes in service will be focussed on quality, safety and value for money. Ultimately these changes will provide support to a workforce which is currently operating at full capacity.

1.7 Information Communication Technology (ICT)

Technology has a pivotal role in helping the service to work smarter and more efficiently. Key principles of the current HSC ICT strategy are:

- Improve the care experience for service users
- Support and empower staff in undertaking their work
- Improve the efficiency of current service delivery
- Facilitate service innovation and development

The application of these principles will inform the implementation of electronic care records and improving electronic care communications. In order to realise the potential from investment in ICT, it will require the development of clinical informatic skills across the HSC. Clinical engagement is essential to maximise the delivery of Telemonitoring NI and other innovations. Consideration should also be given to the utilisation of the UK Health Informatics Framework in order to realise the whole systems skills required in a successful IT infrastructure across the region.

Electronic Care Records

Electronic care records will provide historic and current information to help healthcare professionals manage and deliver the best care possible. It will help staff coordinate care across multi-professional teams and ensure current patient medicines information is available. It will also improve patient safety when responsibility for an individual's care passes from one team or organisation to another. All this will be managed within a secure environment and accessed only under strict data protection protocols.

The development of the ECR is essential to realise many of the current policy action plans including Palliative Care, Northern Ireland Single Assessment Tool (NISAT) and achieve input and access to real time patient information.

Electronic Care Communications

Effective electronic care communications are also essential to improving safety and productivity in many of the processes involved in delivering care. For example, a new system to support GPs making referrals has been installed in all practices. This will enable hospitals and other services to receive referrals instantly rather than taking a number of days in the post.

Another example is the Northern Ireland Picture Archiving Communications System (NIPACS) which enables diagnostic images and data to be stored electronically, viewed on computer screens and for the first time ever there will be near instant access to diagnostic images across all hospitals throughout Northern Ireland.

The approach for 2012/13 will be pragmatic, building on what already exists and addressing gaps where good ICT systems are not already in place. The focus is on securely storing service user information in digital form and providing more convenient ways of accessing this information in such a way as to improve work processes, increase the quality and timeliness of care, and facilitate flexibility in where the care is actually provided.

All HSC organisations are duty bound to ensure there will be clear governance arrangements with regards the sharing of patient information across the HSC system including GP information systems.

1.8 Evidence Based Commissioning

Throughout the plan a consistent theme is to improve the quality of service and outcomes for patients, clients and carers. The commissioning proposals set out in the plan have been informed by a range of evidence based guidance about the standards and outcomes we need to achieve. These include:

- DHSSPS minimum care standards (where they apply) and standards for delivery of high quality, safe and effective health and social care which are developed by national bodies such as the National Institute for Health and Clinical Evidence (NICE) and the Northern Ireland versions of guidance from the Social Care Institute for Excellence (SCIE);
- Service frameworks which set out standards for health and social care that are evidence based and capable of being measured;

- Managed clinical networks which have been established to link groups of health professionals to support the provision of evidence based high quality, sustainable, safe and effective services;
- Detailed service specifications which set out the model of care that the HSCB and PHA wish to commission.

During 2012/13 the HSCB and PHA will continue to use a range of quality assurance methods including monitoring the implementation of guidance, participation in national audits, taking account of best practice as set out by the Guidelines and Audit Implementation Network (GAIN), peer review, benchmarking, feedback from patients, clients and carers to ensure that improvements in outcomes – both short term and long term - have been achieved.

2 Ensuring Financial Stability and Effective Use of Resources

2.1 Introduction

The current Spending Review period will undoubtedly be the most challenging in the history of Health and Social Care in Northern Ireland. The key challenge for the HSCB and PHA is to ensure the delivery of the same or greater levels of activity currently being commissioned within a financial envelope which is reducing in real terms, over the Spending Review period. This will involve both ensuring financial balance in addition to setting financial parameters for the rest of the Spending Review period, which will underpin the longer term plans set out in *Transforming Your Care* to reform and modernise health and social care.

Responsibility for maintaining operational financial control and maintaining financial stability across the HSC was delegated to the Health and Social Care Board during 2010. In order to achieve this objective the HSCB has established an effective, open and transparent financial framework which seeks to ensure financial resources are managed and used to best effect. This has involved establishing clear roles and responsibilities, streamlined processes and a robust accountability framework across the HSC.

The overall aim of the financial framework is to ensure that Health and Social Care organisations meet their key financial statutory duty to contain expenditure within resources available.

This section of the commissioning plan provides an overview of:

- The key principles and approach of the financial framework
- An overview of the Financial Plans for 2012/13, 2013/14 and 2014/15
- An overview of the planned investment of Health and Social Care Board and Public Health Agency resources

2.2 Financial Framework HSCB - Key Principles

A central approach will be used to manage HSC resources over the Spending Review period with all key organisations represented in the already established Financial Stability Programme Board.

Only specific inescapable pressures will be reflected in financial plans, sufficient to enable the maintenance of existing activity levels, address Ministerial targets, fund agreed service developments and meet residual demand.

The HSCB will set overall cash and productivity targets for individual HSC Trusts for each of the remaining years in the Spending Review period in light of the allocation received from the DHSSPS. These targets will take account of the relative efficiency levels and the relative incidence of pressures within each Trust.

Agreed cash and productivity targets will be attributed to the organisation incurring the pressures.

Local Commissioning Groups will play a pivotal role in developing, implementing and monitoring local Financial Plans and the Financial Plan will take account, as far as possible funding inequities across Local Commissioning Groups.

All organisations will be held to account through an agreed monitoring and accountability process.

2.3 Financial Plan - Approach

This section sets out the approach of the HSCB in respect of producing the Financial Plan, allocating resources, monitoring and delivering financial stability across the Spending Review period.

Financial Plans for 2012/13, 2013/14 and 2014/15 have been developed in an overall HSC context. This involved:

- An assessment of available income
- An assessment of the emerging inescapable pressures
- A review of additional solutions to meet expenditure requirements
- Identification of cash and productivity targets to all organisations.

The HSCB has a central role monitoring progress in respect of the financial plan and will hold Trusts to account on the full delivery of their element of the overall HSC Financial Plan and on their individual requirement to break-even in-year and on a recurrent basis.

A minimum dataset of financial and non-financial performance measures will be issued to all relevant organisations.

2.4 Financial Plan - Overview

This section provides key extracts from the three year outline plan and the detailed 2012/13 plan to illustrate the impact across key organisations.

Table1 below summarises the overall budgetary requirements for the HSCB/PHA for the next three years. The cash allocation figures were provided by the DHSSPS and take account of the differential planned Executive funding allocations over the three years. It is important to note that the 2012/13 year will be the most challenging in cash terms given that only an additional £58m will be made available in this year. As this will also be the initial year of the implementation of *Transforming Your Care*, it is important to recognise that over and above the pressures identified, there will be a requirement for transitional funding to allow implementation of the new care models to be taken forward. In 2012/13 this is estimated to be £25m.

Table 1 – Budgetary requirements 2012/13 – 2014/15

	2012/13	2013/14	2014/15
	£m	£m	£m
Allocation - Cash	3,994	4,118	4,202
Total Expenditure	(4,209)	(4,404)	(4,585)
Deficit	**(215)**	**(286)**	**(383)**

Total pressures across the three years are detailed in Table 2 overleaf. In arriving at these expenditure forecasts the approach has been both conservative and realistic, seeking to minimise pressures and identify only those which are likely to be viewed as inescapable.

Table 2 – Detailed Budgetary requirements 2012/13 – 2014/15

Summary	2012/13 £m	2013/14 £m	2014/15 £m
Gap (brought forward overcommitment) *	**-30**	**-188**	**-257**
Pressures:			
Pay inflation	-22	-35	-29
Non Pay inflation	-46	-35	-36
Service Developments	0	0	-20
Demography - General	-25	-25	-25
Demography - Acute Elective > 55yrs	-4	-4	-4
Demography - Acute Non Elective > 55yrs	-6	-6	-6
Specialist Hospital Services	-5	-5	-5
NICE Drugs	-17	-13	-12
Rates	-1	-1	-1
RCCE	-30	-8	-7
MH resettlements	-4	-5	-4
LD resettlements	-5	-7	-6
Residual Demand Other	-9	-10	-10
General Pharmacy Services	-29	-32	-34
General Dental Services	-12	-4	-5
Genreal Medical Services	-3	-5	-5
General Ophthalmic Services	0	-1	-1
Elective Care Non Recurrent	-25	-25	0
Extra Contractual Referrals	-1	-1	-1
Total pressures	**-244**	**-221**	**-211**
Pressures Gap before DHSSPS income	**-273**	**-410**	**-467**
Cash allocation from DHSSPS	58	124	84
Projected Deficit	**-215**	**-286**	**-383**

*Non recurrent pressures from previous year excluded from opening gap (Excluded from the opening gap 2013/14 -£27m, 2014/15 £29m)

2.5 Inescapable Funding Areas

Pay

This includes a one off nationally agreed uplift of £250 for employees who earn an annual salary of less than £21k. It also includes

incremental progress in the first two years and a pay uplift of 1% in the final two years.

Non-Pay

This is to cover the inflationary increases for goods and services.

Service Developments

The plan recognises that despite the tight financial restraints it is important to reflect a level of investment of new service developments in Year 3 and therefore £20m has been included for 2014/15.

Demography

The total demography general pressure for non-acute non FPS was identified last year through the detailed departmental working based on capitation costs and population projections. In 2012/13 these provide the basis for the estimate of £25m in the budget gap analysis. The acute element relating to those over 55 is separately identified.

Specialist Hospital Services

This funding has been identified to recognise the need for Specialist Hospital Services.

NICE Drugs

This funding has been identified to enable the implementation of relevant NICE approved treatments in NI.

Revenue Consequences of Capital Expenditure (RCCE)

The RCCE pressure is to address those revenue costs arising from capital projects committed to, and planned to be committed to, over the Spending Review period including the South West Hospital.

Mental Health Resettlements

This funding will be used for the resettlement of mental health patients from hospital to a community setting. Further work is ongoing with Trusts to validate total client numbers over the Spending Review period.

Learning Disability Resettlements

This funding will be used for the resettlement of learning disability patients from hospital to a community setting. HSCB has instigated a community integration programme to oversee the resettlement process,

comprising representatives from DHSSPS, HSCB, Trusts and other stakeholders.

Residual Demand

This funding will be used to address the growing demand for services caused by new drugs and technologies, changes in disease profile and other factors which increase demand for care, other than demographics.

The aforementioned increase in the birth rate and associated demands within Maternal and Child Health and Child and Family Care Programmes will require further consideration. The national picture also reflected across Trusts in Northern Ireland has seen increased referral rates for Children's Social Services and increases in child protection activity.

Family Health Services (FHS)

The pressures identified for FHS are primarily to cover anticipated increased costs in Prescribing, Dental, General Medical and Ophthalmic Services including demography, residual demand and non-pay inflation.

Elective Care

This funding has been identified to assist in ensuring reasonable waiting times for elective care (including outpatients, diagnostics and surgery).

Extra Contractual Referrals

This funding has been identified to assist in meeting additional extra contractual referrals.

Table 3- Summary of projected deficit and funding solutions for2012/13

2012/13	£m
Total Pressures	(273)
Less DHSSPS funding	58
Projected deficit	**(215)**
Sources:	
In year easements	30
Trust Efficiency Target	107
FHS Efficiencies	42
HSCB Over- commitment	15
Deficit	21
Total resource requirement	**215**

Table 3 above summarises the identified funding solutions/sources to address the 2012/13 projected deficit. Table 4 sets out the application of the £107m efficiencies to Trusts, which includes both cash and non-cash elements. All Trusts have been given a minimum 4% productivity target to include both cash release and general efficiencies. This is in line with other health economies in the NHS.

Table 4 - Application of £107m

Acute Productivity	£34m
Staff Productivity	£41m
Social Care Reform	£19m
Misc – Other Productivity measures	£13m
Total	**£107m**

2.6 Locality Equity

Achieving equity in commissioning health and social care for its local population is a key objective of the Commissioning Plan. In order to support the delivery of this objective, the Health and Social Care Board's strategic direction will continue towards ensuring all local populations have fair and equal:

- Access to services related to need
- Allocation of resources dependent upon availability of funds
- Levels of high quality, safe and effective care subject to agreed standards and recommended best practice.

In order to implement this, the HSCB/PHA will draw on a range of information sources to allow it to identify measure and address equity gaps in the three areas above.

Ensuring equity of access to services for local populations is a key objective of commissioning. This does not necessarily mean all services being available locally but rather that all of the NI population has an equal opportunity to have their needs for health and social care services met regardless of where those services are based. A key measure which informs the HSCB in assessing whether resources have been allocated fairly to local populations is the capitation formula. This is a statistical formula which measures the relative need for available resources across local populations. The formula takes account of the factors which most differentiate one area's need for resources from

another. The primary factor is the number of people living within a locality.

A second key factor is the age profile of the population, as the very elderly and the very young are the greatest users of health and social care resources. Other factors include the different socio economic profiles of local populations, as areas of higher deprivation have a higher than average need for health and social care resources.

The table below sets out the variance that each locality is away from its fair share of resources as determined by the Capitation Formula before the 2012/13 financial plan. The primary reason for these differences is the relative changes in population numbers across localities over time.

Table 5 - Equity Analysis (Planned spend excluding A&E, NIAS, FHS and Admin 2011/12)

LCG	Variance £m	% distance from fair share
Belfast	25	4.2%
Northern	-2	-0.3%
South Eastern	-5	-0.9%
Southern	-14	-2.6%
Western	-4	-0.8%
Total	**0**	

The HSCB/PHA will seek to address these gaps in a way that is fair and not destabilising to services. The following table shows how we plan to allocate relevant inescapable funding and productivity/savings requirements differentially across local commissioning groups in 2012/13. The impact of these allocations should be to reduce the current differential in funding to different localities.

RCCE and FHS have been excluded from the comparison. RCCE is part of a long term investment strategy which can distort comparison year on year, with significant investments such as the Southwest Hospital included in this year's pressures. FHS is not commissioned on the same population basis as other services i.e. it is commissioned by practice population rather than resident local population.

Table 6 – Impact of 2012/13 plan on Equity

LCG	Belfast £m	North £m	South East £m	South £m	West £m
Share of Funding above capitation share	-1.7	0.5	0.1	1.6	-0.5
Productivity/Savings requirement less than capitation share	-1.0	-0.7	0.3	1.0	0.3
Impact on Equity	-2.7	-0.2	0.4	2.6	-0.2

2.7 Planned Investment HSCB (including LCGs) & PHA

The Health and Social Care Board and Public Health Agency will receive some £3,994m for commissioning health and social care on behalf of Northern Ireland's 1.8m resident population.

Table 7 – Total Allocation

	2012/13 £m
HSCB	3,913
PHA	81
TOTAL	**3,994**

Of the total received, £2,953m is allocated to the six provider Trusts and £1,041m allocated to other providers of care such as Family Health Services and voluntary organisations. Figure 5 illustrates this for both the HSCB and PHA.

Figure 5 – Total Planned Spend by Organisation

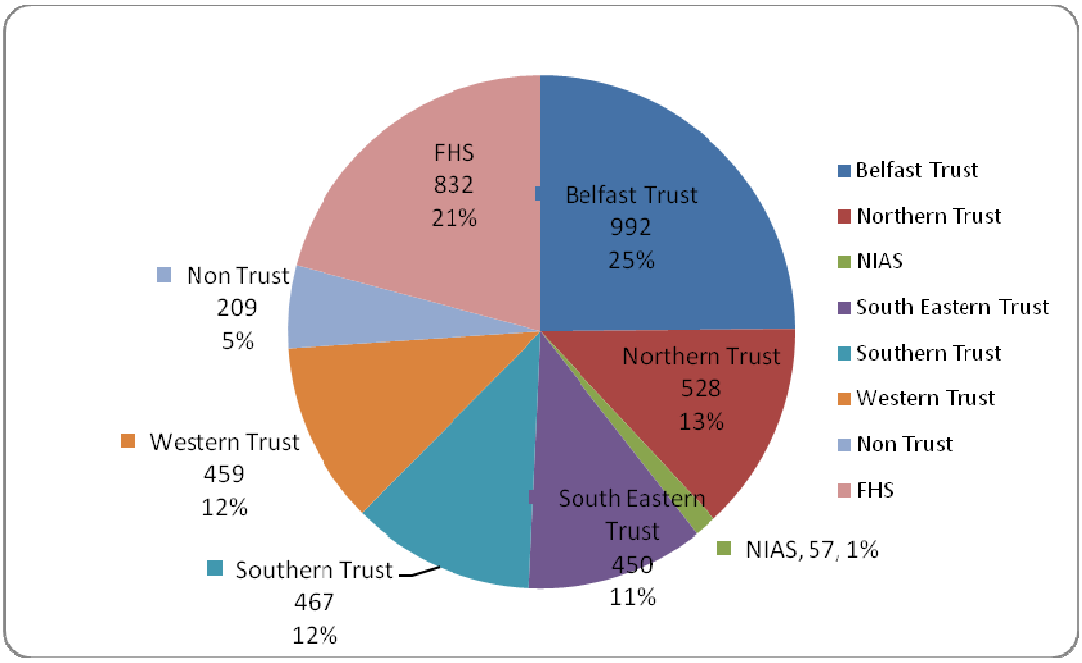


Table 8 sets out how the total resources are planned to be allocated across the programmes of care and Family Health Services.

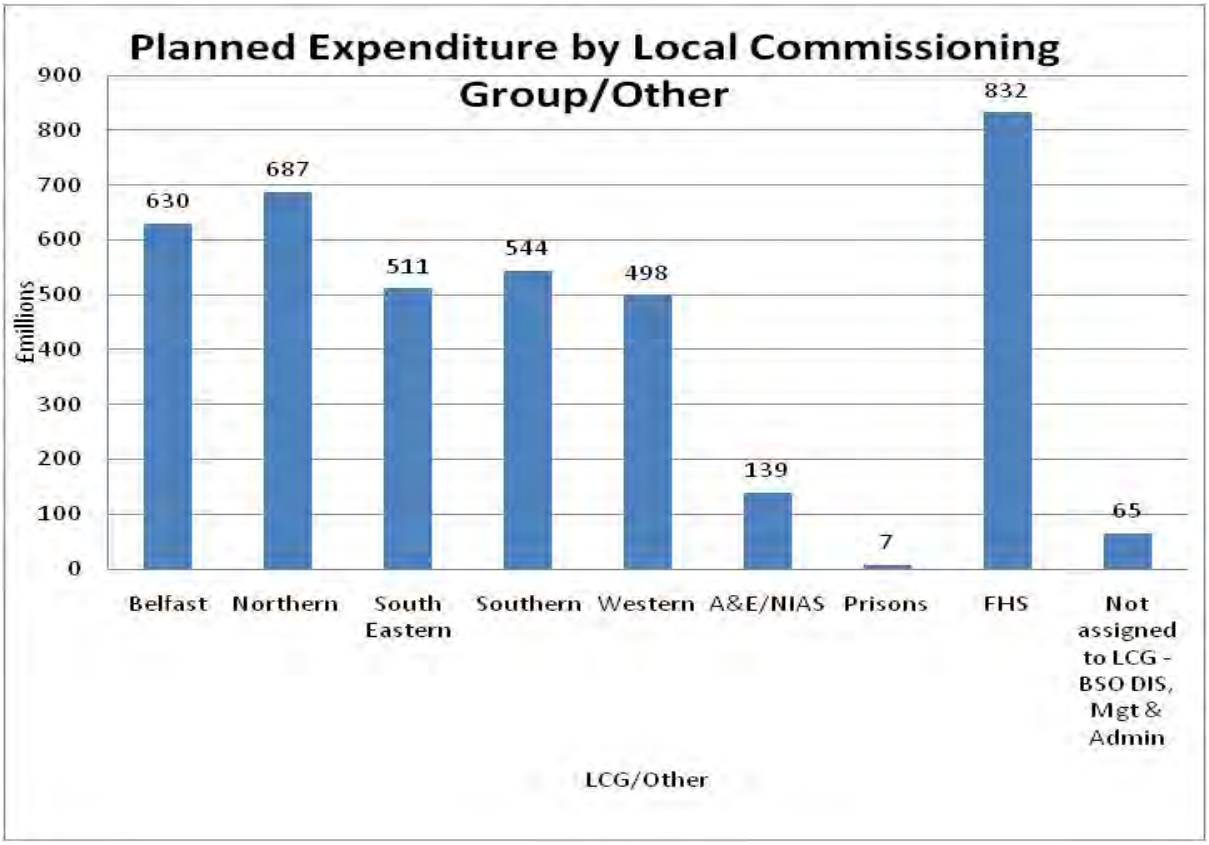
Table 8 – Planned Expenditure by Programme of Care

Programme of Care	PHA		HSCB		TOTAL	
	£m	%	£m	%	£m	%
Acute Services	0	0.15%	1,352	44.84%	1,352	43.90%
Maternal & Child Health	0	0.00%	129	4.29%	129	4.20%
Family & Child care	0	0.00%	198	6.55%	198	6.42%
Older People	0	0.00%	634	21.02%	634	20.58%
Mental Health	1	1.85%	237	7.85%	238	7.72%
Learning Disability	0	0.00%	225	7.46%	225	7.30%
Physical & Sensory Disability	0	0.00%	93	3.10%	93	3.03%
Health Promotion	63	97.84%	46	1.54%	110	3.56%
Primary Health & Adult Community	0	0.16%	101	3.35%	101	3.29%
Sub Total	*65*		*3,015*		*3,080*	
FHS	0		832		832	
Not allocated to PoC*	17		65		82	
Total	**81**		**3,913**		**3,994**	
* BSO, DIS, Management &Admin						

As noted above, the Commissioning Plan seeks to ensure that resources are fairly distributed across local populations is a core objective in the Commissioning process. Figure 6 shows how the HSCB resources are planned to be spent across localities. This reflects the different population sizes and need profiles within each locality e.g. the

Northern LCG crude resident population is the largest with 25.49% and the Western LCG the smallest with 16.68%. Family Health Services (FHS) are not assigned to LCG in the graph as these are managed on a different population base, as stated above. A&E and Prisons have not been assigned to LCG as these are regional services.

Figure 6



The high level summary information in Table 9 provides an indication of the activity commissioned in 2012/13. The summary was collated in advance of the HSCB/PHA Strategic Resource Report which presents costs and activity and is due with the DHSSPS at the end of June 2012.

The figures cover various contract currencies depending on the programme of care. A contract currency is a term used to briefly describe or define the activity. Examples include inpatient episodes, births, domiciliary care hours and face to face contacts.

Table 9 – High level summary of Activity Commissioned from HSC Trusts by HSCB in 2012/13

		Programme of Care									
	Contract Currency	ACUTE	MCH	FCC	ELD	MH	LD	PD	HP	PRIM	Total
Acute	Inpatients	408,000									408,000
	Outpatients	1,730,000									1,730,000
	Daycases	187,000									187,000
Maternity	Births		23,000								23,000
FCC	FCC Residential Beddays			65,700							65,700
	Social Work Caseload			22,000	48,000	20,022	9,000	15,000			114,000
MH	Psychiatric Inpatient Occupied Beddays					235,000					235,000
LD	Leaning Disability Inpatient Occupied Beddays						116,000				116,000
Adult Community	Domiciliary Care Hours		0	22,500	12,685,000	363,500	940,000	1,720,000	0	0	15,731,000
	Residential Home Occupied Beddays		0	0	1,100,100	174,000	381,000	35,000	0	0	1,690,100
	Nursing Home Occupied Beddays		0	0	3,151,000	180,000	145,000	140,000	0	0	3,616,000
	Daycare Attendances		0	0	428,000	260,000	829,000	179,000	0	2,000	1,698,000
	AHP face to face contacts		318,000	500	700,000	136,000	144,000	121,000	17,000	338,000	1,774,500
	Nursing Face to face Contacts		468,000	700	1,801,000	238,000	58,000	70,000	539,000	883,000	4,057,700

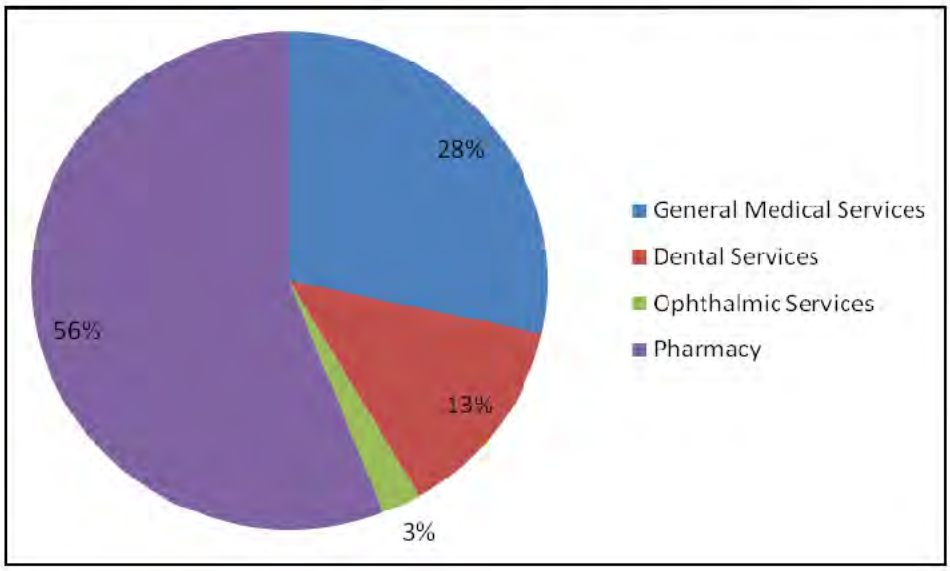
Table 10 below demonstrates how each Local Commissioning Group plans to allocate its resources to providers of Health and Social Care.

Table 10 – HSCB Spend by LCG by Organisation in 2011/12

HSCB / Trust	Local Commissioning Group								
	A&E/ NIAS £m	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Prisons £m	FHS £m	Total £m
BHSCT	21	563	147	134	77	46			989
NHSCT	13	2	507	1	1	2			525
NIAS	57	0	0	0	0	0			57
SEHSCT	20	43	6	359	10	2	7		449
SHSCT	17	0	3	1	441	1			464
WHSCT	10	0	8	0	4	434			455
Non Trust - Vols, Extra Contractual Referrals etc		21	16	15	11	13		832	909
Sub Total	**139**	**630**	**687**	**511**	**544**	**498**	**7**	**832**	**3,848**
Not Assigned to LCG*									65
TOTAL									**3,913**
* BSO, DIS, Mgt & Admin									

The HSCB/PHA commissions services from a range of Family Health Services. Figure 7 below shows the breakdown of planned spend across these services.

Figure 7 – Planned Spend for Family Health Services



3 Personal and Public Involvement

Personal and Public Involvement (PPI) is a legislative requirement for Health and Social Care Organisations laid down in the Health & Social Care (Reform) Act (Northern Ireland) 2009. Departmental Guidance on PPI, issued in 2007, sets out the core values and principles to which the HSCB/PHA adhere. PPI is core to the effective and efficient commissioning, design, delivery and evaluation of Health and Social Care services. It means actively engaging with those who use our services and the public to discuss: their ideas, our plans; their experiences, our experiences; why services need to change; what people want from services; how to make the best use of resources; and how to listen to these views and therefore improve the quality and safety of services.

PPI is a way of working, an approach that the HSC system is determined to embrace into our culture and practice. Effective service user, carer and public involvement is central to the delivery of safe, high quality services and as such, is a key element of clinical and social care governance. It provides the framework for quality improvement and assurance of the quality of services commissioned, or provided by HSC organisations.

However, apart from the legislative and policy requirements and obligations, we also recognise that there is a clear rationale for the adoption of PPI approaches. These range from; tailoring services to need, to securing efficiencies, to improving quality, to reducing and transforming complaints, to valuing patient and carer expertise, to fostering a sense of partnership, ownership and self-responsibility for one's own health and social well-being.

Regional HSC PPI Forum

The Regional HSC PPI Forum established and chaired by the PHA brings together senior representation from all HSC organisations in Northern Ireland, alongside service users, carers and community & voluntary organisations.

The Forum works to promote a whole systems approach to PPI, working to share best practice across the system, driving forward improvement and reducing duplication. In the last year, the Forum has; published an Annual PPI Report, developed a PPI Training Self-Assessment Framework and fully rolled out a HSC wide policy for the Re-

imbursement of out of pocket expenses for service users and carers involved with / supporting the work of HSC organisations.

In the coming year, the Forum will be; developing a formal Action Plan to guide its work, producing its second Annual PPI Report and examining opportunities for further collaboration and sharing of good practice across the HSC in terms of PPI.

The People's Priorities 2011 (PCC)

In November 2011, the Patient and Client Council engaged with almost 3,500 people across Northern Ireland to identify the top ten priorities regarding the future development of services within health and social care. As with previous publications, the report is an important source of intelligence in the identification/confirmation of commissioning priorities for the coming year.

Top Priorities 2011

1. Timely access to important hospital services such as A&E and improving the standards of care e.g. hospital cleanliness
2. Supporting the elderly to live independently through sustainable domiciliary care
3. Reducing waiting times for outpatient assessment, treatment and diagnostic services to acceptable levels
4. Shorter waiting times for diagnostics and treatment for cancer
5. Improving the quality of Mental Health and Learning Disability services including implementation of the Bamford Review
6. Increase the number of specialist staff e.g. nurse specialists
7. Quicker access to GPs and better consultation times
8. Improving child care, child protection and other support services for the very young
9. Reducing the costs of Administration and Management
10. Improving quality generally across the full range of HSC services.

Joint PHA & HSCB PPI Strategy

The PHA has led on the development of a joint PPI Strategy with the HSCB. This emerged from the development of our respective Consultation Schemes, where we collaborated together. The development of the joint PPI Strategy was a hugely intensive exercise involving in excess of 500 participants, including service users and carers, the voluntary and community sectors, other HSC organisations and HSCB/PHA Staff. Targeted approaches were also adopted to ensure input was secured from marginalised and excluded groups, such as Travellers, Children & Young People and the Lesbian, Gay, Bisexual and Transgender (LGB&T) Community amongst others.

The Strategy was subjected to an 18 week public consultation period, with some 48 written responses. These were analysed and further changes made to the Strategy as a result of the input received. The confirmed six key priority areas of work are:

- Cultural Integration of Personal and Public Involvement
- Awareness and Understanding of Personal and Public Involvement
- Training and Skills Development
- Impact Measurement
- Stakeholder Support
- Communication and Co-ordination.

An Action Plan will now be developed to translate these priority areas into tangible actions. Among the indicative actions that we envisage taking forward in the incoming year is:

- Commissioning the development of a generic PPI Training programme for Staff, whereby service users and carers will be active participants in the design and subsequent delivery of the training.
- Rolling out of a programme of support for projects that promote and advance the concept and practice of PPI within the HSC.
- Redevelopment of the Engage website as the primary forum for online sharing of information and best practice with respect to PPI.

- Developing an indicative set of standards and key performance indicators for PPI. This will assist the Department to take forward their responsibility for the development of formal standards for PPI, for adoption across the HSC.

PPI in Practice

The PHA & HSCB recognise PPI as an essential part of the quality improvement agenda linking the areas of equality, advocacy, patient experience, safety, complaints and community development. We will endeavour to work collectively across these related areas and in partnership with other HSC organisations including the PCC, to share learning and insights, to improve processes and systems including monitoring, evaluation and reporting and most importantly to improve outcomes for service users and carers.

PPI is an integral element of HSCB/PHA working. It complements, enhances and sets the context for the ongoing work being progressed through the PHA & HSCB and through Local Commissioning Groups and Service Commissioning Teams. It has contributed directly to the shape and content of the Commissioning Plan for 2012/13. A small number of examples of PPI in action are outlined below.

In respect of Learning Disability Services, the principles of PPI are reflected in a number of initiatives including the inclusion of carers' representatives on the Bamford Project Board. Other examples in this area include the Regional Autism Network, where parents, carers and users of services are involved throughout the regional and local planning process as Reference Group members. This encompasses a wide range of working groups, workshops and training events. Moving forward, parents, carers and users of Autism services have prepared new guidance, to ensure improved liaison between Trusts and Autism Reference Group members. The guidance will become effective from the 1April 2012 across each Trust area.

In Mental Health, there is a Regional Eating Disorder Network which works closely with services users, carers and their advocates through the Eating Disorders Association which is working to develop appropriate engagement mechanism at local Trust level. There have also been Innovating for Excellence Workshops where service managers and clinicians, service users and carers have been working collaboratively to establish priorities for the future of mental health services.

Maternity Services have had Maternity Services Liaison Groups, with whom they have worked to take on board the views of services users to help shape services moving forward. There are other good examples including Family Nurse Partnerships and developing work around Neonatal Networks.

The Commissioning Teams for Cancer and Long Term Conditions have utilised existing partnership structures, building on established relationships and contacts with services user and carer groups and contacts. In both these areas, work to finalise their PPI plans is moving ahead. A lot of the work in this area is to co-ordinate activity with existing forums. Included are joint training and planning workshops with service users and carers. Plans are also being developed to ensure involvement operates on a 2 way basis, not just the Commissioner wishing to consult with service users and carers when it is deemed necessary to do so.

In Palliative Care, the Commissioning Team is actively working to embed PPI values and principles into their way of working. This includes an active focus on the involvement of staff, with a series of initiatives aimed at securing Clinical involvement, including the Clinical Engagement Forum. The Commissioning Team are working through sub groups to develop Communication and Involvement plans and are working with service users and clinical colleagues to take forward initiatives such as the Patient Held Passport which aims to make the patients journey a smoother experience each time they come into contact with the HSC System.

PPI is something which has long been core to the way of working for those involved in Children's Services. In the Regional ASD Reference Group service users, carers and their advocates have been involved in drafting and commissioning of pathways, where they have been involved in the review of ASD initiatives and also in performance review.

The Children & Young People's Strategic Partnership has used Locality Planning Forums to take involvement to a location and a level that encourages involvement of local people. It utilises many of the traditional involvement techniques such as focus groups, surveys etc., but plans are being finalised to take forward the use of new technology with which young people are comfortable, such as the use of fan pages on Facebook.

Working together, the HSCB/PHA recently led on the development of a Neurological Conditions Reference Group. This followed on from a very successful engagement exercise with people living with or caring for those with a Neurological Condition. This was an innovative approach, whereby the PHA & HSCB worked alongside the Northern Ireland Neurological Charities Alliance, service users and carers to ascertain their priorities and to explore how we could work together to help address those needs.

A key tool at the disposal of the group was the use of Sense Maker. It is a tool which facilitates the collection of experiences and stories and supports quantitative analysis of trends and patterns in the qualitative information provided by service users. This supported the identification of common issues and themes across a disparate range of conditions. With the help of service users and carers, a series of recommendations were brought forward to try and address the identified needs. The group will be working under the Long Term Conditions Service Commissioning Team, alongside Clinical colleagues and in partnership with the new Reference Group, to transform these recommendations into tangible actions for the benefit of service users and carers.

Whilst the value of these and other examples of PPI is acknowledged, there is also a recognition and acceptance that more needs to be done to truly embed PPI values and principles into our culture and practice. To that end, LCGs and Service Commissioning Teams will be required to develop and implement PPI Action Plans to facilitate and encourage the active involvement of service users, carers and public in the commissioning and design of services. We will also expect Trusts to demonstrate in their Delivery Plans, how they intend to ensure that there is effective and meaningful involvement of service users, carers and the public in the development and delivery of health and social care services in line with PPI responsibilities.

4 Equality, Good Relations and Human Rights

The duty to promote equality in relation to gender, age, race, disability, sexual orientation, political opinion, dependants, marital status and religion is central to our goals to improve health and reduce health and social care inequalities within Northern Ireland.

To support this work the HSCB/PHA has published our Equality Scheme and our Audit of Inequalities Action Plan, both of which are intended to promote and disseminate an understanding of what we need to do corporately and as a commissioning organisation.

Our commitment runs through all our functions, including employment, and is a key part of the organisational values.

The HSCB/PHA has a number of key principles intended to embed equality and diversity and human rights in our organisation including:

- Commissioning services which are inclusive and reflect and promote privacy, dignity and accessibility;
- Engaging with and involving local communities and service users so that we understand their needs and give them a sense of ownership of their own health and social care outcomes; and
- Partnering with others to deliver improved outcomes for our communities.

We recognise that to deliver equality we need to understand diversity and that diversity exists even within and between equality groups. One standard approach will not address the needs of everyone and we are committed to working with staff and our communities to ensure that needs are understood and addressed

We have embedded equality and diversity and human rights into the mainstream commissioning cycle including the conduct of screening undertaken by each service team. This is to ensure that in the developmental stage commissioning decisions are informed by an explicit consideration of the needs, experiences of, and impacts on, those across the 9 categories protected by the equality duties.

We believe that it is important that decisions are informed by human rights standards and principles with attention to those areas of

commissioning that have a higher risk of raising human rights issues such as older people, mental health and children.

Ensuring that services users, their carers and wider public are meaningfully involved in the design and delivery of services promotes the human rights agenda. As outlined in DHSSPS Quality 2020 Strategy there is already a body of evidence from around the world that involving patients and clients in decisions about their care and treatment improves the outcome and their satisfaction with the services they receive and at the same time reduces demands on services. Their participation helps ensure that we are responsive to the particular needs of disadvantaged groups. It is therefore essential that there is evidence of user and carer involvement at all levels of decision making.

A key priority is to improve the evidence base both in the collection, use and monitoring of information to inform commissioning. Aligning this activity to other equality objectives and targets as outlined in our Audit of Inequalities and Action Plan and Audit of Information Systems will assist in ensuring that these objectives are not mutually exclusive.

An equality screening template detailing the overarching screening outcomes and the screening outcomes from each service team area accompanies this Commissioning Plan. It is also published as part of the HSCB's screening outcome report as is required as part of the equality duties.

5 Local Commissioning Groups

The arrangements for commissioning health and social care are given a local focus through the work of the five Local Commissioning Groups. Details of the groups and their geography can be found on the HSCB website. Local Commissioning Groups (LCGs) are made up of political and professional representatives. Each LCG has a strong and influential role in shaping local services and contributing to the formulation of HSCB/PHA policies.

Each has a statutory responsibility to assess the health and care needs of its local population plan to meet those needs and to secure delivery of services. This is done in partnership with users and carers, local councils and communities, health and social care professionals and other service providers and agencies. They are supported by regular information on finance, quality and performance with additional input from Regional Service Teams to ensure broad regional consistency.

Each LCG is committed to integrated approaches to care which break down organisational boundaries and develop much improved coordination between secondary and primary care, services delivered by community and voluntary organisations and the important contribution of other agencies.

In 2012/13 the leadership role provided by LCGs will be of paramount importance during a year that sees the beginning of major change in the model of HSC in Northern Ireland. Section 1 of this Plan described the review of the HSC as set out in *Transforming Your Care*. This reform puts the individual at the centre with health and social care services becoming increasingly accessible in local areas. LCGs will be pivotal in making HSC reform tangible at a local level, securing the right care for their populations and ensuring that the care is available at the right time for the patient.

Transforming Your Care recommends that local communities bring forward proposals in the form of Population Plans. LCGs will work with local HSC Trusts and other stakeholders in taking forward the plans.

The key challenges for each LCG

Improving health and well-being and reducing inequalities

Each LCG will work with local communities, the PHA and other organisations to reduce life inequalities. Direct intervention has its limits and the wider determinants of health and well-being require a concerted approach by many organisations, led by local communities.

Commissioning care closer to home

Transforming Your Care envisages that care should be provided at home or as close to home as possible, where this is safe and sustainable. The development over the past year of Primary Care Partnerships helps to take this agenda forward. During 2012/13 the PCPs will evolve into Integrated Care Partnerships. There will be 17 ICPs across Northern Ireland creating a closer working relationship between hospital and community services.

Being more responsive to demand

Referrals from GPs for outpatient consultations increased in recent years and in some specialties the available clinics were insufficient in number, leading to longer waiting lists and long delays for follow-up appointments. LCGs have worked with Trusts to ensure their capacity to respond to GP referrals is maximised for the resources available, agreed levels for follow-up appointments based on good practice and identified services that require additional investment. Where referrals still exceed the capacity available, alternatives being considered will include the provision of clinics in primary care.

Medicine Management

Expenditure on medicines per patient varies across Northern Ireland. LCGs were, as a minimum, to achieve average costs of £218 per patient. The latest figures at the time of writing show that the average in February 2011 was £211 per patient (HSCB Monitoring Figures). Challenges include reducing waste, reducing the use of Oral Nutrition Supplements in favour of meals, greater use of cheaper versions of some high cost drugs where these are proven to be equally effective and reducing variability in the prescribing patterns among GPs. Each LCG is making significant progress and savings made can be reinvested in local health economies.

Responding to the challenges

Engagement through Personal and Public Involvement - Each LCG has developed an extensive programme of engagement with users and local communities. Monthly public meetings are held in community facilities across each locality. LCGs work closely with their local Trust and have been pro-active in involving community groups and advocates from their local areas.

The development of Integrated Care Partnerships - The experience gained in developing PCPs will be built upon in the next year with the development of Integrated Care Partnerships which will be similar but with an even closer relationship between primary and secondary care clinicians and a more significant role for community providers.

A wide range of services will be transferred from hospital to community settings, with more rapid access to care when it is needed. This will require new forms of contract with providers and the development of primary care infrastructure.

Population Plans - Each LCG and HSC Trust has been asked to work with other providers to develop Population Plans by June 2012. These will explain how the growing needs and expectations within the LCG area will be addressed within a strictly constrained financial context, while ensuring that quality is improved through transforming the way care is delivered. These plans will demonstrate how optimum use is being made of existing resources across each local health economy.

Figure 9

Local Commissioning Plans 2012/13

Each Local Commissioning Group has produced a Local Plan for 2012/13 in which the key areas highlighted within the Commissioning Plan are addressed. These plans are enclosed and should be read in conjunction with this overarching Commissioning Plan. The local plans provide more detail in regard to the challenges highlighted above and other major commissioning intentions for the year.

Copies of each of the Local Commissioning Plans can be obtained from the HSCB website.

Local Commissioning Group Chairs

Dr G O Neill

Belfast

Dr N Campbell

South Eastern

Dr B O Hare

Western

Mr S McKeagney

Southern

Dr B Hunter

Northern

6 Response to the Commissioning Plan Direction

6.1 Response to Ministerial Priorities

In February 2012, the DHSSPS issued the Commissioning Plan Direction for 2012/13. This section of the Commissioning Plan sets out in detail the Minister's priorities for action and how the HSCB and PHA propose to ensure that these targets are met.

The Commissioning Direction identifies six broad themes as priorities, namely:

1. Improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion and earlier intervention.
2. Improve the quality of services and outcomes for patients, clients and carers.
3. Develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community.
4. Improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector.
5. Improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities.
6. Ensure that the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services.

The HSCB/PHA commentary and response on each theme is provided in the paragraphs below.

6.2 Improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion and earlier intervention

The Commissioning Plan must demonstrate how the services to be commissioned reflect the contents of Investing for Health and are conductive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland to fulfil the requirements of section 2(3) (g) of the Act.

Improving health and reducing inequality requires coordinated action across many different sections of government and delivery organisations in order to address the determinants of health and wellbeing and maximise the potential for good health. It is expected that a new cross departmental public health framework for Northern Ireland will be issued for consultation during 2012/13 and will give continued impetus to this agenda. The PHA and HSCB will develop an implementation plan to take this agenda forward.

The recent strategic review of health inequalities in England[1] by Professor Sir Michael Marmot provided advice to government on preventable ill health. The report makes clear that action to reduce health inequalities must start before birth and be followed through the life of the child, adopting 'a life course' approach. The Marmot review of inequalities has guided the development of the commissioning direction and PHA plans. This direction has naturally included an assimilation of the former Investing for Health policy.

Inequalities in health between different groups are well documented and long-standing. Evidence also suggests that health and social needs and outcomes are far from homogenous. There are different barriers to accessing services and there may be different obstacles for interventions consequently it is necessary that we understand each group's experiences.

In Northern Ireland life expectancy increased between 1998-2000 and 2008-2010from74.5 years to 77.0 years for men and from 79.6 years to 81.4 years for women.

However, against this positive overall trend, inequalities are evident when mortality rates are compared across geographical areas. Many of the electoral wards which have the highest death rates are also those which have some of the highest levels of deprivation.

Relative deprivation in Northern Ireland is assessed by looking at income, employment, education, health, including disability and early death, local environment, crime and proximity of an area to services such as GP surgeries, hospitals or shops. Individual areas are ranked across Northern Ireland based on these. The 20% most deprived areas represent nearly 340,000 people. Some of the most common

[1] Fair Society Healthy Lives – The Marmot Review: A strategic Review 2010

characteristics associated with being born into poverty rather than more affluent circumstances are:

- Lower life expectancy than the Northern Ireland average
- 39% more likely to die under 75 than the Northern Ireland average
- 23% higher rates of emergency admission to hospital than the Northern Ireland average
- 177% higher rates of respiratory mortality (under 75s) than in the 20% least deprived areas
- 65% higher rates of lung cancer
- 228% higher rates of suicide than in the 20% least deprived areas
- Self-harm admissions at twice the Northern Ireland average
- 124% higher rates of smoking related deaths than in the 20% least deprived areas
- 450% higher rates of alcohol related deaths than in the 20% least deprived areas.

In addition, it is recognised that certain groups also experience disadvantage e.g. life expectancy for male Travellers is estimated at some 15 years less and Traveller women at some 10 years less than the adult population as a whole.

The current economic climate also presents a challenge. As financial pressures will undoubtedly increase within health and social care budgets, the need to spend more on prevention becomes clearer, yet also more difficult because of the pressure on service delivery. It is also likely to be compounded by financial pressures experienced by other government departments whose policies will impact on the development of health.

The downturn in the economy is in itself likely to have an impact on health and wellbeing, for example there is clear evidence of the link between unemployment and poor health with every 1% increase in unemployment met with 0.8% increase in suicide.

The impact of financial pressures in other government departments' funding plans are likely to impact on protective programmes such as those at neighbourhood level. The development of effective

partnerships offers the opportunity for making the most of public expenditure, building synergy of action at a local level.

The role of prevention is increasingly seen as both cost effective and integral to the delivery of sustainable health and social care and to optimising outcomes. The importance of prevention has been highlighted by several UK Health Care Reviews and Assembly Inquiries e.g. inequalities have been estimated in England to cost £5.5 billion to the NHS alone; total annual inpatient costs as a result of smoking to health and social services in Northern Ireland were estimated at £119 million in 2008/9; loss to the local economy is estimated at £500million as a result of obesity with 59% of the population either overweight or obese and some £24.5 million spent on prescribed anti diabetic medication; the impact of alcohol is estimated at some £250 million on the health and social care system with almost £600 million estimated as the wider social costs. Furthermore, it is estimated that alcohol is a significant factor in 40% of all hospital admissions, rising to 70% of Accident and Emergency weekend attendances.

A further significant challenge is halting the rise in the proportion of the population who are overweight or obese, 59% of all adults measured were either overweight (35%) or obese (24%). [2]The impact of this increase is now being experienced in different areas of service provision e.g. complications in pregnancy, increase in type 2 diabetes, coronary heart disease, stroke and a number of cancers. It is also known that obese children are more likely to become obese adults.

A key goal must be to improve health and wellbeing and reduce the gap between more affluent and less affluent groups and those communities known to be at increased risk in our society. It is essential therefore we:

- Influence the environment positively so that healthier choices become easier
- Increase knowledge, skills and behaviours that promote health and wellbeing
- Develop models of effective practice that inform future direction, including the shape of health and social care services
- Develop partnership models which empower communities and which seek to address with others the determinants of health

[2]Northern Ireland Health and Social Wellbeing Survey 2005/06

- Contribute to, and improve understanding about, health inequalities and effective interventions
- Promote and inform health and social care staff (and others) about their role in promoting health and wellbeing

In addition to the health improvement elements within the detailed commissioning intentions for key service areas, the HSCB and PHA will wish to progress required elements using the following framework:

- Giving every child and young person the best start in life
- Working with others to ensure a decent standard of living
- Building sustainable communities
- Making healthy choices easier

Further details can be found in section 7.2.

6.3 Improve the quality of services and outcomes for patients, clients and carers

Our vision for commissioning safe and effective, high quality care for the population of Northern Ireland is to be world class, achieving excellence and best practice in all that we do. Pursuing excellence in the quality and safety of commissioned services is a key priority within this Commissioning Plan.

The Commissioning Plan Direction states clearly the Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for clients and patients and their carers, to improve outcomes and ensure Patients, Clients and Carers have the best possible experience in every aspect of their treatment, care and support.

During 2012/13 the HSCB and PHA through the Safety and Quality Service Group will produce a Quality and Safety Assurance Framework. The Framework will address the three components of Quality: Safety, Effectiveness and Patient and Client Focus as set out in the DHSSPS *Quality 2020* Strategy, as well as taking full account of the Review of Health and Social Care in Northern Ireland – *Transforming Your Care*. The objectives of the Assurance Framework are:

- To ensure that services being commissioned are safe, personal and effective
- To ensure the right quality mechanisms are in place so that standards of Patient Safety and Quality are understood, met and effectively demonstrated
- To provide assurance that patient safety and quality outcomes and benefits are being realised, and recommend action if the Safety & Quality of commissioned services is compromised
- To promote the continuous improvement and innovation in the safety & quality of commissioned services

Delivering high quality care as set out in Quality 2020 charges commissioners with measuring quality across three domains:

- Safety
- Effectiveness
- Patient and Client Focus

Consistent with the vision for Safety, Quality, and Patient and Client Focus, our key priorities are:

- To bring clarity to quality in the commissioning of services, we will develop and implement Regional Standards and Key Performance Indicators for Nursing and Midwifery Services and reflect these in Commissioning specifications and contracts. These indicators will lead to improved patient experience outcomes, and will provide evidence of the quality of nursing and midwifery care in Northern Ireland, generated from the use of evidence based clinical, organisational and patient experience indicators.
- Produce Quality and Safety Information. We will collect and publish Hospital Standardised Mortality Rates (HSMR) for all HSC Trusts annually. We will work with Trusts to produce information on Serious Adverse Incidents, Complaints and Patient Experience Standards and where possible other benchmarking data. The information on Serious Adverse Incidents (SAI), Complaints and implementation of the Patient and Client Experience Standards will be used to affect learning and improvements in our services.
- Agree with Trusts a detailed work plan for further roll out and implementation of the patient and client experience standards. The

monitoring of standards will be repeated in a sample area where there was significant issues reported in 2011/12, as well as three additional hospital services and one additional community service in each quarter. The planned programme of work will include the independent collection of staff and patient stories.

- Through 2012/13, we will work with Trusts to collect and publish at least 10 patient stories in each Clinical area and Community Services.
- Agree a comprehensive work plan for the Patient Safety Forum and agree with providers appropriate additional collaboratives 2012/13. The focus will be to reduce harm through risk satisfaction and applying evidence based IHI methodologies.
- Agree nurse/bed ratios with Normative Staffing ranges to be applied in general and specialist areas.
- Agree regional development and implementation of Specialist Nurse job plans to deliver on Safety, Quality and Patient Experience outcomes.
- Raise standards in nursing and midwifery services through transformation of the ward sister and first line nurse manager role in all care settings. A comprehensive programme of work will continue to build on existing work to strengthen the capacity and capabilities of the ward sister and first line nurse manager roles. The focus will be on their responsibilities for delivering safe, effective, high quality care that delivers on patient experience outcomes.
- Develop and implement patient safety initiatives that lead to a reduction in the incidence of pressure ulcers occurring in hospital medical and surgical care between 0-300 days.
- Develop patient safety initiatives that will lead to significant reduction (to be determined) in the number of falls in hospital settings. The work will include development of quality measures to support the monitoring of progress towards 95% compliance with all elements of the falls bundle.
- Agree Trusts' key priorities for development and implementation of Quality Improvement Plans (QIPs) and associated action plans. The QIPs will be submitted to the PHA for approval and monitoring of progress. For 2012/13 the regional priorities within the Trust QIPs will include the following objectives:

- WHO Surgical checklist – achieve at least 85% compliance with the WHO surgical Safety checklist across all the theatre areas
- Prevent harm from Venous Thromboembolism (VTE) – increase the percentage of appropriate VTE prophylaxis prescribing in all clinical areas by 95% by March 2013
- Crash Call Rates – To reduce by 50% crash calls – based on Trust 2011/12 baseline data
- Modified Early Warning Scores (MEWS) – To continue to achieve 95% compliance of MEWS in all areas by March 2013
- Emergency Medicine – To work with the HSC Safety Forum on the development of quality indicators for emergency medicine ensuring baseline measures are reported by August 2012
- Pressure Ulcers – to spread the SKIN Bundle to 80% of ward areas ensuring 95% compliance by March 2013 and to reduce the incidence of pressure ulcers by 25% by March 2013
- HSMR (Standardised Mortality Rate) – to monitor monthly HSMR and review all case notes with a high RAMI score
- Infection Rates – SSI, VAP and CLI – to continue to report and monitor infection rates as per HISC – to achieve a 20% reduction in the Trust mean yearly SSI rate for Caesarean Section Patients in 2012/13; maintain the Trust yearly mean SSI rate in Orthopaedics or less by March 2013; to achieve a goal of 500 ventilator days between VAPs during the period April 2012 – March 2013 and maintain the CLI days between infections greater than 2000 by March 2013
- Global Trigger Tool – to train staff on the use of the Global Trigger Tool across medical and surgical Directorates to identify adverse events, and review 20 patient charts per month from medicine and surgery across all hospital sites
- Prevent harm from drugs – 100% compliance with Controlled Drugs policy by September 2012
- KPIs for Nursing – to spread an electronic system for monitoring compliance with Nursing Indicators across all wards by August 2012

- Stroke Collaborative – to achieve 95% compliance with patients presenting at A & E (or identified within the hospital) within 3 hours of onset of stroke symptoms being assessed and thrombolysed, if deemed appropriate, within 60 minutes by March 2013
- Mental Health – Multidisciplinary reviews of acute mental health inpatients – to conduct weekly team reviews on all adult mental health inpatients by March 2013
- Mental Health Risk Assessment – to conduct multidisciplinary risk assessments on all adult mental health inpatients by March 2013
- Reduce patient harm from falls - Trusts will put in place a Test and Spread plan to ensure 95% compliance with the falls bundle in all clinical areas by March 2013
- Perinatal Collaborative – to achieve 95% compliance with the Electronic Fetal Monitoring Bundle by December 2012

6.4 Develop more innovative, accessible and responsive services, promoting choice and by making more services available in the community

The Commissioning Plan must demonstrate how the services commissioned will improve access to primary care and community-based services which prevent people unnecessary entering hospital and enable them to return home safely as soon as they are fit to do so.

A key commissioning priority for 2012/13 and beyond is the development of a range of innovative and accessible services in the community to support people to live as independently as possible. Individuals will be supported to maintain good health and wellbeing, preventing the onset of illness and avoiding deterioration with any existing conditions. Primary care and community-based services will be enhanced, avoiding the need for people to attend hospital and ensuring that, when hospital care is necessary, they are able to be discharged from hospital as soon as they are fit to do so.

We will seek to achieve a closer integration of primary, community and secondary care with the aim of delivering comprehensive treatment and care across a variety of care settings, with care providers operating collaboratively as an inter-dependent care network planning and delivering care for the populations they serve. Integrated Care Partnerships (ICPs) involving the full range of health and social care

services in each area including GPs, community health and social care providers, hospital specialists and representatives from the community and voluntary sector will play a lead role in taking forward this key agenda. ICPs will help to enable changes to the way in which our health estate is used to deliver care more appropriately, and the development of a more community-based workforce.

This new way of integrated working will be supported by technology. Electronic Care Records will allow all health and social care staff access to a common patient record including details of the patient's conditions, their medication, tests results and treatments. Tele-health and tele-monitoring technology will also continue to be rolled out to allow specialist advice to be made available remotely in local settings and even into patients' homes, contributing to enhanced care being delivered locally, enhancing the patient experience and avoiding unnecessary hospital visits and possibly hospital admissions.

More of the planned care services that currently require a hospital visit will be available locally, including new and review outpatient assessments, minor surgery and diagnostics such as X-ray. Large numbers of outpatient assessments are already being provided in community settings by GPs with a specialist interest, often avoiding the need for a hospital visit. In addition, through a scheme in the Western area, GPs have provided minor surgery in local settings for some 500 patients who otherwise would have attended hospital. In parallel with the delivery of enhanced services in local settings by GPs and other community clinicians, more specialist care will be provided in community settings, with specialist hospital clinicians working in partnership with community clinicians to deliver services safely and effectively, as locally as possible.

The further development of unscheduled care services will also be a priority in 2012/13 and beyond, delivered in people's homes or local facilities. Enhanced intermediate care services will be an important component of the new arrangements, with escalation provided in local settings to avoid the need for hospital admission and step down beds to facilitate earlier discharge, rehabilitation and a return to home. Through the re-ablement programme, the focus will be on maximising independence, helping people to resume a more active and improved quality of life, at home and within their communities.

Key priorities in relation to the development of community-based services in 2012/13 will include:

- Establishment of 17 Integrated Care Partnerships to specifically target groups including older people, paediatrics, people with a long term condition and people suffering with diabetes
- Expansion of outpatient services - new/review/specialist
- Personalised care pathways enabling home based management of the LTC
- Step-up/ step down and respite care beds in the community
- Multidisciplinary teams providing integrated planning and delivery of care
- Expanded role for community pharmacy
- Closing long stay mental health and learning disability institutions working towards completing the resettlement process by 2015
- Delivery of a Primary Care Infrastructure Programme
- Enhanced support to the Nursing Home sector for end of life care.

6.5 Improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector

The Commissioning Plan must detail how the Regional Board proposes to take forward the design and delivery of services developed around the needs of patients through strengthened local commissioning and performance management systems. The Commissioning Plan should include proposals for taking forward the agreed recommendations from Transforming Your Care.

With responsibility through the commissioning process for investing public funds the HSCB, PHA and LCGs work to ensure decisions reflect the needs, priorities and aspirations of the local population. We will continue to be proactive in seeking out the views and experiences of the public, patients, their carers and other stakeholders.

Stakeholder involvement is enshrined through the PPI strategy (Chapter 3) and is core to the effective and efficient commissioning, design and delivery of Health and Social Care services. With the publication of *Transforming Your Care* the need for involvement and consultation with service users, carers and the wider public in taking forward reform is

readily acknowledged. Engagement and Communication Plans will be drawn up by Local Commissioning Groups to ensure the community has a say in HSC change.

Chapter 5 highlighted how each LCG is committed to integrated approaches to care which break down organisational boundaries and develop much improved coordination between secondary and primary care, services delivered by community and voluntary organisations and the important contribution of other agencies.

One area where this approach will have a major impact concerns the management of Type 2 Diabetes. To ensure consistency with how patients are cared for South Belfast PCP established a group including representatives from Diabetes UK, Belfast Trust, Primary Care and local ethnic community groups such as the Muslim Centre, Indian Community Centre and Chinese Welfare Association to look at a new pathway of care. As a result, a Type 2 Diabetes management pack has been developed to ensure all patients receive standardised, high quality care. This involves treating patients in the most appropriate setting, proactively managing patients at risk of developing Type 2 Diabetes and referring all newly diagnosed patients to structured patient activity and an appropriate physical activity scheme.

On a regional basis, to improve services for patients with glaucoma, a workshop was held which was attended by 12 users and carers and was facilitated by RNIB and Guide Dogs for the Blind. This highlighted the excessive waiting times requiring repeated phone calls to the hospital, inadequate and inaccessible accommodation and long waits and repeat visits for diagnostic tests. The result of detailed work with stakeholders has led to an agreed Hub and Satellite service for the management of new and review patients based on a One Stop Shop approach. This will radically improve the arrangements for responding to patients with suspected glaucoma with implementation going forward during 2012/13.

Working together, the HSCB/PHA recently led on the development of a Neurological Conditions Reference Group. This followed on from a very successful engagement exercise with people living with or caring for those with a Neurological Condition. This was an innovative approach, whereby the PHA & HSCB worked alongside the Northern Ireland Neurological Charities Alliance, service users and carers to ascertain their priorities and to explore how we could work together to help address those needs.

Each LCG and HSC Trust has been asked to work with other providers to develop Population Plans by June 2012. These will explain how the growing needs and expectations within the LCG area will be addressed within a strictly constrained financial context, while ensuring that quality is improved through transforming the way care is delivered. These plans will demonstrate how optimum use is being made of existing resources across each local health economy. The LCGs are in a unique position to represent their local populations in this process.

Key priorities in relation to the involvement of individuals, communities and the independent sector in 2012/13 will include:

- Commissioning the development of a generic PPI Training programme for Staff, whereby service users and carers will be active participants in the design and subsequent delivery of the training.
- Ensuring Commissioning teams develop and implement action plans to facilitate user, carer and stakeholder involvement to inform their commissioning intentions and decisions. A standard template will be produced to assist this process.
- Development of a protocol which requires Commissioning teams to provide evidence of PPI as part of the proposals for investment or service redesign.

6.6 Improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient client outcomes. It must also demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act.

Since its establishment the HSCB has sought to secure the delivery of stretching productivity targets across the HSC whilst ensuring overall financial stability within an increasingly constrained financial envelope. The Commissioning Plan will continue to act as a key driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes.

Recent independent reviews including *'Reshaping the System'* undertaken by McKinsey concluded that there are still significant opportunities to improve quality, productivity, efficiency and effectiveness and costs. These assessments have been made largely through comparison with top quartile performing organisations in GB. They also recognise that achieving the scale of improvements identified will require the longer term reform of the HSC system and its structures.

The model of health and social care which will drive the future shape of the service to facilitate these improvements is now available through *Transforming Your Care*. At the same time the financial projections detailed in Chapter 2 set out the overall financial challenge over the next three years. With additional expenditure requirements exceeding total available additional income by £395m, far reaching savings and productivity plans are required if we are to continue to live within the resources available.

With a funding gap of £215m in 2012/13 there will be an unprecedented challenge for the HSC to breakeven and at the same time maintain the integrity of the service and drive forward the transition necessary to begin to implement the long terms reforms that are so urgently required across the HSC.

Given the scale of the challenge the HSCB has initiated a process across the HSC whereby the productivity and financial challenges can be managed in a streamlined way and in the longer term context of *Transforming Your Care*. The approach will ensure that there is a clear plan to allow the system to breakeven and that this is delivered through maximising productivity and minimising the impact on patient and client outcomes.

This will involve both top down and bottom up planning processes. With a regional approach for those areas impacting on major strategy and policy areas and the bottom up planning process being taken forward at local health economy level by Trusts, LCGs and new Integrated Care Partnerships.

To date this has included:

- Setting all organisations an annual total efficiency improvement target and in 2012/13 this will be 4%

- Providing an indicative high level assessment of potential opportunity areas across the HSC for the next three years covering the following areas: acute productivity, staff productivity, social care and other including Prescribing
- Setting clear targets across the HSC to allocate the requirements between cash, savings requirements and productivity
- Initiating the development of high level and detailed bottom up plans to meet the targets
- Establishing robust monitoring and accountability arrangements in respect of these targets.

Local Health Economies will set out, in response to the above targets, local plans to summarise how the cash release element of the target will be achieved.

These plans set out how they will address the immediate requirement to maintain financial stability during 2012/13 and ensure they are in a position to implement their Local Health Economy Population Plans throughout the Spending Review period. These plans include a wide range of initiatives under the following headings:

Acute Productivity

- Focus on reducing excess bed days and increased patient management within an Outpatient & Day Case setting
- Day Surgery Reform – both in terms of achieving Day Case rates and consolidation of Day Surgery Services
- Reducing excess bed days in line with best practice

Social Care Reform

- Planning and implementation of Re-ablement initiative
- Price negotiations with independent domiciliary care providers
- Savings in management / administration of Older People Homes to reflect lower occupancy levels
- Improved management of Community Care and increased usage of Independent sector

Staff Productivity

- Workforce cost reduction through sickness absence control, reduction on agency reliance and vacancy control
- Unit cost management through management of skill mix, overtime and additional hours
- Electronic data management , E-Rostering of hospital wards, Expand E-Rostering outside Nursing, and capital invest to save schemes
- Implementation of scrutiny of permanent and temporary vacancies resulting in posts being held for an agreed period of time

Miscellaneous Productivity

- Targeting management admin and clerical costs managed through Voluntary Redundancy / Voluntary Early Retirement (VR/VER), reducing backfill and non-replacement of vacant posts
- Lean processes to be introduced harnessing new technology methodologies
- Targeting discretionary expenditure items including Travel, Training etc.
- Various procurement initiatives
- Variety of estates schemes e.g. energy, standardising car park charges, review/rationalise maintenance contracts

Prescribing Efficiency

The HSCB in conjunction with LCGs and ICPs will continue to deliver prescribing efficiencies through a range of initiatives including:

- Maximising generic dispensing
- Product standardisation
- Cost effective switching and the effective systems management of prescribing
- Development of effective prescribing guidelines for both primary and secondary care
- Development of a Northern Ireland formulary

Further high level plans for 2013/14 and 2014/15 will be submitted early in the new financial year following joint consideration by Local Health Economies as part of the agreed Population Plans.

6.7 Ensure that the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services

The Commissioning Plan must demonstrate that the services being commissioned are sufficient to ensure that statutory responsibilities to access needs, protect and support vulnerable groups will be met with a particular emphasis on prevention and early intervention.

The main thrust of social care legislation and policy in relation to children and adults is to protect and support the most vulnerable in our society. There is a long history of safeguarding arrangements for children but more recent developments have focused on the need to have similarly robust arrangements for adults.

In addition, the progress of community care has recognised the need for different kinds of support to vulnerable people that is provided to them earlier, assisting them to take more control over their own lives and helps them to navigate the public services to ensure that the appropriate support is provided in a timely manner.

Transforming Your Care reiterates the principle that people should be provided with more services within their community and at home. This will require more integrated arrangements between community and primary care and a shift in services to ensure the further development of community supports that are safe and effective.

To achieve this we will have to strengthen our partnership with other agencies, promote more widely the benefits of voluntary and community sector provision, develop a more mixed economy of providers and develop new ways to procure these services.

Significant challenges continue in relation to safeguarding children, not least the increase in referrals and the complexity of some of the situations in which children find themselves. In particular we will be ensuring that current Child Protection Practice within and across agencies is of the highest standard and we will continue to add to the significant debates that are taking place in relation to research evidence and the development of policy and procedures throughout the coming year.

We have steered the developments from the Reform and Implementation Process and issues highlighted by the Children's

Services Improvement Programme. In particular issues around the single point of entry in Gateway, threshold activity and support for those making critical decisions within Gateway by developing a Professional Support Network to help them in making decisions will be important developments.

Further work will be undertaken in 2012/2013 to finalise an inter-agency information sharing policy; develop a training strategy for children's services staff and continue to monitor and address where possible the demand and capacity needs of the service.

The Northern Ireland Adult Safeguarding Partnership (NIASP) was established in 2012, following the publication of *'Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements'* by the DHSSPS and Northern Ireland Office (now Department of Justice).

The HSCB Assistant Director chairs NIASP for Older People and Adults, and membership is drawn from the statutory, voluntary and community sectors.

Partner organisations include: the PHA, district councils, NIHE, the faith community, independent providers, the Royal College of Nursing, NI Association of Social Work, voluntary sector providers such as Praxis, Age NI, Red Cross and Victim Support, the PSNI and Probation Board. The 5 Health and Social Care Trusts are also represented.

NIASP has an annual work plan in place, which addresses the broad themes of Prevention of Abuse, Protection from Harm and Partnership Working. NIASP meets quarterly to receive reports of progress against the work plan, agree any products and address emerging issues wherever possible.

Within the next year NIASP will bring forward a draft Strategic Plan for the period 2012 – 2017 for public consultation. This plan will highlight a range of strategic developments, which are necessary to take forward adult safeguarding. These can be grouped under the following broad themes:

1. Leadership and Partnership Working
2. Public Awareness and Prevention
3. Access to Adult Safeguarding Services
4. Effective Intervention

5. The User Experience
6. Training and Practice Developments
7. Governance, Audit and Quality Assurance

The issues of suicide and self-harm continue to affect too many people in Northern Ireland. We will continue to work with others in the statutory and voluntary / community sectors to reduce the incidence of suicide and self-harm through the Refreshed Protect Life Strategy (2012)

Some people who use our services may be particularly vulnerable for a number of reasons; age, disability, communication difficulties or capacity issues.

During 2011 the HSCB worked with the DHSSPS, Service Users, their Carers and Trusts to agree Guidance for Commissioners on Advocacy. This will be launched by the Minister for Health, Social Services & Public Safety, in 2012 and passed to the Health & Social Care Board for implementation. The Guidance outlines shared definitions of the varieties of Advocacy e.g. Peer, Self, Professional etc.

Importantly the Guidance for the first time in Northern Ireland also sets out standards for advocacy in terms of independence, governance and training. Through the implementation of the Guidance the HSCB intend to raise the standard of advocacy provided to people who find it difficult to make their voices heard and in so doing an important protective factor will be achieved.

We are also exploring the models of self-directed support or personalisation that have been developed in England and Scotland. These provide the opportunity for vulnerable people to have control over the design of their support package, have an identified budget for that support and be more creative in the ways in which the support is provided. Some work has already commenced to deliver this model for Northern Ireland but this will be given greater impetus in 2012/13, harnessing the enthusiasm and support for this approach evident from feedback from service users, families and voluntary and community sector organisations who wish to see further work in this area.

Key priorities in relation to safeguarding and supporting vulnerable people in 2012 / 13 will include:

- Further development of adult protection arrangements including implementation of the recommendations in the recent RQIA report
- Progress the integration and recovery approaches as outlined in the Bamford vision for Mental Health Services
- Further progress the resettlement of people from long stay hospital beds to appropriate living arrangements in the community
- Progress the re-design of social care services to older people to ensure a focus on rehabilitation through the Re-ablement model
- Support the transition from the Regional Child Protection Committee to the newly established independent Safeguarding Board for Northern Ireland
- Implement the three year plan for meeting the accommodation and support needs of young homeless and young people leaving care
- Develop an early intervention framework for supporting children and families through the Children and Young People Strategic Partnership
- Develop a range of ways to provide additional support to vulnerable families and children including further roll out of Family Support Hubs
- Co-operate with others to deliver the Refreshed Protect Life Strategy (2012)

6.8 Response to Ministerial Targets

The text below details the special targets set by the Minister to be achieved in 2012/13 together with the commissioning response. While inevitably there are risks associated with the delivery of a number of targets and standards, we have sought to highlight only the most material risks in the responses below.

MINISTERIAL PRIORITY:		**To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion and earlier intervention.**
	Area	
1	Bowel Screening	Extend the Bowel Cancer Screening Programme to invite 50% of all eligible men and women aged 60-71 by March 2013, with a screening uptake of at least 55%

The Bowel Cancer Screening Programme (BCSP) was fully rolled out to all Trust areas in Northern Ireland from January 2012. The programme invites all eligible men and women aged 60-71 to participate in screening. The programme was launched for men and women aged 60 – 69 before the upper age limit was extended to 71 from April 2012.

A full screening cycle occurs over 2 years with50% of the total eligible population invited each year. The service is expected to achieve the target of inviting 50% of all eligible men and women aged 60-71 by March 2013. The BCSP IT system, BSIM, is set to call 50% of the eligible population each year. This target will be achieved in 2012/13 and has been achieved each year since the commencement of the programme. The BSIM system has a back-up in the event of any problems.

Uptake rates to date are approximately 48% (at 3 months post invite). (Uptake figures are 51% as of end of April 2012.) Uptake is monitored each month by the Quality Assurance Reference Centre within the PHA.

A public information campaign to raise awareness of the programme was launched on 3 February 2012 and ran from February to March. In 2012/13 the impact of the public information campaign on uptake rates will be evaluated.

The PHA aims to increase awareness of the screening programme so the eligible population can make an informed choice as to whether they wish to complete the screening test. There is capacity within the different service delivery functions of the screening programme for 60% uptake.

MINISTERIAL PRIORITY:		**To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion and earlier intervention.**
	Area	
2	AAA Screening	By June 2012, have in place a Northern Ireland - wide programme to screen men aged 65 for abdominal aortic aneurysm.

The Northern Ireland AAA Screening Programme will commence in June 2012. Screening will be delivered locally at a number of fixed Health & Social Care locations throughout Northern Ireland in line with NHS AAA

Screening quality standards and protocols. Invitation letters will be sent directly to eligible men by the Central Screening Office based at the Belfast HSC Trust three weeks prior to appointment. The Trust will be responsible for organising the screening and surveillance clinics, inviting men for screening, issuing results letters and arranging the referral of men, who have a large aneurysm identified, to the vascular service based at the Royal Victoria Hospital (RVH) in Belfast.

Men will be invited for screening during the year they turn 65; men over 65 will be able to self-refer. The Northern Ireland AAA Screening Programme will start by inviting the cohort of men who turn 65 between 1st July 2012 and 31st March 2013.

The PHA is responsible for commissioning and quality assuring the programme. A publicity campaign is planned for early 2013.

MINISTERIAL PRIORITY:		**To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion and earlier intervention.**
	Area	
3	Public Health	By March 2013, have in place a community pharmacy health promoting pharmacies programme.

The establishment of this programme is dependent upon progression with the community pharmacy contract including infrastructure development. Work to develop a programme has already commenced through the development of relevant service specifications as part of ongoing community pharmacy contract negotiations.

A review of other programmes elsewhere in the UK is underway which will also take into account the evaluation and experience of the Community Pharmacy Partnership in Northern Ireland with the Community Development and Health Network.

It is anticipated that by end of June 2012, the review and a strategic position statement will be completed; end of September enabling infrastructure (staff premises development) will have been reviewed and a development plan in place; end December services will have been specified and agreed and at end of March 2013 the programme will have commenced.

MINISTERIAL PRIORITY:		**To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion and earlier intervention.**
	Area	
4	Public Health	By March 2013, develop an implementation plan to take forward new Public Health Strategic Framework and related population health strategies.

During 2012/13 the new Public Health Strategic Framework will be informed and refined by a full consultation process. The timeframe for the consultation will be determined by the Department but is likely to run from end of June to September, with a final Framework agreed by December 2012.

The Framework will set out a clear direction for improving the public's health and wellbeing and reducing inequalities. An implementation plan with costs will be developed during 2012/13 and completed by 31 March 2013. The implementation plan will take into account specific strategies to address key strategic priorities and population groupings.

MINISTERIAL PRIORITY:		**To improve the quality of services and outcomes for patients, clients and carers.**
	Area	
5	Fractures	From April 2012, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

There has been considerable investment in the past to meet target waiting times for fracture services. The HSCB/PHA has also paid significant attention to managing Trust performance in this respect.

During 2012/13 the HSCB will be comparing activity by site to identify any capacity/demand gap and will seek reports from Trusts demonstrating productivity, including theatre sessions delivered against funded capacity, cases per session, the spread across seven day working, average length of pre-operative and post-operative stay, and delayed discharges.

Against the above background, the HSCB will work with Trusts to support the delivery of hip fracture waiting time standard.

MINISTERIAL PRIORITY:		To improve the quality of services and outcomes for patients, clients and carers.
	Area	
6	Cancer Care	From April 2012, ensure that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

The HSCB/PHA will continue to work with Primary Care and Trusts to support the delivery of the cancer waiting time standard. Where patients are not able to be treated within 62 days, the HSCB/PHA will ensure appropriate tracking, breach analysis and follow up to minimise future delays in referral, diagnosis and treatment.

The HSCB/PHA has recently established weekly patient-level performance meetings with Trusts for suspected cancer patients. This is expected to support a more proactive management of the cancer PTL, and ensure the timely diagnosis and treatment of suspect cancer patients. The HSCB is aware of the need for effective triage and access timely diagnostic services to achieve the cancer waiting times targets.

The overall regional performance (81% in 11/12) is significantly impacted by Belfast and Northernism performance. For Belfast a significant part of their performance issues relates to urological cancers and late Inter-Trust Transfers (ITTs) from other Trusts. Northernism performance is particularly affected by their position on Lower GI waiting times.

The HSCB's focus on cancer issues in 2012/13 will therefore particularly be on Belfast and Northern Trusts, although with a continuing focus on ensuring timely ITTs from other Trusts.

Key actions to be taken forward with Trusts in 2012/13 therefore include:

- Full implementation of the urology review, particularly ensuring full recruitment to the consultant teams for which Trusts are now advising recruitment should be completed by August for Team East and September for Team South) (Team Northwest has a locum covering their vacancy and is progressing with the substantive post)
- Explore options to introduce appropriate mechanisms for transfer of urology referrals for Team East both to elsewhere in the region

and also to other parts of Team East where capacity exists and would enable shorter waiting times

- Developing alternative pathways and implement ineffective procedures where there is limited evidence to justify commissioning the service for urology procedures of lower clinical value
- Ensuring appropriate use of suspect cancer red flag referrals (for which meetings are underway between the HSCB, PHA and NICAN)
- Reducing cancellation/DNA rates in the utilisation of urology capacity. This includes the piloting of text message reminders for urology patients
- Ensuring timely ITTs
- Ensuring agreed capacity issues identified in the Commissioning Plan are implemented, included the additional investment in thoracic surgery within Belfast referenced within page 174 of the Commissioning Plan

MINISTERIAL PRIORITY:		**To improve the quality of services and outcomes for patients, clients and carers.**
	Area	
7	Organ Transplants	By March 2013, ensure delivery of a minimum of 50 live donor transplants.

The live donor transplantation service in Belfast Trust will be consolidated by increasing the clinical team and supporting infrastructure with the expectation that we can continue to provide at least 50 live donor transplants in 2012/13 consistent with the previous two years. The programme has been extremely successful to date. Access to live donor transplantation is currently higher in Northern Ireland than in any other UK region. A key challenge in sustaining these levels will be our ability to recruit 2 additional consultant transplant surgeons.

MINISTERIAL PRIORITY:		To improve the quality of services and outcomes for patients, clients and carers.
	Area	
8	A&E	From April 2012, 95% of patients attending any Type 1, 2 or 3 A&E Departments are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; no patient attending any emergency department should wait longer than 12 hours.

Waiting times for A&E services in Northern Ireland are unacceptable, falling well short of the Minister's required standards for 2012/13. The Ministerial standards for 4-hour and 12-hour performance, as set out above, will not be fully achieved by all Trusts in 2012/13 given current levels of performance. However, a substantial improvement in performance is possible with the elimination of 12-hour breaches from 1 July 2012, and the securing of a substantial improvement in 4-hour performance in the remainder of the year working towards the Minister's 95% target. The HSCB/PHA will continue to work with Trusts to ensure the issue of ED performance is given the highest priority.

To this end, the HSCB/PHA has established an Emergency Department Improvement Action Group to work with Trusts to secure a step-change improvement in A&E performance by June 2012, with a particular focus on ensuring delivery of agreed best practice re patient flows.

MINISTERIAL PRIORITY:		To improve the quality of services and outcomes for patients, clients and carers.
	Area	
9	Elective Care – Outpatients/ Diagnostics / Inpatients	From April 2012, at least 50% of patients wait no longer than nine weeks for their first outpatient appointment with no one waiting longer than 21 weeks, increasing to 60% by March 2013 and no one waits longer than 18 weeks.
10	Elective Care – Outpatients/ Diagnostics/ Inpatients	From April 2012, no patient waits longer than nine weeks for a diagnostic test (13 weeks for a day case endoscopy), and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.
11	Elective Care – Outpatients/	From April 2012, at least 50%, of inpatients and day cases are treated within 13 weeks with no one

	Diagnostics / Inpatients	waiting longer than 36 weeks, increasing to 60% by March 2013, and no patient waits longer than 30 weeks for treatment.

The HSCB/PHA has worked with Trusts to secure significant improvements in elective care waiting times in the period September 2011 to March 2012. The HSCB will continue to ensure this area is prioritised in 2012/13, seeking as far as possible within available resources to maintain the current momentum and secure further reduction in maximum waiting times for patient assessment and treatment. In addition, the HSCB has secured in-year resources of £10m to deliver and in some cases improve upon the Minister's target maximum waiting times for March 2013.

Further performance improvement will be secured through a combination of ensuring Trusts deliver core capacity, together with investment in additional in-house or Independent Sector activity where this is required. Pending the securing of this additional in-house capacity there will remain a risk of longer waiting times in these specialities.

During 2012/13 the HSCB/PHA will make targeted recurrent investments in specialities where there is an agreed capacity gap relative to demand with investment being made in additional Trust services and primary care. A priority will be those regional services for which there is no readily available Independent Sector solution when additional activity is required. It is likely that waiting times in these specialities will remain as outliers, potentially beyond the 18 and 30 week maximums during 2012/13, pending the full establishment of the necessary additional capacity.

In relation to endoscopy, the HSCB completed a capacity/demand analysis during 2011/12, and has worked with Trusts to reduce the number of patients waiting more than 13 weeks from over 5,600 in September 2011 to only 3 patients in March 2012. The HSCB aims to reduce further the maximum waiting time for endoscopy tests to 9 weeks by September 2012.

Finally, In relation to diagnostics reporting, the HSCB/PHA will continue to work with Trusts to ensure timely reporting of urgent tests. The HSCB will work with Trusts to ensure the effective planning and implementation of those RQIA review recommendations for which the HSCB is in the lead.

MINISTERIAL PRIORITY:		**To improve the quality of services and outcomes for patients, clients and carers.**
	Area	
12	Hospital Readmissions	By March 2013, secure a 10% reduction in the number of emergency readmissions within 30 days.

This target will be achieved through greater focus on those conditions which make up the greatest proportion of emergency readmissions and will include the management of long term conditions.

There will be an extension of patient group and one-to-one education and self-management programmes. Remote tele-monitoring will be an important tool and the commissioner will seek to extend current schemes more widely. Effective medicines management will also be given renewed focus. It will be essential that communication between primary and secondary care is effective in preventing readmissions through prioritisation of review of those patients recently discharged following an emergency admission.

MINISTERIAL PRIORITY:		**To improve the quality of services and outcomes for patients, clients and carers.**
	Area	
13	Healthcare Associated Infections	By March 2013, secure a 29% reduction in MRSA and Clostridium Difficile infections compared with 2011/12.

During 2011/12 the regional target for reduction in *Clostridium difficile* infections (CDI) was achieved. However the regional target for reduction in Meticillin-resistant S*taphylococcus aureus* (MRSA) bloodstream infections was not achieved. Reduction and prevention of healthcare associated infections remains a very high priority for PHA/HSCB.

During 2012/13 the PHA will:

- Continue to lead and deliver CDI and MRSA surveillance programmes across the HSC. These surveillance programmes underpin all work to deliver reductions in both CDI and MRSA
- Continue to validate and quality assure all CDI and MRSA information

- Continue to issue monthly monitoring and quarterly CDI and MRSA surveillance reports across HSC
- Continue to support, advise and provide specialist improvement support to Trusts as required

All HSC Trusts will be required to maintain and continue their focused HCAI improvement programmes to deliver the HCAI reduction target of 29% during 2012/13. Monthly monitoring reports will continue to inform the requirement for PHA and HSCB to jointly assess progress in CDI and MRSA reduction across the region and for individual Trusts. PHA/HSCB will continue to work with Trusts to ensure further focused work in relation to action planning, prudent prescribing, root cause analysis, embedding improvement into front-line service delivery, and professional leadership for HCAI improvement.

MRSA performance and proposed targets for 2012/13

MRSA	Target set for 2011/12	Actual cases in 2011/2012	Target for 2012/2013	Case reduction required in 2012/13
BHSCT	32	46	28	18
NHSCT	13	19	12	7
SEHSCT	13	14	10	4
SHSCT	11	10	10	0
WHSCT	11	7	7	0
NI	80	96	67	29

***Clostridium difficile* infection: performance and proposed targets for 2012/13**

C. Difficile	Target set for 2011/12	Actual cases in 2011/2012	Target for 2012/2013	Case reduction required in 2012/13
BHSCT	194	169	126	43
NHSCT	88	94	59	35
SEHSCT	80	91	66	25
SHSCT	22	33	22	11
WHSCT	63	50	40	10
NI	447	437	313	124

MINISTERIAL PRIORITY:		To improve the quality of services and outcomes for patients, clients and carers.
	Area	
14	Pharmacy	From April 2012, ensure that HSCB achieve 70% compliance with the Northern Ireland Medicines Formulary is achieved within Primary Care.

Publication of the formulary is being progressed on a phased basis:

- Four chapters will be released by June 2012
- Four further chapters by September 2012
- Web-enablement of the formulary will be achieved by October 2012
- Commissioning statements in respect of the formulary will be issued by October 2012
- Ongoing monitoring, audit and performance review in primary care to achieve a 70% compliance target by year end

With each chapter that is published, baseline assessments are being undertaken to ascertain the level of prescribing that is compliant with that section. An implementation team has been established which will inform the implementation, monitoring and audit activities.

MINISTERIAL PRIORITY:		To develop more innovative, accessible and responsive services; promoting choice and by making more services available in the community.
	Area	
15	Specialist Drugs	From April 2012, no patient should wait longer than 9 months to commence NICE-approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis, decreasing to 3 months by September 2012.

Progress towards achievement of this target has already taken place. In December 2011, Trusts were directed to increase the take-on rate for these NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis. At the end of March 2012, no patient was waiting longer than six months to commence therapy for the agreed conditions. Plans are in place and each Trust has confirmed

at the monthly Regional Biologic Therapies meeting that the 3 month maximum waiting time was achieved at the end of June 2012. Progress against the target will continue to be monitored on a monthly basis.

MINISTERIAL PRIORITY:		**To develop more innovative, accessible and responsive services; promoting choice and by making more services available in the community.**
	Area	
16	Specialist Drugs	By March 2013, increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis.

This target is being achieved and 24/7 thrombolysis has been available in all 5 Trusts since September 2011. Performance monitoring arrangements for this target have been agreed with Trusts and remote assessment using tele-health has been tested in three of the five Trusts. Options for connecting all 5 Trusts using tele-health will be explored in 2012/13.

MINISTERIAL PRIORITY:		**To develop more innovative, accessible and responsive services; promoting choice and by making more services available in the community.**
	Area	
17	Allied Health Professionals	From April 2012, no patient waits longer than nine weeks from referral to commencement of AHP treatment.

The HSCB is expecting all Trusts to achieve a maximum waiting time of nine weeks by end of March 2012 for the large majority of AHP services. For a few exceptions the maximum wait will be no longer than 16 weeks. The HSCB/PHA will continue to target the longest waiters with a view to ensuring a maximum waiting time of 9 weeks for all patients as soon as possible in 2012/13.

The PHA over the next year will continue in partnership with HSC Trusts to lead on the Implementation of the Speech & Language Therapy Action plan. We will also continue to drive forward AHP reform ensuring that all aspects of this work will be informed by the Commissioning Direction, Commissioning Plan and priorities within the Commissioning

Service Teams, the needs of our Local Health Economies and current service provision.

MINISTERIAL PRIORITY:		**To develop more innovative, accessible and responsive services; promoting choice and by making more services available in the community.**
	Area	
18	LTC	By March 2013, achieve 400,000 Monitored Patient Days (equivalent to approximately 2,200 patients) from the provision of remote tele-monitoring services through the Tele-MonitoringNI contract.

The number of patients receiving tele-monitoring services in 2011/12 was 1330.The target for 2012/13 therefore represents an increase of 65% against the expected 2011/12 outturn.

There are some indications from some Trusts that a substantial proportion of potential tele-monitoring referrals have already been identified from existing specialist nurse caseloads and it is recognised that achieving this target will require significant effort from Trusts.

CCHSC will be requesting each Trust to produce a detailed implementation plan outlining monthly/quarterly targets alongside key actions required in order to meet them. The delivery of these plans is anticipated at the end of June, with regular monitoring of progress against targets to be carried out on a monthly basis.

Achieving the target may also benefit from further engagement with the primary care sector in order to determine an appropriate role for tele-monitoring in:

- Supporting patients who are not as yet known to hospital and specialist nursing teams; and
- Supporting an appropriate balance and integration of service provision between primary care services and Trust specialist nursing services.

Alongside Trusts initiatives, there are plans to support clinical engagement through developing a service improvement initiative and establishing a Tele-MonitoringNI Clinical Forum. Putting in place an

independent evaluation of Tele-MonitoringNI and developing a Connected Health Strategy will also help in this regard.

Trusts have indicated they are committed to promoting the use of remote tele-monitoring for patient-centred care and to developing care pathways that include remote tele-monitoring. They have also confirmed they have appropriate systems established and in place to report and monitor against the agreed baseline activity.

MINISTERIAL PRIORITY:		**To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector.**
	Area	
19	Transforming Your Care	By June 2012, produce population plans for implementation following the *Transforming Your Care* report.

The Transformation Programme which will undertake the HSCB's responsibilities with regard to *Transforming Your Care* is in the process of mobilisation and establishment. As part of this mobilisation strong focus is being placed on the production of Population Plans by June 2012. Work is progressing on setting up the enabling structures to ensure this happens, including the governance arrangements.

Work towards this target is currently on track but is heavily reliant on confirmation of transitional funding and swift progress on the business case for external consultancy support which is currently under review.

MINISTERIAL PRIORITY:		**To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector.**
	Area	
20	Transforming Your Care	During 2012/13, develop and implement Integrated Care Partnerships in supporting the implementation of *Transforming Your Care.*

Population Plans will outline service changes over a 3 year period. In addition during the Plan/Design phase planning for Integrated Care Partnerships (ICPs) will be progressed with a view to establishing 17 ICPs. This information will be available in June 2012.

Work towards this target is currently on track but is reliant on any necessary policy changes to support the move to Integrated Care Partnerships.

The creation of opportunities to shift resourcing into community services including the commissioning of social care services to help avoid the causes of delayed discharges will be detailed further in the local Population Plans.

MINISTERIAL PRIORITY:		**To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities.**
	Area	
21	Unplanned admissions	By March 2013, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.

Actions for Target 12 apply.

MINISTERIAL PRIORITY:		**To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities.**
	Area	
22	Unnecessary hospital stays	By March 2013, reduce the number of excess bed days for the acute programme of care by 5%.

During 2012/13, through the Emergency Department Improvement Action Group referred to above, the HSCB/PHA will work with Trusts towards delivering the Minister's target by improving patient flows through wards, maximising the number of patients discharged before 1pm, ensuring surgical patients are admitted on the day of treatment, and other actions to reduce length of stay.

Ward sisters will have a key role to play in relation to timely discharge. They will be expected to take the lead to ensure that all elements (pharmacy, NIAS, AHP assessment, bed cleaning teams, etc.) are in place to allow a patient to leave the ward quickly once deemed fit for discharge and that there is timely communication of discharge information to relevant parties.

Work on the development and implementation of Population Plans will also be relevant in this area.

MINISTERIAL PRIORITY:		To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities.
	Area	
23	Patient Discharge	From April 2012, ensure that all learning disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge; 90% of all complex discharges take place within 48 hours; all non-complex discharges from an acute hospital take place within 6 hours; and no discharge from an acute hospital takes more than 7 days.

During 2012/13, the HSCB/PHA will continue to work with Trusts to ensure effective care planning and timely discharge of patients across all programmes of care. The seven-day target will not be achieved for all patients as there are always a small number of people with complex needs who require a longer period of planning for discharge and ensuring adequate supports are in place in the community to facilitate this. In practice, the HSCB would expect 90% of hospital discharges to be completed within 7 days, with the aim of achieving 100% in due course.

MINISTERIAL PRIORITY:		To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services.
	Area	
24	Children In Care	From April 2012, increase the number of children with no placement change to 82%.

There is a recognised need to promote greater stability for looked after children. It is envisaged that this target will, in the main, relate to children and young people whose placement has been agreed by the resource / placement panel and will not include the first planned placement after assessment. This target also relates to *Transforming Your Care* and highlights the need to finalise the review of residential child care and progress specialist foster care services which will allow for placements to meet the assessed needs of children.

The HSCB will continue to monitor the number of placement moves for looked after children through the DSF process and performance management arrangements.

MINISTERIAL PRIORITY:		To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services.
	Area	
25	Children In Care	By March 2013, increase the number of care leavers aged 19 in education, training or employment to 72%.

In the current economic climate the achievement of this target will prove to be particularly challenging but care leavers deserve to have every opportunity if inter – generational family disruption is to be averted and if care leavers are going to be facilitated to make a positive contribution into adulthood. There is already an existing taskforce in place jointly chaired by DEL and the HSCB Director of Social Care and Children which will continue to work collaboratively to address this target.

MINISTERIAL PRIORITY:		To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services.
	Area	
26	Children In Care	From April 2012, ensure a 3 year time-frame for all children to be adopted from care

This target further recognises that children should not drift within the care system. The HSCB, Trust and voluntary agencies and providers will work collaboratively through the Regional Adoption and Fostering Taskforce (RAFT) to have greater emphasis on targeted recruitment and promotion of concurrent planning where appropriate to minimise disruption to children.

The HSCB has previously issued Permanency Guidance and will seek to reinforce the need to adhere to this to promote timely and effective decision making.

A recent national study has concluded that legal processes need to be factored into the equation as this can on occasion also result in delay.

MINISTERIAL PRIORITY:		To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services.
	Area	
27	Community Care	From April 2012, people with continuing care needs wait no longer than 8 weeks for assessment to be completed, and have the main components of their care needs met within a further 12 weeks.

The current high level of achievement of care needs being assessed within 8 weeks, which stands at almost 100%, will be maintained. Local vacancy controls will be closely monitored to address any potential adverse impact sustaining this level of performance.
Improved quality of assessment will continue to be progressed via the implementation of the Northern Ireland Single Assessment Tool (NISAT).

Currently some 95% of patients have the main components of their care needs met within 12 weeks. The HSCB/PHA will work with Trusts in 2012/13 to further improve performance.

The roll out of ‘re-ablement’ regionally during 2012-13 will further support achievement of the target by ensuring that people have access to an early assessment of their needs, and that where care services are required, these are targeted, rehabilitative and goal focussed in nature.

‘Re-ablement’ will be delivered in partnership with the Community and Voluntary sector. This approach will deliver a range of care responses as determined by the complexity of an individual’s assessed needs, and in addition will ensure community resources are deployed for no longer than is necessary to achieve agreed re-ablement goals.

MINISTERIAL PRIORITY:		To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services.
	Area	
28	Learning Disability / Mental Health	By March 2013, 40% of the remaining long-stay patients in learning disability and psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.

Significant progress has already been made towards this target for March 2015. At March 2012 there had been 27 mental health patients and 24 patients with a learning disability resettled to appropriate places. Resettlement of long stay patients was highlighted as one of the key recommendations within the *Bamford Report* and has been reinforced with the recent publication of *Transforming Your Care*. Ongoing monthly monitoring will continue in addition to regular dialogue with Local Health Economies.

MINISTERIAL PRIORITY:		**To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services.**
	Area	
29	Mental Health	From April 2012, no patient waits longer than 9 weeks to access child and adolescent services or adult mental health services, and 13 weeks for psychological therapies (any age).

Work is already being progressed to achieve this target. Monitoring arrangements are in place to ensure the ongoing delivery of the required performance. To ensure the CAMHS target is achieved there is weekly reporting on waiting times across the region and regular engagement at senior levels. One service is subject to an external review and the interim report is expected in early July 2012. Meanwhile the HSCB continues to work with Trusts on service reform.

6.9 Response to Indicators of Performance

The priorities and targets detailed above are complemented by a number of indicators of performance. The HSCB will ensure that robust information systems are maintained that will enable the HSCB to measure performance against the targets.

The Indicators will be used in the performance management of the Trusts in support of Commissioning. The HSCB and LCGs will ensure the implementation of appropriate monitoring arrangements to confirm that commissioned services are delivered, to benchmark comparative performance, and to ensure that quality outcomes including positive user experiences are delivered. Providers must in turn have appropriate monitoring arrangements to ensure that they are meeting the requirements of commissioners and performing efficiently, effectively and economically.

Section Two

Detailed Commissioning Intentions in 2012/13

7 Commissioning Intentions in 2012/13 – Summaries by Service Group

7.1 Introduction

This section provides details of the specific commissioning intentions for 2012/13 and beyond.

Whilst services are funded along groups called Programmes of Care the HSCB/PHA has organised its commissioning teams to reflect key service areas. Commissioning proposals are therefore presented in the following service areas:

1. Health and Social Wellbeing Improvement, Health Protection and Screening
2. Unscheduled Care
3. Elective Care
4. Cancer Care
5. Palliative and End of Life Care
6. Long Term Conditions
7. Maternity and Child Health
8. Community Care, Older People and Physical Disability
9. Children and Families
10. Mental Health and Learning Disability
11. Prison Health
12. Specialist Services

Each service area has a dedicated team which is tasked with working together with stakeholders to identify and deliver on the commissioning priorities within their service area for the year.

During the course of the year, teams will work up detailed plans which outline how the priorities will be met. Detailed equality screening and impact assessments may be required in relation to a number of the priorities identified and these will be completed in advance on any service changes being taken forward.

NICE Guidelines

The Department of Health, Social Services and Public Safety has reviewed the process for endorsing and securing implementation of NICE guidelines in Northern Ireland. NICE is the independent organisation tasked with producing national guidance on the promotion of good health and the prevention and treatment of ill health.

The new system will provide a single process for endorsing NICE guidance. Throughout this section each Commissioning Team has highlighted the relevant NICE guidance on which they will work with Trusts to implement.

NICE Guidelines (previously held in abeyance)

There are a number of endorsed clinical guidelines which relate to guidance published by NICE prior to the introduction of the new Departmental process in September 2011. Over the next 12 to 15 months the commissioning teams will prioritise the guidance outlined below and arrange to issue service notifications to Trust and other relevant stakeholders as soon as they have completed a baseline assessment and developed detailed plans. The service notifications will be sent out in a timely manner across the 12-15 month period ensuring that Trusts can commence implementation at the earliest opportunity and full implementation is achieved within the planned timeframes.

CG36	Atrial Fibrillation http://guidance.nice.org.uk/CG36
CG77	Antisocial Personality Disorder http://guidance.nice.org.uk/CG77
CG79	Rheumatoid Arthritis in Adults http://guidance.nice.org.uk/CG79
CG82	Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care (update) http://guidance.nice.org.uk/CG82
CG86	Coeliac Disease – Recognition and Assessment of Coeliac Disease http://guidance.nice.org.uk/CG86

CG87 Type 2 Diabetes – Newer Agents (update of CG66) The management of type 2 diabetes
http://guidance.nice.org.uk/CG87

CG95 Chest Pain of Recent Onset
http://guidance.nice.org.uk/CG95

CG97 The management of lower urinary tract symptoms in men
http://guidance.nice.org.uk/CG97

CG98 Recognition and treatment of neonatal jaundice
http://guidance.nice.org.uk/CG98

CG101 Management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update)
http://guidance.nice.org.uk/CG101

CG103 Delirium: diagnosis, prevention and management
http://guidance.nice.org.uk/CG103

CG104 Diagnosis and management of metastatic malignant disease of unknown primary origin
http://guidance.nice.org.uk/CG104

CG105 The use of non-invasive ventilation in the management of motor neurone disease
http://guidance.nice.org.uk/CG105

CG112 Sedation in children and young people
http://guidance.nice.org.uk/CG112

CG114 Anaemia management in people with chronic kidney disease
http://guidance.nice.org.uk/CG114

CG117 Tuberculosis
http://guidance.nice.org.uk/CG117

CG118 Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas
http://guidance.nice.org.uk/CG118

CG119 Diabetic foot problems - inpatient management
http://guidance.nice.org.uk/CG119

CG120 Psychosis with coexisting substance misuse
http://guidance.nice.org.uk/CG120

CG121 Lung Cancer
http://guidance.nice.org.uk/CG121

CG122 Ovarian Cancer
http://guidance.nice.org.uk/CG122

CG123 Common Mental Health Disorders: Identification and Pathways to Care
http://guidance.nice.org.uk/CG123

CG124 The management of Hip Fracture in adults
http://guidance.nice.org.uk/CG124

CG125 Peritoneal Dialysis
http://guidance.nice.org.uk/CG125

CG126 Stable Angina
http://guidance.nice.org.uk/CG126

CG127 Hypertension
http://guidance.nice.org.uk/CG127

CG 110 Pregnancy & Complex Social Factors
http://guidance.nice.org.uk/CG110

7.2 Health and Social Wellbeing Improvement, Health Protection and Screening

Health and Social Wellbeing Improvement

This section describes the model of health and social wellbeing improvement that the HSCB and PHA wish to commission. The model consists of increasing the emphasis on prevention and health improvement within commissioned health and social care services alongside the development of effective partnerships with other sectors, including communities, in order to influence the wider determinants of health.

The evidence is clear – approximately 4,000 people die prematurely each year in Northern Ireland due to preventable ill health. Perhaps more significantly, the pattern of health inequalities is persistent over time. It is true that health has improved for the population as a whole but this improvement has not been seen in all groups at the same rate.

A new public health framework for Northern Ireland will be issued for consultation later in 2012. It will propose an updated strategic direction for public health which will inform implementation at regional and local levels of actions to promote good health, wellbeing, reduce ill health, address inequalities and create better outcomes for service users. Important aspects to be advanced through this framework are:

Giving every child and young person the best start in life

This will be achieved through improving maternal and child health along with supporting vulnerable parents.

Working with others to ensure a decent standard of living

The changing demographics in the population require a particular focus on those who experience greatest inequalities and working with other sectors to ensure effective services in the home and community settings.

Building sustainable communities

Adopting a community development approach to service design and delivery and using community leaders to promote change within local communities will be important for improving health.

Making healthy choices easier

Simple appeals for individual behaviour change will have limited value without also creating a supportive environment through the alignment of policy and action. A focus on specific health issues such as cancer, circulatory disease, respiratory disease, alcohol and drug use, obesity, diabetes, mental health and sexual health all point toward the need for interconnected action across a range of fronts.

Underpinning Themes

The underpinning themes included in this section include:

- Adopting a “life course” approach, that is, looking across the life span and determining when and how intervention should be managed
- Focusing efforts on those geographic and other communities in greatest need e.g. BME and migrant people, homeless people
- Effective collaboration at interdepartmental, regional and local statutory, community and voluntary organisations
- Developing partnership approaches which empower communities and which seek to address the determinants of health
- The need to prevent ill health and thereby reduce demand across service areas
- Integration of health and social wellbeing improvement across all elements of primary and secondary health and social care
- Creation of robust data and evidence gathering systems that inform decision making
- Using the power of the health and social care workforce to promote health and wellbeing through their interactions with the public and in their own family and social networks

Give Every Child the Best Start in Life

The required elements for all local health economies are:

- Work toward establishing a minimum of one Family Nurse Partnership Programme in each Trust area with two being established in 2012/13

- Implement other evidenced based parent support programmes to increase capacity annually to cover 50% of first time mothers by 2015
- Take forward the recommendations of 'Healthy Child Healthy Future' and ensure that services are offered to children and families
- Work with the HSCB and PHA to review the content of antenatal education and ensure that it includes appropriate information about parent child interaction that will promote infant brain and emotional development and its long term impact on health
- Provide training for midwives, health visitors, social workers, GPs and others on infant mental health
- Meet the UNICEF UK Baby Friendly Initiative standards to support breast feeding
- Support the development of peer support models for breast feeding in areas where breastfeeding levels are low
- Establish an effective and systematic approach to training for key staff so that they can promote and support breast feeding practice
- Implement evidence based parent support programmes
- Work with the PHA to extend the Roots of Empathy programme in schools on a planned basis

Work with others to ensure a decent standard of living

- Provide support to programmes which tackle poverty (including fuel poverty) and maximise access to benefits, grants and a range of services
- Ensure current health and wellbeing improvement programmes are tailored to meet the needs of those at risk of poverty, including Travellers, Looked After Children, lone parents and homeless people
- Establish programmes that address employability and the needs of long term unemployed people with a focus on skills development and opportunities for training and employment within the health and social care sector
- Support social economy businesses ,and community skills development using the power of the H&SC sector through public procurement, such as the RAFAEL programme

- Support health improvement within schools and the education sector as a whole

Build Sustainable Communities

- Develop a common approach and reporting framework for the Community Development Strategy and Action Plan, PPI, Patient Experience and Equality Action Plans
- Support local community networks and community participation in health improvement programmes in the top 20% most disadvantaged areas in each LCG area
- Work with the PHA and HSCB to develop common standards for community gardens/allotments and the roll out of good practice
- Lead and support the NI Travellers Health Forum and develop a coordinated Action Plan to meet the needs of Travellers which will include cultural awareness training for staff, and the employment or development of volunteer Traveller lay health advisors
- Work with the PHA, LCGs and HSCB to develop a community pharmacy health promoting pharmacies programme
- Contribute to the Migrant Health and Wellbeing Steering Group and the action plan to meet need, including the development of the network and building the capacity of staff
- Establish a HSC volunteers programme and lead the implementation of standards for volunteering at a local level

Make Healthier Choices Easier

- Contribute to the implementation plan to take forward the new Public Health Strategic Framework and related population health strategies
- Support the establishment of a community pharmacy health promoting pharmacies programme
- Support the implementation of A Fitter Future For All implementation plan to address the prevention of obesity through a number of actions, including healthier food policies in all health and social care and other settings
- Ensure delivery of the statutory Healthy Start Scheme, through the role of health professionals (including GPs, midwives and health visitors) in the promotion and support of the Scheme and the availability of vitamins throughout NI

- Contribute to the development and implementation of a standardised physical activity referral scheme
- Provide support to the implementation of Food in Schools, sexual health, tobacco, obesity prevention and other school based programmes
- Work with the PHA and others to provide training and support to teachers in implementing health improvement programmes
- Develop a systematic approach to ensure that all key staff receive training on 'brief intervention' on substance misuse (tobacco, alcohol, and drugs) in primary care, community and secondary care setting
- Support the expansion of the One Stop Shops initiative following successful award of the tender
- Develop a systematic approach to the implementation of the Regional Initial Assessment tool within services working with young people
- Implement the Hidden Harm Action Plan
- Provide stop smoking support services to those in areas of greatest need and specifically develop targeted services for pregnant women, young people in education settings, patients for elective surgery and patients with long term conditions
- Provide support for the implementation of the Tobacco Control strategy including tobacco control legislation
- Incrementally expand capacity in order to improve access to (1) contraceptive and sexual health services specifically tailored to the needs of young people and (2) providers of sexual health services, particularly for groups at high risk of HIV and STIs and meet the 48 hour access targets
- Support multi-sectoral partnerships at local level which are focused in improving health and reducing inequalities
- Contribute to the implementation of the recommendations of the Mental Health and Learning Disability Taskforce
- Ensure that mechanisms are in place to implement the refreshed Protect Life strategy and that each area has established clear actions in relation to: uptake of Lifeline Service; extension and management of Deliberate Self Harm Registry; local action plans for mental health and wellbeing and suicide prevention taking account of particular areas of need; community resource plans;

agreed quality standards for training and counselling support programmes

- Contribute to the implementation of the Skin Cancer Prevention Strategy
- Develop a falls prevention action plan
- Develop a coordinated approach to the provision of training for HSC staff to increase their understanding of the specific health needs of LGB&T people in primary, secondary and community care settings and ensure that all services are LGB&T 'friendly'
- Support the development and implementation of guidance for older LGB&T people living in nursing and residential settings
- Provide programmes which address the needs of homeless people and contribute to the development of a regional action plan
- Develop a systematic approach to improving the health and wellbeing of the workforce and build confidence and skills of staff to promote health and wellbeing through their interactions with service users, as well as through their family and social networks

Health Protection

The Health Protection Service has a front line role in protecting the Northern Ireland population from infectious diseases and environmental hazards through a range of functions such as surveillance and monitoring, operational support and advice, response to health protection incidents, education, training and research. Working closely with partner organisations in the UK and through international networks such as those of the Health Protection Agency (HPA), World Health Organisation (WHO) and the European Centre for Disease Prevention and Control (ECDC), the overall objective is to have the best quality health protection service possible for Northern Ireland.

It will continue to achieve this through delivering on the following objectives:

- Providing an expert, timely and co-ordinated response to adverse incidents such as outbreaks of Infectious diseases, environmental issues and other emergencies.
- Leading specialist work programmes for the prevention and control of communicable diseases and environmental hazards.
- Conducting effective surveillance of communicable diseases.

- Introducing and maintaining prevention initiatives, such as immunisation programmes to prevent infectious disease.
- Test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruptive events

Service Priorities

- Achieve uptake targets for seasonal influenza vaccine, including uptake by front-line Health and Social Care workers
- Maintain and build on Northern Ireland's current very high uptake levels for childhood and influenza vaccines
- Continue to provide a co-ordinated regional service for the prevention and control of communicable diseases and maintain high quality surveillance systems and processes
- Work with local Trusts and healthcare providers to further reduce and prevent avoidable Healthcare Associated Infections (HCAI) occurring in Acute, Primary and Community Care settings in Northern Ireland
- Continue to deliver HCAI surveillance programmes – providing robust information for action across Health and Social Care
- Ensure appropriate surveillance and prevention activities are in place for Blood Borne Viruses and Sexually Transmitted Infections
- Develop links with relevant voluntary organisations in relation to TB (Tuberculosis), with Trusts following up on TB cases.
- The HSCB/PHA will work with the Trusts and others to ensure that the recommendations of the RQIA Independent Review of Pseudomonas in Neonatal Units are implemented
- Maintain the current capability and capacity of the Hazardous Area Response Team in NIAS
- Contribute to taking forward the implementation of any new guidance issued by the DHSSPS on Group B Streptococcal infections in pregnancy and neonates as advised by the GBS Steering Group chaired by the Chief Medical Officer

Summary of Key Deliverables for 2012/13

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to:

- Consult on and implement the new Public Health Framework

- Take forward the recommendations of Healthy Futures for health visiting and school health services
- Implement the Family Nurse Partnership programme
- Implement and expand the Roots of Empathy programme
- Meet the UNICEF Baby Friendly standards to support breast feeding, including systematic training for key staff that have primary responsibility for the care of mothers and babies
- Provide support to programmes which tackle poverty, including MARA, and integrate with other related areas of service delivery
- Develop plans to meet the needs of Travellers, including cultural awareness training for staff and the development of employment and volunteer opportunities within the HSCT
- Implement the Fitter Futures for All (obesity prevention) strategy, including the provision of healthier food choices within all HSC facilities
- Deliver targeted smoking cessation services to meet the needs of specific groups such as pregnant women, patients with long term conditions
- Implement clear interagency action plans to prevent suicide and self-harm
- Extend and manage the Deliberate Self Harm Registry
- Develop a health promoting pharmacies programme

Screening

Screening is an important public health function that involves inviting members of the public, who have no symptoms of a particular disease, to be tested to see if they might have the disease, or are at risk of getting it.

Population screening allows certain diseases and conditions to be identified at an early stage when they are more amenable to treatment. The PHA is the lead organisation for commissioning and for quality assuring population screening programmes. It is committed to the following key objectives:

- Ensuring access to high quality population screening and testing programmes

- Introducing newly approved screening and testing programmes within available resources
- Ensuring screening programmes meet required standards
- Maximising the uptake of all screening programmes

Service Priorities

- We will ensure that, where possible, screening programmes are accessible and where it is safe and affordable, promote models of service that minimise the need for people to travel
- Produce a consultative document and implement recommendations to cancer screening to improve uptake and coverage (particularly in hard to reach groups)
- Prepare for the development of digital mammography
- Prepare for the introduction of surveillance of women at high risk of breast cancer by the NI Breast Screening Programme
- Prepare for the introduction of Human Papillomavirus (HPV) triage and test of cure in Cervical Screening
- Review capacity of Diabetic Retinopathy Screening Programme within BHSCT and ensure screening intervals are maintained
- Develop direct referral mechanism from Diabetic Retinopathy Screening services in Ophthalmology
- Establish a Quality Assurance (QA) monitoring group for Diabetic Retinopathy
- Deliver a Bowel Cancer Screening Programme for the 60– 71yrs age group
- Complete implementation and follow up of Newborn Sickle Cell Screening
- Implement a screening programme for Abdominal Aortic Aneurysms (AAA)
- Implementation of DHSSPS 2011 standards in Antenatal infections
- Take forward further blood spot quality improvements in line with revised UK standards, including:
  - Implementation of revised guidance on blood spot sampling
  - Reduction of avoidable repeat samples

  - Introduction of the revised preterm congenital hypothyroidism screening policy
  - Development of a database to support reporting and failsafe of clinical referrals and management of screen positive infants
- Specify the requirements to implement electronic linkage within the newborn blood spot programme, including universal use and application of H&C number
- Address sustainability of regional services for follow up of infants screened positive for Phenylketonuria (PKU), Congenital Hypothyroidism (CHT) & Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD) in blood spot screening.
- Establish QA structures and monitoring processes in Newborn Hearing Screening Programme.
- Review arrangements for Developmental Dysplasia of the Hip.

NICE Guidelines (previously held in abeyance)

Trusts will be expected to put in place arrangements to comply with the following NICE guideline. Over the next 12 to 15 months the commissioning team will review and set plans in place with Trusts to fully implement the required standards over an agreed timeframe.

CG 117 Tuberculosis
http://guidance.nice.org.uk/CG117

Specific targets to be achieved for Health & Wellbeing services in 2012/13 are:

- By March 2013, have in place a community pharmacy health promoting pharmacies programme.
- By March 2013, develop an implementation plan to take forward new Public Health Strategic Framework and related population health strategies.

Summary of Key Deliverables for 2012/13

- Produce a consultative document and implement recommendations for cancer screening to improve uptake and coverage (particularly in hard to reach groups).

- Prepare for the development of digital mammography in breast screening.
- Prepare for the introduction of Human Papillomavirus (HPV) triage and test of cure in Cervical Screening.
- Develop a direct referral mechanism from Diabetic Retinopathy Screening services to Ophthalmology.
- Deliver a Bowel Cancer Screening Programme for the 60– 71yrs age group.
- Implement a screening programme for Abdominal Aortic Aneurysms (AAA).
- Implement DHSSPS (2011) standards in Antenatal infections.
- Take forward further blood spot quality improvements in line with revised UK standards

7.3 Unscheduled Care

Waiting times for A&E services in Northern Ireland are currently unacceptable, falling well short of the Minister's required standards for 2012/13. The HSCB/PHA will continue to work with Trusts to ensure this issue is given the highest priority during 2012/13.

As noted earlier in this Plan, the HSCB/PHA has established an Emergency Department Improvement Action Group to work with Trusts to secure a step-change improvement in A&E performance by June 2012, with a particular focus on ensuring delivery of agreed best practice including Patient flows.

The HSCB/PHA will be working with Trusts and LCGs in local economies to implement the new model in 2012/13 and beyond. The new service model has the potential to realise the *Transforming Your Care* principles, placing the individual at the centre of the pathway; greater integration among HSC professionals; care delivered as close to home as possible; maximisation of opportunities offered by technology; and sustainable service provision in the face of staffing challenges.

Service Priorities

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to progress:

Proactive Management of Long Term Conditions

The aim is to reduce unscheduled hospital admissions, initially by 10% during 2012/13 and work to realise reduced length of stay and maximise the number of people managing their own condition through the use of supported care planning. Practice registers of patients with asthma, COPD, diabetes, heart failure, and cardiovascular disease will be key enablers, supporting proactive regular recall of those patients within primary care to review clinical management. This will be underpinned by integrated community teams to meet patient needs and escalation procedures to seek advice and involve specialist services and effective medicines management. Patient education and self-management programmes will be more widely available.

Within Population Plans, LCGs and Trusts will bring forward proposals to integrate the management of specified long-term conditions within agreed care pathways with the key objective of reducing unscheduled hospital admissions and length of stay.

Regional Care Pathways

Consistent care pathways will be developed across primary and secondary care for appropriate implementation within the five local economies. These pathways will cover the clinical management of acute episodes due to Asthma, COPD, Diabetes, Heart Failure, and Ischaemic Heart Disease patients including investigations; treatment; criteria for managing patients in primary and secondary care, including rapid outpatient or other ambulatory assessment and acute care at home. Local Health Economies will implement regional pathways for these specified conditions, describing the expected impact of the pathways on local inpatient bed requirements, the reinvestment required in primary and community care and net expected savings.

HSC Trusts will work with NIAS to put into operation regional “treat and leave” and, in 2013/14, “assess and refer” protocols at the local level. There will also be an increased requirement on Emergency Departments for timely ‘release’ of ambulances in order to reduce turnaround times, working towards a 30 minute target by April 2013.

ED healthcare professionals will enable speedier onward referral or discharge. Trusts will provide plans, by December 2012, which clearly describe arrangements for in-reach to ED from inpatient medical staff in order to prevent emergency admissions and readmissions.

Intermediate care beds may continue to be appropriate in some areas for a small number of patients who cannot be cared for in their usual home but who do not need the level of clinical support that can only be provided in an acute inpatient setting. Local Health Economies will review the role and function of intermediate care beds during 2012/13 to ensure that they are delivering a clinically appropriate and cost-effective contribution to whole system flow.

Reform of Emergency Department Services

In keeping with *Transforming Your Care* we will seek to secure robust, substantive, high quality emergency care services at large district hospitals and provide complementary services at local hospitals, such as minor injuries services, in the future. Close monitoring of demand will enable better use of limited capacity. Triage by senior doctors (including GPs) and nurses will be improved with clear options to respond to patients, including referral to primary care and ambulatory assessment. Plans to improve unscheduled access to radiology will be developed and implemented.

Crucially, by 2013/14, Trusts will ensure that Emergency Medicine Consultants actively manage observation/short stay ‘stations’ to an expected length of stay of 6-12 hours and have an ‘on the floor’ presence on at least one ED site per Trust (8am-10pm, 7 days per week) to enable Consultant vetting of all emergency admissions during those hours. Population Plans will provide an indication of how this will be taken forward.

Trusts will also ensure at least twice daily senior doctor review of all patients in the Medical Assessment Units or equivalent and that all non-elective admissions are seen by a consultant within 24 hours. It is also anticipated that in future there will be daily consultant review of all in-patients and daily social work and AHP input to in-patient wards. It will also be required that a weekly review of a small number of patient charts from the previous week’s discharges will be undertaken by the ward sister, consultant, social care, pharmacy and AHP staff. This will review the quality of care; feedback from patients or their families and make improvements for patients admitted in the upcoming week

There is continued commitment to provide in each major acute hospital, within the next three years, a medical assessment unit for undifferentiated admissions, with an expected length of stay of no more than 2 midnights, complemented by specialty wards for designated conditions. Hospitals with inpatient paediatrics will provide an ambulatory paediatric service. In due course, in-patient care pathways for the most common conditions until the day of discharge will be established, with proactive liaison with acute care at home services to facilitate early supported discharge. Notification to families of the expected date of discharge will be as soon as possible after admission. Population Plans will indicate how this will be progressed, in the context of an ambulatory care model, in each local HSC economy with key developments anticipated during 2013/14.

Local Health Economies, to prevent unnecessary admissions, will analyse the capacity and reinvestment costs required for domiciliary care, supported housing, residential and nursing home places with clear arrangements to review patient/client home care needs regularly and clear thresholds for access to care. It will also be a priority to reduce palliative care admissions with clear arrangements for palliative care to be provided at home or into residential or nursing homes through available community services.

Pre-hospital care

Early intervention in the event of out-of-hospital emergency incidents is key to ensuring that the patient has the greatest chance of a successful outcome. The volunteer Community First Responder schemes which have been established in rural areas have been an important development in improving pre-hospital care. Schemes are made up from volunteers who live or work within a community or village and have been trained to attend certain 999 calls in support of the Northern Ireland Ambulance Service (NIAS). Their purpose is to provide first aid including oxygen therapy and Cardiac defibrillation if required, until an ambulance arrives. In addition, the HSCB is supportive in principle to introducing community resuscitation services within its *Transforming Your Care* programme.

Primary and Community Care

Management of acute episodes in primary and community settings to prevent unnecessary attendances at Emergency Departments will become an increasing feature of the unscheduled care pathway during the next three years. There will be greater GP access, in-hours and out-of hours, to advice and consultation with senior hospital doctors and rapid outpatient assessment or other urgent ambulatory assessment following clinical discussion. Population Plans will outline hospital specific unscheduled care pathways and ensure implementation begins during 2012/13.

Local Health Economies will provide an acute care at home service that operates as a ‘community ward’ with active management of patients in the ‘ward’ to ensure timely treatment and patient flow with GP direct referral, multi-disciplinary input and clear protocols for active management and handover. Population Plans will outline proposals for putting an acute care at home service in place during 2013/14.

During 2012/13, LCGs will work with GP practices to better understand demand and capacity requirements for these developments.GP out-of-hours services will also demonstrate flexible arrangements in place to meet peaks in demand.

Primary Care Infrastructure Programme

A Health Infrastructure Board (HIB) was established by the Minister in October 2011, to develop a Strategic Implementation Plan (SIP) for the

development and delivery of the total infrastructure needs required to support the strategic service model developed in *Transforming Your Care*. The HIB is also responsible for the development of a Strategic Business Case (SBC) to identify and analyse the range of options available, including the use of third party development (3PD), to facilitate the injection of private capital and secure a significant boost in the development of primary care and community facilities.

High on the Minister's list of priorities for 2012 and beyond is the accelerated delivery of a range of Primary and Community Care Centres (PCCCs) with the objective of facilitating earlier, more cost-effective interventions in these settings and so prevent less cost-effective hospital attendances or admissions.

This is entirely consistent with the approach envisaged in Transforming Your Care and will require significant re-engineering of the way in which a range of services are provided. This will potentially include an increased role for GPs and community based staff to support the recommendations of *Transforming Your Care*.

To help facilitate these changes the HSCB will work, in conjunction with the relevant stakeholders, to develop an appropriate service model that will be both an integral part of the commissioning process and draw on the emerging thinking in *Transforming Your Care*. The HSCB will set out clear commissioning intentions and the expected outcomes from the investment in primary care infrastructure.

In 2012/13 each Local Health Economy will be asked to consider the service model which supports the delivery of *Transforming Your Care* within their area and examine the need for infrastructure development throughout the Local Health Economy area identifying those schemes which have the potential to be funded through alternative funding models. It is thought that a 'hub and spoke model' would make a sound basis for ensuring full GP engagement and also potentially support the development of Integrated Care Partnerships. Local Health Economies are asked to consider this when developing their plans.

NICE Guidelines (previously held in abeyance)

Trusts will be expected to put in place arrangements to comply with the following NICE guidelines. Over the next 12 to 15 months the commissioning team will review each of these areas and set plans in place with Trusts to fully implement these standards over an agreed timeframe.

CG 86 Coeliac Disease – Recognition and Assessment of Coeliac Disease
http://guidance.nice.org.uk/CG17

CG 124 The management of Hip Fracture in adults
http://guidance.nice.org.uk/CG17

Specific targets to be achieved for unscheduled care services in 2012/13 are:

- From April 2012, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.
- From April 2012, 95% of patients attending any Type 1, 2 or 3 A&E Departments are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; no patient attending any emergency department should wait longer than 12 hours.
- By March 2013, secure a 10% reduction in the number of emergency readmissions within 30 days.
- By March 2013, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.
- By March 2013, reduce the number of excess bed days for the acute programme of care by 5%.

Summary of Key Deliverables for 2012/13

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to:

- Advance proposals to integrate the management of specified long-term conditions within agreed care pathways
- Implement regional pathways for specified conditions, describing the expected impact of the pathways on local inpatient bed requirements, the reinvestment required in primary and community care and net expected savings.
- Put into operation with NIAS regional “treat and leave” and, in 2013/14, “assess and refer” protocols at the local level.
- Ensure timely ‘release’ of ambulances in order to reduce turnaround times, working towards a 30 minute target by April 2013.

- Ensure Trusts provide plans, by December 2012, which clearly describe arrangements for in-reach to ED from inpatient medical staff in order to prevent emergency admissions and readmissions.
- Ensure Population Plans outline hospital specific unscheduled care pathways, including ambulatory care model.
- Accelerate the delivery of Primary and Community Care Centre

7.4 Elective Care (including Diagnostics)

Each year nearly 600,000 people are referred to hospital for specialist assessment by their GPs or dentists. Every year around 450,000 people receive planned inpatient or day-case operations.

The overriding priority for the elective care system in Northern Ireland are to ensure that all urgent operations are completed in a safe and timely manner and that patients waiting for routine assessment or treatment should wait no longer than the maximum times set by the Department. This is achieved by ensuring that:

- There is sufficient elective capacity to meet need
- Appropriate referral pathways, including appropriate alternatives to acute assessment and treatment are agreed through work with General Practitioners and other referrers
- Assessment and treatment protocols linked to higher value procedure pathways are developed in conjunction with consultants, GPs and other clinicians

Advances in technology and medicines coupled with the fact people are living longer means the demand for elective services, including surgery, is expected to continue grow. It will be important for local health economies to develop and support innovative solutions to improve access to elective services.

In order to meet the expected requirements for elective services, there is a need to improve the productivity of the current workforce, introduce new workforce roles and train additional staff to meet future needs over the longer term.

As noted earlier in this Plan, the HSCB/PHA has worked with Trusts to secure significant improvements in elective care waiting times for patients in the period September 2011 to March 2012. The HSCB will continue to ensure this area is prioritised in 2012/13, maintaining the current momentum and securing further reduction in maximum waiting times for patient assessment and treatment. The use of the regional theatre management system should be maximised to help identify areas for service improvement and increased activity throughput.

Further performance improvement will be secured through a combination of ensuring Trusts deliver core capacity, together with investment in additional in-house or Independent Sector activity where this is required.

During 2012/13 the HSCB/PHA will make targeted recurrent investments in specialities where there is an agreed capacity gap relative to demand with investment being made in additional Trust services and low primary care. A priority will be those regional services for which there is no readily available Independent Sector solution when additional activity is required.

In relation to diagnosis reporting, the HSCB/PHA will continue to work with Trusts to ensure timely reporting of urgent tests. The HSCB/PHA is working to understand the potential impact of any changes to radiological reporting as a result of the RQIA review in relation to reporting protocols and staffing levels.

Diabetic Retinopathy Screening

It is a priority to improve an already successful and established screening programme. This will foster improvements in the protection of health and well-being, and reduce inequalities of service that might otherwise exist.

Procedures of Higher Clinical Value

During 2012/13 the HSCB/PHA will take forward a process to ensure that only procedures of higher clinical value are undertaken. The table below highlights the procedures to be reviewed in 2012/13 where redesigned patient pathways could result in a potential reduction in the number of procedures undertaken within a secondary care setting. The HSCB/PHA will also seek to secure input from service users into the development of these plans, where appropriate. This transfer will be on the basis of a phased implementation focusing on the suggested groups of procedures, as defined below.

Group 1 - High volume or high cost procedures where refined pathway development, based on national clinical guidance, could potentially release additional capacity into the local health economy and improve quality of care.

Group 2 - Relatively ineffective procedures where there is limited clinical evidence to justify commissioning the service.

Group 3 - Procedures that could be moved to a primary care setting or alternative provider settings.

The Elective Commissioning Team recognises that to ensure quality outcomes are delivered, it is important to engage with and involve clinical teams, the public and patients in the development of the pathways.

		Current Demand	Potential Reduction
		Activity 10/11 IPDC	
Group	**Procedure**	**Combined**	**Activity**
Group 1	Varicose veins	1313	50%
	Breast surgery	229	20%
	Tonsillectomy	3301	10%
	Grommets	1249	10%
	Anal surgery	1787	7%
	D&Cs	99	30%
	Hysterectomy	289	5%
Group 2	Reversal of vasectomy	31	95%
	Reversal of sterilisation	16	95%
	IS Laser		100%
	Circumcision (under 2s)	41	10%
Group 3	Skin lesions	5678*	50%
	Vasectomy	1763*	90%

* Move to a different setting

Service Priorities

During 2012/13 the HSCB will work with Trusts take forward the recommendations detailed in the recently issued Departmental guidance and standards for general paediatric surgery paediatric Ear, Nose and Throat (ENT) surgery.

In addition the HSCB will work with Trusts to take forward recommendations to improve the peri-operative care of adults and children made by the National Confidential Enquiry into Peri-operative Death (NCEPOD).

We would also wish to improve the delivery of infant hip ultrasound service for infants at risk of or with suspected developmental dysplasia of the hip in line with the standards and guidance of the UK National Screening Committee, the Royal College of Radiologists and the College of Radiographers.

The HSCB will also examine the potential development of a Podiatric Surgical Service in Northern Ireland and how such services could be commissioned this year.

NICE Guidelines (previously held in abeyance)

Trusts will be expected to put in place arrangements to comply with the following NICE guidelines. Over the next 12 to 15 months the commissioning team will review each of these areas and set plans in place with Trusts to fully implement these standards over an agreed timeframe.

CG 17	Dyspepsia: Managing dyspepsia in adults in primary care http://guidance.nice.org.uk/CG17
CG 97	The management of lower urinary tract symptoms in men http://guidance.nice.org.uk/CG97
CG 112	Sedation in children and young people http://guidance.nice.org.uk/CG112

CG118 Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas
http://guidance.nice.org.uk/CG118

TA 204 Denosumab for the prevention of osteoporotic fractures in postmenopausal women
http://guidance.nice.org.uk/TA204

Specific targets to be achieved for elective care services in 2012/13 are:

- From April 2012, at least 50% of patients wait no longer than nine weeks for their first outpatient appointment with no one waiting longer than 21 weeks, increasing to 60% by March 2013 and no one waits longer than 18 weeks.
- From April 2012, no patient waits longer than nine weeks from referral to commencement of AHP treatment.
- From April 2012, no patient waits longer than nine weeks for a diagnostic test (13 weeks for a day case endoscopy), and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.
- From April 2012, at least 50%, of inpatients and day cases are treated within 13 weeks with no one waiting longer than 36 weeks, increasing to 60% by March 2013, and no patient waits longer than 30 weeks for treatment.

Summary Key Deliverables for 2012/13

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to:

- Work with Trusts to ensure that, as a minimum, elective core capacity is delivered.
- For those elective specialities where there are recurrent capacity gaps, make targeted investment to secure additional capacity in Trusts and/or primary care, with a particular focus on those specialities where Independent Sector solutions are not readily available.
- Complete outstanding elements of radiology capacity planning work for key modalities including plain film, MRI, CT and non-obstetric ultrasound to identify core capacity within Trusts.

- Ensure the actions arising from the RQIA Radiological Reports are taken forward.
- Complete outstanding elements of AHP capacity planning work to identify core capacity within Trusts.
- Complete outstanding elements of dental capacity work to identify core capacity.
- Develop agreed electronic referral protocols on a phased basis for priority service areas.
- Fully utilise Theatre Management System (TMS) to help identify process improvements and improved productivity.
- Recommend Northern Ireland Quality Standards for Audiology Services to the Department by June 2012.
- Support the commencement of the Abdominal Aortic Aneurysm (AAA) programme from June 2012.
- From April 2012, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

In addition to the Commissioning Service Team agenda there a number of priorities relating to elective care which will be taken forward. These are detailed below.

Primary Care Partnerships

In line with *Transforming Your Care*, and in a bid to deliver services as safely, effectively, as close to home as possible where it is safe to do so, the HSCB, PHA and Primary Care Partnerships will take forward the following key projects.

Glaucoma Modernisation

A new service model for the diagnosis, treatment and monitoring of glaucoma will be commissioned with the aim of improving the quality of services and the outcomes for patients. This will be provided by a multidisciplinary team based on the latest clinical evidence and will comply with NICE Guidance by removing those patients who do not have the disease from the referral process. At risk patients will be monitored safely in primary care and there will be improved access to exemplary services for those most in need. Implementation plans and timescales will be finalised during April to September of 2012.

Triage and access to the treatment of minor anterior eye conditions

To provide more innovative and accessible services that are more responsive to patient needs and which free capacity in secondary care, work will be undertaken to streamline the referral process from General Ophthalmic Services to secondary care and/or appropriate primary care-facing services.

Domiciliary Eye Care

Consideration will be given to the possibility of commissioning a stand-alone domiciliary service for vulnerable members of society, delivering a quality, timely service, at an affordable cost. This would improve productivity by reducing duplication of effort and improving accountability.

Dentistry

In 2012/13 the HSCB will continue to work with DHSSPS and HSC Trusts to ensure that Trust-based specialist dental services are of high quality and meet access targets. In particular, the demand–capacity work initiated with BHSCT in 2011/12 will be completed and will be extended to the other main provider Trusts for specialist dental services. In terms of managing demand, the HSCB will be working with dental specialists and other stakeholders to develop a suite of referral criteria and accompanying referral pathways for the main dental specialties.

New criteria and pathways will help ensure that patients move more efficiently from presentation in primary care to receiving appropriate specialist care.

New Dental Contracts

It is envisaged that new contracts for primary care dental services in Northern Ireland will be introduced separately for oral surgery, orthodontics and general dentistry. Following a successful consultation exercise, the Board of HSCB approved the use of pilot Personal Dental Services to test the new oral surgery contract in the Southern LCG area. The pilot will run for a 6 month period and will be accompanied by an extensive evaluation exercise which will look at patient experience as well as satisfaction levels among referring and treating practitioners.

During the pilot period all patients requiring specialist oral surgery care will be referred to a dedicated Referral Management Centre (RMC). The RMC will use a completed pro forma for each patient along with submitted radiographs to determine whether the patient is most appropriately treated in primary or in secondary care. Two key elements

of the evaluation will be the proportion of all referrals ultimately seen in a primary care setting and the treatment outcomes for patients.

In contrast to the new oral surgery contract the new orthodontic contract will not involve a step-change from the current contract but rather will evolve through incremental advances. The most significant of these is the introduction of an orthodontic needs index which will be used to determine which cases are appropriate for health service orthodontic care. This is due to be introduced in the first quarter of 2012/13.

Negotiations on the detail of the new general contract continue but it is likely that the testing of this contract will not begin until the oral surgery pilot process is complete. In that way, any lessons learnt from the smaller pilot can feed into the larger one.

7.5 Cancer Care

Cancer affects all of us. Over 10,000 people in Northern Ireland are diagnosed with cancer every year and 3,885 people die from the disease.

Cancer patients have a complex series of planned journeys through screening, diagnostics, treatment (surgery/systemic anti-cancer therapies/radiotherapy) and follow up. In addition, patients may develop complications of the disease or its treatment which require access to unscheduled care.

The HSC will need to respond to the long term pressures associated with an ageing population, more people living with cancer as a chronic illness and the new demands created by evolving treatments and technologies.

While cancer survival rates have increased significantly over the past 10-15 years, international benchmarking projects shows that the NI survival rates for colorectal, lung, ovarian and breast cancer lag behind the best performing countries. In addition, people who live in the 20% most deprived areas of NI have cancer rates that are 2-3 times higher than those who live in the 20% most affluent areas; later diagnosis and poorer survival rates are also seen.

The National Audit Office reported recently that almost one in four cancers are detected only when a patient is admitted to hospital as an emergency. Survival rates for those diagnosed as emergencies are considerably lower than for other cancer patients, mainly because of more advanced disease at the time of presentation.

Cancer symptoms can overlap with those of other diseases. It is a very significant challenge to provide sufficient diagnostic and service capacity to assess all potential cases in a timely way in order to detect patients who have cancer.

Equally, the public need to be aware of the symptoms of potential cancer so that they seek early medical advice early. Informing the public in a balanced way, with simple actionable messages is a key challenge and a national project is underway to address this.

Much has been done to standardise cancer care across NI, in line with evidence based guidelines. The DHSSPS Cancer Service Framework will also help to standardise care, as will care pathways which describe the clinical management of patients throughout investigation, treatment and follow-up.

With better cancer survival rates, many people are living beyond a cancer diagnosis. The nature of caring for people with cancer is therefore changing and services must evolve and respond accordingly.

To secure further improvements for everyone and to close the health inequality gap between NI and other countries, and between socioeconomic groups, we need to reduce smoking rates, ensure high uptake of screening programmes in all areas, enable diagnosis of cancer and provide high quality care and support to all.

The overarching aim is the delivery of high quality services across cancer prevention, treatment and care in N.Ireland within the available resources.

The overall goal is to reduce the burden of cancer by:

- Decreasing its incidence through primary prevention – reducing smoking rates and exposure to other risk factors such as UV exposure and alcohol, could reduce the incidence of cancer significantly; in particular reducing smoking would decrease the life expectancy gap between the most and least deprived
- Increasing survival through early diagnosis. Early diagnosis requires greater public awareness of cancer symptoms to allow for timely assessment, access to diagnostics, and increased uptake of existing Cancer Screening Programmes
- Ensuring high quality treatment and patient care. Care pathways and Clinical Management Guidelines will describe the investigations, treatment, and support and follow up that each patient should receive
- Transforming follow up and after care by modernising follow up to support transitions (recovery, self-management, triggered re-entry and managing late effects) will contribute to individual health and well-being and increase service capacity
- Measuring clinical quality. Delivery of the Cancer Service Framework (CSF) and implementation of national guidelines together with peer review of multi-disciplinary teams and

participation in clinical audit and quality improvement, will enable clinical staff to measure, review and improve their service

- Measuring patient experience. Patient stories and other feedback need to be captured routinely and systematically and used by clinical teams and others in planning and delivering services
- Measuring long term outcomes. Effective capture and analysis of clinical data (utilisation of Cancer Patient Pathways System [CAPPs], participation in national clinical audits, NI Cancer Registry reports, European benchmarking studies etc.) will allow the HSC to review long term outcomes and improve its performance

Service Priorities

- Develop an agreed specification for a Regional Information System for Oncology and Haematology in accordance with Project Plan
- Roll out of Chemotherapy Capacity Planning Tool (C-PORT) in all Trusts
- Prioritise implementation of key components of the DHSSPSNI Cancer Services Framework
- Support NICaN to develop and implement a regional process for reviewing Cancer MDT functioning, activity and outcomes. This will identify future high impact actions across all cancer pathways in order to improve outcomes for patients
- Support the roll out of the National Cancer Patient Experience Survey for NI which will enable benchmarking against England. CCT will give consideration to required action arising from the completed survey
- Use the PHA Tobacco Action Team Pilot smoking cessation advice in out-patients/in-patients/day-case settings at 2 tumour sites (to include staff training)

Summary of Key Deliverables for 2012/13

During 2012/13 the HSCB/PHA will work with LCGs, Trusts and NICaN to ensure effective arrangements are in place to:

Improve Cancer Awareness/Early Diagnosis

- Working with PHA Health Improvement Team, develop a cancer awareness campaign for 2012/13. This will take account of the current level of awareness as reflected in the data available from International Cancer Benchmarking Project, and best available evidence on improving awareness and initiating appropriate action.

Improve Quality of Care

Improve the quality of care, patient outcomes and survival for cancers in which N.Ireland has less favourable outcomes than other areas of Europe.

- Improve compliance with best available evidence on ovarian cancer, consistent with NICE guidance
- Improve compliance with best available evidence on colorectal cancer, consistent with NICE guidance
- Improve compliance with best available on lung cancer, consistent with NICE guidance and quality standards and taking account of the National Lung Cancer Audit Report and relevant NI data

Improve the Appropriateness of Patient Follow-Up

Implementation of the Regional Transforming Cancer Follow Up Programme in accordance with project plan which will include:

- Self-directed follow up for appropriate cohort of breast cancer patients across all Trusts
- Development and implementation of prostate pathways (Elevated PSA negative biopsy and prostate cancer)
- Collection of data to inform programme evaluation

Improving the Management of Cancer Treatment complications

The HSCB will commission services to improve access to acute oncology services. This will help improve the management of patients with complications arising from their cancer disease or its treatment (including suspected Metastatic Spinal Cord Compression).

Monitor Trust adherence to the following standards:

- Patients receiving chemotherapy will have access to a 24 hour telephone triage system which will assess their clinical status,

provide advice or direct them to the most appropriate place for further assessment and treatment

- Patients at risk of neutropenia who attend hospital as an emergency will be assessed, and where appropriate treated on a neutropenic sepsis pathway (1 hour antibiotic treatment). EDs will take action to limit the risk of secondary infection in this group of patients from exposure to others

Improve Access to Radiotherapy Services

Ensure timely and equitable access to a safe and effective radiotherapy service for all patients who require such care including:

- Sufficient radiotherapy capacity continues to be available in the Belfast Cancer Centre.
- Planning for the introduction of radiotherapy services at Altnagelvin Hospital. This will include implementation of arrangements to ensure the necessary complement of appropriately skilled and experienced staff at Altnagelvin.

Identify Potential Improvements in Services for Teenagers and young adults

- Undertake a scoping project to determine current service provision and referral patterns for Teenage and Young Adults to inform service improvement
- Recruitment of Regional Teenage and Young Adults Project Manager to undertake above (on a fixed term basis).

NICE Guidelines (previously held in abeyance)

Trusts will be expected to put in place arrangements to comply with the following NICE guidelines. Over the next 12 to 15 months the commissioning team will review each of these areas and set plans in place with Trusts to fully implement these standards over an agreed timeframe.

CG 104	Diagnosis and management of metastatic malignant disease of unknown primary origin http://guidance.nice.org.uk/CG104
CG 121	Lung Cancer http://guidance.nice.org.uk/CG121

CG 122 Ovarian Cancer
http://guidance.nice.org.uk/CG122

Specific target/s to be achieved for cancer care services in 2012/13 are:

- From April 2012, ensure that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days

In addition the HSCB/PHA will monitor:

- All urgent breast cancer referrals should be seen within 14 days
- 98% of cancer patients commence treatment within 31 days of the decision to treat

7.6 Palliative and End of Life Care

The overarching aim for palliative and end of life care is to improve quality of life and meet the patient/carer needs particularly in the last year of life; meet the bereavement needs of families; and support patients' preference to die in their preferred place of death, usually their home. This is based on the quality standards in the regional strategy, Living Matters, Dying Matters, which the Service Team has responsibility for implementing, and is also reiterated in *Transforming Your Care* in addition to current Service Frameworks.

Palliative Care is defined as the active, holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is to achieve the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments. More latterly the importance of early identification and impeccable assessment have been added to this definition as it is thought that problems at the end of life can have their origins at an earlier time in the progression of the illness and should therefore be recognised and dealt with sooner.

End of Life care is an integral part of the wider concept of palliative care and consequently many of the same principles apply. For the purposes of this Commissioning Plan 'end of life' will be described as that time where an individual's condition has deteriorated to the point where death is probable or would not be an unexpected event within the next year. This time scale can be uncertain in many conditions. An End of Life Operational Model has been developed and will be promoted by Trusts going forward to support implementation of palliative care needs. It supports the use of a combined palliative and acute treatment approach where it is not possible to identify clearly the last few months/weeks at the end of life.

The Palliative Care approach has traditionally been used for people mainly with a cancer diagnosis. However services for this patient group have not been equally developed across Northern Ireland.

It is estimated also that two thirds of all deaths in Northern Ireland per year (circa 9,600) would benefit from the palliative care approach in the last year of life, but do not receive it. This approach is appropriate for

those with chronic conditions such as respiratory disease, heart failure, neurological, renal and other degenerative conditions like dementia and those elderly people approaching end of life. We would wish to enhance workforce skills and redesign pathways to ensure identification of palliative care needs across all conditions; and the development of care plans to meet these needs.

The HSCB/PHA now has a number of regional service teams in place and the Palliative and End of Life Team will continue to work closely with our colleagues in the Cancer, Unscheduled Care, Long Term Conditions and Community Care, Older People and Physical Disability teams to ensure a continued coordinated approach to the development of palliative care services

We would also seek to support people to die in their preferred place of care, usually their own home (including nursing and residential homes). Over the last five year period 51% of all deaths and 44% of all cancer deaths occurred in hospital. We intend to develop pathways and services which support people to die at home when that is appropriate and it is their preferred place of death.

Work needs to be progressed in adapting the skills of our workforce; and core communication and network systems developed between primary, community, voluntary and secondary care to support service redesign.

The Commissioner has made significant progress in the last year, for example:

- In raising awareness of non-cancer palliative care requirements
- Supporting staff training across many disciplines to support implementation of the Palliative Care Strategy
- Development of new training initiatives and systems across a wide range of staff
- Development of information systems to support implementation
- Improved co-ordination systems across acute, community and primary care
- Development of care pathways
- Development of the key worker function
- Development of agreed prognostic indicators across a number of conditions
- Agreed use of advance care plans and an holistic assessment tool

- Development is progressing, in collaboration with the Royal College of General Practitioners, of a patient held passport
- Development is progressing, in association with RQIA, of palliative care standards in nursing homes.

Service Priorities

Working with the Voluntary Sector

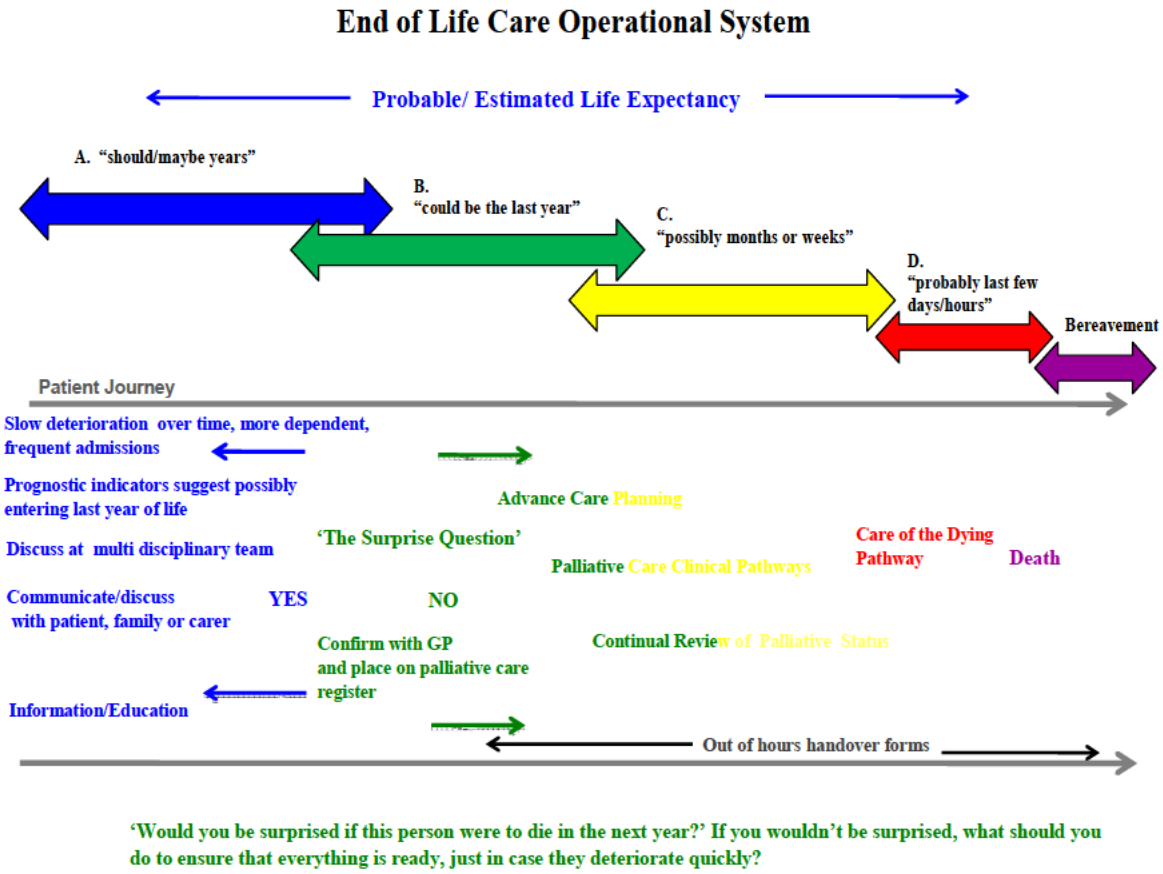
The Commissioner acknowledges the particular contribution made by the Voluntary Sector in the provision of Palliative Care services. The Commissioner will continue its engagement with the Sector with a view to aligning specifications and quality standards within contracts.

Identification, Assessment and Advance Care Planning

To have systems and processes in primary, community and secondary care to:

- Identify those approaching the end of life as per regionally agreed prognostic indicators. With consent, these individuals should be put onto GP Palliative Care registers. (The Operational System for End of Life Care should be implemented by all services).
- Appropriately assess those in the last year of life to ensure that symptoms are controlled – physical, psychological, social, financial & spiritual e.g. using NISAT.
- Have care plans developed and reviewed for those in the last year of life. These should include DNAR wishes and referral for carer's assessment.
- Ensure that people identified as being in the last year of life have been given the opportunity to have an advance care plans developed at the appropriate time.
- Ensure that all people on admission to a nursing home have been offered the opportunity to have an advance care plan developed within three months of admission.
- Ensure that all people who have an anticipated deterioration in their condition in the future e.g. on diagnosis of dementia have been offered the opportunity to have an advance care plan developed.

- Ensure that a standardised approach, such as the Care of the Dying Pathway (e.g. LCP), is implemented according to quality standards across all care settings.



Co-ordination of Care across Organisational Boundaries

Processes will be put in place ensure that care for individuals (identified in being in the last year of life on GP registers) is co-ordinated across organisational boundaries 24/7 e.g. The implementation of (1) the regionally agreed key worker function and (2) the use of multi-disciplinary records in the home and out-of-hours handover. Work will continue to develop to improve co-ordination and communication between primary, community/secondary and voluntary services particularly in regard to electronic information systems.

Availability of Services

We would wish to see an increase in general palliative care services in the community, with a shift from acute to community.

- Those approaching the last few weeks of life should have access to all necessary equipment required in their homes within 24 – 48 hours to maintain people at home and enable rapid discharge from hospital.

- Patients at the last few weeks/days of life should be transferred within 24-48 hours by the effective commissioning of ambulance and other transport services to transport people from hospital to die at home.
- There should be appropriate provision of specialist palliative care services to support primary, community and secondary care general palliative care services. This includes:
    - Community palliative care multidisciplinary teams (AHP, social care, consultant, specialist nursing)
    - Palliative care day hospice and outpatient services
    - Hospice inpatient service
    - Education and training
- Patients should have access to advice from specialists in palliative care irrespective of diagnosis or location. This service should be available face to face seven days a week 9-5 if needed. Professionals should have access to specialist palliative care advice 7 days per week until 11pm.
- Nursing homes are supported to meet the standards currently being developed in conjunction with RQIA (in place at the end of 2014).
- Proposals are developed to ensure the sustainability of palliative co-ordinator posts beyond 2012/13.

Education and Training

We would wish to ensure that the need for education and training in communication and end of life care for all staff (e.g. GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers etc.) has been assessed and prioritised and appropriate programmes are delivered.

Key Deliverables

The delivery of Palliative and End of Life Care depends upon all aspects of a complex interrelated system being in place; therefore local economies should implement all key requirements associated with long term conditions such as cancer, heart failure, renal disease, stroke and respiratory disease by March 2013 and for other patients by March 2014.

7.7 Long-Term Conditions

Long-term conditions (LTCs) refer to any condition that cannot be cured but can be controlled by medication and/or therapy. Our overall aim is to reduce the impact of long term conditions on individuals, families and the population. Significant public health challenges include:

- An increase in the percentage of children and adults who are overweight or obese
- An increase in the number of people with long term conditions, such as diabetes
- A higher frequency of risk factors for heart, stroke, vascular and respiratory diseases in more disadvantaged communities
- Higher death rates from conditions such as coronary heart disease, stroke, vascular and respiratory diseases in more disadvantaged communities
- The number of people living with neurological conditions and their carers.

In 2011/12 the focus was heart disease, vascular disease, respiratory disease, stroke, and diabetes in adults and children including the implementation of the Cardiovascular and Respiratory Health & Wellbeing Frameworks. Implementation of these frameworks remains a priority for local economies and additionally in 2012/13 the five local economies will also focus on:

- Proactive management of LTCs
- Proactive management of risk factors associated with LTCs e.g. atrial fibrillation and prevention of subsequent stroke
- Management of acute episodes in primary and community settings
- Implementing care pathways across primary and secondary care
- Expanding provision of insulin pumps over the 4 years from April 2012 for children and adults.

Neurological Conditions

In 2011-2012 The Neurological Conditions Network developed the Speak Out for Change Experience Survey. The survey provides an opportunity for people to describe the impact Neurological Conditions have on their lives.

12 Recommendations were developed to reflect the 142 experiences shared by people living with neurological conditions and their carers. A key success of this engagement exercise was the establishment of the Neurological Conditions Service User and Carer Reference Group. In addition the establishment of a Neurological Conditions Subgroup has been agreed in response to recommendation 5. This subgroup will report through the Long Term Conditions Commissioning Team. Over the next 12 months the focus will be to the delivery of the implementation of the action plan to take forward the recommendations.

Service Priorities

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to progress:

- Risk profiling of patients with LTCs
- Regular primary care review
- Integrated community teams
- Escalation procedures to seek advice and involve specialist services
- Patient education and self-management programmes
- Effective medicines management
- Remote tele-monitoring and its expansion to reach a specified target by 2014/15

A model of how this works in practice has been completed for COPD (Northern Ireland COPD Integrated Care Pathway) and local economies should implement this locally.

Children may have Long Term Conditions too and any investment by local economies in LTCs must ensure that the needs of children with LTCs have been addressed. This is particularly important in the next 4 years with the planned expansion of insulin pumps in children and adequate dietetic and specialist nursing support must be provided. Hospital admission should be avoided for children with diabetes whenever possible.

All specialties where people with LTCs are admitted must be considered during the risk profiling exercise for a LTC e.g. for diabetes the specialities of ophthalmology, nephrology, vascular surgery, cardiology, geriatric medicine and endocrine and metabolic medicine must be considered for those occasions where diabetes has been recorded as a

secondary diagnoses so that the full impact of diabetes can be assessed.

The use of clinical information systems in secondary care should be actively promoted by Trusts and participation in national audits e.g. NPDA will be mandatory from 2012/13.

Primary / Secondary Care Interface

Local Health Economies should ensure effective arrangements are in place to implement care pathways across primary and secondary care which describes the clinical management of acute episodes due to asthma, COPD, diabetes, heart failure, atrial fibrillation.

Arrangements need to be in place for GPs to discuss complex cases with local consultants in hours and support communication between GP, Emergency Departments and acute care at home teams out of hours. For patients with multi-morbidity (more than one LTC) there should be one stop assessment or ambulatory services developed that offer alternatives to hospital admission and support community and primary services to care for these patients in their own homes.

NICE Guidelines (previously held in abeyance)

Trusts will be expected to put in place arrangements to comply with the following NICE guidelines. Over the next 12 to 15 months the commissioning team will review each of these areas and set plans in place with Trusts to fully implement these standards over an agreed timeframe.

CG 36	Atrial Fibrillation http://guidance.nice.org.uk/CG36
CG 87	Type 2 Diabetes – Newer Agents (update of CG66) The management of type 2 diabetes http://guidance.nice.org.uk/CG87
CG 95	Chest Pain of Recent Onset http://guidance.nice.org.uk/CG95
CG 101	Management of chronic obstructive pulmonary disease in adults in primary and secondary care (partial update) http://guidance.nice.org.uk/CG101

CG 105	The use of non-invasive ventilation in the management of motor neurone disease http://guidance.nice.org.uk/CG105
CG 119	Diabetic foot problems - inpatient management http://guidance.nice.org.uk/CG119
CG 126	Stable Angina http://guidance.nice.org.uk/CG126.

Specific targets to be achieved for Long Term Conditions (LTCs) in 2012/13 are:

- By March 2013, increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis
- By March 2013, achieve 400,000 Monitored Patient Days (equivalent to approximately 2,200 patients) from the provision of remote tele-monitoring services through the Tele-monitoring NI contract.

Summary of Key Deliverables for 2012/13

- Identify and evaluate the current baseline of patient education and self-management programs that are currently in place in each Trust area.
- Implement the Northern Ireland COPD Integrated Care Pathway
- Expand the provision of insulin pumps to children and adults with Type 1 diabetes and evaluate the impact of this investment
- Undertake an evidence review in relation to the provision of specialist neuro-physiotherapy

7.8 Maternity, Paediatrics and Child Health

During 2012/13 the DHSSPS will be publishing a Maternity Strategy for Northern Ireland that will set the future direction for commissioners and providers of maternity services. The strategy will seek to address a number of challenges to further improve the service and to address inequalities which persist in maternal and infant outcomes as a consequence of maternal vulnerability e.g. teenage mothers, material disadvantage and social complexity.

In addition, a renewed focus needs to be given to public health messages and preconception care to ensure that women are as healthy as possible before becoming pregnant. There also needs to be a greater emphasis on normalising birth through midwives taking the lead role in the care of women with straightforward pregnancies, and providing more antenatal care closer to home in community settings. Women need to have a greater choice of where to give birth, including the choice of the different models of care to include midwife led units.

Northern Ireland has higher intervention rates in labour and birth than other parts of the UK, and there is also variation between maternity units within Northern Ireland. We need to ensure that consultant obstetric units are appropriately staffed to be able to cope with the growing number of pregnant women with complex pregnancies. These challenges will necessitate changes to how maternity services are provided, and in some parts of Northern Ireland the configuration of maternity units will also need to change over the coming years.

Children's services should reflect their specific needs as a defined sub set of the population. Significant inequalities continue to exist in health outcomes for children as a result of social deprivation and family vulnerability. Effective intervention in early years is vital for more vulnerable children and their families.

There are a number of key programmes/policies/documents both in existence and in development which point to the direction of travel for paediatric and child health services.

A key outcome identified in all of these is that all children should have equal access to the services they require, delivered in appropriate environments by suitably trained staff.

During 2012/13 it will be important to implement the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units and also any new guidance issued by the DHSSPS on Group B Streptococcal infection in pregnancy and neonates.

The HSCB with advice from PHA, all Trusts and Neonatal Network, will agree arrangements to formally establish the neonatal network as a managed clinical network by September 2012.

The HSCB will also consider the potential for further expansion of the regional transfer service for neonates by the end July 2012.

NICE Guidelines (previously held in abeyance)

Trusts will be expected to put in place arrangements to comply with the following NICE guidelines. Over the next 12 to 15 months the commissioning team will review each of these areas and set plans in place with Trusts to fully implement these standards over an agreed timeframe.

CG 98	Recognition and treatment of neonatal jaundice http://guidance.nice.org.uk/CG98
CG 110	Pregnancy & Complex Social Factors http://guidance.nice.org.uk/CG110

Summary of Key Deliverables for 2012/13

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to:

- Ensure safe, sustainable inpatient maternity services are in place across NI
- Promote public health messages and preconception care to ensure women are as healthy as possible before becoming pregnant
- Ensure secondary care specialists advise all women of child bearing age who have long term conditions about pregnancy, even if they are not actively planning a pregnancy
- By 2013 /2014 identify the specific locations they will have in place for antenatal booking clinics in the community which will offer:
    - reasonable access for women

  - confirmation of pregnancy scan
  - access to NIMATS
  - bookings and risk assessment carried out by 12 weeks and
  - receive their maternity hand held record
- Increase the percentage normal births and reduce unexplained variation in intervention rates
- Contribute to taking forward the implementation of any new guidance issued by the DHSSPS on Group B Streptococcal infections in pregnancy and neonates as advised by the GBS Steering Group chaired by the Chief Medical Officer
- Work with Trusts and others to ensure that the recommendations of the RQIA Independent Review of Pseudomonas in Neonatal Units are implemented. Work to develop a managed clinical network for neonatal services should ensure appropriate links with other networks(in particular adults and paediatric intensive care) are maximised and consolidated. All local economies should ensures that BADGER net (clinical information system) is integrated in all neonatal units.
- Contribute to the development of a regional plan for the safe escalation of PICU (Paediatric Intensive Care Unit) capacity
- Ensure that robust arrangements are in place to facilitate collaborative and coordinated discharge planning for children with complex physical needs to the community. Local Health Economies should ensure that the UNOCINI 4 level model for children in need is in place
- Identify their plans for the future location of paediatric and child health hospital and community services taking account of the recommendations in *Transforming Your Care* and recognised standards for modern safe, high quality and sustainable paediatric and child health services including the ongoing children's services framework and planned paediatric review. Services should include the development of SSPAUs (Short Stay Paediatric Assessment Unit)where not currently available
- Finalise the regional care pathway for sub fertility and make plans for the introduction of Frozen Embryo Transfer (FET) in selected circumstances early in 2012/13
- Put in place arrangements by March 2013 with the South Eastern Trust for the formal evaluation of the Downe MLU as described in the business case which establish the unit.

7.9 Community Care, Older People and Physical Disability

The commissioning objectives for older people and those with disabilities will be shaped by *Transforming Your Care* which identifies many elements of the change agenda common to both programmes. There is also a need to factor in the significant strategic statements emanating from the recently launched Dementia and Physical Disability strategies and the forthcoming Service Framework for Older People.

Collectively, they outline a consistent direction of travel for services which will require a preparedness to rethink and renegotiate the traditional roles of service users, carers, care professionals, the voluntary, community and independent sectors and other partner agencies. This is essential in view of the pace of demographic change in the number of people over 65 combined with changing expectations both within this population and people with disabilities. The scale of the financial challenge facing the older peoples' programme in particular need to be counterbalanced by the significant impact on the elderly and younger people with disabilities of proposed changes to benefits and pension entitlement.

The proposed change programme will require the following approaches to be progressed in a coordinated fashion; - health improvement initiatives; improved assessment processes; service users being given greater choice and control over service provision; reducing dependence on statutory services through rehabilitation and/or diversion to community/voluntary sector provision; providing additional support for carers; building in additional support and strengthened safeguarding procedures to manage risk; reducing reliance on/reconfiguring traditional service models and service delivery arrangements. It is important to consider these in the round to emphasise that change on this scale must be coordinated and synchronised in order to avoid instability and piecemeal development.

Key Priorities

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to progress:

Strategy Implementation

- Regional Project structures to review and implement the Action Plans associated with the Dementia and Physical Disability strategies.
- Revised monitoring arrangements to maintain improvements in the reform of specialist services e.g. wheelchair provision, brain injury, neurological conditions.

Health Improvement

- Targeted health and wellbeing improvement services to improve uptake of preventive health programmes focusing on increasing physical activity levels, stopping smoking, reducing alcohol and drug misuse, improving sexual health and improving mental health and wellbeing;
- A falls prevention programme to reduce the risk of falling at home and in care settings.
- A targeted nutritional screening programme in hospital, residential and community settings to reduce the risk of malnutrition and use of oral nutrition supplements.
- A programme to reduce the variation across primary care practice populations in the uptake of targeted screening and vaccination programmes.
- Collaborative working arrangements with community, statutory and voluntary partners to reduce social isolation and poverty.

Improving Assessment

- Project structures to progress the further roll out of the Northern Ireland single Assessment Tool (NISAT) and its prospective, associated ICT support system.
- Arrangements to ensure people with continuing care needs are assessed within 8 weeks and have the main components of their care met within a further 12 weeks.

Choice and Empowerment

- Initiatives to promote and support the update of Direct Payments/Self Directed Support arrangements.
- Plans to review and promote the use of local advocacy services.

Re-ablement

- Local project structures to maintain and develop effective re-ablement services in line with agreed service models.
- Local audits of voluntary/community sector services to negotiate effective diversion from statutory services via re-ablement.
- Effective monitoring arrangements to determine cost effectiveness and performance of the re-ablement model.

Support for Carers

- A review of the capacity to flexibly reconfigure existing services to provide enhanced respite opportunities.
- Local carer support structures to support the work of the regional Carers Strategy Group

Safeguarding

- Local partnership structures to support and promote forthcoming revised regional policies and procedures and associated operational changes

Service redesign

- Proposals to reduce reliance on statutory residential care through service refocusing, redesign or refurbishment involving consideration of supported housing models.
- A review of the capacity for nursing home provision to address the needs of people with dementia, challenging behaviour or who require palliative care.
- A review of the potential for traditional day care provision to be refocused or redesigned to promote services delivered in conjunction with voluntary and community sector providers.

NICE Guidelines (previously held in abeyance)

Trusts will be expected to put in place arrangements to comply with the following NICE guideline. Over the next 12 to 15 months the commissioning team will review each of these areas and set plans in place with Trusts to fully implement these standards over an agreed timeframe.

CG103	Delirium: diagnosis, prevention and management http://guidance.nice.org.uk/CG103

Specific targets to be achieved for Community Care, Older People and Physical Disability services in 2012/13 are:

- From April 2012, people with continuing care needs wait no longer than 8 weeks for assessment to be completed, and have the main components of their care needs met within a further 12 weeks.

Summary of Key Deliverables for 2012/13

- Trusts and LCGs will actively progress service redesign in line with the re-ablement change agenda via local project team and action planning arrangements.
- Trusts and LCGs will review their requirements for accommodation based care in the context of wider market capacity, re-ablement and supported housing options.
- Local Health Economies will collaborate proactively with the HSCB and other partners in progressing the Dementia and Physical Disability and Sensory Impairment strategies.
- Trusts will work with the HSCB to develop improved social care procurement arrangements in relation to residential/nursing and domiciliary care.
- Local Health Economies will review current service provision to provide increased support for carers via increase respite and review of traditional models e.g. day care.
- Trusts and LCGs will incorporate Health and Wellbeing Improvement and prevention as an integral part of care pathways for older people
- Local Health Economies will have in place a coordinated, multi-faceted Falls Prevention Service in all areas.
- Local Health Economies will have in place a coordinated, multi-sectoral service to identify potentially at risk older people and provide low level social care and support to reduce the risk of social isolation and maintain wellbeing.

7.10 Children and Families

The number of children being referred into statutory social services has continued to be significant and the need for responsive and quality services is further reinforced with the substantive numbers of children within the looked after and child protection systems. This picture is consistent with the national position which has evidenced growing demand. Much of this has been attributed to concerns emanating from high profile cases which have reflected where agency and professional responses could be made in a more timely fashion and be more authoritative as well as stating that families, communities and wider society has a responsibility to protect children.

The HSCB and PHA are committed to delivering on an early intervention agenda, as further stipulated within *Transforming Your Care*. Within Children's Services much of this work is most effectively delivered through the many partnership arrangements. Examples of partnerships specifically addressing this agenda include:

- Children and Young People's Strategic Partnership
- Childcare Partnerships
- Regional Autism Spectrum Disorders Network (RASDN)
- Healthy Child – Healthy Futures

These partnerships and others will continue to play a pivotal role in promoting an agenda which recognises that, on occasions and for a wide range of reasons, some parents may require a bit of extra help. The intention is to signpost parents to this assistance, one off or more intensive, at the earliest possible stage to address any difficulties or pressures and to promote strong parent – child attachments to maximise life chances for all.

Service Priorities

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to progress:

Family Support

A significant proportion of this work is delivered jointly with partners within the voluntary and community sector. The required elements are:

- The development of integrated planning arrangements at local and regional levels

- The development of integrated delivery mechanisms locally, based on Family Support Hubs
- A range of accessible early years and family support services made available

Children with Disability / Autism

Through collaborative work Trusts, HSCB / PHA, working with children, young people and their families will ensure services are:

- **Equitable:** in respect of provision of services based upon assessment of need and not based upon eligibility criteria such as IQ.
- **Accessible**: The appropriate service or best alternative is available following the assessment of need in a timely and responsive manner.
- **Inclusive Assessment:** Service delivery should be undertaken in a person centred manner.
- **Early Intervention:** The vast majority of Children with Disabilities will be known to HSC /Education service from a young age and appropriate assessment and service provision should be available at level 1-2 of the NI Family support model (DHSSPS 2009).
- **Collaborative working:** During school years Health and Social Care and education should seek to work collaboratively as the two key agencies providing services to Children with Disabilities to ensure appropriate coordination of services, collaborative commissioning and planning**.**

Trusts should continue to implement the existing regional Autism Action Plan (or any revised plan as a consequence of the Autism Act). This requires agreement and appropriate coordination between directorates/services to ensure that person centred solutions are identified to meet the needs of individuals with Autism.

Children with Life Limiting Illness/ Palliative care

The HSCB/ PHA recognise that there are a small but increasing number of children who are surviving for longer periods than may previously have been the case through advancements in medical technology. It is important that appropriate support services are available for families. This should facilitate discharge from acute services where this is appropriate and also respite provision for children and their families. It is

also recognised that such services operate across a continuum from hospital respite to supports being provided within the home and through community provision.

The HSCB/ PHA will continue to work with all relevant partners with a view to ensuring that families can care for their children to optimum effect.

Safeguarding

A significant development during the year will be the introduction of the Safeguarding Board for Northern Ireland (SBNI) which is being established as an independent entity accompanied by legislation which introduces a statutory duty to co-operate.

The HSCB / PHA are working closely with the chair designate of the SBNI during the transition phase which will see responsibilities move from the current Regional Child Protection Committee (accountable to the HSCB) to the SBNI. In addition there is a need for clarity as to the relationship between SBNI and the Children and Young People's Strategic Partnership which is also being progressed as part of the transition.

The primary responsibility for safeguarding children rests with their parents who should ensure that children are safe from danger in the home and free from risk from others where this is within their control. Some parents cannot always ensure this degree of safety and it may be necessary for statutory agencies to intervene to ensure that the child is adequately protected.

Each Trust is required to have in place a Child Protection system consistent with the Children Order, Co-operating to Safeguarding Children and Delegated Statutory Functions. In particular services are geared towards:

- Protecting Children
- Children exposed to Domestic Violence
- Public Protection Arrangements in Northern Ireland (PPANI) processes
- Young people who may pose a risk to others
- Working with those who may pose a risk to children but who have not yet been brought before the courts.

- Children at risk of sexual exploitation

Trusts will continue to have a key role in discharging duties to children in these service areas.

Children and Adolescent Mental Health Service (CAMHS)

The DHSSPS policy guidance shortly to be published will shape the future commissioning of CAMHS. The model to be adopted is a stepped care approach which will ensure service development:

- Is consistent across the region;
- Reduces service variation;
- And supports better integration of CAMHS within children's services.

It is considered that reform, redirected focus or improvement is required to address a number of issues, including;

- Reducing DNA and CNA rates;
- Integration and cohesion with other children's services and transition to adult services;
- Dedicated services to children who are looked after and consider the interface with those in Youth Justice.

The HSCB / PHA have had some initial discussions with the Belfast HSC Trust in relation to Tier 4 services and would now wish to progress this debate on a regional basis.

There is a need to take account of overall capacity and re-evaluate whether the current configuration of beds is the most effective and whether the current model is delivering on best outcomes for children and their families.

In regard to the need for a CAMHS Forensic Service, it is recognised that a small number of children and young people are presenting with very complex and challenging behaviours which has on occasion resulted in movement through the CAMHS / Looked After Children and Youth Justice Services. In some instances placements have been sought outside Northern Ireland. This matter will require to be given further consideration.

Looked After Children / Leaving and Aftercare / Permanency

Children who enter these systems will invariably have suffered adverse experiences which in turn demand robust assessment, consistent and quality care giving, the promotion of stability and therapeutic interventions to meet assessed needs.

The regional review of residential child care is one area where further work will be undertaken in 12/13. The work to date has reinforced the view that Statements of Purpose for Children's Homes should be explicit and that there is a need for further refinement across the LAC continuum of service which includes kinship and stranger foster care, residential child care and secure accommodation. *Transforming Your Care* referred to the potential for decreased reliance on residential child care. This will however only be feasible if other developments have been progressed and there are sufficient community supports and intensive support fostering placements.

The majority of looked after children are cared for within family settings. The need for placements within and out with families of origin has been stressed in *Transforming Your Care* and has been a driver within the Regional Adoption and Fostering Taskforce (RAFT). It is imperative that placement choices are available and that permanency, however assessed as best being achieved, is expedited.

Nationally, there is a further drive to promote adoption for children. This should clearly be the case where the assessment has concluded this to be the case and in the vast majority of circumstances this has to be progressed through the courts. The need to avoid delay is also an area which all those with the child's best interests to the fore subscribe to. The HSCB/PHA has tendered for a regional database to link and match children awaiting adoption across N.I which should assist in the avoidance of delay.

Regional Adoption and Fostering Taskforce

The Regional Adoption and Fostering Taskforce is progressing a range of initiatives to improve the consistency and quality of fostering and adoption services across the region. In the main this is being achieved through better cross Trust collaboration and co-operation and through regionalisation and commissioning of services to support this for example the aforementioned service linking children in need of adoption to families from across Northern Ireland, and the re-commissioning of inter country adoption into one regional service.

In light of the increase in kinship foster carers the development of regional policy and procedures for these carers is underway as a priority. Trusts are also looking at collaborating to consider their use of the independent sector fostering agencies and to get best value for money.

The importance of the educational and health needs of LAC has also been recognised in the past year with further work to be taken forward in the forthcoming year.

Young people can retain looked after status through to 18 years of age and then Trusts require to discharge Care leaver duties up to the age of 21 years (or 24 years where the Care Leaver is in full time education)

The HSCB working jointly with NIHE and collaboratively with Trusts is commissioning a range of supported Accommodation Projects to offer flexible, responsive services to care leavers and young homeless. The development of these services will be a significant focus over the next few years as will be the promotion of opportunities for care leavers whether in education, training or employment. The expectations are that:

- Young care leavers will have clear pathways into adult services that ensure continued support;
- Trusts will have in place comprehensive services which provide
    - Advice, assistance and pathway planning delivered by a dedicated social worker/personal advisor;
    - Personal support;
    - Education, training and employment support;
    - Financial and practical life skills support;
    - Access to a range of suitable, safe and supported accommodation;
    - Access to health services including specialist services to address emotional needs.

Specific targets to be achieved for Children and Family services in 2012/13 are:

- From April 2012, increase the number of children with no placement change to 82%

- By March 2013, increase the number of care leavers aged 19 in education, training or employment to 72%
- From April 2012, ensure a 3 year time-frame for all children to be adopted from care

Summary of Key Deliverables for 2012/13

- Progress integrated planning for children's services and the development of Family Support Hubs through the Children and Young People's Strategic Partnership
- Implement the Regional Autism Action Plan
- The HSCB/ PHA, conjointly with Trusts, will review the configuration of Tier 4 Child and Adolescent Mental Health Services and the need for a dedicated forensic service for children
- Further work is to progress on the development of intensive community supports and specialist foster care provision to address the *Transforming Your Care* recommendation on the potential to reduce reliance on residential child care
- As identified in the 11/12 Commissioning Plan, the HSCB/ PHA will continue to progress the review of AHP provision within special schools
- The HSCB jointly with the Northern Ireland Housing Executive will progress the joint commissioning of supported accommodation projects for care leavers and young homeless.

7.11 Mental Health and Learning Disability

Mental Health

All of the priorities outlined below must be delivered with the clear understanding that Recovery for people using services is the aim. Services and crucially staff delivering services can play an important role in promoting Recovery. Local Health Economies will be judged by how they promote Recovery approaches.

Service Priorities

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to progress:

Mental Health and Wellbeing Promotion and Suicide Prevention

- Implement the Local Mental Health and Wellbeing Action Plan in each Trust
- Implement the refreshed Protect Life recommendations
- Implement SD1 (Sudden Death Notification) post bereavement support and suicide surveillance function
- Have in place a Community Response Plan to be activated in the event of a series of related suicides
- Implement the recommendations of the National Confidential Inquiry into Suicides NI (2011) and the *'Providing Meaningful Care'* Report, 2011.

In order to ensure effective early intervention leading to reduced illness and acuity, Local Health Economies must:

- Review existing primary care facing community and voluntary providers in line with the Belfast PCP pathfinder on mental health
- Monitor the Card Before You Leave service

Community Mental Health Teams

- Create a Robust Single Point of Entry for all Secondary Care Referrals
- Develop a common (single) assessment framework for all Mental Health Services including the implementation of Electronic referral system

- Ensure urgent care appointments are provided within 5 working days of referral
- Ensure routine appointments are provided within maximum 9 weeks of referral
- Ensure Assertive Outreach is established as a key function of service delivery

Promoting Personalisation

- Increase access to Direct Payments in the Mental Health Programme of Care
- Harmonise practices across Local Health Economies to increase consistency, equity and ease of use of Direct Payments
- Enhance monitoring arrangements to track the promotion of Direct Payments and expenditure.

Eating Disorders

Each Trust should participate in the Eating Disorders service improvement process that will be undertaken within the Regional Eating Disorders Network (REDNG). Key regional aims are:

- Develop and implement an agreed regional Integrated Care Pathway for Eating Disorders
- Develop regional agreement regarding demand and capacity management within community based Eating Disorders services and, where necessary, re-align service delivery models accordingly
- Develop a regional service proposal which will address Extra Contractual Referrals (ECR) within a local Northern Ireland based setting
- Each Trust must have a dedicated ED Community Team adhering to the integrated care pathway for Eating Disorders
- Each Trust must have access to dedicated ED beds in mental health or general hospitals which are supported by Community ED Team in reach

Substance Misuse

Key aims are to increase community awareness of alcohol/substance misuse related harm and provide appropriate interventions.

Services must:

- Implement existing Health Improvement strategies which aim to increase population awareness of alcohol/substance misuse related harm
- Implement the regional Integrated Care Pathway for substance misuse and ensure practice reflects such care across Tiers 3 & 4
- Work with primary care (and other community based services) to undertake agreed 'screening and brief intervention' programmes and, as necessary, refer to Tier 2 & Tier 3 services where additional support is required.

Psychological Therapies

- Fully implement all the recommendations of the DHSSPS Psychological Therapies Strategy. This will involve each Trust mapping across step 1 - 5:
  - The Range and Scope of Talking Therapies
  - Service Demand
  - Current workforce and skill mix
  - Service Capacity
  - Care Outcomes

Implement Psychological Therapies Matched Care Matrix. This guidance sets out the *threshold criteria* for psychological therapies matched with the appropriate step of care. Local Health Economies will be required to align their services to this matrix.

Forensic Services

The key aim of Forensic Services are to ensure that individuals are managed and cared for in the least restrictive environment (based on their individual assessment) and as close to home as possible.

- Each Trust must implement the Regional Forensic Care Pathway. This should lead to a reduction in the number of referrals to out of area placements.
- Each Trust must foster positive working partnership arrangements with Criminal Justice agencies to improve Care Pathway for mentally disordered offenders transferring between the Criminal Justice Services and Health.

Prison Mental Health

Ensure that prisoners have at least the equivalent standard of mental health care as would be received in the community.

- The Prison Mental Health Service will work with Primary Care colleagues to provide a stepped care model to address mental health problems. This will be achieved by providing a range of therapies to meet the differing needs of prisoners
- South Eastern Trust will complete a Mental Health Needs assessment of prisoners in Northern Ireland (in conjunction with HSCB/PHA)
- South Eastern Trust must also develop care pathways into and out of prison in collaboration with the other four Local Health Economies
- Services will also be provided to prisoners who have misused alcohol and/or drugs in line with the integrated care pathway for substance misuse.

Personality Disorders

People with borderline or anti-social personality disorders should not be excluded from any health or social care service because of their diagnosis. NICE guidelines on the treatment of borderline and antisocial personality disorder were published in 2009 and services should be provided as far as is practical in line with the guidance.

- Each Trust must work within the regional personality disorder network to develop effective pathways, working towards providing a comprehensive and co-ordinated spectrum of services.
- Local Health Economies must have in place mechanisms to involve user/carers in service developments.

Acute Provision

- Sustain the implementation of the Releasing Time To Care (RTTC) programme across all Acute Mental Health Wards in each Trust.
- Provide an in-patient acute site per Trust with co-located or integrated Psychiatric Intensive Care Unit (PICU) alongside the acute in-patient service.
- Strengthen provision of an integrated Crisis Resolution and Home Treatment Service in line with HSCB recommendations and deliver

- Provide, regardless of diagnosis or need, classification, robust crisis assessment capacity 7 days a week and a specified volume of home treatment episodes provided on a 24 hour basis
- Ensure a reduction in unnecessary use of acute beds and through the development of rapid assessment and discharging planning ensure an average length of stay is not greater than 21 days for all patients not classified as delayed discharges.
- Fully implement the revised Regional Bed Management Protocol and maintain daily reporting of beds states via the regional acute bed management data base.
- Maintain Discharge Standards and 7 Day Follow Up requirements.

Perinatal Care

The NICE Clinical guideline on Perinatal Mental Health problems was issued in February 2007.The guideline highlighted key areas for implementation across the HSC which include the following 5 themes:

1. Co-ordination of service delivery
2. The competencies of the multidisciplinary team
3. Promotion, prediction and detection
4. Effective communication
5. Appropriate use of medication

- Local Health Economies must deliver services in line with the Regional Integrated Care Pathway for Perinatal Care (2012) within available resources.
- Take forward the recommendations of the GAIN audit (2012) once completed
- Work with Commissioners to produce patient information on perinatal mental health and develop public awareness.

The *Bamford Action Plan* also recognises the importance of perinatal mental health and prioritises the development of an integrated care pathway, the provision of training for staff, and a key action to improve the detection and treatment of mental illness during pregnancy and the postnatal period in Northern Ireland. A sub-group on perinatal mental health is currently taking forward these actions.

Other services which interface with maternity services include paediatric/neonatal, anaesthetic, gynaecology and specialist mental health services. While these specialist services are not considered part of this strategy it is important that good links are forged between the services to ensure the best quality care for women throughout pregnancy and following birth.

Resettlement

- In line with Government policy and *Transforming Your Care* no-one should be living in a mental health hospital by the latest date of 31 March 2015. Funds associated with these long stay patients must be re-deployed to support living in the community as per the HSCB/Local Health Economies agreed retraction formula.
- By 31 March 2013 40% of the long stay population at 1/4/12 must be resettled (NB 1/4/12 figure is based on full achievement of 2011/12 target).

Partnership for Service Improvement (Innovating for Excellence

Working collaboratively with HSCB, Local Health Economies will support the implementation of the Mental Health Innovating for Excellence programme across the following key areas:-

- Embed a recovery model across all Mental Health Services
- Develop a whole systems approach to the delivery of mental health care across their respective Health and Social Care Economies.
- Fully and comprehensively implement the Choice and Partnership framework across all mental health services
- Support the realignment, development, and implementation, of integrated care pathways across all mental health services.
- Adopt a managed care approach (case management) for delivery of care across all mental health services.
- Take steps to further embed experts by experience in leading and in delivering mental health care across all mental health services.
- Working with primary should take steps to promote earlier intervention by:
    - Improving access to mental health care through the improving access to psychological/talking therapies across local economy system

  - Developing proactive outreach function across all mental health care services.
  - Strengthening the primary and secondary care interface through the development of a primary mental health care coordinator aligned to G.P practices.

- Take steps to develop an integrated acute team which will support both a reduction in the number of admission and length of stay.
- Fully and comprehensively support Ward Managers to take lead responsibility for the implementation of Releasing Time to Care programme and ensure SMART Boards are fully utilized across all Acute Mental Health Wards.
- Develop service improvement plan which:
  - Increases the effectiveness of assessment and care planning processes by reducing duplication, promoting relational practice, and are safe and commensurate with need
  - Improve information management across mental health care service
  - Reduces DNA and CNA rates across all mental health services
  - Supports essential skills development and new ways of working across the mental health workforce

Specific targets to be achieved for Mental Health services in 2012/13 are:

- From April 2012, no patient waits longer than 9 weeks to access child and adolescent services or adult mental health services, and 13 weeks for psychological therapies (any age)
- By 31st March 2013 40% of the long stay population at 1/4/12 must be resettled (NB: 1/4/12 baseline figure is based on full achievement of 2011/12 target).

NICE Guidelines (previously held in abeyance)

Trusts will be expected to put in place arrangements to comply with the following NICE guidelines. Over the next 12 to 15 months the commissioning team will review each of these areas and set plans in

place with Trusts to fully implement these standards over an agreed timeframe.

CG 77	Antisocial Personality Disorder http://guidance.nice.org.uk/CG77
CG 82	Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care (update) http://guidance.nice.org.uk/CG82
CG 120	Psychosis with coexisting substance misuse http://guidance.nice.org.uk/CG120
CG123	Common Mental Health Disorders: Identification and Pathways to Care http://guidance.nice.org.uk/CG123

Summary of Key Deliverables for 2012/13

- By 31 March 2013 40% of the long stay population at 1/4/12 must be resettled (NB: 1/4/12 baseline figure is based on full achievement of 2011/12 target)
- Maintain and improve the Mental Health access targets
- Implement SD1 (Sudden Death Notification), post bereavement support and suicide surveillance function including Community Response Plans
- Trusts will develop and implement revised integrated elective access care pathways for community mental health services to include an acute outreach function
- Each Trust must have access to dedicated ED beds in mental health or general hospitals which are supported by Community ED Team in reach
- Implement the recommendations of the regional Review of Tier 4 and Tier 3 Substance Misuse Services
- Maintain access to psychological therapies and develop a specification for the delivery of a primary care based psychological therapy service
- Complete the mental health needs assessment across the NI prison population

- Establish a Personality Disorder service in each Trust
- Implement the Regional Acute Inpatient Review recommendations
- Implement the recommendations of the Gain Audit on Perinatal Mental Health
- Take forward the Investing for Excellence Programme to promote Recovery approaches in line with the Mental Health Service Framework
- Implement the Regulation and Quality Improvement Authority review of CAMHS recommendations within available resources

Learning Disability

The required objectives described below should be delivered in line with the following principles:

- Promotion of choice and independence
- Ensuring maximum access to socially valued lifestyles through inclusive activities
- Working together with other statutory and non-statutory bodies to promote citizenship
- Person centred approaches to services which support people to have their voices heard in decision making
- Personalisation to include greater take-up of Direct Payments and other emerging self-directed support approaches
- Advocacy services for people with a learning disability to include peer and independent advocacy

Service Priorities

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to progress:

Physical and Mental Health and Wellbeing

- Each Trust must ensure equality of access to the full range of Health Services.
- The Learning Disability Directed Enhanced service in each Trust must ensure that all adults receive an annual physical and mental

health check from their GP as per regional specification. This will be monitored and evaluated for outcomes during 2012/13.

- Local Health Economies must ensure that secondary health services provide reasonable adjustment to enable people with a learning disability to access these services in line with GAIN Guidance.

Transition to Adulthood

- The Trust must ensure that each adult with a learning disability post school has a care and support plan developed alongside education and other partners based on the young person's identified needs, expressed wishes and known preferences.
- Each Trust must have in place arrangements for planning for transition to adulthood which needs to begin at age 14. This process must involve children's and adult services.

Community Living Support Services

Day Opportunities play a key role in supporting people's lives in the community. Provision should include a range of services which seek to promote inclusion in local community activities and independence.

- Day Support Services should be based on the assessed needs of people and on the regular re-assessment of needs throughout their lives
- Local Health Economies should provide a range of Day Support Services to include further education, vocational training, supported employment and support for people with more complex needs
- Services aimed at vocational training and supported employment should be delivered by or in partnership with mainstream statutory and voluntary bodies whose primary function this is
- Local Health Economies must deliver a range of day opportunities in line with the regional model to be developed in 2012/13.

Supported Living

In accordance with the principles of Citizenship and Human Rights enjoyed by all, people with a learning disability are entitled to live in their own homes in the community.

- Local Health Economies must have a range of housing options with support across the span of required support levels reflected in the services available to the population.
- These services should be provided in partnership with local statutory housing (NIHE) and voluntary (Housing Associations) and local voluntary care and support organisations.
- Arrangements should be put in place through local Area Supporting People Partnerships to plan for Supported Living Services. These are services which enable people to have their own housing tenancy with support from care services which allows them to live more independently than in hospital or institutional care.

Carer Support

- The majority of people with a learning disability live with and are cared for and supported by family members. Local Health Economies must ensure that the appropriate range and level of specialist supports are available to these families.
- Short breaks and respite services must be provided on an equitable basis founded on assessed need in line with the regional respite recommendations.
- The range of such services should include:
  - Domiciliary services across the week, day and night
  - Host family schemes with trained and approved carers
  - Social and recreational activities provided by volunteer or paid staff
  - Residential/Nursing home provision where required

Promoting Personalisation

Self-Directed Support describes a range of initiatives designed to give people greater control over how care should be provided and how it should be procured.

Each Trust must:

- Increase access to Direct Payments in the Learning Disability Programme of Care.

Specialist Community Services

In addition to mainstream community support social care and health care services some people with a learning disability also require more specialist support services in the community. These should include community based assessment and treatment services. Each Trust must provide:

- Community Learning Disability Teams to include psychiatry, learning disability nursing, social work, AHP and psychology.

Resettlement – Community Integration Programme

- In line with Government policy and *Transforming Your Care*, no-one with a learning disability should be living in hospital by the latest date of 31 March 2015. Funds associated with these long stay patients must be re-deployed to support living in the community as per the HSCB/Local Health Economies agreed retraction formula.
- By 31 March 2013 40% of the long stay population at 1/4/12 must be resettled (NB 1/4/12 figure is based on full achievement of 2011/12 target).

ASD – Adult services

Autism services for those aged under 18yrs are covered within corresponding children's services document

Local Health Economies should continue to implement the existing regional Autism Action Plan. This requires, within adult services, agreement and appropriate coordination between directorates/services to ensure that person centred solutions are identified to meet the needs of individuals with Autism. This includes:

- Continuing to develop the skills and capacity of the wider range of both specialist and non-specialist teams across Local Health Economies, i.e. so that they are better enable to support people with Autism
- Implementing the anticipated new Adult Autism care pathway for assessment and subsequent care. Ensure the individual elements of the pathway are validated as functioning and effective in terms of securing input across Trust services as required (including effective 'transition' between services and also 'signposting' to or securing input from other agencies).

- Working towards developing specific diagnostic service capacity for adults with Autism

Specific targets to be achieved for Learning Disability services in 2012/13 are:

- By March 2013, 40% of the remaining long-stay patients in learning disability and psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.

Summary of Key Deliverables for 2012/13

- By 31March 2013 40% of the long stay population at 1/4/12 must be resettled (NB: 1/4/12 baseline figure is based on full achievement of 2011/12 target).
- The full implementation of the Directed Enhanced Service for Learning Disability will be evaluated during 2012/13.
- A regional model for Learning Disability Day Opportunities will be developed during 2012/13.
- The range of short break/respite options based on assessed needs will be widened in line with the Regional Working Groups recommendations.
- The Guidance for Commissioners on Advocacy will begin to be implemented during 2012/13 in Learning Disability.
- The number and % of Direct Payments for people with a Learning Disability and their families should be increased.
- All children and young people with a Learning Disability will have a transition plan in place prior to leaving school.

7.12 Prison Health Services

Since 2008 the DHSSPS has had responsibility for Prison Health Services. The commissioning of Prison Health Services is now the function of the Health and Social Care Board and the management of Prison Health Systems the responsibility of the South Eastern Health and Social Care Trust. A Prison Health Partnership Board has been set up to coordinate prison health strategies and policies and to take forward the aims of the Prison Health Partnership Agreement. The Department has recently commissioned a review of the transfer of prison health services from the Prison service to Health and Social Care. The outcome of this review should be available early in 2012/2013 and the structures and governance arrangements for Prison Health will be reviewed in the context of its conclusions and recommendations.

Healthcare services in Northern Ireland are delivered within three prison establishments: HMP Maghaberry; HMP YOC Hydebank Wood and HMP Magilligan. There are approximately 5,000 committals annually and approximately 1,760 prisoners placed within the prison estate at any point in time. This represents an estimated increase of around 20% in the prison population in the last year. A major contributory factor to this increase may have been the introduction of new sentencing guidelines in 2008.

In 2012/2013 prison health services will be provided in an environment of change. The prison review reform implementation process will take place with many staff leaving the Northern Ireland Prison Service. Healthcare staff will become employees of the South Eastern Trust.

Prisoners receive a full range of healthcare services. The majority of services provided within the prison are primary care services. Access to secondary care services are usually provided in acute hospitals through normal referral processes.

Needs Profile

There are particular challenges in delivering health care in an environment whose principal purpose is security.

A considerable amount of research has been carried out on the prevalence of personality disorders in prisons. It is estimated that 60-80% of male prisoners and 50% of female prisoners have a personality disorder compared with 6-15% of the general population.

Offenders have very high rates of mental ill health; recent estimates suggest that up to 90% of all those in custody will have some form of mental health need (OMHCP, 2005), with both sexes similarly affected. The offender population is at much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses.

Many of those with a mental health illness also have addiction problems. Evidence would suggest that as many as 3 in 5 prisoners may have a dependency problem.

Half of the UK prison population has been identified as having literacy difficulties and Home Office studies have shown that 35% of offenders have speaking and listening skills at a basic level (Davis K et al 2004). Further studies have shown that these skills are below level 1 of the national curriculum (age equivalent to 5yrs) (Davis K et al 2004)

A needs assessment following the Birmingham Toolkit will take place in 2012/2013. This will further inform the re-profiling of services and service development.

Service Priorities

The overarching aims and key priorities for prison healthcare remain unchanged.

The overarching aims for Prison Healthcare are to:

- Ensure that prisoners have the equivalent standard of healthcare as would be received in the community
- Ensure services are delivered to high quality standards and are in line with HSC standards and best practice
- Ensure services are delivered in line with the assessed needs of the prison population
- Promote health and social wellbeing in order to reduce or mitigate the effects of unhealthy or high-risk behaviours
- Promote effective links with health and social services in the community to improve continuity of care
- Work with the NIPS to ensure a holistic approach to Health Improvement and patient care for example in relation to purposeful activity, for prisoners and prisoners having access to healthcare services.

- Improve the committal process for people with complex needs; including substance misuse, diabetes and epilepsy.
- Ensure best value for money is secured.
- The Prison Mental Health Service will work with Primary Care colleagues to provide a stepped care model to prisoners with mental health difficulties.
- Provision of services to those prisoners who have misused alcohol and/or drugs in line with the integrated care pathway for substance misuse

Summary of Key Deliverables for 2012/13

- Deliver an up to date needs assessment of the N.Ireland prison population using the Birmingham Tool Kit
- Clarify with the Departments of Health and Justice the action needed in the light of recommendations arising out of recent reviews and reports relating to the delivery of prison healthcare.
- Agree with the South Eastern Trust an appropriate staffing profile taking into consideration the level of resourcing available and the best information available on the needs of the prison population. This will be linked to the outcome of the needs assessment identified in Priority (1).
- Ensure that the Trust has appropriate information systems and that there are improved healthcare information flows from prison to the community and vice versa.
- Progress the development of improved delivery of medical services and chronic disease management in line with the principle of equivalence, ensuring that primary medical services both in and out of hours are further improved.
- Further develop care pathways in and out of prison.
- Encourage the development of appropriate care pathways for prisoners with a learning disability. It is anticipated that this will involve the implementation of the learning disability screening questionnaire which will identify the number of prisoners with a learning disability currently in the prison system.
- Work with the South Eastern Trust to ensure the introduction of the stepped care model within prisons to address mental health problems both at acute and sub-acute levels by providing a range of therapies to meet the differing needs of prisoners.

- Further develop and implement a personality disorder service to prisoners which will include linkages with community personality disorder services.
- Finalise a Health Improvement Strategy and agree appropriate actions and outcome measure during the currency of 2012/13.
- Continue to develop with the criminal justice system and prison health partners' action to ensure the identification of people with mental health problems and/or a learning disability at an early stage in their progression through the criminal justice system.
- Investigate the possible use of Telemedicine as a means of facilitating prisoner access to healthcare.

7.13 Specialist Services

Specialist Services for acute care include highly specialist tertiary services delivered through a single provider in Northern Ireland or in Great Britain. High cost specialist drugs also fall within the remit of this branch of commissioning.

Due to our small population size, many of our more specialist services are becoming increasingly difficult to sustain as specialist teams are small, often delivering services with only 1 or 2 lead clinicians. Whilst this level of staffing is sufficient to meet the needs of patients, it is not a sustainable model for providing all year round availability on the 24/7 basis that we need.

The nature of specialist care is also changing. Staff are working within an increasing clinically complex environment. To ensure that they can offer the best care for patients, senior clinical staff need access to significant clinical infrastructure, multidisciplinary team-based care, sub specialty expertise and larger teams of senior colleagues. Therefore we need to pursue opportunities to link our clinical teams to larger centres in Great Britain and Republic of Ireland. These networks will support the long term sustainability of services locally.

We need to ensure that we commission specialist care for our population in line with established quality standards, best evidence and clinical guidelines. Inevitably this will mean for some very specialist services, that people will need to travel outside of Northern Ireland to receive their care.

In the last 5 to 10 years the rate of development of new high cost specialist drugs has been extensive. In the last 4 years, Northern Ireland has invested over £50m to provide treatments for rheumatoid arthritis, inflammatory bowel disease, cancer, sight threatening conditions and a range of other diseases.

Although not always predictable, a reasonable estimate of the resources needed for new specialist drugs per year is around £6m. We also know that we need around another £6m just to support growth in the number of people on existing specialist drug regimes. To fully support these pressures in specialist drugs in the current financial climate will be very difficult.

Processes to support how we make decisions about services will need to be put in place. To do this successfully we need the expertise, support, engagement and input of our clinicians to make sure we utilise funding to gain the highest levels of benefit in health terms for our population. Specialist services cannot be commissioned without expert support and relies heavily on the participation of clinical teams in planning and reviewing care through a number of established mechanisms.

Service Priorities

The priorities for specialist services are all expected to be progressed over the next 12 to 24 month period and can be summarised as follows:

Kidney Transplantation and Nephrology Services

The live donor transplantation service will be consolidated by increasing the clinical team and supporting infrastructure with the expectation that we can continue to provide at least 50 live donor transplants per annum. Recent data suggests that Northern Ireland offers a higher level of access to this service than any other region in the UK. A key challenge in sustaining these levels will be our ability to recruit 2 additional consultant transplant surgeons.

During the last 2 years over 100 patients received a live donor kidney transplant. These developments and other factors such as improvements in pre dialysis management in primary care, adherence to NICE guidelines on the use of peritoneal dialysis, supported dialysis models and more availability of home haemodialysis will also impact on the need for hospital based haemodialysis.

Sustaining Specialist Paediatrics and Clinical Networks

During 2011/12 we focused on a number of services in the Children's Hospital and made significant investment of around £650,000 to strengthen the staffing infrastructure and establish formal clinical networks with Great Britain and across Northern Ireland providing specialist advice and support from the Children's Hospital to paediatric services in the local Trusts. In 2012/13, we will be driving forward full implementation of the network arrangements.

In 2012/13, we will also develop arrangements for the integration of Paediatric Intensive care with the Critical Care Network to support management of capacity and transport working closely with colleagues responsible for neo natal service.

Paediatric Congenital Cardiac Surgery

In 2012/2013 the HSCB/PHA will commission an external review of the Paediatric Congenital Cardiac Surgery Service (PCCS) provided in the Belfast Trust. Standards for this service are increasing across the UK with a move towards surgeons working in larger teams delivering higher volumes of activity.

Benchmarking cost and usage of High Cost Drugs

We spend very large amounts of money on specialist drugs each year. Expenditure on drugs for Multiple Sclerosis, rheumatology and cancer care alone amounts to around £60m annually. We need to use every mechanism available to ensure that we using our money in the most cost effective way.

Adherence to NICE guidance regarding the least expensive approved regime for first line treatments and mandatory participation in Patient Access Schemes will be reviewed and evaluated during 2012/13.

NICE guidance provides valuable assurances on the efficacy of drugs and therapeutic regimes. It also reports on drugs (both new drugs and drugs currently in use) where it finds no evidence of benefit. In such instances we will take action to ensure that the service does not proceed to either introduce or continue to use non NICE approved regimes. Where this relates to drugs already in use, we will take action to ensure funds are retracted for reinvestment in proven therapies.

Macular Disease

Specialist services have now been established in both the Western and Belfast Trusts to provide treatment for wet age related macular degeneration for the population of Northern Ireland.

In 2011/12 a regional group was established with input from clinical teams, Trust management and RNIB. A key objective for the group in 2012/13 is to agree the care model and ensure consistency of regional care pathways.

Timely access to this treatment is essential to secure an effective outcome. Fortnightly monitoring systems for waiting times were put in place in 2011/12 and escalation plans have been agreed in the event of breaches beyond the agreed standards. In 2012/13 we will seek to reduce waiting times further, acknowledging the challenge this may present given the recruitment issues.

Rare Diseases

Working with our local clinical genetics services and interfacing with Rare Disease UK we are clear about the key priorities for this group of patients. The Patient Client Council has supported the establishment of an independent Rare Disease Partnership group. We will talk with this group about the patient experience and how they want to be involved in designing our service links to specialist diagnostic and service providers.

Individual Funding Requests

Implementation of the new arrangements for the management of exceptional funding requests and extra contractual referrals will be taken forward in 2012/13.

Radiotherapy

Good progress has been made under the auspices of the regional group in specifying and commissioning additional radiotherapy capacity in the Belfast City Hospital and Altnagelvin Hospital. Additional capacity will come on stream in Belfast in the autumn of 2012.

Cardiac Catheterisation Services

During 2012/13 we will develop the service profile for cardiac catheterisation services to support the projected demand in this area.

Quality Assurance

In 2012/13 we will work towards identifying key quality and evidenced outcome indicators for specialist services and develop assurance monitoring mechanisms.

Patient and Public Involvement

In 2012/13 we will develop and implement proposals for patient involvement in a further 3 areas over the next 12 – 24 months. There is currently patient representation in renal care, long term neurological care and inflammatory bowel disease care.

Elective Access

In 2012/13 we will ensure that waiting times for specialist services are in line with agreed standards.

Investment Proposals

In 2012/13 the areas for investment will be:

- Biologics service for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis to achieve a maximum waiting time of 3 months
- Biologic service for inflammatory bowel disease
- Developing the model for Regional Intestinal Services
- Biologics service for the treatment of psoriasis to maintain a maximum waiting time of 39 weeks
- Oncology and haematology drugs and infrastructure
- Provision of bi-lateral cochlear implant service
- Kidney Transplantation Services
- Services for people with macular disease
- HIV services
- Specialist drugs for Multiple Sclerosis
- Infectious Disease Services
- Thoracic surgery to support improvements in waiting times for cancer surgery
- NICE approved Technical Appraisals and Guidelines introduced in 2012/2013

NICE Guidelines (previously held in abeyance)

Trusts will be expected to put in place arrangements to comply with the following NICE guidelines. Over the next 12 to 15 months the commissioning team will review each of these areas and set plans in place with Trusts to fully implement these standards over an agreed timeframe.

CG 79	Rheumatoid Arthritis in Adults http://guidance.nice.org.uk/CG79
CG 114	Anaemia management in people with chronic kidney disease http://guidance.nice.org.uk/CG114
CG 125	Peritoneal Dialysis http://guidance.nice.org.uk/CG125

Specific targets to be achieved for specialist services in 2012/13 are:

- By March 2013, ensure delivery of a minimum of at least 50 live donor transplants
- From April 2012, no patient should wait longer than 9 months to commence NICE-approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis, decreasing to 3 months by September 2012

8 GLOSSARY

Glossary of Terms

The Bamford Report – a major study commissioned by the Department of Health in Northern Ireland to provide a long term strategic plan for the development of mental health services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and need regular treatment and medication.

Community and Voluntary Sector – the collective name for organisations working in health but not publicly funded.

Evidence Based Commissioning – the provision of health and social care services based upon proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, work in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses “joined up” health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these area development of Primary Care Partnerships which join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent and voluntary sector.

Lesbian, Gay, Bisexual & Transsexual (LGBT) –this is an abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – these are committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the Board arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff.

National Institute for Clinical Excellence – an expert organisation based in London that guides health care organisations across the UK on the effectiveness of new treatments, new drugs and other innovations.

Northern Ireland Block – this refers to the total amount of financial support given to Northern Ireland by the Treasury in London.

Palliative Care – services for people who are typically in their last year of life and who suffer from conditions such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of Northern Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Population Plans – Plans developed by LCGs and Trusts to radically reshape the way services are delivered from 2012 -2015 and beyond

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) –These pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked

group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Transforming Your Care – This is a strategic assessment across all aspects of health and social care services examining the present quality and accessibility of services.

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Ms Louise McMahon, Director, Performance Management and Service Improvement
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