

HEALTH AND SOCIAL CARE BOARD PUBLIC HEALTH AGENCY

COMMISSIONING PLAN 2012/13

13 September 2012

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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	<i>What</i> services are to be provided	2012/13	HSCB/ LCGs/PHA	April 2012
Trust Delivery Plans	Commissioning Plan/ Local Commissioning Plans	<i>How</i> 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. During 2012/13 the 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 to 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.

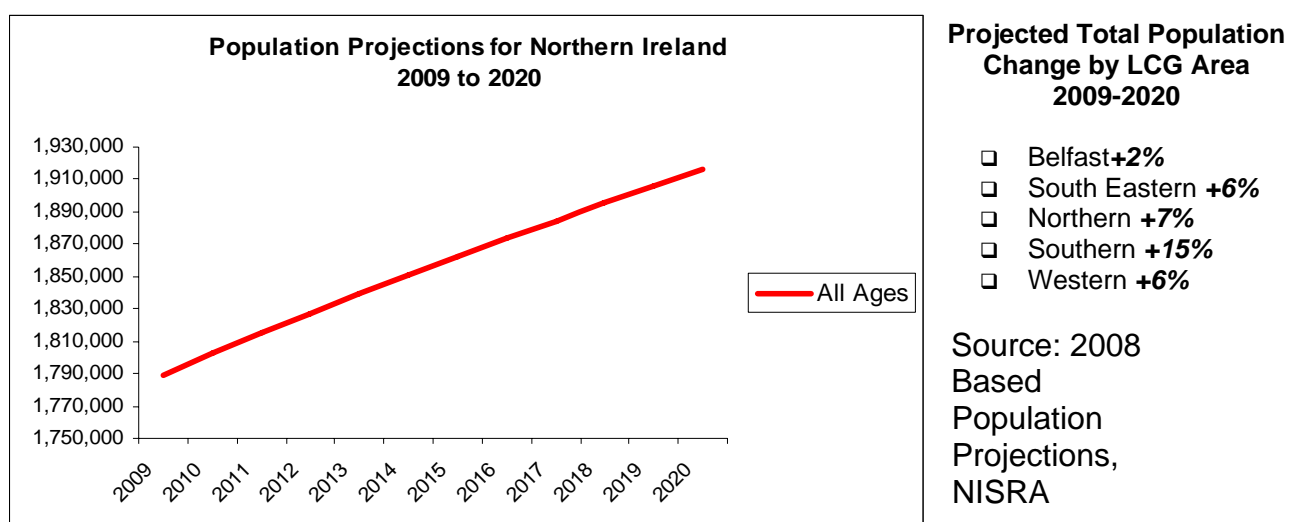
1.1 Demography

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 2008-2010 from 74.5 years to 77 years for men and from 79.6 years to 81.4 years for women.

Figure 1

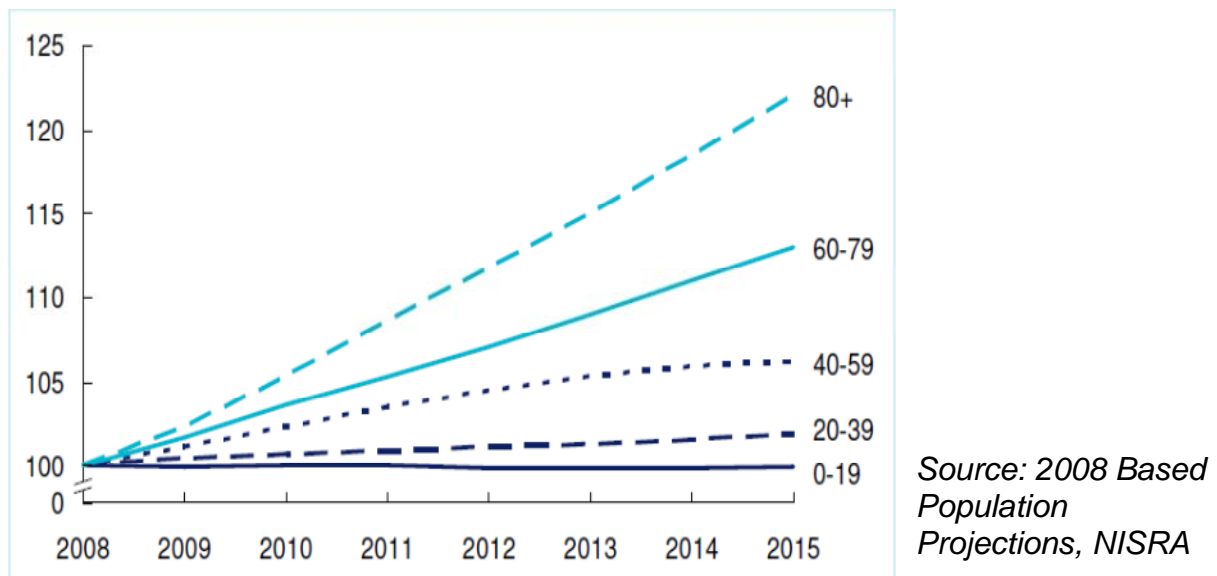
Population Projections



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+

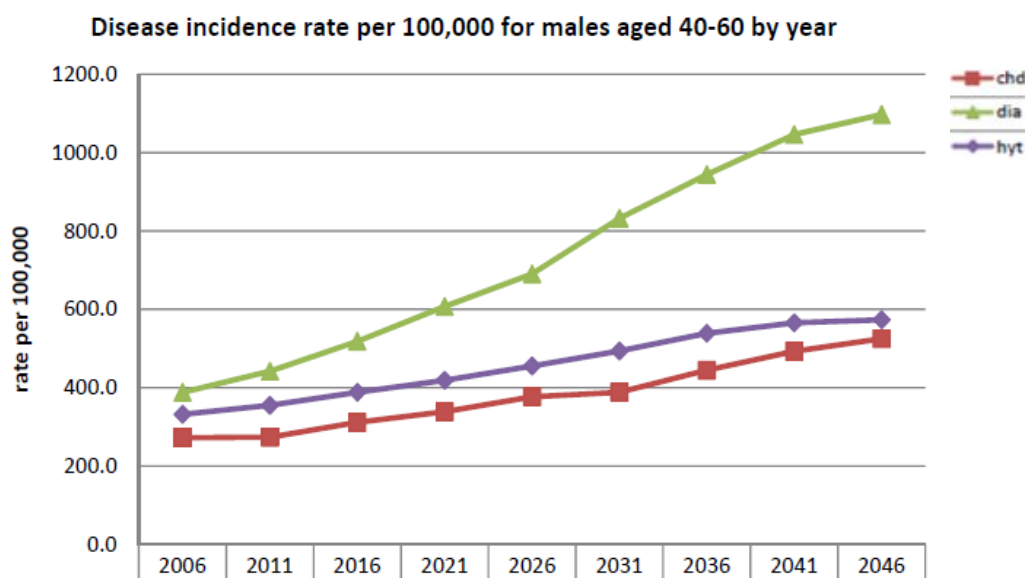


Advancements in modern treatments should be celebrated, but the implications on health and social care provision need to be recognised and planned for accordingly. In addition to an ever increasing older population, health and social care is also required to respond effectively to the growing incidence 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 aged 60-74 from 1st April 2014	Invest an additional £10m in public health (increase based on 2011/12 spend)
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 accessed 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

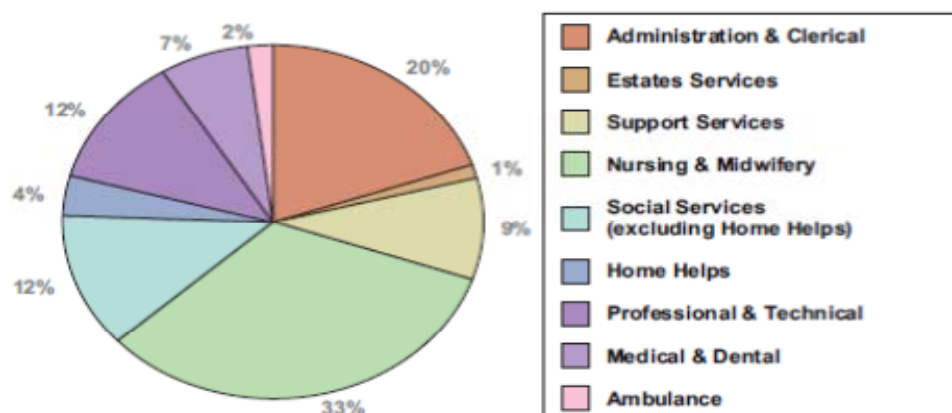
This transformation will not be straightforward - described recently by the Minister, in presenting to the Health Committee of the NI Assembly, as a 'major undertaking in the coming months'. It will require fundamental changes in the way services are delivered, including an estimated shift of £83 million 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 78,000 people 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 Census 2011](#)

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.

Table 1 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	2013/14	2014/15
	£m	£m	£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
General 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 for 2012/13

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

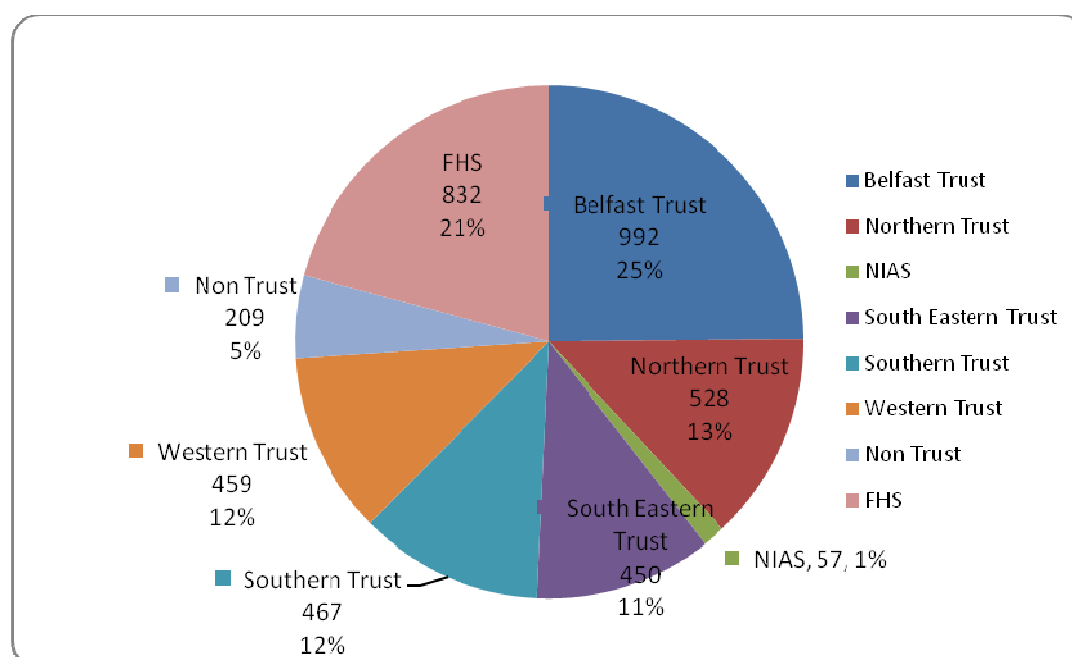


Table 8 sets out how the total resources are planned to be allocated across the programmes of care and Family Health Services.

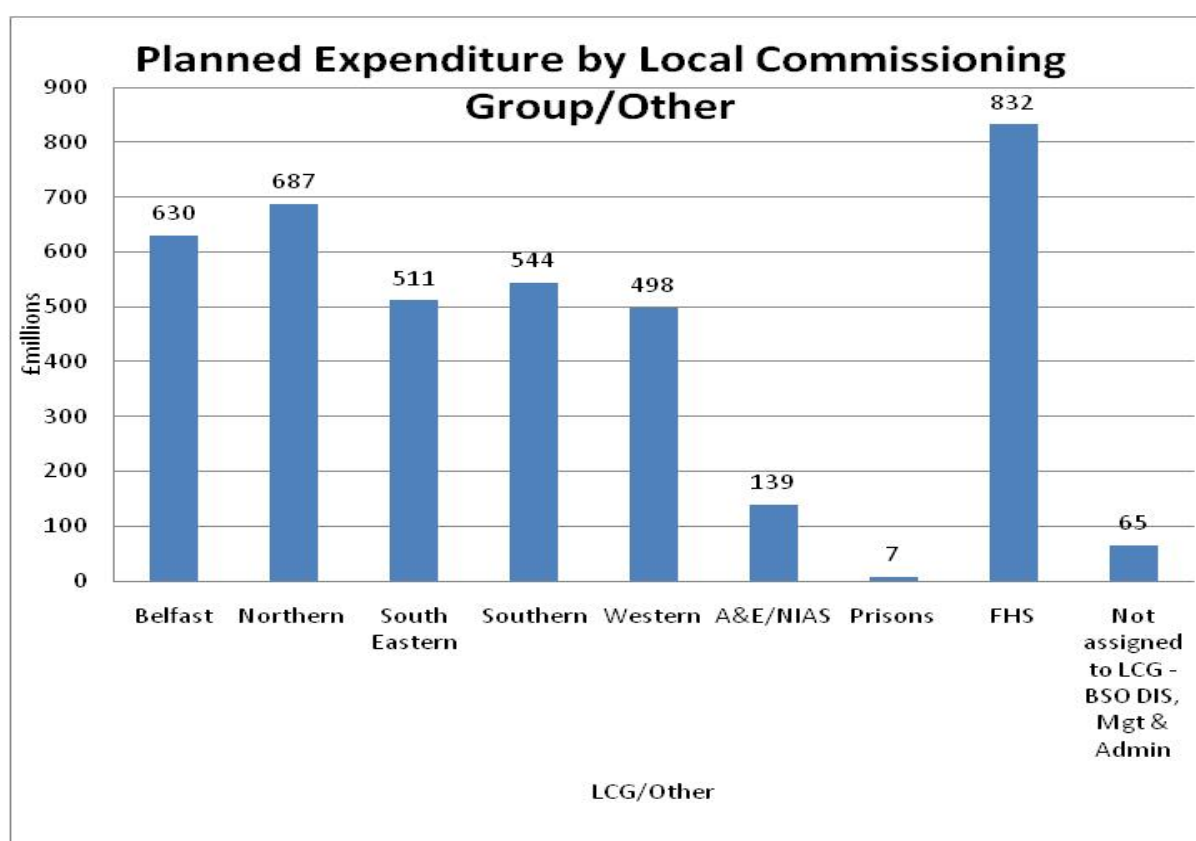
Table 8 – Planned Expenditure by Programme of Care

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%
<i>Sub Total</i>	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

	Contract Currency	Programme of Care									Total
		ACUTE	MCH	FCC	ELD	MH	LD	PD	HP	PRIM	
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	Learning 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

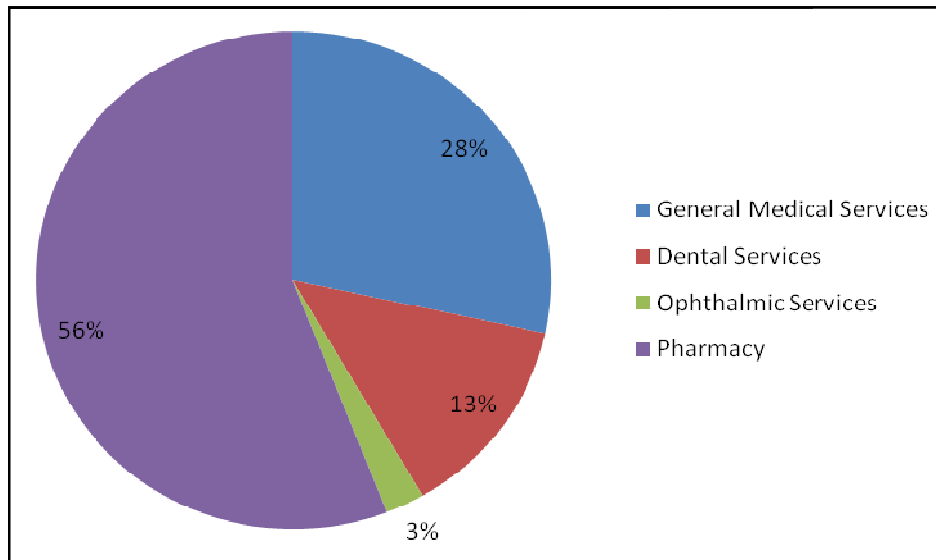
Table 10 below demonstrates how each Local Commissioning Group plans to allocate its resources to providers of Health and Social Care.

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 1 April 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

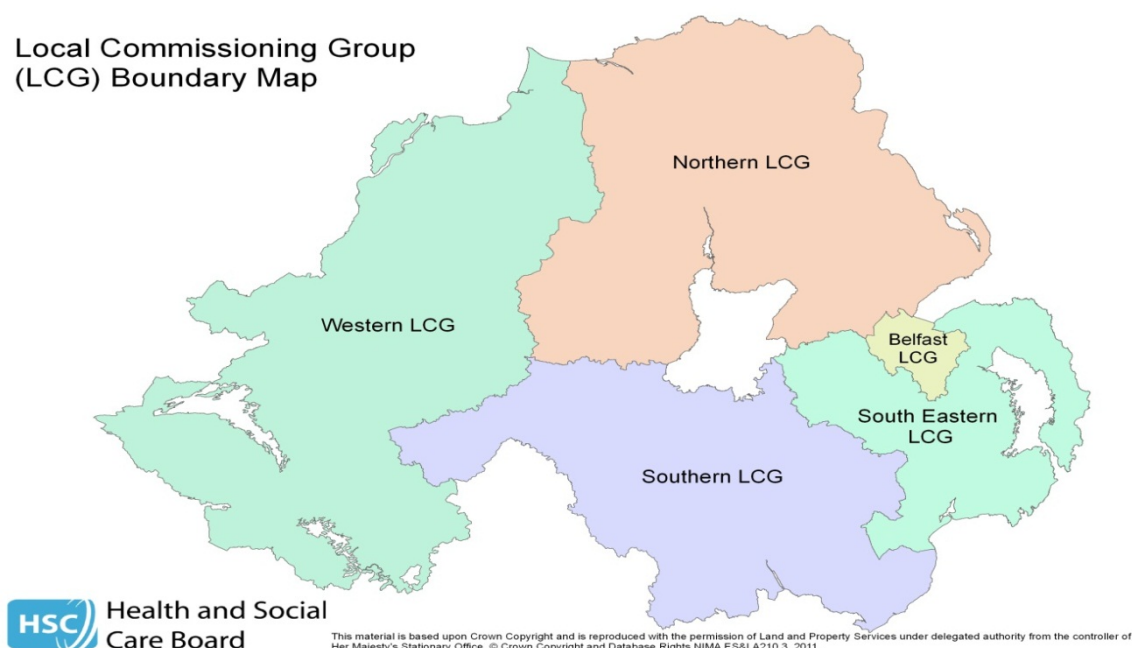
Engagement through Personal and Public Involvement - Each LCG has developed an extensive programme of engagement with users and local communities. Monthly public meetings are held in community facilities across each locality. LCGs work closely with their local Trust and have been pro-active in involving 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 conducive 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 England¹ 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 2008-2010 from 74.5 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%).²The 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

²Northern 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 unnecessarily 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 with 50% 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.
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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 *Staphylococcus 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**

<i>C. Difficile</i>	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 <i>Transforming Your Care</i> 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 <i>Transforming Your Care</i> .

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 BHSC 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 NICA 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 NICA 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>

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.

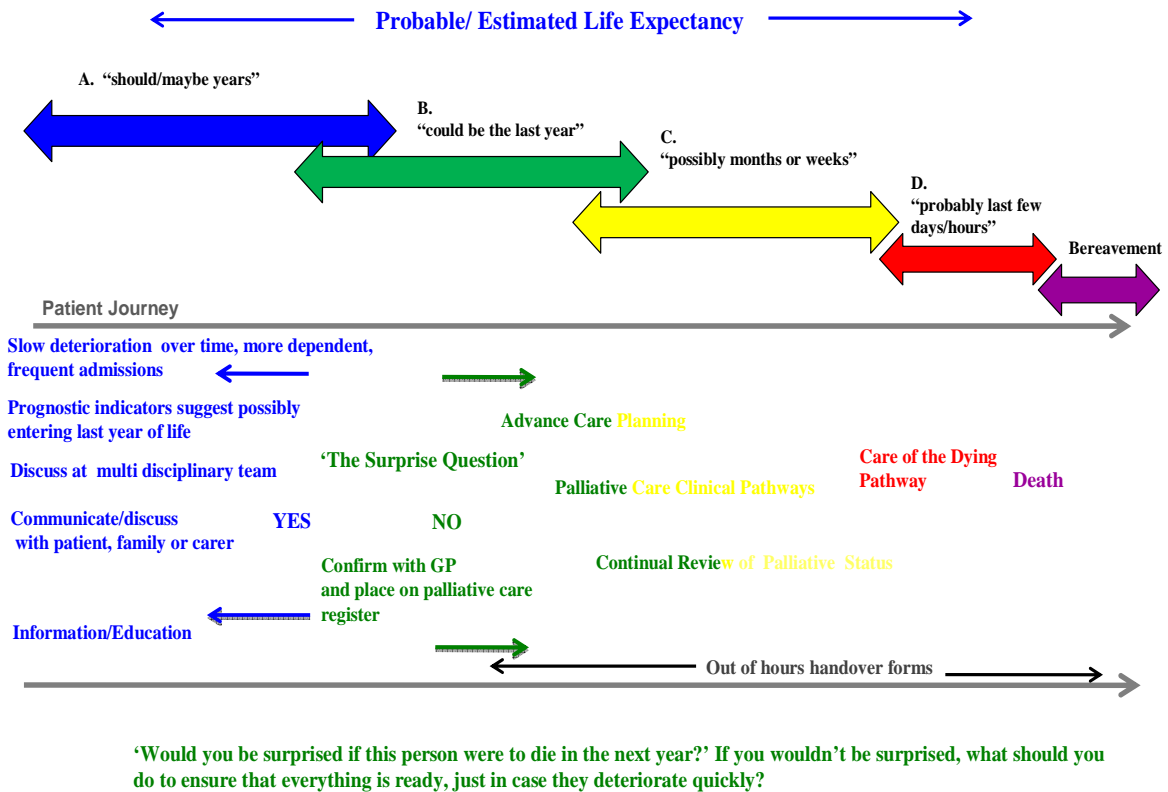
Identification, Assessment and Advance Care Planning

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.

End of Life Care Operational System



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 subset 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 ensure 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 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).
- 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.

Board Membership

Health and Social Care Board Membership

Dr Ian Clements – Chair
Mr John Compton – Chief Executive

Non-Executive Directors

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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
Ms Louise McMahon, Director, Performance Management and Service Improvement
Dr Sloan Harper, Director, Integrated Care
Mr Michael Bloomfield, Head of Corporate Services

Public Health Agency Board Membership

Ms Mary McMahon – Chair
Dr Eddie Rooney – Chief Executive

Non-Executive Directors

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Dr Jeremy Harbinson
Ms Miriam Karp
Mr Thomas Mahaffy
Councillor Billy Ashe
Alderman Paul Porter
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

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Mr Iain Deboys, Commissioning Lead
Cllr. Tim Attwood
Mrs Eleanor Ross
Mr Kevin McMahon
Dr Grainne Bonner
Mr Gerry Burns
Dr Jenny Gingles
Alderman Michael Henderson
Cllr. Mervyn Jones
Dr Terry Maguire
Ms Valerie McConnell
Mr Danny Power
Alderman Geraldine 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 Robert Irvine
Mrs Jenny Irvine
Dr Caroline Mason
Cllr Sorchá McAnespy
Mr Seamus McErlean
Mrs Clare McGartland
Mrs Siobhán McIntyre
Ms Loretta McManus
Dr Andrew Moore
Mr Eamon O'Kane
Mr Martin Quinn
Cllr Bernice Swift

Northern Local Commissioning Group

Dr Brian Hunter
Mrs Bride Harkin, Commissioning Lead
Ms Sharon Sinclair
Mrs Linda Clements
Cllr Thomas Burns
Cllr David Barbour
Cllr Thomas Nicholl
Cllr Adrian Cochrane-Watson
Dr Terry Magowan
Dr Turlough Tracey
Dr Ian Buchanan
Mr Laurence O'Kane
Dr Una Lernihan
Mrs Eileen Kennedy
Dr Fiona Kennedy
Mr Paul Kavanagh
Ms Corrina Grimes
Mr Derek Manson

South Eastern Local Commissioning Group

Dr Nigel Campbell (Chair)
Mr Paul Turley, Commissioning Lead
Ms Oriel Brown
Cllr. Angus Carson
Cllr. Dermot Curran
Dr Paul Darragh
Mr Donal Diffin
Mr John Duffy
Cllr. Andrew Ewing
Mr Brendan Forde
Mr David Heron
Dr Garth Logan
Ms Louise Seymour
Dr Paul Megarrity
Mrs Heather Monteverde
Mr Peter Mullan
Dr Ultan McGill
Cllr. Cadogan Enright

Southern Local Commissioning Group

Mr Sheelin McKeagney (Chair)
Mrs Lyn Donnelly, Commissioning Lead
Dr Walter Boyd
Mrs Beverly Burns
Dr Sean Digney
Mr Iolo Eilian
Mrs Mary Emerson
Dr Brid Farrell
Mr Paul Maguire
Mr Miceal McCoy
Mrs Janis McCulla
Cllr. Sean McGuigan
Cllr. Sylvia McRoberts
Mr Kieran McShane
Dr Tom O'Leary
Elected Representative (Vacant)
Elected Representative (Vacant)
General Practitioner (Vacant)

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Jonathan Houston (jonathan.houston@hscni.net)