

# **HEALTH AND SOCIAL CARE BOARD PUBLIC HEALTH AGENCY**

## **DRAFT COMMISSIONING PLAN 2011/2012**

**23 June 2011**

**(For consideration by HSCB/PHA Board  
30 June 2011)**

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## Foreword

Legislation enacted on 1 April 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.

The Board 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 service teams. The Board's commissioning processes are underpinned by the five LCGs which are committees of the Board 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 2011/12 which is appended to and should be read in conjunction with this document.) The Board 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 Board's commissioning processes are underpinned by the five LCGs which are committees of the Board*

The Board is accountable to the Department and the Minister for the achievement of Ministerial priorities, standards and targets. 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 organization.

This is the second Commissioning Plan to be produced by the Health and Social Care Board and Public Health Agency. It takes forward and builds upon the key themes set out in the Commissioning Plan 2010/11, in particular tackling health inequalities, reforming acute hospital services, reforming social care services and establishing Primary Care Partnerships.

This 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 Priorities for Action.

## **Purpose**

The core purpose of this Commissioning Plan is to provide a clear roadmap for the future development of health and social care services in 2011/12 and beyond. The Plan is driven primarily by the desire to improve safety, quality and the patient experience – rather than by money. It seeks to describe as simply as possible the issues and opportunities associated with the current arrangements, and to plot a clear and reasonable way forward that maximises benefit to patients and clients within available resources.

This Commissioning 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.

It is our aim that this Plan is straightforward and written in a manner which will encourage public engagement and understanding. We wish to show clearly how the commissioning task is to be approached and to signal the decisions necessary to ensure the maintenance of a health and social care system in Northern Ireland which responds to the population it serves.

*The Plan is driven primarily by the desire to improve safety, quality and the patient experience – rather than by money.*

## **Need to change the status quo**

Health and Social Care in Northern Ireland is at a cross-roads. The NI Budget settlement for the four-year period 2011 to 2015 provides health and social care with a 2% annual growth in resources over four years to £4.6b. The forecast annual cost pressures of 6% would require £5.4b if the status quo is to be maintained.

Consequently, our choices are stark. As a system we can try to maintain existing arrangements for service delivery, but this will become increasingly difficult as the gap between available resources and the demands upon them grows. The inevitable outcome without change to the status quo will be an unplanned and unmanaged collapse in key health and social care services. This would almost certainly have a detrimental impact on patients and clients.

Or alternatively, we can begin now to radically reshape health and social care services in Northern Ireland. The objective is to maintain quality, deliver good outcomes and recognise that there is the opportunity even in a difficult financial environment to provide an excellent health and social care service to the population. In so doing the system would 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.

***There is the opportunity even in a difficult financial environment to provide an excellent health and social care service to the population.***

This Commissioning Plan pursues the latter approach. The Plan signals significant change to both the range of health and social care services that will be provided in the future and where and how those services will be provided.

It is more important than ever, therefore, that we secure value for money through commissioning, ensuring that we achieve maximum benefit from all available resources. There are no neutral decisions: every decision will have consequences and opportunity costs for patients and clients. A failure to take action to maximise the cost-effectiveness in any one service area or location will simply translate into wasteful expenditure or lost opportunities to develop or improve services.

There are three areas where change is most urgently required, both to free up resources for investment in new services and generate capacity within existing services to be able to deal with the increased levels of activity that will be required to meet the needs of our increasingly elderly population.

The first priority area for change is the transformation of how and where acute hospital services are provided. The simple fact is that, for a population of 1.8m, NI has too many acute hospitals. On the basis of widely accepted norms, a population the size of NI's requires between five and a maximum of seven acute hospitals, each serving a population of some 250,000 to 350,000.

***For a population of 1.8m, NI has too many acute hospitals.***

Currently we have 10 acute hospitals, most of which provide around-

the-clock A&E, emergency surgery services, emergency medical services and obstetrics.

Trying to maintain acute services across this number of sites has been difficult from every perspective. Scarce staffing and other resources are spread too thinly, making it impossible to ensure that permanent senior medical cover for emergencies is available at all sites, 24/7/365. Instead, most sites – and not just the smaller ones – rely on a combination of junior doctors and temporary locums to provide much of the cover required, particularly out of hours. This inevitably impacts on quality and cost.

The relatively small size of many of NI's hospitals also means that economies of scale are lost, staff productivity is lower, and the cost of any given treatment is higher than would otherwise be the case. Repeated reviews have demonstrated this fact. The required efficiency gains will be very difficult to achieve without hospital reshape. In addition, we admit more people and our lengths of stay for emergency and planned treatments are significantly longer than the best performing organisations in GB. This is often because if a hospital is there it is used and the alternatives to hospital are restricted because resources are committed to maintaining the hospital rather than to more effective community-based models of care. There are huge opportunity costs associated with our current model of acute hospital services – in terms of the cost effectiveness of the care provided and the lost opportunity to invest some of the resources currently locked into hospital care in other priority service areas.

***Providing people with real choice about how their care is provided is the key objective.***

The second priority area for change is the reshaping of social care services for older people and other client groups. We need to review the way in which services are perceived and delivered to achieve a balance between meeting the needs of the most vulnerable and promoting independence and self determination. There is a need to significantly increase the proportion of people cared for at home rather than becoming overly reliant on residential or nursing home care. Providing people with real choice about how their care is provided is the key objective. In parallel we need to ensure best value is secured from the providers of residential and domiciliary care services. These changes are essential to ensure that health and social care is able to respond to

the significant increases in the over 65 (+16%) and over 85 populations (+29%) over the next four years. This will require a mixed economy of service provision, the introduction of new contractual arrangements for institutional care and much greater use of direct payments.

The third priority area for change in 2011/12 is to reshape primary health and social care. Working through the LCGs, Primary Care Partnerships will increasingly have a role in demand management, redesigning care pathways and taking forward new opportunities to provide services in primary and community care settings. A key priority for the Commissioner will be to take forward the commissioning of attached integrated teams of professionals aligned to individual practices and using the GP list as the primary building block for the development of services. A further key priority in 2011/12 will be the control of pharmacy expenditure, building on arrangements already in place. There will be a requirement to modernize reimbursement arrangements for the pharmacy industry, to promote the use of a formulary and top set demanding targets for the use of generic drugs.

While significant improvements have been secured locally in the last year, NI continues to spend significantly more per head on prescription medicines than other countries in the UK; if our prescribing expenditure per head was the same as in Wales, we could save more than £[50]m each year. These resources must be freed up to allow investment in other areas that will provide greater benefit to the health and wellbeing of the population of NI. The expectation will be to close this gap by at least £[30] million by the end of 2011/12.

*NI continues to spend significantly more per head on prescription medicines than other countries in the UK*

### **Over-riding objectives**

Our commissioning of health and social care services shall seek to achieve the following objectives within the resources available:

- To protect the most **vulnerable** and **disadvantaged**
- To 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

- To ensure that the services we commission are **evidence-based**, safe and of high quality, and deliver improved outcomes for patients and clients
- To **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
- To 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
- To maintain or increase current volumes of activity, with cost pressures being absorbed as far as possible by provider organisations through increased **productivity** and new ways of working
- More generally, to secure **value for money**, maximize efficiency and effectiveness in service delivery and drive out waste
- To leverage, through the newly established **Primary Care Partnerships**, the essential knowledge and experience of GPs and other primary care practitioners as clinical gatekeepers in influencing system-wide change
- To support people to **live at home**, with services being reshaped to promote independence, recovery and rehabilitation
- To provide services as **locally** as possible, where this can be done safely, sustainably and cost-effectively. However significant change to the current pattern of acute hospital services is essential if standards of quality and safety are to be maintained or improved
- To ensure appropriate access to those existing **and new services and treatments** for which there is a clear evidence base to demonstrate cost-effectiveness and patient benefit, and which are affordable
- To maintain **reasonable waiting times** for all of the services we commission, consistent with the prioritised needs of patients and clients

- To create a working environment that enables the **committed** workforce to do their job **sensitively and effectively**.

*Where a commissioning decision is taken primarily to make a saving or service reduction, this will be explicitly stated.*

In all of our commissioning activities we will be open, accessible and straightforward even if at times this requires 'uncomfortable' debate.

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 recognize that our primary and direct line of accountability is to the Minister, as a public body we shall seek to work openly and effectively with the Assembly Health Committee and other elected representatives.

A key objective will be to ensure that effective arrangements are in place to allow us to engage and communicate with clinicians and other professionals, patients and clients, the public and their elected representatives at all stages in the commissioning process. In this regard, we have sought to reflect throughout this Plan the people's priorities identified recently by the Patient Client Council, namely:

- Ensuring that front line staff, particularly nurses, are protected
- Maintaining reasonable waiting times for hospital in-patients, outpatients, diagnostics and GP appointments
- Ensure effective arrangements to care for the elderly, including domiciliary care
- Ensuring effective mental health and learning disability services
- Maximising funding for health and social care services
- Ensuring local access to hospital services, including A&E and out-patients services
- Ensuring access to high quality GP services including out of hours services
- Ensuring access to high quality cancer care services

- Ensuring effective communication arrangements are in place
- Tackling the rising costs of prescription drugs.

## Two Distinct Planning Periods – 2011/12 and 2012/13 to 2014/15

The trajectory of the budget settlement together with the lead time associated with many of the key strategic reforms requires a particular approach to be taken to commissioning for the 2011/12 financial year, distinct from the approach in the subsequent three years 2012/13 to 2014/15.

*Financial break-even over this planning period will pose major challenges.*

Financial break-even over this planning period will pose major challenges. To appreciate the task it is necessary to provide context for 2010/11. Break-even last year was only achieved with substantial non-recurrent support. This came from workforce control, suspension of a range of planned investments and a relentless drive on efficiency. The financial base for the period 2011 to 2015 will require the temporary decisions taken in 2010/11 to become permanent. This means the £40 million achieved through temporary control of the workforce will become permanent; this is the equivalent to confirming a reduction in the total workforce of around 2,000. All parts of the HSC will be set the challenge of break-even.

During 2011/12 we shall also plan and begin the implementation of the key strategic reforms necessary to ensure the integrity of the health and social care system in 2012/13 and beyond. Reforms in the three priority areas referred to above will be particularly important, namely:

- i. The transformation of how and where acute services are provided to ensure the hospital system can respond safely, effectively and sustainably to the increasing needs of the population within a largely static resource base. This will require significant improvements in hospital productivity, throughput and effectiveness
- ii. The reshaping of social care services with the introduction of the Re-ablement model and other measures to significantly increase the proportion of people cared for at home rather than in residential care

- iii. The implementation of more effective prescribing arrangements through the range of initiatives being progressed by LCGs and PCPs within a coherent regional framework.

These and other reforms must be substantially in place in the last quarter of 2011/12 to ensure the continued integrity and financial viability of health and social care in 2012/13 and beyond. It is essential therefore that early decisions are taken on these key changes.

During the period 2012/13 to 2014/15 our focus will be on ensuring the full implementation of all elements of strategic reform some of which because of scale, the need for infrastructure investment or other factors will take some time to roll out. It will be essential throughout the four-year period 2011 to 2015 that appropriate support and assurance arrangements – including external support for the most critical reforms – are in place to ensure timely and effective implementation.

### **Summary of priority issues in 2011/12 (HSCB)**

- *Reconfigure A&E and emergency surgery services*
- *Improve hospital efficiency creating additional capacity for future demand*
- *Maintain reasonable waiting times for planned services*
- *Expand diagnostics capacity ensuring full use of NIPAC*
- *Establish single site provision of elective care specialities in all Trusts*
- *Review arrangements for the provision of patient transport services*
- *Increase capacity of radiotherapy services in Belfast and prepare for the opening of the new unit in Londonderry*
- *Implement the recommendations of the DHSSPS maternity services review*
- *Undertake evaluations of the stand-alone midwifery units in Downpatrick (2011) and Lisburn (2012)*
- *Introduce new community-based teams for long term condition management*
- *Reshape social care services with the introduction of the Re-ablement model*
- *Improve value from social care services through a mixed economy of service*

*provision, the introduction of new contractual arrangements and greater use of direct payments*

- *Fully establish 17 Primary Care Partnerships*
- *Establish integrated multi-professional teams attached to GP practices*
- *To bring prescribing expenditure in line with other comparable parts of the UK*
- *To modernize reimbursement arrangements for the pharmacy industry*
- *Reconfigure inpatient mental health services*
- *Maintain momentum with the resettlement programme for mental health and learning disability patients*
- *Increase capacity and resilience of child protection services*
- *Promote health and wellbeing through commissioned services*

### **Summary of priority issues in 2011/12 (PHA)**

- *Introduce a cardiovascular risk factor management programme with HSCB*
- *Roll out the bowel cancer screening programme NI-wide and complete the preparatory work to introduce a new screening programme for abdominal aortic aneurysm (AAA)*
- *Introduce automated systems for existing screening programmes, specifically breast cancer and diabetic retinopathy programmes*
- *Support Trusts to achieve further reductions in Healthcare Associated Infections (HCAIs), specifically MRSA and C. Diff*
- *Ensure plans are in place to respond to seasonal flu and other emergency situations*
- *Roll out the next phase of early years programmes to support children in schools and at home and strengthen antenatal care*
- *Expand programmes to tackle the determinants of health, including a rural poverty initiative with DARD*
- *Develop and implement a community development plan with HSCB and other partners*
- *Target stop smoking services to areas with high prevalence of smoking and introduce further programmes in FE Colleges, antenatal and pre-op*

*assessment clinics and workplaces*

- *Implement actions within the regional Obesity Framework when published*
- *Roll out community suicide response plans and target intensive interventions to areas with high rates of suicide and poor mental health*
- *Implement the sexual health action plan with the Sexual Health Network*
- *Develop an overarching quality and safety assurance framework, through the Quality & Safety Service Forum*
- *Develop a range of nursing and midwifery key performance indicators to further support the provision of safe and effective care.*
- *Introduce a regional initiative to gather 3,000 patient/clients stories to ensure that individual and collective needs and expectations of patients and clients are at the centre of all decision making.*
- *Adaptation and implementation of PPI strategy and implementation plan*
- *Reform and Modernisation of AHP services and the development regional standardized care pathways*
- *Delivery of the AHP commissioning intent projects including AHP input into children with special educational needs in mainstream and special schools.*
- *To ensure implementation of the RTNI contract and the provision of remote telemonitoring to 1,800 people during the 2011/12 year (in line with draft PfA)*
- *To commission an independent evaluation of the RTNI service*
- *To work with relevant stakeholders to develop a broad strategy for the development of connected health within the HSC*

## **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 2011 and submitted to the Department for consideration. The final Commissioning Plan was approved by the new Minister on XX 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.

***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***

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 formal project management arrangements on a regional basis to ensure the delivery of the three key strategic reforms, namely, reforming acute hospital services, reforming social care services and reducing prescribing expenditure. 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 the endorsement by the Minister and the Department.



Dr Ian Clements  
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# Section One

## Context and Key Themes

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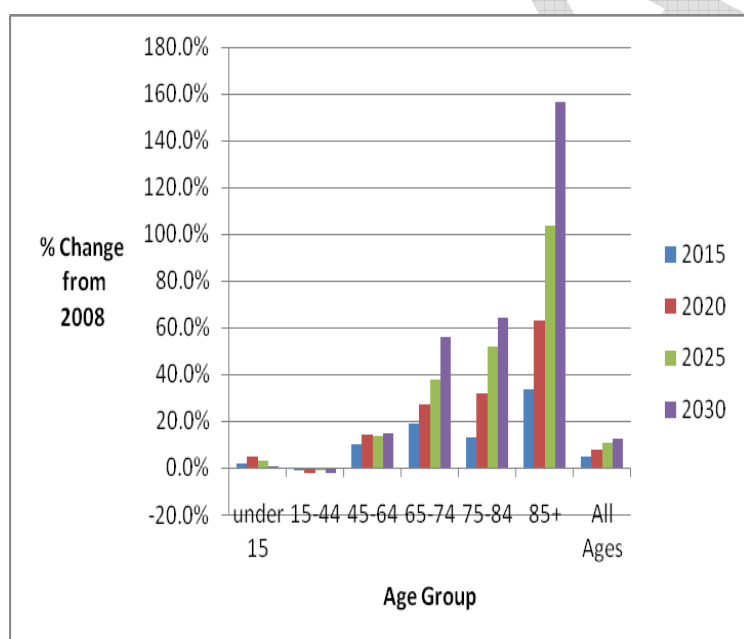
# 1 Strategic Context

This section sets out the key environmental factors influencing policy formulation and on the major policy imperatives which define the future direction of travel for service development and redesign.

## 1.1 Demographic Changes

Northern Ireland is becoming an older society. While the absolute size of our population is estimated to increase over the next 10 years, of greater significance to the demand for Health and Social Care is the likelihood that the average age of our population will also continue to increase at a faster rate. Specifically, estimates are that between 2008 and 2020:

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



*Figure 1: Changing Demography of Northern Ireland - % Change by 2015, 2020 and 2030 by age group.*

Older people are major users of our Health and Social Care system. If systems remain unchanged by 2020 demand placed on our systems by an increasing elderly population mean that hospital admissions will have increased by 17% and beds used by 23%.

Older people tell us that they want care, support and treatment in or close to home (Health & Wellbeing Strategy for Older People 2006-16). Commissioning must therefore continue to reform and modernise the Health and Social Care system, responding to growing demand with an increased emphasis on community based services.

*Older people tell us that they want care, support and treatment in or close to home.*

An important element within this plan is to promote older people's health and wellbeing, through a further shift to supporting people at home and giving individuals, their family and local communities' greater control over the range and delivery of services. Major features will be positive health promotion, the active prioritisation of direct payment schemes, the focus on support for carers, the management of people with chronic diseases in their own homes with the help of technology, and the delivery of palliative care in the community.

## **1.2 Safe and Sustainable Services**

The overall aim in commissioning is to ensure that the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. To maintain and to continue to achieve this standard of service will mean a re-profiling of the current pattern of services. To meet best clinical practice some services may have to be delivered on a national, regional or sub regional basis. This is not a new approach and we have demonstrated in the past – for example by consolidating cancer care into the major acute hospitals with streamlined access to a regional service – that we can provide evidence based practice standards and achieve improved outcomes for people with cancer.

Frequently these changes are simplistically portrayed as centralisation. The Commissioner will wish to secure local services for local people but simultaneously provide safe, sustainable services for the population at large.

The safety of services provided is paramount and we will progress strategies for reducing infection rates, reducing untoward events across all areas of practice, achieving real improvement in hygiene to improve outcomes and the patient/client experience.

Commissioning is about securing good outcomes and providing safe services. We recognise the importance of patient and client choice and the need for people to have confidence in how our services are provided. Choice will therefore be a major theme in driving commissioning but this must be realistic and consistent with the delivery of safe, effective care.

### 1.3 Modern Treatments

Since 1948 the nature of Health and Social Care services has been characterised by the need to respond to new demands, treatments and interventions. For example many surgical procedures previously requiring inpatient stays in hospital now happen safely on a day case basis allowing patients to return home on the same day as their treatment occurs.

In recent years, we have seen the day case rate as a percentage of total elective work increase in certain key service areas and there is now a requirement that all Trusts in Northern Ireland achieve and maintain a 75% day case rate across a basket of 24 specified procedures.

Treatment for cancer has been revolutionised over the past decade with survival rates improving across a range of cancers, although we still fall behind European survival rates in a number of cancers, so further work needs to be done.

***As survival rates continue to increase the nature of caring for people with cancer will change.***

Improved survival rates have occurred at a time of significant investment in improving access to cancer services including drug regimes. As survival rates continue to increase the nature of caring for people with cancer will change. More people will be living with cancer as a chronic illness and our services must evolve responsively to these needs.

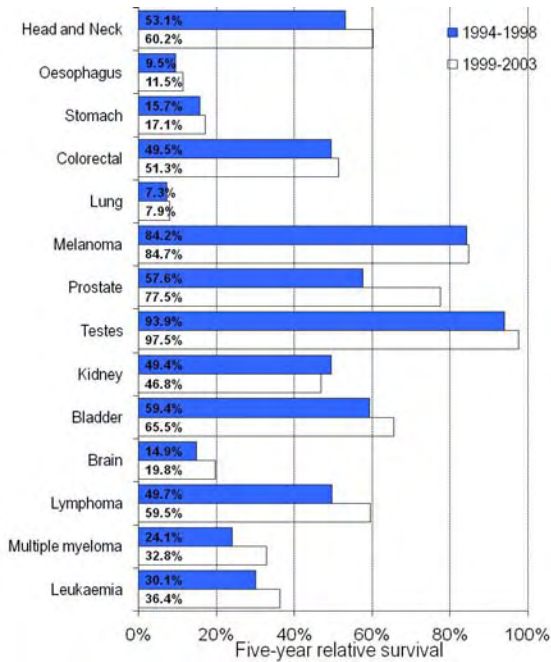


Figure 2: Changes in survival for male patient with cancer by cancer site, 1994 – 2003 (Five year relative survival by sex, cancer site and period of diagnosis. Source NI Cancer registry).

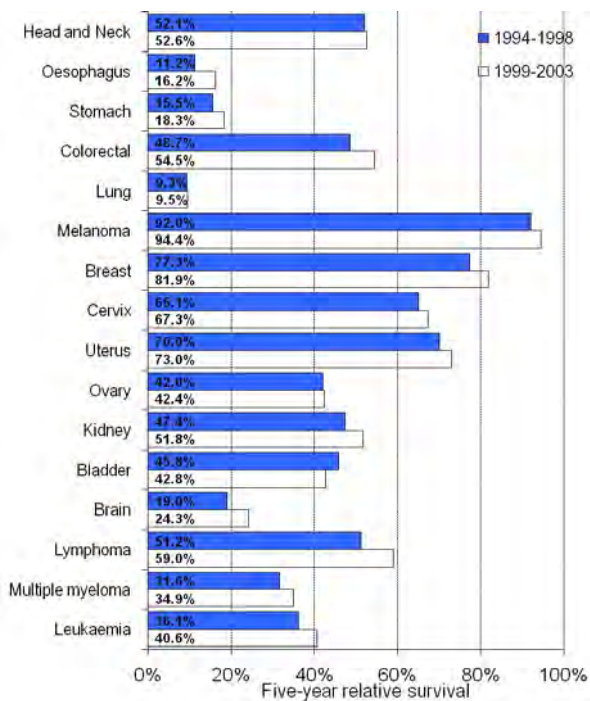


Figure 3: Changes in survival for female patient with cancer by cancer site, 1994 – 2003 (Five year relative survival by sex, cancer site and period of diagnosis. Source NI Cancer registry).

New drugs and treatment techniques for a wide range of healthcare needs are constantly being developed and their efficacy and value assessed by the National Institute for Clinical Excellence.

Traditional support supplied in children’s residential care has been revolutionised by a much expanded and more skilled fostering service.

Home based treatment in mental health services has introduced a recovery model of treatment and led to major changes in how hospital care is provided.

Primary Care has been given the opportunity to provide more care and treatment in the community through locally enhanced services. The decision to introduce and implement these kinds of improvements and innovations is linked to how we use resources. Sometimes this will happen with new funding, or possibly the re-use of funding released by greater efficiency or a decision to change the priority of an existing service.

*Home based treatment in mental health services has introduced a recovery model of treatment and led to major changes in how hospital care is provided.*

The introduction of a service can also depend on the availability within Northern Ireland of staff with the appropriate expertise and skills. For example, with a local population of 1.8m it is difficult to support the full range of modern acute services. Some very specialist services for our population will either be commissioned outside Northern Ireland or will be jointly commissioned with other regions.

It is also essential to recognise that it will not always be possible to commission immediately every new service that is available, even where approved by the National Institute for Clinical Excellence. Commissioning in these areas will inevitably make for difficult choices. For example, we do not currently commission bariatric surgery. There is no certainty that we will be in a position to commission this service in the immediate future and we may opt instead for prevention and support services as alternatives for those with obesity problems. Similarly, there are a number of instances where users of social care services patients have been the subject of transfer to high cost facilities outside Northern Ireland. It will be important to scrutinise these and other similar future cases in order to determine whether appropriate alternatives can be supplied locally.

## **1.4 Resources**

Discussion about money is always controversial. In the public perception, proposed changes or debates about money are frequently assumed to be about savings or perceived cuts. Where any commissioning decisions are primarily taken to make a saving or service reduction, this will be explicitly stated.

In fact many of the decisions to make change are not driven by money but by a desire to improve quality or effectiveness. Commissioners will not avoid such decisions but will seek to take them in an informed and sensitive manner that reflects the potential implications for individuals and communities. In the end however there are no neutral decisions. Unnecessary preservation of an existing pattern of service delivery will in all probability mean denial of new developments. Making choices is a reality for any commissioning system. This is vitally important to understand in the financial climate that commissioning is entering. For over a decade Health and Social Care has invested in one year and met the full cost from a growth in funding the following year. The period 2011-15 will not permit such a pattern. It is much more likely that the money currently in the Health and Social Care system is the most that will be available leading to a number of difficult years ahead. Whilst this represents a different climate the Health and Social Care system is likely to continue to spend nearly 40% of the Northern Ireland Block. We commit more than £10m every 24 hours to support the delivery of services to the population of Northern Ireland. Opportunities to develop new services remain but only if there is significant change and greater efficiency in the current service patterns.

Often when there is a debate in regards to resource, the problem is presented in terms of unnecessary bureaucracy. While it is important that administration and management costs are tightly controlled and represent value for money, this does not reflect where the real focus needs to be. Within Health and Social Care today we commit just over 4% of the commissioning resource to management costs. We need a properly managed system that is responsibly resourced. The real debate about resource is an understanding of the need for change and decisions about what can and cannot be provided. This Plan will not be distracted from this central issue. However, as Commissioners, we fully appreciate that final decisions require to be endorsed by the Minister and the Department.

***Unnecessary preservation of an existing pattern of service delivery will in all probability mean denial of new developments.***

## **1.5 Workforce**

Successful commissioning needs to have a keen appreciation of the workforce implications of what it wishes to see provided. This holds true for all types of grades and staff working in the sector. It also requires the Commissioner to have an appreciation of capacity within the delivery system. This interest spreads across both the statutory and independent

sector. In 2010/11 some [£40m] was spent on locum doctors and nurses in Northern Ireland to support the existing hospital system. Such expenditure not only represents poor value for money but also impacts on the continuity and therefore the quality of care provided. Commissioning in 2011 and beyond will seek to reshape the hospital sector in a manner which minimises the need for such expenditure. This change is also required to respond to the implementation of the European Working Time Directive and take account of the actual medical workforce availability.

Such a change is driven principally by quality, and the interplay of quality, volume and value for money is at the core of this decision making process. Although there will be a requirement for rapid change it will be done in such a manner as to reflect the need to respond to capacity. Failure to acknowledge this would simply lead to unplanned service change or collapse and inappropriate commissioning which does not take account of responsible risk management.

## 1.6 Demand

Reference has already been made to demographic change and the effect this has on demand for services. During 2010/11, we have achieved significant success through the local commissioning arrangements in better understanding and managing demand. As might be expected, the pattern of demand for services in 2010 shows some variation to that experienced in 2009, depending on the nature of the service being sought; for example:

- Outpatient referrals to the acute hospital sector for specialist assessment have remained more or less constant between 2009 and 2010 at around 618,000.
- Referrals in family and child care services for children at most risk rose by just under 11% from 4,322 to 4,792
- The number of older people discharged from hospital with complex care needs rose by 2% from 11,920 to 12,176
- The number of care packages for those in residential accommodation rose by 2% from 9,485 to 9,677 while those in receipt of intensive care at home (domiciliary care) rose by over 10% from 5,619 to 6,217.



Further developing our understanding of these demand patterns and working with providers in primary, community and secondary care to ensure more effective management of demand will continue to be a central issue for commissioning in 2011/12 and beyond. The Local Commissioning Groups and the newly established PCPs provide us with an opportunity to engage with family practitioners, patients, carers and local care providers to examine both the nature of demand and the potential for local alternatives for appropriate assessment and treatment.

## 1.7 Developing Better Services

Written in 2002, this DHSSPS strategy addresses the future shape of hospital provision for Northern Ireland. Although time has moved on its core principles remain. Changes have occurred at Downpatrick, Lisburn, Enniskillen, Omagh, South Tyrone and most recently Magherafelt and Whiteabbey, and further changes in Lisburn with the introduction in February 2011 of a stand-alone midwife-led unit. In 2011/12 we will take forward the implementation of the final stages of this strategy so that transition to this model will be substantially completed by 2013.

The principal driver remains the maintenance of quality of intervention and whilst local services and central delivery will be balanced in the commissioning process, safety, sustainability and outcome will be the key determinants.

*Local Commissioning Groups and the newly established PCPs provide us with an opportunity to engage with family practitioners, patients, carers and local care providers*

## 1.8 The Bamford Report

The Bamford Report and the 'Protect Life' Strategy set out the vision for the reform and modernisation of Mental Health, Learning Disability and Child and Adolescent Mental Health Services over a 15-year horizon. Since the publication of the individual reports, further evidence based models of service delivery have emerged and these will be integrated during the implementation of the Bamford recommendations.

The Health and Social Care Board and the Public Health Agency have established a number of core task groups to take this work forward and this will be led by the Bamford Project Board, chaired by the Health and Social Care Board's Chief Executive.

A core theme will be the need to promote mental health and wellbeing and to strengthen community services to promote a recovery based model of care provided predominantly in or close to people's homes. As outlined in "Delivering the Bamford Vision" (DHSSPS, 2009), key themes include:

*A core theme will be the need to promote mental health and wellbeing and to strengthen community services.*

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers
- Providing better public services to meet people's needs
- Providing structures and a legislative base to deliver the Bamford Vision.

## 1.9 Older People

The strategic direction for services for older people has been guided by Priorities for Action in recent years, with the focus being on a continuum of integrated primary and community care services, supporting independence and reducing inappropriate reliance on hospitals and other institutional care.

The anticipated Service Framework for Older People's Health and Wellbeing and the NI Dementia Strategy will form the future strategic direction for commissioning, with the agreement of evidence based standards, targets and measurable outcomes. Using this strategic base, commissioning will aim to ensure a balance of provision between disease prevention, health promotion and healthy ageing, and the required network of care and treatment services for those most at risk.

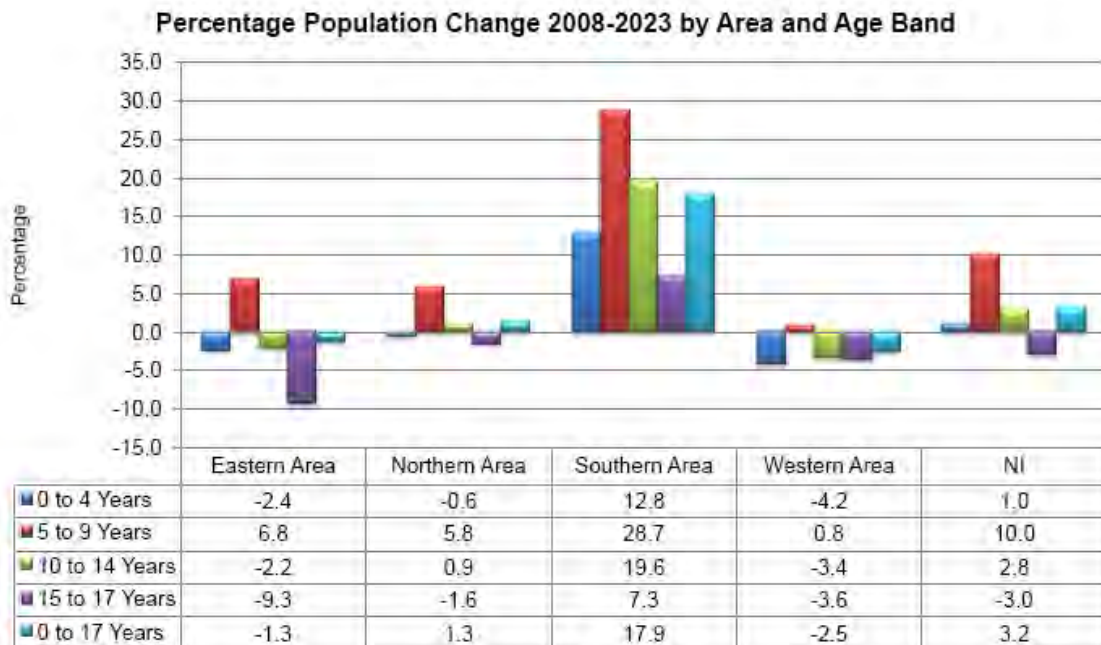
## 1.10 Children

It has been acknowledged by several independent authors that the level of investment in Children and Families Services in NI is approximately 30% less than in other parts of the United Kingdom. There are also examples of initiatives funded in other parts of the United Kingdom where there has been no direct read across to NI which has added to this imbalance.

It had been predicted that the number of births in Northern Ireland was to decline but this has proven not to be the case with birth rates remaining broadly static.

## 15-Year Population Projections by Age Band

Data Source: NISRA 2008 Population Projections



As Figure 4 above illustrates, percentage increases between geographical areas is variable but the overall increase leads to increased demand, particularly for family support services but also at the upper end of the continuum.

It is evident that the needs of children and families can only be addressed through multi-agency working and where partnership working is well established.

The fundamental principle of the Children (NI) Order 1995 is one of non intervention. In keeping with this principle we recognise that considerable efforts should be made to maintain children within their family of origin. At the same time we need to recognise the lifelong damage which can be done to some children if left for too long within a highly dysfunctional family to the point where alternative care arrangements will always struggle to meaningfully engage with the young person.

*The strategic direction over the past few years has recognised the importance of early intervention*

The strategic direction over the past few years has recognised the importance of early intervention.

There are a range of excellent examples operating in each of the Trust areas and being provided by the range of partners. This focus has been heightened even further with the publication of “Families Matter”, “Healthy Child – Healthy Future” and the “Family Nurse Partnership Initiative”. The concept of Family Support Hubs aligned with locality planning is developing and will be progressed. In addition the Family Support database, to be launched, should serve as an excellent resource to families, communities and professionals and be available to signpost families to support services at the earliest possible opportunity.

There is a need to consider the range of placements available for looked after children and those within CAMHS. This will include an exploration of the relative value of transfers to provision outside NI compared to that offered locally across the independent, statutory and voluntary sectors.

In the past year the Regional Quality Improvement Authority (RQIA) completed an inspection of Child and Adolescent Mental Health Services (CAMHS) and work will progress jointly with Trusts to progress the recommendations. The overall strategic direction continues to be as shaped by the Bamford Report.

The needs of children with a disability, including autism, remain a priority for the HSCB/ PHA and the various stakeholders involved in delivering services and working jointly with service users. The Regional Autism Spectrum Disorder Network (RASDN) has been seen to be an effective vehicle to engage users and take forward the agenda for children and adults with autism.

### **1.11 Disability**

The Regional Strategy for People with Physical Disabilities and Sensory Impairment will be the strategic framework for services for this client group. The focus will continue to be on promoting health and wellbeing, independence and empowerment and improving the quality and responsiveness of Health and Social Care services for people with disabilities and their carers. The Strategy will adopt a life cycle approach covering all age groups and will promote the importance of partnership working across community and independent sectors.

## 1.12 Reducing Inequalities and Promoting Health and Social Wellbeing

In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 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% of most deprived areas represent nearly 340,000 people.

***In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women.***

Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances are:

- Lower life expectancy than the Northern Ireland average
- 23% higher rates of emergency admission to hospital
- 66% higher rates of respiratory mortality
- 65% higher rates of lung cancer
- 73% higher rates of suicide
- Self harm admissions at twice the Northern Ireland average
- 50% higher rates of smoking related deaths
- 120% higher rates of alcohol related deaths.

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.

It is clear therefore that we need to do more to narrow the gap in health inequalities and improve the health and wellbeing of our population. This means working to address the determinants of ill health and reduce risk factors, including those associated with poverty and social exclusion.

The ability to positively impact on health and social inequalities cannot be exclusively addressed by the Public Health Agency and Health and Social Care Board. Meaningful partnerships and a common agenda need to be developed with our Trusts, our colleagues in local government, housing, education and the environment, and our communities if we are to effectively deliver on improving the health of our population. The Public Health Agency will have a key role in developing programmes to drive this agenda forward in the context of the review of the Investing for Health Strategy and the work that will be developed on a new Investing for Health Strategy for beyond 2012.

### **1.13 Performance Management**

Strong performance management will be the key to achieving an outcome which is positive and publicly understood, and ensures compliance with standards, statutory obligations and Priorities for Action targets set annually by the DHSSPS. In 2011/12 we will continue to develop the use and publication of a range of high level commissioning milestones as a benchmark of performance. While performance management of our care providers such as Trusts, General Practitioners and other primary care providers will be conducted in a supportive manner, we will be clear our first obligation is to ensure safe, sustainable services which respond effectively to the population's needs and represent value for money.

### **1.14 Evidence Based Commissioning**

Commissioning needs to be carried out within a framework of formal evidenced based guidance about the standards and outcomes we need to achieve. There are two key drivers in developing this approach:

#### **Managed Clinical Networks**

Managed Clinical Networks are a way of supporting the provision of high quality, sustainable, safe and effective services to our population. Integration and partnerships with clinical colleagues, either regionally,

***Commissioning needs to be carried out within a framework of formal evidenced based guidance about the standards and outcomes we need to achieve.***

nationally or with the Republic of Ireland means that in Northern Ireland, despite our small population, we can be assured that our services are delivered to the highest possible standards. We already have some networks in place for paediatric cardiac surgery, adult intensive care, cancer and pathology services, and we will continue to develop these arrangements linking into our newly established regional commissioning teams.

## **Service Frameworks**

Service Frameworks are sets of guidance on the highest quality of care and good practice spanning specific conditions or service areas. This guidance encompasses nationally supported evidence based standards, as well as the input of local clinical experts, in the development of recommendations applicable to our local services. Work is currently underway on the implementation of the Service Frameworks for Cardiovascular and Respiratory Services. Other Service Frameworks for Cancer, Mental Health and Wellbeing, Learning Disability, the Health and Wellbeing of Children and Young People and the Wellbeing of Older People are at various stages of development.

***Service Frameworks are sets of guidance on the highest quality of care and good practice spanning specific conditions or service areas.***

Commissioning will make progress with the implementation of these recommendations. However, there will be a need to balance how and when the recommendations can be fully implemented with affordability, workforce skills and capital investment. Approaches in the near future are therefore likely to focus on standardisation of good practice and re-profiling of care systems in the first instance, rather than assuming that significant additional resources will be available for service development.

## 2 Ensuring Financial Stability and Effective Use of Resources

The key objective of the Commissioning Plan is to use all available resources to ensure the overall investment in services secures as broad a range as is practicable along with the best possible outcomes for local populations. In developing the Commissioning Plan the Health and Social Care Board, supported by the Public Health Agency, recognises that significant resources are available to support its successful delivery. In 2011/12 this will include access to £3,894m of commissioning revenue resources.

The delivery of a successful Commissioning Plan requires the Board to be sensitive to the financial parameters within which commissioning operates. It is vitally important that we provide as much clarity as we can to the public in relation to the financial climate within which commissioning will operate during the current Budget period 2011-15.

***The NI Executive allocations for DHSSPS represent a real terms reduction in current expenditure by 2014/15***

The NI Executive allocations for DHSSPS represent a real terms reduction in current expenditure by 2014/15 with the result that the level of growth funds available in recent years will not be available in the period 2011-15.

The key challenge for 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 new spending review period. In 2011/12 this will involve both ensuring we achieve financial balance and also that we set the financial parameters for the rest of the spending review period which will underpin the longer term plans to reform and modernise health and social care.

This section of the Commissioning Plan provides an overview of:

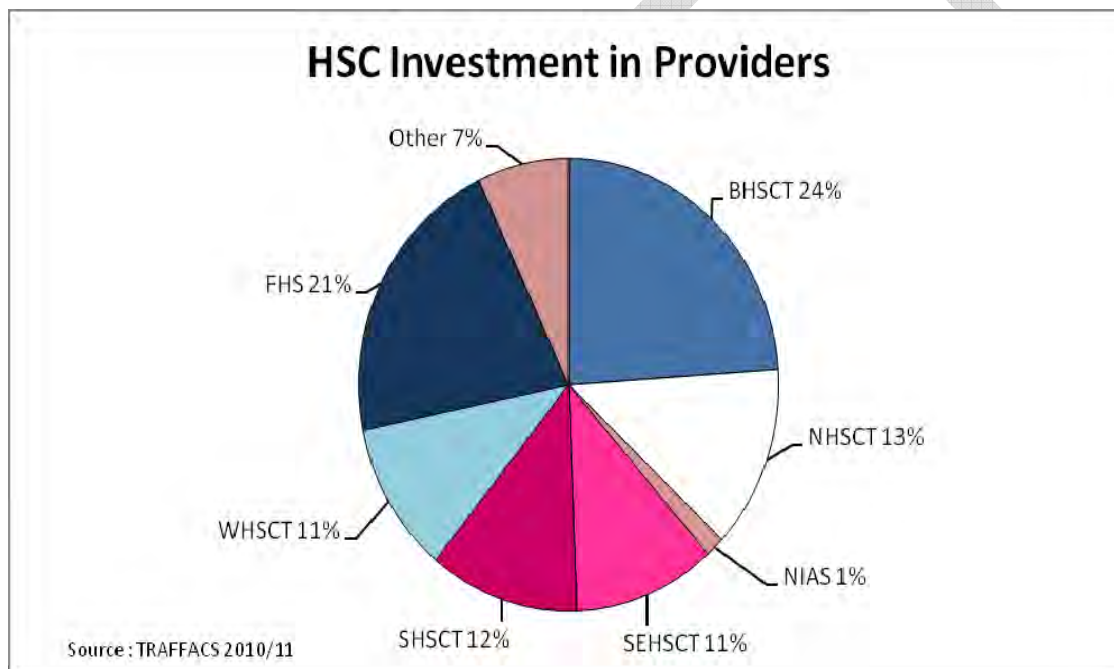
- The existing investment of Health and Social Care Board and Public Health Agency resources
- Financial performance in 2010/11
- The financial plan for 2011/12 and key financial targets
- The financial challenges for 2011-2015.



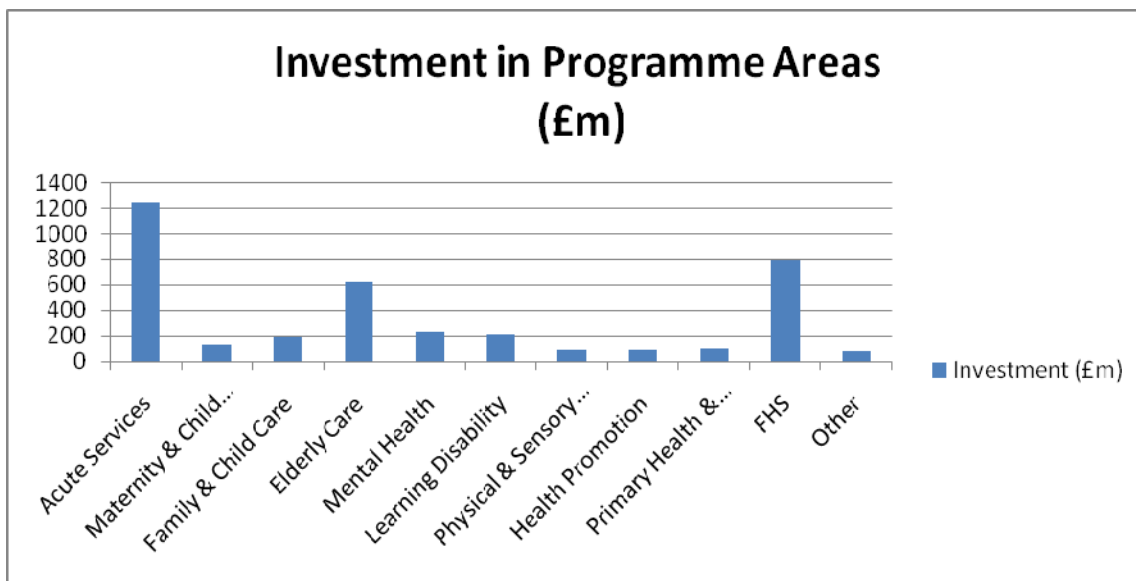
## 2.1 Existing Investment

The DHSSPS received an overall recurrent budget of £4.3bn in 2010/11. Of this, the Health and Social Care Board and Public Health Agency received some £3.8bn for commissioning Health and Social Care on behalf of Northern Ireland's 1.7m resident population. The DHSSPS utilise the remaining £0.5bn on NI Fire and Rescue Service i.e. Public Safety, Capital and other Agencies.

Of the £3.8bn received by HSCB and PHA, £2.7bn is deployed to the six provider Trusts and £1.1bn allocated across other providers of care such as voluntary organisations and General Practitioners in meet the health and social care needs of the population. Figure 5 illustrates the breakdown of the commissioning resources across providers.



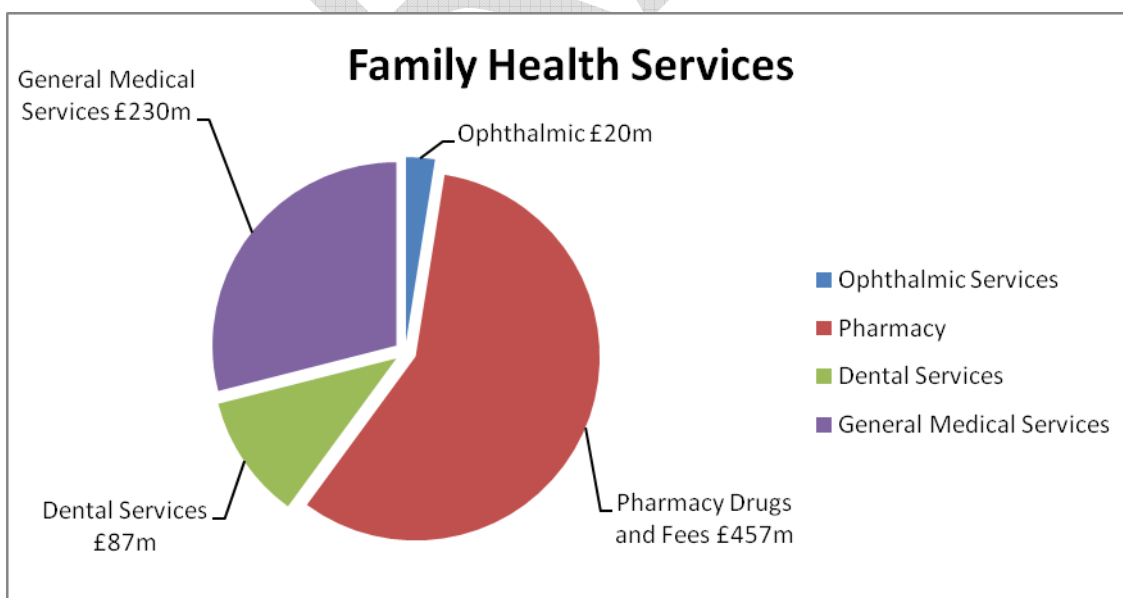
The PHA and HSCB invest £2.9bn across the 9 Programmes of Care areas and a further £0.8bn in Family Health Services (FHS) to meet the health and social care needs of local populations. The FHS funding was devolved to the HSCB from DHSSPS in 2010/11. Figure 6 (overleaf) illustrates how funding has been mapped to the Programme of Care areas.



In addition to Programme of Care funding, £0.8bn investment is made across the four areas of FHS which relates to the following services:

- General Medical Services
- Dental Services
- Pharmaceutical Services
- Ophthalmic Services

Figure 7



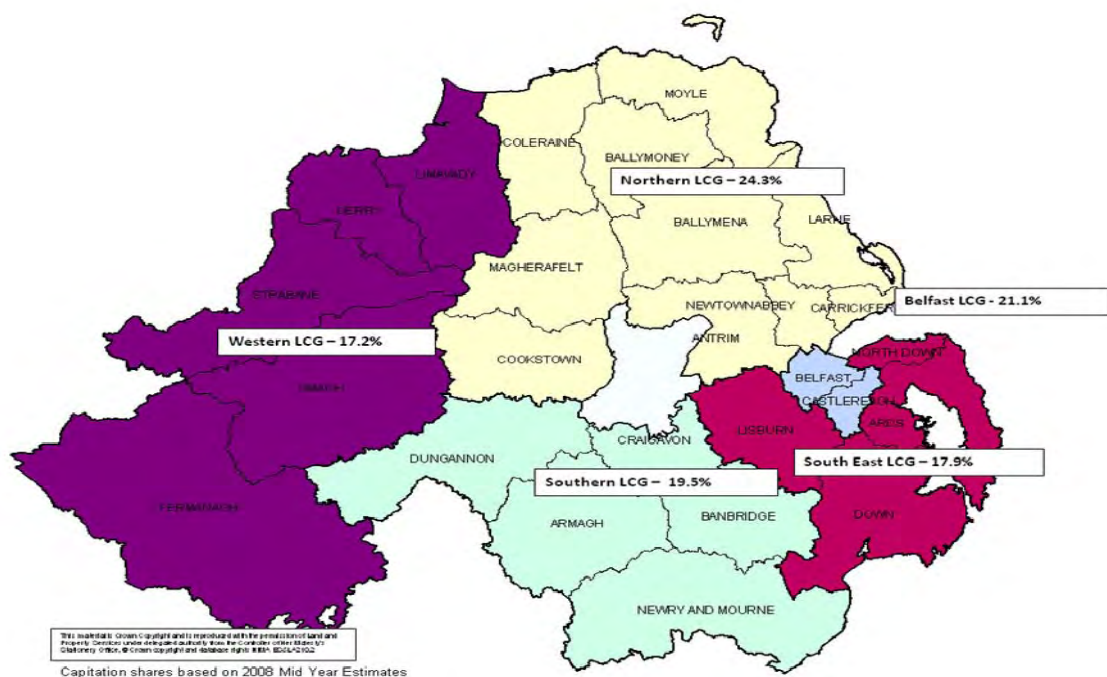
Ensuring these resources are fairly distributed across local populations is a core objective of the commissioning process.

Account must be taken of the population profile in a locality. Resources must be targeted to meet the diverse needs of populations based on its age and gender make up, for example, areas with a high number of elderly or very young are primary users of health care.

Also, the level of deprivation in an area is a key determinant in the requirement for health and social care in that area. Areas with high levels of deprivation require a higher than average investment in areas such as social care and health improvement.

The Health and Social Care Board uses a validated statistical resource allocation formula to inform its investment decisions made for the population in their localities. This is the “capitation formula”. It reflects the different needs of the population based on age, gender and deprivation. Figure 8 shows the relevant capitation shares mapped to localities.

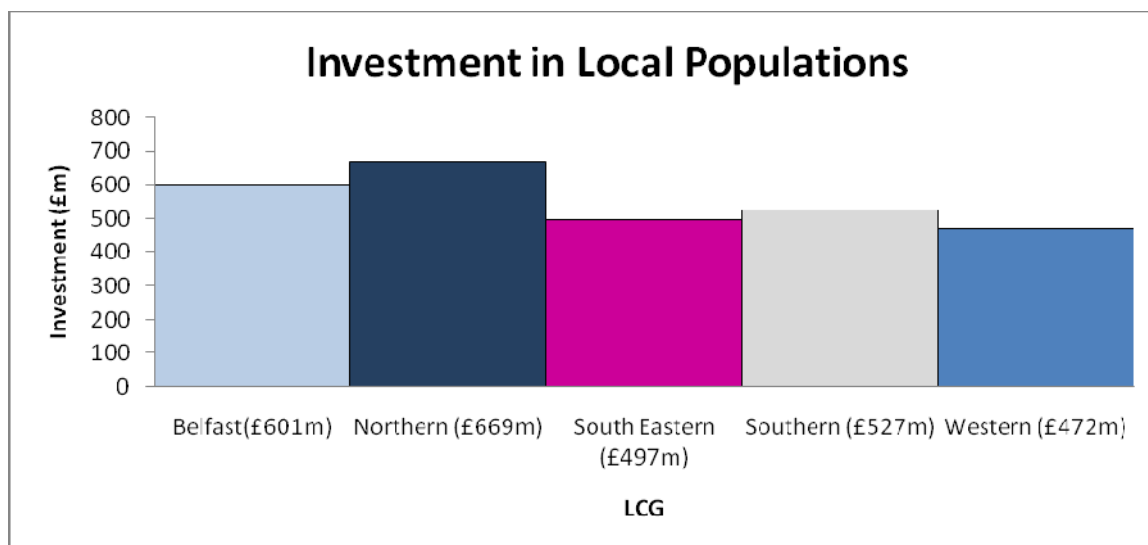
### Capitation shares by LCG



There is a separate capitation formula for Family Health Services. It is based on GP practice list populations.

Figure 9 illustrates how existing resources are invested in localities.

Figure 9



Where localities funding levels are out of line with their capitation based entitlement, equity strategies are developed to address the inequities, over a manageable period of time.

However, it is also important to appreciate that services provided for and accessible by a population may not always be located in that geography e.g. regional services such as specialist residential care for children and cardiac surgery. This is to ensure that the population has a safe and sustainable service.

## 2.2 Overview of Financial Performance in 2010/11

In 2010/11 Health and Social Care was asked to deliver savings of £284m arising from:

- The third year of the Comprehensive Spending Review efficiency savings as agreed in 2008
- The additional reductions decided by the Northern Ireland Executive in 2010
- The need to cover elective care costs consistent with the Minister's priorities as set out in Priorities for Action.

Due to this financial position, the DHSSPS's commissioning direction of the Health and Social Care Board required it to plan for savings of £204m. The sources of funds identified are summarised in Table 1:

Table 1

Description	£m
Comprehensive Spending Review Year 3:	
Trust Payroll;	40
Strategic Service Redesign and efficiency	15
Additional Income	3
Deferral of funds associated with Maintaining Existing Services	42
Deferral of originally planned Service Developments	58
Family Health Services Pharmacy Control	46
<b>Total</b>	<b>204</b>

There were major and complex management challenges involved in meeting these financial pressures and these were addressed through the establishment of a Financial Stability Programme Board chaired by the Commissioner, with involvement from DHSSPS and the provider Trusts.

Close monitoring of the performance of each organisation against each of the savings targets outlined above, with appropriate management action and contingency planning, enabled the Health and Social Care system to achieve a financially stable position by March 2011.

### 2.3 Overview of Financial Plan 2011/12

Following the approval by the NI Assembly of the Budget for the period 2011-15 the DHSSPS has published resource plans for Health and Social Care spanning 2011/12-2014/15. These were approved by the Northern Ireland Executive.

The financial climate for Health and Social Care in 2011/12 is extremely challenging given the range of inescapable requirements that must be met from the approved allocations. The key objective remains the need to deliver safe and effective Health and Social Care in a way that ensures appropriate and equitable use of all available resources and effective and efficient service delivery across all areas in the context of increasing demand for services from a growing and ageing population. The approach to developing financial plan for 2011 was:

- To identify HSC-wide and HSCB/PHA specific inescapable pressures to enable the maintenance of existing activity levels
- To evaluate Trusts' financial positions for 2011/12
- To identify the potential solutions to address the 2011/12 savings requirement.

The key financial targets for 2011/12 remain financial breakeven and delivery of efficiency savings, therefore the commissioning system will expect all organisations to live within the resources allocated. To achieve this objective the financial aspects of the Commissioning Plan have robustly focused on ensuring there is a source of funds for all expenditure and prioritisation of inescapable funding requirements.

In relation to the level of bureaucracy within the Health and Social Care system, the Health and Social Care Board will always wish to drive down such costs and add to productivity. However, the notion that the financial constraints can be exclusively addressed as a consequence of these issues is not accurate and diverts from the real public debate that will be required on resources and its utilisation.

***The key financial targets for 2011/12 remain financial breakeven and delivery of efficiency savings.***

## **2.4 HSCB/PHA Resource Allocation 2011/12**

The DHSSPS have allocated to HSCB/PHA for 2011/12 total revenue resources of £3,894m for the commissioning of HSC services and provision of Family Health Services.

## **2.5 Inescapable Funding Pressures**

The HSC faces a number of inescapable demands including:

- Demographic change
- Demand pressures
- Pay costs and pay inflation
- Goods and service inflation

- Completion and commissioning of new buildings

A review of the impact of the emerging 2011/12 HSC financial environment, taking account of the allocations confirmed in the approved budget outcome identified and quantified the range of inescapable pressures across the HSC. The HSCB/PHA element of these pressures is £226m, as set out in the table below:

Table 2

Area	Amount (£m)
Pay costs	45
National Insurance Contributions (NIC)	19
Non-pay inflation	23
Revenue Consequences on Capital Developments	7
Mental Health resettlement	3
Learning Disability resettlement	6
Demographics	26
Residual demand **	14
HSCB/PHA central pressures	9
NICE approved drug therapies	2
Pharmaceutical growth	40
Ministerial commitment	10
Elective care	15
Service developments revenue tail	7
<b>Total</b>	<b>226</b>

\* Further details in Section 2.8

\*\* Includes £3.4m monies to be redirected to other organisations

## 2.6 Trusts' Financial Positions

Trusts have continued to experience increasing financial difficulties during the course of 2010/11 with the requirement to initiate Contingency Plans, over and above the financial targets referred to in paragraph 2.2 above, in order to fulfil their statutory duty to financially breakeven. In the context of 2011/12, therefore, the Health and Social Care system anticipates that it will need to invest in maintaining existing services as well as developing new provision.

**Trusts will be expected to live within the resources allocated.**

Trusts will be expected to live within the resources allocated. To achieve this objective Trusts will be required to implement robust plans to achieve a recurrent breakeven position by 31 March 2012. The Board will closely monitor progress against these plans via the Financial Stability Progress Board (FSPB).

## 2.7 Steps to address the 2011/12 savings target

For 2011/12 the HSCB/PHA has been tasked with addressing a savings target of £130m (3.2% of total revenue resources) in order that overall expenditure and the inescapable pressures are contained within approved budget allocations. The HSCB/PHA has identified potential (recurrent and non-recurrent) solutions to contribute to alleviating this target, but at this stage a residual element of £41m remains, as detailed in Table 3 below. The HSCB/PHA will continue to review how this remaining savings deficit can be addressed in order to maintain the key target of financial balance whilst at the same time meeting Ministerial Priorities for Action (PFA) targets.

Table 3

	£m	£m
<b>Total Savings Target</b>		<b>130</b>
<b>Proposed Solutions:</b>		
Pharmacy Savings	30	
Pay Pressures no longer required	13	
Cost Pressure Slippage	10	
Full Year Effect of 2010/11 Savings	36	
<b>Total Proposed Solutions</b>		<b>89</b>
<b>Current Savings Deficit</b>		<b>41</b>

## 2.8 Inescapable Funding Areas 2011/12

Key elements of new funding:



- Revenue consequences of capital £7.0m
- Revenue tail from 10/11 service developments £7.2m
- Ministerial commitments £9.2m
- Demography £19.8m (but £5m already committed)
- Residual demand £8.9m
- NICE £2.2m
- Community pharmacy growth £40m (gross)
- Specialist drugs £2.9m
- Non-recurrent funding for MH/LD resettlement (£9.2m) and elective care (£15m)

This section provides further detail on each of the identified areas in 2.5.

### **Pay costs**

This includes a nationally agreed uplift for employees of £250 who earn an annual salary of less than £21k, employers' national insurance increases, outstanding Agenda for Change appeals and incremental progress.

### **National Insurance Contributions**

This reflects the 1% increase on the employer's cost element of National Insurance Contributions for 2011/12.

### **Non-pay inflation**

To cover goods and services inflationary increases.

### **Revenue Consequences of Capital Developments**

This funding is to address the revenue consequences arising from capital projects committed to in previous years and to be committed in 2011/12.

### **Mental Health and Learning Disability resettlements**

This non-recurrent funding will be used for resettlement of mental health and learning disability patients from hospital to community setting.

### **Demographics**

This funding has been identified to cover the costs of demographic pressures arising from a growing and ageing population.

### **Residual demand**

This funding is to address the growing demand for services caused by new drugs and technologies to deliver quality services.

### **NICE approved drug therapies**

This funding has been identified to enable the implementation of relevant NICE approved treatments in Northern Ireland.

### **Ministerial Commitments**

These resources have been identified to fund a range of areas where the Minister has made a prior commitment to resource e.g. the Regional Decontamination Strategy.

### **HSCB/PHA central pressures**

Pressures arising with the HSCB/PHA in order to maintain existing services.

### **Elective care**

Non-recurrent funding has been made available to assist in meeting elective care waiting time targets.

### **Service developments revenue tail**

This is to fund the full year recurrent cost of service developments commenced during 2010/11 financial year.

### **Pharmaceutical growth**

Resources identified for this area will be used primarily to cover anticipated growth within general prescribing. However this additional resource must be seen in the context of the material efficiency and savings required from this area.

## **2.9 Planning for the Future**

The budget outcome for the period 2011-15 sets out a challenging position for Health and Social Care in the coming years. Whilst the financial plan outlined above will be required to deliver financial stability in 2011/12 it is clear that if the financial challenges continue as anticipated in 2012/13 and beyond, then it will be necessary to radically reform and modernise services if we are to continue to meet existing activity levels and address new demographic pressures. We will be

*The “Reshaping the System” document initiated by the HSCB will form a starting point for planning for the future.*

required to have a long term strategic financial plan. This may involve the following:

- Improvements in productivity
- Reviewing administrative costs
- Reconfiguration of Health and Social Care Services
- Bearing down of pay and price inflation
- Seeking greater contributions from service users.

It is essential that the Health and Social Care System begins to robustly plan for the future challenges during 2011/12 to ensure that it is in a position to maintain financial stability throughout this budget period and beyond. The “Reshaping the System” document initiated by the HSCB will form a starting point for planning for the future and the Board/PHA through the Commissioning Workstreams will play a fundamental role in this.

DRAFT

### 3 Personal and Public Involvement

Personal and Public Involvement (PPI) is a legislative requirement for Health and Social Care Organisations as laid down in the Health & Social Services (Reform) Northern Ireland Act 2009. Departmental Guidance issued in 2007 sets out the core values and principles to which

***PPI is core to the effective and efficient commissioning, design and delivery of Health and Social Care services.***

we are expected to adhere. PPI is core to the effective and efficient commissioning, design and delivery of Health and Social Care services. PPI 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.

Whilst the term Personal and Public Involvement may be relatively new, the concept is not. Health and Social Care has long recognised the benefits of meaningful and effective engagement of service users, carers and the public. We have made considerable efforts in 2010/ 2011 to further embed Personal and Public Involvement in our everyday work.

Personal and Public Involvement work is happening throughout health and Social Care. It complements, enhances and sets the context for the ongoing engagement work being progressed through the Local Commissioning Groups which will contribute to the content of the 2011/12 Commissioning Plan.

A Regional HSC Personal and Public Involvement Forum has been established on a collaborative basis between the Health and Social Care Board and the Agency, under the chairmanship of the Director of Nursing, Public Health Agency. The Forum comprises senior representation from all Health and Social Care Organisations in Northern Ireland. Service Users, Carers and Community & Voluntary Organisations also form part of its membership. The Forum will:

- Undertake a training needs analysis and roll out a training and development programme
- Analyse information from engagement activity to inform priorities and future practice

- Develop impact assessment methods to evaluate the effectiveness of PPI.

The Forum will work to promote a whole system approach and reduce unnecessary duplication. In addition it will develop an agreed process for the reimbursement of expenses for service users and carers involved in engagement.

An extensive process of engagement was undertaken on behalf of the Health and Social Care Board and Public Health Agency in respect of the development of a Draft Joint PPI Strategy. This included seeking the views on the preparation, content, purpose and goals of a PPI Strategy. A series of workshops were held in the second half of 2010 to inform the development of our Consultation Schemes and PPI Strategy. Amongst these were workshops with the Regional HSC PPI Forum and workshops held specifically with community and voluntary sector partners. These helped gain their insight into PPI, what it can deliver and how best Health and Social Care can work with Service Users, Carers, the Community & Voluntary Sector and the wider public to embed PPI into our culture and practice. Further workshops were held in early 2011 throughout Northern Ireland aimed at further involving Health and Social Care staff, the community and voluntary sector, service users and the general public. Input was secured from marginalized and excluded groups by using targeted approaches; and one to one interviews were conducted with key Health and Social Care staff.

The engagement carried out to develop the draft Strategy has identified six key priority areas of work:

- 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.

These key priority areas will be delivered through the work of a Joint Public Health Agency/Health and Social Care Board PPI Implementation Group which will encompass PPI Leads from each of the Directorates in both organisations. This Group will ensure the development of tailored

Action Plans, specific to each organisation, which will assist us in delivering on the agreed strategic priority areas, ensuring more effective commissioning, service development and delivery. Opportunities for joint working will be identified and taken forward in the incoming year. Examples of tangible products will include:

- A framework of methods of engagement
- Development of a protocol for ensuring PPI responsibilities are adhered to before plans and or investment decisions are endorsed
- A PPI Training framework and roll out of appropriate training
- Development of a unified Expenses Reimbursement policy for services users and carers involved in engagement work.

*Local Commissioning Groups continue to engage with service users, carers, the community and voluntary sectors and the wider public, to assist them in the development of their local priorities.*

An 'Easy Read' version of the PPI Strategy is currently being developed and it along with the full Strategy will be formally consulted upon. It is anticipated that we will commence this consultation in June 2011.

The Health and Social Care Board and Public Health Agency will also work with the Patient and Client Council to explore the opportunities offered by their Membership Scheme to support the Personal and Public Involvement Strategy.

Local Commissioning Groups continue to engage with service users, carers, the community and voluntary sectors and the wider public, to assist them in the development of their local priorities. The Local Commissioning Groups intend to build on this process throughout 2011/12 and beyond, working with PPI Leads in both the Public Health Agency and the Health and Social Care Board.

The Health and Social Care Board, including its Local Commissioning Groups, and the Public Health Agency are committed to working in partnership with the Patient and Client Council, other Health and Social Care Organisations and statutory bodies such as Local Councils, to promote Personal and Public Involvement and identify joint Public Involvement opportunities and reduce duplication.

We recognise Personal and Public Involvement as an integral process linking human rights and equality, patient and client experience, user involvement and community development. Section 75 of the Northern Ireland Act 1998 provides a legislative framework for the promotion of equality of opportunity and good relations.

***We recognise Personal and Public Involvement as an integral process linking human rights and equality, patient and client experience, user involvement and community development.***

The Commissioning Plan has the potential to impact on Section 75 categories and the categories under Good Relations. It also has the potential to impact on the human rights of individuals. In this context, substantial work has been undertaken to ensure that the development of our Personal and Public Involvement consultation schemes were in compliance with the requirements of Section 75 of the Northern Ireland Act (1998), the Human Rights Act (1988) and the Disability Discrimination Act (1995).

Once the Commissioning Plan has been approved by the DHSSPS and the Minister, appropriate arrangements will be put in place to ensure key elements of the Plan are equality screened and, where screening indicates the need for more thorough examination, an equality impact assessment will be considered.

## 4 Local Commissioning Groups

### 4.1 Background

The five Local Commissioning Groups have developed Local Commissioning Plans which echo and reflect the key themes in the Commissioning Plan for 2011/12. Each of the Regional Commissioning Service Teams has produced a statement of commissioning intent for 2011/12 which has been translated into a series of actions and priorities for each of the LCG plans, as appropriate. While progress against each of the key themes may vary depending on local circumstances, the underlying direction of travel will be consistent across all localities. As local expressions of the Health and Social Care Board, the LCGs are well placed to shape and steer the commissioning agenda in their respective areas.

#### **Tackling Health Inequalities**

The Commissioning Plan includes specific measures to address the determinants of health and reduce inequalities. LCGs are supportive of collaborative working with other partners and agencies to tackle the wide ranging causes of poor health and inequalities. Access to local intelligence will also help shape this agenda in going forward. LCGs are keen to commission upstream interventions to make a difference in outcomes longer term.

#### **Primary Care Partnerships**

One such agenda is the establishment of Primary Care Partnerships (PCPs). LCGs have been tasked with establishing PCPs to operate as networks of primary care providers rooted in geographical communities. Partnerships will include GP Practices, pharmacists, nurses and other providers of health and care in the area. Serving practice populations of circa 100,000, PCPs will be the main vehicle for taking forward key commissioning objectives in terms of system reform and pathway redesign.

Significant progress has been made in driving this agenda forward with some 15 pathfinder projects completed. 2011/12 will be a landmark year in terms of bringing these models centre stage. This will be helped by the appointment of both GP and Pharmacy Clinical Leads for each PCP who will engage with peers and with secondary care clinicians and Trust management to implement regional strategic plans within a local health



economy. It will be important for PCPs to be underpinned by a cross – directorate team of Board and Agency staff in each local office working in concert to support the Clinical Leads and the wider PCP developmental agenda.

## **Reshaping Acute Hospital Services**

The Commissioning Plan commits the Board and Agency to taking forward a comprehensive programme to reform and modernize acute hospital services. LCGs will also have a key role to play in the reshaping of acute hospital services and will want to ensure that acute hospital services for their resident populations are safe, sustainable and reliable. It will be important to maximize the potential offered by the network of local hospitals, especially in those areas with dispersed rural populations.

## **Living at Home**

As one of the key themes of the Commissioning Plan, the focus in the LCG Plans is on promoting independence, recovery and rehabilitation to support as many people as possible to live in their own homes. The introduction of a re-ablement model has already shown its potential and will be rolled out across all LCGs in 2011/12. Key to the success of this initiative is the engagement with wider society on the merits of the new model. LCGs can play their part in helping raise awareness of the benefits of healthy ageing.

## **Quality and Safety**

In keeping with the commitments in the Commissioning Plan agreed by the Board and Agency, LCGs will commission services underpinned by quality and safety considerations. As part of a programme of reviewing patient pathways, LCGs will want to ensure that patients receive the outcomes they expect and that care is delivered by staff with the requisite skills and experience. The focus will be on ensuring that patients are able to access safe services without unreasonable delays in environments conducive to the delivery of good quality care.

## **Patient/Client Experience**

LCGs have listened and will continue to listen to local communities and the voluntary and community sector about the patient and client experience. Improving the experience enhances outcomes and facilitates

better communication between patients/clients and the wider HSC. Taking forward the PCP agenda, LCGs will embed patient experience within the reshaping of pathways and will link with the Patient and Client Council and other representative bodies in pursuit of this aim.

### **Value for Money**

LCGs are keenly aware of the financial challenges ahead and the opportunities that this will present. In going forward, LCGs will seek to maximize the potential of PCPs to act as gatekeepers to secondary care services. Furthermore, LCGs will strive to provide services in community rather than hospital settings where it is safe and appropriate to do so. Commissioning of services will be evidence-based and make the best use of available resources along the entirety of the patient pathway.

### **Local Commissioning Group Chairs**



Dr G O Neill  
Belfast



Dr N Campbell  
South Eastern



Dr B O Hare  
Western



Mr S  
McKeagney  
Southern



Dr B Hunter,  
Northern



**Local Commissioning Area**

Belfast

South Eastern

Southern

Western

Northern

**Population**

335,000

340,000

348,700

300,000

450,000

# Overarching Themes

## 5.1 Introduction

This section details the key commissioning themes which provide the backdrop for much of the commissioning agenda in 2011-12 and beyond.

Progress with each of these themes has already been made in the last year. Maintaining this momentum will be essential to the delivery of safe, sustainable, high quality and affordable services for people of Northern Ireland.

## 5.2 Tackling Health Inequalities

This Commissioning Plan contains specific measures to address this challenging agenda, but it is equally important that health protection and improvement is actively considered as an integral part of all of our commissioning strategies.

To address the determinants of health and reduce inequalities, concerted and co-ordinated action is required across many government departments and delivery organisations. Health and Social Care organisations can have a significant impact: firstly, by taking a leadership role in championing the issues and working collaboratively with other sectors to

***Disadvantaged communities are known to be disproportionately affected by infectious diseases, major disasters and their adverse consequences.***

address the challenge; secondly by shifting resources, and commissioning 'upstream' interventions; and thirdly, by creating healthy workplaces using the entire health and social care workforce as an opportunity to improve their own and their families' health as well as using every interaction with the public to promote health and wellbeing. Critically, it requires active engagement with local communities.

***Inequalities in health arise because of inequalities in society. Addressing inequality therefore requires coordinated action across many different sectors and government.***

The recent strategic review of health inequalities in England by Professor Sir Michael Marmot provided advice to government on preventable ill

health. The report argues 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 PHA, taking into account this evidence and a range of other policy objectives, has adopted a framework of four Building Blocks to reduce inequalities and promote health and wellbeing:

- **Give Every Child and Young Person the best start in life** – invest more in a package of programmes to support children and families in the antenatal period, first 5 years, and through to adulthood
- **Ensure a decent standard of living for all** – work with others to tackle poverty, maximise benefits and income and use the power of the public sector to procure goods locally and where appropriate, through the social economy
- **Build sustainable communities** – work with local communities to develop capacity, increase community participation, and support community based approaches such as community gardens/allotments with for those experiencing the greatest inequalities
- **Making Healthy Choices Easier** – provide information and create environments which make it easier for people to make healthy choices e.g. through public information campaigns.

## Health Protection

Disadvantaged communities are known to be disproportionately affected by infectious diseases, major disasters and their adverse consequences. Key priorities for tackling Health Protection inequalities include the need to:

- Achieve good uptake rates for childhood immunisation in disadvantaged communities, including migrants
- Ensure equity of access to and uptake of services for the prevention, diagnosis and treatment of TB, HIV, Sexually Transmitted Infections, Hepatitis B and C
- Reduce the incidence of HCAs which disproportionately affect the elderly and those with underlying health problems

- Ensure all Health and Social Care organisations have strong emergency preparedness plans which have been tested and cover major emergencies such as an influenza pandemic, and severe disruption to the drinking water supply.

## **Screening Programmes**

Population screening is an important public health activity that focuses on the early detection of disease. This allows for earlier interventions contributing to improved outcomes. Work is ongoing to improve screening programme coverage in hard to reach groups, including those who are disadvantaged.

Screening policy is set by the DHSSPS on the advice of the UK National Screening Committee. Screening involves inviting people who have no symptoms of a particular disease, to be tested to see if they have the disease, or are at risk of getting it. Early detection and treatment can therefore result in better outcomes.

There are a number of issues and challenges relating to screening programmes. These include:

- The need to improve the performance of existing screening services to meet standards.
- The need to improve the performance of related diagnostic & treatment services to meet standards.
- The need to implement policy and current PFA targets for new screening programmes and developments in existing programmes.

Screening is different from the usual type of health care in which a patient makes contact with the health service because he or she has symptoms or signs of disease. For this reason quality assurance is an integral part of screening programmes. This helps to ensure that minimum standards are maintained and that the programmes are continually improved. In this way the benefits of screening can be maximized and harms (such as over diagnosis and overtreatment) minimized.

### **5.3 Primary Care Partnerships**

As Health and Social Care enters a period of unprecedented system-wide change, an evermore pressing need exists to ensure that local

communities are engaged and that local providers of health and care (HSC Trusts, independent contractors and the voluntary sector) have a shared understanding of new models of care and the impact of changes on their area and community.

Primary care Partnerships (PCPs) will be a critical enabler in establishing an integrated approach across primary, secondary and community care. They 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.

Plans to reduce the HSC's dependency on hospital and institutional care will have consequences for community and primary care based services and enhanced capacity needs to be developed outside the hospital environment. Implementing service change safely demands a careful and considered approach, one which takes on board the views of local clinical and social care leaders from primary, community and secondary care settings.

PCPs will be the main vehicle for taking forward key commissioning objectives, in particular the establishment of strong clinical leadership in community and primary care across NI, and the development and implementation of local reform plans to improve patient and client 'flow' and to manage demand for services in more efficient and effective ways. The PCP arrangements will recognise the essential knowledge and experience of GPs and other primary care practitioners as clinical gatekeepers in influencing system-wide change.

## **The Model**

PCPs will be provider networks built around local communities – typically serving populations of c.100, 000 – and will include GP practices, pharmacists, nurses and other providers of health and care based in their area. The Partnerships will have a key and central relationship with the five Local Commissioning Groups and so will be in a position to provide a more local expression of need into the commissioning process. PCPs will be clinically led to ensure strong clinical governance and decision making and commissioners will ensure that they can contribute meaningfully to leading reform across all sectors of our health and social care services.

***Primary care Partnerships (PCPs) will be a critical enabler in establishing an integrated approach across primary, secondary and community care.***

As a new approach to managing change it is important at the outset to state the agreed rules governing engagement with PCPs. In this regard the HSCB will ensure that new investments and service changes in primary, community and secondary care are made with appropriate input from local representatives of the affected sectors. This fundamental principle recognises the system wide consequences of reform.

Proposals for change will be required to include: (i) a clear identification of the relevant clinical pathway (e.g. diabetic care) which will facilitate integration through multiprofessional input and ensure that social care, disease prevention and health promotion delivery are given equal status to clinical services; and, (ii) analysis of local demand and existing service capacity, necessary if we are to invest efficiently in service change.

Local Commissioning Groups will be asked to lead this process and to ensure that these fundamental principles are embedded going forward.

### **Progress and next steps**

Following the Minister's launch of PCP pathfinder projects in November 2010, an external evaluation of their progress by the Beeches Management Centre reported in April 2011. The five LCGs have identified 17 PCP areas and, consistent with the recommendations of the Pathfinder review, will recruit clinical leads for each of their PCPs.

Fifteen LCG led pathfinders covered a range of areas including:

- Mental health and suicide response – Belfast LCG
- ENT pathway – Belfast LCG
- Prescribing demand – Western LCG
- Dermatology pathway – South Eastern LCG
- Online Guidelines for the Management of Dyspepsia – Southern LCG
- Accident & Emergency care pathway – Northern LCG

During 2011/12, informed by the outcome of the external evaluation, PCPs will start work on:

- Identifying clinical leads – GPs, pharmacists and nurses



- Communicating with local providers, primary care, community and hospital based
- Agreeing plans with Trusts to establish 'wraparound' community services clustered around GP practices
- Mapping local clinical pathways which reflect the regional priorities set out in the Commissioning Plan 2011/12 e.g. urgent care services
- Using pathways as a basis for bringing forward proposals for change
- Facilitating local review of referral pathways and activity and practice prescribing action plans, required through the Quality and Outcomes Framework (GP Contract) performance indicators.

The HSCB will support these developments through providing the required investment, leadership development and administrative support to ensure that PCPs have the tools required to take forward what will be a demanding programme of reform.

#### 5.4 Reshaping Acute Hospital Services

In commissioning acute hospital services, our primary consideration is to ensure appropriate services are in place to respond to the existing and emerging needs of the population in Northern Ireland. It is a given that services must be safe and effective. But they must also be *reliable*: patients should be confident of receiving the same high quality service regardless of location, the time of day or the day of the week.

*Many of our services – and not just those provided in smaller units – are becoming more dependent on the use of locum cover.*

Developments in medical technology continue to provide exciting new opportunities to improve outcomes for patients through new arrangements for diagnosis and treatment. But new technologies can be expensive and require the skills of specially trained staff. To keep abreast of the pace of change, doctors, nurses and other clinical staff are being required to develop their expertise in increasingly narrow fields and specialisms. Clinical staff are needing to work in a different way, with access to a significant clinical infrastructure, sub-speciality expertise and larger teams of senior colleagues to discuss and to make decisions about the best treatment and care for patients.

***The drive for change in how we commission and provide acute care is about making sure that all of our population, irrespective of where they live, has access to the same standard of high quality, safe clinical care, provided reliably and sustainably by appropriately qualified staff.***

For many years Health and Social Care has tried its best to secure the right clinical staffing profile to maintain acute services but this is becoming increasingly difficult. Many of our services – and not just those provided in smaller units – are becoming more dependent on the use of locum cover which by its nature must impact on the continuity of care because we cannot attract or retain permanent specialist staff. All of our acute hospitals face challenges in ensuring that a sufficiently senior doctor is routinely available – that is, 24/7, 365 days a year – to assess and treat patients in an emergency. Where permanent senior cover is not available and there is a reliance on more junior staff and/or locums, it is inevitable that there is an impact on the quality of service provided to patients.

Workforce challenges also exist within a number of specialist regional acute services, including a number of specialist services for children. The nature of these services means that they are only provided at one centre in NI – typically in Belfast. But even with this centralization, the population of NI is simply too small to generate sufficient critical mass and allow Health and Social Care to safely sustain all existing services on a ‘stand-alone’ basis. As commissioners we will continue to support the development of network arrangements for specialist services with other providers in ROI or GB with a view to maintaining local provision. Our over-riding criteria will be safety and quality however, even where this may local provision to cease and patients to travel outside of NI for the very specialized care they require.

The drive for change in how we commission and provide acute care is about making sure that all of our population, irrespective of where they live, has access to the same standard of high quality, safe clinical care, provided reliably and sustainably by appropriately qualified staff. These issues – rather than money – are the over-riding drivers for change to the existing pattern of service in acute hospitals.

Changes to acute hospital services have already been happening. Over the last 10 years, cancer care has been consolidated into the major acute hospital sites with streamlined access to the regional cancer

centre as needed and we are seeing better outcomes for patients as a result. A similar approach is being taken with the modernization of urology services, with specialist surgery being provided on fewer sites by specialist teams working across Trust boundaries.

The implementation of the 2002 DHSSPS Strategy “Developing Better Services” has resulted in changes to acute hospital care across Northern Ireland. In the last year there have been changes to the pattern of acute services in Magherafelt, Whiteabbey, Downpatrick and Lisburn.

Remote populations can be concerned about access to life-saving interventions in the event of an emergency. Proximity to an acute hospital is often perceived as the determining factor as to whether the local population’s needs will be adequately provided for. Increasingly however it is not the distance to the appropriate facility that may determine the outcome for the patient but the timeliness of the initial clinical intervention and the ability to provide appropriate care for the patient during a transfer to the most appropriate destination. In our commissioning therefore we will seek to ensure appropriate supporting measures for dispersed rural communities are further developed, for example, including first responder schemes, improved ambulance services, etc. We will also seek to ensure the full establishment of the regional neonatal and paediatric transport service which was launched last year.

***We will seek to ensure appropriate supporting measures for dispersed rural communities are further developed.***

***We want to maintain as much local access for local people as possible, where it is possible to do so safely, sustainably and cost-effectively.***

Around 80% of hospital care is made up of diagnostics, outpatients, day care and ambulatory services. Therefore it becomes clear that, irrespective the changes that will have to happen for inpatient hospital care, there remains a very important and key role for smaller local hospitals where much of this activity takes place. We want to maintain as much local access for local people as possible, where it is possible to do so safely, sustainably and cost-effectively. The local hospital has a key role in refining the diagnosis for patients and referring them through the system as appropriate, with close linkages to local primary care practitioners. The role of local hospitals is particularly important in relation to the provision of services to more dispersed, rural communities that may be some distance from a large acute hospital. However, the value of such hospitals when located

nearby to a large acute facility is less clear and there may be opportunities to secure greater cost-effectiveness by locating more services on the acute site, without significantly impacting on patient access.

Hospital services are dependent upon those delivering primary and community care services to ensure that people are not inappropriately referred to hospital services where there is a safe and effective means of caring for the patient in the community. Primary and community services must also respond to the needs of patients following discharge from hospital to ensure patients have access to a range of services needed to support them in the community. 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. Local Commissioning Groups through the new Primary Care Partnerships will play a lead role in taking forward this key agenda.

We will also seek to maximize the potential offered by ICT for improved communication with remote sites, between primary and secondary settings and transfer, in real time, of data, information and images. Radiology services in across Northern Ireland are now connected by the PACs system which allows digital radiology images to be sent electronically within and across Health and Social Care organizations. Technology is also in place or being introduced to allow specialist advice to be made available remotely to smaller institutions and even into patients' homes, contributing to enhanced care being delivered locally, enhancing the patient experience and avoiding many hospital visits and possibly hospital admissions.

During 2011/12 we will take forward a comprehensive programme to reform and modernise NI's acute hospitals. This programme will include:

- The full implementation of the outstanding elements of DBS by 2013
- The completion of the review of the existing pattern of A&E services to ensure the provision of safe and reliable emergency service in each Trust area delivered by senior medical staff, 24/7, 365 days a year

- The completion of the review of the current profile of inpatient emergency surgical services to support emerging sub-specialisation and appropriate staffing and expertise
- To review the arrangements for the provision of paediatric inpatient services taking account of the recommendations of the DHSSPS Maternity Review and other relevant considerations
- “Right Sizing” the number of acute medical inpatient beds for our population in line with national standards for lengths of stay, admission rates, daycase rates, etc to release resources for reinvestment in front line services
- Developing clinical partnerships with larger acute providers in the Republic of Ireland and GB as well as continuing with the programme for establishing local Clinical Networks to ensure our services are delivered to the highest possible standards
- Acknowledging that a population of 1.8m may be too small to sustain some highly specialised services, but securing new arrangements which make sure our population gets timely access to these services when they are needed
- Further investment in modern diagnostic services across the hospital network, and providing GPs through PCPs with direct access to appropriate services
- Further investment in ambulance services to ensure patients are receive timely access to life-saving care
- Review the existing arrangements for providing patient transport services
- The further development of the role and function of the local hospital network in providing access to diagnostics, outpatients, day and ambulatory care and establishing care pathways through the rest of the hospital system
- The review of the current profile of minor injuries and other local hospital services on those sites which are close to larger acute hospitals
- The implementation of the recommendations of the DHSSPS Review of Maternity Services
- The development of a portfolio of staffing ratios for the nursing workforce in all major specialities to support the provision of high quality care in acute hospital settings.

If Northern Ireland is to continue to have access to high quality services we must be able to respond to increasing professional standards and new and developing treatments and interventions while maintaining local services where appropriate. This may mean that some services will inevitably need to change, with some services provided locally and some on a national or regional basis. It also means that it will not always be possible to commission immediately every new service or treatment that is available.

***Commissioning is about making difficult choices, ensuring that the population gets access to a high quality service within the resources available.***

Commissioning is about making difficult choices, ensuring that the population gets access to a high quality service within the resources available. Through this plan and in our ongoing arrangements for engagement we will seek to provide an open and honest statement of what services can and cannot be delivered in local communities with clear explanation of the reason for this. Our commissioning decisions will be taken in a sensitive manner that reflects the potential implications for individuals and communities.

## **5.5 Living at Home**

The overarching intention of community care is to help people to live at home with appropriate and timely support. Reshaping our services to promote independence, recovery and rehabilitation means that people may not need care and support long term. Rather there is more intensive support to help people to resume a more active and improved quality of life, at home and within their communities.

Of course we recognise that some people will require ongoing care and support on a long term basis. But currently we spend too much of our resources providing costly long term packages or purchasing beds in residential and nursing homes.

Government policies and strategies published in recent years have promoted this approach and we are beginning to see change. There are many community based services that are promoting these principles but we still have a greater reliance on residential type services than England, Scotland and Wales.

This is particularly true in relation to services for older people where increasing demand has stretched our ability to deliver community care packages. We intend to invest more money in this area but alongside

this investment we have been exploring a Re-ablement Model to change the way we view older people and their needs.

***Delivering the Bamford Vision (2009) clearly set out the way in which services for people with mental health problems or a learning disability should be provided.***

This model has been rolled out in other parts of the UK. It promotes healthy ageing; provides a single contact point for information and access to services; stimulates the voluntary and community sector to provide support services such as shopping, cleaning and befriending. It drives and promotes rehabilitation in all our services to sustain independence.

Delivering the Bamford Vision (2009) clearly set out the way in which services for people with mental health problems or a learning disability should be provided. We will continue to implement the recommendations of this report, consistent with

available funding, with an emphasis on the development of community and primary care based services, thus moving services out of the hospital setting. The continued programme of resettlement of people from long stay hospitals to community living will be progressed ensuring that the alternatives meet the needs and wishes of the individual concerned and, as far as possible, their families.

We will continue to review the way in which we support children and families. Our main strategy is to provide earlier intervention to promote positive outcomes for children, using the six high level outcomes developed by Government.

This means providing more support to families in the early years of children's lives and in the early stages when difficulties and challenges arise.

The development of Family Support Hubs will help us to achieve this aim. These are local, community based centres, underpinned by a new web based database of family support services, which will help to direct people to the most appropriate support service without the need to always come through Social Services.

Where children and families require direct intervention and support from social services we will continue to ensure that this is provided to achieve the best outcome

***Where children and families require direct intervention and support from social services we will continue to ensure that this is provided to achieve the best outcome possible for children and young people.***

possible for children and young people. Where children cannot be looked after by their parents we will continue to make all efforts to ensure that they have experience of family life.

The changes outlined above require effective collaboration between the HSCB and PHA, the Local Commissioning Groups, Primary Care Partnerships, other statutory agencies, the voluntary sectors, communities and individuals who require our support. We are committed to a partnership approach that will help us to deliver this challenging agenda because we fully recognize that we cannot do this alone.

## 5.6 Quality and Safety

Everyone in Northern Ireland expects to be provided with high quality health and social services. They expect services to be safe, effective and reliable, that these services are able to respond to the needs of individuals and where possible, that these services are provided locally.

The public have told us that they want services to be provided in an environment that is safe and clean, delivered by staff with expert knowledge, compassionate in their work all within a service that treats each individual with respect and dignity.

Commissioning is about securing good outcomes and safe services. While considerable progress has been made in areas such as infection control and environmental hygiene, we will consolidate this progress and work with Trusts to reduce further rates of infection, maintain high standards of hygiene, and improve the experience each individual has while in our care.

***We will also work with patients, clients, carers, professional staff and organisations to define good practice for quality, safety and patient/client experience which will focus on what is important to those that use our services.***

We will collaborate with national and international experts to ensure that staff can access the best evidence for improvement, to help guide standards and improve practice and to help inform the public of the quality of care they can expect to receive. Organisations such as the HSC Safety Forum will work with Trusts to further develop staff capacity in leadership skills for quality.

We will also work with patients, clients, carers, professional staff and organisations to define good practice for quality, safety and patient/client experience which will focus on what is important to



those that use our services. This will include agreeing normative staffing levels for nursing and midwifery staff in all care areas.

If the public is to maintain their confidence in our service they need to be assured of the quality of services provided. Commissioners will scrutinize the quality of care and safety of our services, working with providers to share good practice and learn from serious incidents or service reviews. The aim is to further enhance transparency and openness enabling meaningful engagement with local communities during the planning, commissioning and delivery of service models.

During 2011/12 we will take forward a comprehensive quality and safety programme which will include:

- The collection and publication on a [quarterly] basis of standardized mortality rates for all HSC organization
- Ensuring that, by March 2012, Trusts achieve 95% compliance with all elements of the falls bundle across all in patient acute care settings, 95% compliance with all elements of the SKIN care bundle, and either zero pressure ulcers or at least 300 days between pressure ulcers
- Ensuring that satisfactory progress is made towards the full implementation of local approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection and the crash call rate
- Bringing forward proposals for two additional quality improvement collaboratives
- Monitoring readmission rates to hospital following appropriate elective and unscheduled admissions.

## **5.7 Patient/Client Experience**

A key aim of this year's Plan will be to work alongside patients, families and carers in order to improve the experience of every individual when engaging with health and social care services in Northern Ireland. Through various surveys and work carried out by the Patient and Client Council, commissioners are now fully aware of the expectations of those who access services, including those in a support capacity. Evidence shows that improving the patient/client experience and developing partnerships with patients are linked to improved health outcomes.

A real impact can be made upon the experience of those who use services by:

- Showing respect to every individual
- Displaying a positive attitude towards patients
- Maintaining professional and considerate behaviour at all times
- Communicate in a way which is sensitive to the needs of patients
- Protect the privacy and dignity of patients at all times.

These five high level standards will underpin every service provided within health and social care. In order to fulfil these standards, we will endeavour to take the following actions:

- In words and actions, communicate that the patient's safety and well being are the critical considerations guiding all decision making
- To treat patients and families as partners in care at every level, from decision making bodies to individuals delivering care.
- To ensure that sufficient staff are available with the tools and skills to deliver the care patients need, when they need it.
- To recruit staff and providers with the correct values and talent, support them for success, and hold them accountable for results individually and collectively
- Ensure the physical environment supports care and healing
- Ensure patients are able to access care without long and unreasonable waits and delays

***It is the role of the HSCB and PHA to set standards of excellence and make the necessary changes within the culture, habits, training and purpose of each service and of the organisation as a whole.***

- Provide care that is safe, ensure concerns are addressed, and, if standards are not met, that there is open communication and apology
- Patients receive the outcomes they expect.

In addition to other indicators of quality such as waiting times, it is our belief that the patient/client experience should be regarded as equally important. It is the role of the HSCB and PHA to set standards of excellence and make the necessary changes

within the culture, habits, training and purpose of each service and of the organisation as a whole. Consistent with this prioritisation, during 2011/12 we will continue to monitor the outcome of the patient client experience standards in the settings agreed by the Agency and HSC Trusts in the formal work plan for 2011/12 and take forward an initiative which will systematically collect over 3,000 patient/client stories to help inform the commissioning of services.

## 5.8 Value for Money

In common with all other public services, Health and Social Care is entering a period of unprecedented financial challenge. It is more important than ever, therefore, that we secure value for money through commissioning, ensuring that we achieve maximum benefit from all available resources. There are no neutral decisions: every decision will have consequences and opportunity costs for patients. A failure to take action to maximize the cost-effectiveness in any one service area or location will simply translate into lost opportunities to develop or improve services.

We will seek to respond to the value for money challenge through the following means:

- Ensuring that all of the services we commission are evidence-based, providing real benefits to patients in terms of improved health and wellbeing, consistent with available resources
- Decommissioning treatments of limited clinical value
- Introducing thresholds for accessing certain treatments to ensure they are targeted at those patients likely to benefit most
- Ensuring robust arrangements with appropriate clinical involvement are in place to support the prioritization of new treatments and interventions
- Maximising opportunities through PCPs and other mechanisms to more effectively manage demand and provide services in community rather than residential settings
- Ensuring services are delivered efficiently and effectively consistent with the top 25% of performance in England
- Taking forward a programme of VFM studies across Health and Social Care to identify opportunities to improve efficiency and effectiveness and reduce waste both in relation to front-line services and supporting infrastructure, for example, procurement

and estates. As part of the VFM programme for 2011/12 we will take forward a comprehensive review of management costs across HSC organisations.

Many of the services we recognise today will have to change in order to adapt to the changing needs of the population. We believe that through innovative ways of providing services this can be achieved. These changes should not be seen as a decline or reduction in qualitative and quantitative terms, but instead as an opportunity to redesign services that are tailored to the individual needs of service users. Although the financial restrictions imposed upon health and social care is inevitably one of the drivers of change, the creation of services which are reliable, sustainable and of sufficient quality will remain the primary driver. This aim is underlined by the desire to perform at a level comparable to that of best performing peers elsewhere.

To demonstrate this thinking, we will continue the journey of releasing frontline staff to use their expertise, creativity and skill to find innovative ways to improve quality of care for patients. By realigning funding to frontline services, staff and users will have greater input into where resources should be placed. However, commissioners will continue to have an important role to play by providing the checks and balances which ensure that services are delivered to a standard that reflects the investment made.

It is the role of commissioners to determine priorities and levels of funding for services which may fall anywhere between public health prevention and the provision of treatment responses. Commissioners have this responsibility as they control the budgets for individual services as well as paying providers. We will be driven by the knowledge that these budgets are funded by the taxpayer, therefore reinforcing the need to look for better value for money, more efficiency, greater productivity and less bureaucracy. We will also challenge poor practice, give more emphasis to quality and safety and at all times push for innovation that is in the interest of patients and service users, placing their interests firmly at the centre of future health and social care plans.

Finally we will seek to ensure that our commissioning processes within the HSCB and PHA are as streamlined and cost-effective as possible. This process is already underway, and reviews of various elements of expenditure associated with commissioning will be taken forward over the next year to ensure value for money in all aspects of our work.

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## Section Two

# Detailed Commissioning Intentions in 2011/12

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# Commissioning Intentions in 2011/12 – Summaries by Service Group

## 6.1 Introduction

This section is intended to provide detail on the Board's commissioning intentions in 2011/12 and beyond.

Commissioning discussions have in the past been structured around Programmes of Care. While this categorisation continues to be important in summarising the funding and/or resource reallocation process, the Board has restructured its commissioning groups to reflect key service areas. Commissioning proposals will therefore be presented within the following service areas:

1. Specialist Services
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. Health and Social Wellbeing Improvement

## 6.2 Specialist Services

Specialist Services for acute care include highly specialist tertiary services delivered through a single provider either in Northern Ireland or via a service level agreement with a tertiary centre in GB. They further include services which are in the process of evolving from a single provider model to provision in a number of local settings. 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 the numbers of patients presenting, it is not a sustainable model in providing all year round availability of the service on the 24/7 basis that we need.

The nature of specialist care is also changing. Staff are working within an ever increasing clinically complex environment. To ensure that they can offer the best care for patients, senior clinical staff need access to significant clinical infrastructure, sub specialty expertise and larger teams of senior colleagues. The issue cannot be solved through investment in personnel as there are simply not enough patients presenting to maintain and develop their skills, and avoid future training issues.

We need to pursue opportunities to link our clinical teams to larger tertiary centres in GB and ROI. These network models will support our clinicians working in larger teams and offer access to the clinical infrastructure that we need, for care and training, supporting long term sustainability of services locally.

In the last 5 to 10 years the rate of development of new high cost specialist drugs has been phenomenal. In the last 3 years alone, Northern Ireland has invested over £34m of new monies to provide treatments for rheumatoid arthritis, bowel disease, cancer, sight threatening conditions and a range of other diseases. We need to be sure that we are securing the right levels of access to these regimes for the right patients. We also need to be clear that it is fully supporting the anticipated demand for specialist drugs in the current financial climate will be very difficult.



Very hard choices will need to be made in deciding the services which will receive investment, the services that won't and the services from which disinvestment will be made. This will involve difficult policy decisions being made even between the suite of NICE approved therapies to identify differential benefits between therapies.

In order to make progress with these issues we will need the expertise, support, engagement and input of our clinicians to successfully utilise funding to gain the highest levels of benefit in health terms for our population.

Some conditions are so very rare that they will never be able to be able to have local services provided within Northern Ireland. We will continue to facilitate travel to tertiary centres of excellence for these patients. We are committed to working with colleagues in the Patient Client Council in line with the aspirations of the Rare Disease UK strategy 'Improving lives, Optimising Resources'.

Opportunities for early pre-emptive interventions or other forms of treatment as alternatives to acute care are limited due to the specialist nature of these services. However, there is potential within specialist care to direct resource to secure long term, highly effective benefits of treatment, for example supporting every opportunity for renal transplantation as an alternative to long term dialysis.

There are currently over 1,100 patients receiving various multiple sclerosis therapies supported by a level of investment of over £8m.

Services have been established in both the Western and Belfast Trusts to provide treatment for age related macular degeneration for the population of Northern Ireland. Resources have been made available to both Trusts to ensure that timely treatment is provided to preserve the sight of people affected by this condition in accordance with therapies and regimes approved by the National Institute for Clinical Excellence which recommends Ranibizumab (Lucentis) as an option for the treatment of Wet AMD within specified clinical criteria.

The HSC Board and Public Health Agency recognise the clinical leadership demonstrated within both Trusts to ensure that patients are reviewed and treated within clinically appropriate timescales.

This has been achieved through a process of service redesign including remodelling of the patient care pathway and despite the challenges that have been experienced in recruiting and retaining staff. The additional funding being made available in 2011/12 will ensure that both new and review patients can access this service.

Given the complexity of this service and the potential sense threatening implications arising from delays it is important to ensure that sufficient capacity can be established to meet the projected need. The HSC Board and Public Health Agency remain committed to working with the Western and Belfast Trusts towards establishing a robust and sustainable Wet AMD service for the Northern Ireland population.

In 2010/11, the Belfast Trust delivered 53 live donor transplantation procedures. In the last year, the Board and Agency have worked closely with transplant and nephrology staff to review the current service capacity with a view to securing robust arrangements for the future of this service. The key challenges in 2011/12 will be our ability to attract and recruit 2 additional consultant transplant surgeons to the Northern Ireland service.

### **Key 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:

#### **Clinical Networks to sustain key specialist services**

- To develop options to secure sustainability of key specialist services including the development of clinical networks with providers in ROI and GB. In 2011/12 this will focus on highly specialist paediatric specialties and kidney transplantation.

#### **Introduction of NICE guidance**

- To agree processes to inform decision making on the introduction of NICE guidance in Northern Ireland. This will be progressed by the regional specialist commissioning team

supported by the HSCB Director of Commissioning and the Public Health Agency Director of Public Health.

### **Benchmarking Usage of High Cost Drugs**

- To benchmark usage of relevant high-cost drugs against other areas of the UK. This will be progressed by the HSCB and PHA.

### **Individual Funding Requests**

- To streamline arrangements for the management of exceptional funding requests and extra contractual referrals. These arrangements will require Trusts to ensure that submissions made have been subject to robust, internal scrutiny and supported at medical director level.

### **Rare Diseases**

- To progress mapping and signposting for complex chronic and rare conditions in keeping with national protocols and strategies will be developed.

### **Transport Services**

- Ensure full establishment of the regional neonatal and paediatric transport service which was launched last year.

### **Radiotherapy**

- To commission additional radiotherapy capacity at the Belfast City Hospital and make preparations for the planned development at Altnagelvin Hospital.

### **Investment Proposals**

Supporting the availability of high cost specialist drugs and therapies has never been purely about covering the costs of regime procurement. We recognise that investment also has to be made in maintaining the specialist infrastructure to ensure that patients are safely assessed for treatment and their subsequent care effectively managed by expert clinical staff.

In 2011/12 as well as supporting growth in specialist regimes for rheumatoid arthritis, inflammatory bowel disease, HIV care,

cancer, Wet AMD, new NICE approved therapies, clinical genetics and high cost individual drug requests, we plan to invest in infrastructure to support:

- Biologic regimes for adults and children for inflammatory bowel disease and rheumatoid arthritis;
- Highly specialist regional paediatric services;
- Cancer services;
- Specialist adult congenital cardiology;
- Acute dialysis; and;
- GUM services.

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## 6.3 Unscheduled Care

The A&E department is the main gateway for emergency patients to unscheduled care, such as emergency medicine, emergency surgery, critical care and diagnostics. It is one of the principal contacts with hospital services for the public. Given the gateway role, A&E has a major impact on the rest of acute hospital services. Typically, patients of all types, e.g. people with minor injuries through to heart attack sufferers and cases of major trauma, arrive to the same service. Having one portal of entry means that staff have to stop working on the less seriously ill and injured to attend to emergency cases and this, in turn, contributes to longer waiting times.

Performance at a number of hospital sites has been significantly below the 4-hour minimum standard set by the Department. These standards are routinely achieved in England.

In the last five years, the total number of attendances per annum at emergency care departments has increased by 4% to almost 700,000 - on average, nearly 2,000 patients attend A&E each day in Northern Ireland. Of the patients who attend A&E, approximately one in four are admitted to a hospital bed. Rates of attendance and admission are both considerably higher than in England.

Northern Ireland has approximately a quarter more acute beds (per 100 population) than England. However, these beds are less intensively used and patients tend to stay in hospital for longer periods than the equivalent patient in England.

It is evident that the Health and Social Care system is experiencing challenging workforce issues which have and will continue to undermine commission intentions. Difficulties recruiting and retaining experienced medical staff have restricted a number of acute specialties, including emergency care and paediatrics. Emerging standards will place further challenges to have in place significant numbers of middle grade doctors to ensure quality and safety. Changes in training of junior doctors have also greatly impacted on services due to the European Working Time Directive.

Unscheduled care and admission to hospital for children varies across Northern Ireland. In some cases, children are admitted via a Children's A&E department but, in the majority of cases, they will be admitted via the general hospital Emergency Department. Some departments do not have a designated area for children. In a traditional model, children requiring a longer period of assessment are often admitted to wards, which results in a longer length of stay.

Unless the way services are provided is changed then the situation for patients and staff could deteriorate further with risks to quality, governance and performance.

### **Proposed Model**

The commissioning intention is to separate care for key patient groups so that instead of one portal of entry (i.e. A&E), patients are directed to reorganised services based around specific needs:

- Minor injuries and surgical
- Major injuries and patients requiring resuscitation
- Medical assessment and ambulatory care
- Dedicated children's assessment and treatment.

#### *Medical Assessment Unit*

We envisage moving to a position where all major 24/7 A&E departments are supported by a Medical Assessment Unit (MAU). This is a short stay facility providing safe and efficient acute medical care. It should operate around the clock and be staffed by a multidisciplinary clinical team. The HSC Board will be specifying ambulatory care activity as part of its new contract with HSC Trusts and the operation of an MAU facility will be essential for reforming that part of emergency care.

A key part of the model of care is that all GP-referred medical and surgical patients would be directed to the MAU thus potentially eradicating 4-hour breaches (80% of all breaches in A&E are acute medical patients).

#### *Paediatric Assessment Unit*

We envisage moving to a position where all major 24/7 A&E departments are supported by a Paediatric Assessment Unit (PAU). This is a facility within which children with acute illnesses, injuries and other urgent referrals can be assessed, investigated, observed and treated without requirement for admission to inpatient facilities. The length of stay in a PAU can be tailored to the condition for which a child is being observed (4, 8 or 12 hours) leading to the more effective use of both medical staff and in-patient paediatric beds.

Conditions which are especially suitable for management within a PAU include breathing difficulties, fever, diarrhoea and vomiting, abdominal pain, seizures and rash, as well as head injury and non-intentional poisonings. These are some of the most common reasons for attendance in the Emergency Department.

Like MAU, GP-referred patients will go directly to the PAU, avoiding paediatric admission to A&E and the likelihood of in-patient admission and long lengths of stay in hospital which are unnecessarily costly. PAU will provide a more efficient clinical service for patients and will facilitate earlier discharge for patients. In general, it will result in more effective use of both the medical workforce and in-patient beds and lead to a significant reduction in costs due to reduced number of admissions.

It is anticipated that the PAU would be co-located with a paediatric ward and be run collaboratively by the Paediatric Department and Emergency Department or by the Emergency Department in a specialist paediatric hospital.

As well as the MAU and PAU, the proposed model for unscheduled care will include:

- Co-location GP Out of Hours (Urgent Primary Care) within A&E as many A&E attendances could be managed by Primary Care;
- Dedicated care pathways for children, older people and patients with long-term conditions, particularly heart and respiratory conditions; and
- Appraisal of ambulance services necessary to support reconfigured acute services.

Delivering the model for unscheduled care will be central to the commissioner's commitment to re-shape acute hospital services across Northern Ireland to create a service which is better able to respond safely and effectively to the needs and priorities of the population, taking account of the importance of addressing health inequalities. Moreover redesign will be in the context of a 'shift-left' approach which seeks to reduce the need for hospital care through investing in primary care and in health promotion and prevention. This will necessitate patient education on appropriate use of services, particularly A&E, GP urgent care and in-hours GP services. Improved access to diagnostics in primary, secondary and community care will also be the key.

In tandem with more appropriate use of hospital services, the commissioner will ensure a greater focus on rehabilitation following a period of hospitalisation and is committed to developing the Re-ablement approach evident in Britain.

### **Key Priorities**

- To bring forward and implement appropriate changes to the provision of unscheduled care services, in particular A&E and emergency surgery, to improve safety, quality, sustainability and cost effectiveness
- To ensure that senior clinicians in A&E appropriately re-direct patients who do not require emergency care to other services, such as GP urgent care services and in-hours GP appointment
- To extend GP involvement in A&E departments
- To place an emphasis on ambulatory care, i.e. completing unscheduled care within 23 hours, including diagnostics and treatment, thereby avoiding unnecessary in-patient admission. This will be particularly important at larger acute hospitals with closely linked medical assessment units
- To reduce in-patient lengths of stay for unscheduled care, through an ambulatory care model and the involvement of senior clinicians in care planning and treatment
- To bring forward and implement new care pathways for key acute conditions, including stroke and heart attacks, based on best practice and evidence



- To put in place a paediatric assessment unit (PAU), co-located with a Paediatric ward and supported by the Emergency Department
- To further strengthen emergency ambulance provision, including extending treatment without the need to transfer to hospital where clinically appropriate

Specific targets to be achieved for acute and unscheduled care in 2011/12 are:

- From April 2011, the HSC Board and Trusts should ensure that 95% of patients attending any A&E Department are either treated and discharged home, or admitted within four hours of their arrival in the department, and no patient waits longer than 12 hours
- From April 2011, the HSC Board and NIAS should ensure an average of 72.5% of Category A (life-threatening) calls are responded to within eight minutes (and not less than 65 % in any LCG area)

## 6.4 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. A substantial percentage of these operations (around 30% – 40% on average) are clinically urgent and should be carried out promptly and in the order of their clinical priority. The remainder are routine and generally speaking can be dealt with in date order.

The overarching priorities for the elective care system in Northern Ireland is to ensure that all urgent operations are completed in a timely manner and that patients waiting for routine assessment or treatment should wait no longer than the maximum times set by the Department.

The way we do this is by ensuring that;

- We have sufficient elective capacity to meet need;
- We work with General Practitioners and other referrers to agree appropriate referral pathways, including appropriate alternatives to acute assessment and treatment.
- We work with consultants, GPs and other clinicians to develop assessment and treatment protocols linked to effective use of resources policies.

Service redesign, coupled with further investment in services where needed, is therefore a key component of the reform and modernisation agenda.

### **Key Priorities**

- Establish a Regional Trauma and Orthopaedics Advisory and Implementation Group to examine the systems and arrangements for Orthopaedic service delivery across the region, including the development of agreed regional pathways
- Ensure the agreed implementation of the Urology Review Recommendations

- Establish a process to review the existing Effective Use of Resources Policy and develop an agreed process for effective implementation
- Develop a Commissioning Framework for Procedures of Low Clinical Value (PLCV)
- Complete an analysis of the main reasons for referral and commence work to prioritise the development of regional pathways for these referrals
- Agree with Trusts, GPs and other stakeholders, criteria and guidance for the effective management of elective demand
- Complete an analysis of diagnostic services and develop a regional plan to improve diagnostic services. This will include plans to improve patient pathways and waiting times for endoscopy and radiological investigations
- Work with Trusts to improve the quality of data, in particular the focus will be on clinical coding and Theatre Management Systems
- Use the learning and good practice from the PCP projects to be incorporated into the regional pathways
- Take appropriate action to deliver, in cooperation with Trusts and other stakeholders, the following key targets and standards:
  - The majority of patients should wait no longer than 9 weeks for a first outpatient appointment and non-one waits longer than 21 weeks
  - The majority of inpatients and day cases are treated within 13 weeks and no patient waits longer than 36 weeks
  - All outpatient reviews are completed within the clinically indicated time
  - No patient should wait longer than 9 weeks for a diagnostic test
  - All urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks

- No patient should wait longer than 9 weeks from referral to commencement of AHP treatment
  - 95% of patients, where clinically appropriate, should wait no longer than 48 hours for inpatient treatment for hip fractures and 100% of patients, where clinically appropriate, wait no longer than 7 days for all other inpatient fracture treatment
  - An overall day surgery rate of not less than 75% for the 'basket' of 24 procedures
  - An overall admission rate on the day of surgery of not less than 75%.
- Continue to develop local Primary Care Projects linked to the improved management of patients in:
    - Belfast LCG - ENT Clinical Pathway Redesign
    - Belfast LCG - Elective pathway and referral management
    - Western LCG - Ultrasound access Altnagelvin
    - Western LCG - GP access to MRI
    - Southern LCG - Access to OGD
    - South Eastern LCG - Dermatology Clinical Pathway Redesign
    - South Eastern LCG - Medicines Management Review in Nursing Homes

## 6.5 Cancer Care

Cancer affects all of us. Over 10,000 people in Northern Ireland are diagnosed with cancer every year and nearly 4,000 people die from the disease.

While cancer survival rates have increased significantly over the past 10-15 years, we know that the NI survival rates for colorectal, lung and ovarian lag behind the best performing countries. We also know that even within Northern Ireland there is variation across the region with areas of highest deprivation experiencing cancer rates 2 - 3 to higher for some cancers, than more affluent areas; later diagnosis and poorer survival rates are also seen.

Early detection and treatment are key to supporting improvements in outcomes. We need to ensure that our clinical teams, both in the community and in secondary care are able to identify and distinguish symptoms as cancer related at as early a stage as possible. We also need to ensure the public are informed, in a balanced way, with key actionable messages, so that they know when to seek medical advice early.

Much has been done to standardise cancer care across NI, in line with evidence based guidelines. The DHSSPS Cancer Service Framework will also support this approach, as will care pathways which describe the clinical management of patients throughout investigation, treatment and follow-up.

As well as taking these actions forward, we also need to ensure that we systematically monitor and measure our performance on outcomes, quality of care provided and patient experience.

Patients with potential complications from 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, ( for example: direct admission to hospital, GP, Emergency Department, fast track oncology appointment). Those patients directed via the Helpline to A&E will be assessed by a nurse within 15 minutes, and where appropriate treated on a neutropenic sepsis pathway (i.e. one hour antibiotic treatment). Whilst those patients with potential complications from chemotherapy are in the Emergency Department, the Trusts will take action to limit the risk

of secondary infection in this group of patients from exposure to others.

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, tackle obesity, sun exposure and ensure high uptake of screening programmes in all areas, to enable early diagnosis of cancer and provide high quality care to all.

### **Key Priorities**

- Promote stop smoking services in the areas with the highest smoking rates
- Develop appropriate messages and communication plans to increase public awareness of the signs and symptoms of suspected cancer
- Ensure active engagement and partnership working with patients and carers across cancer commissioning priorities
- Refine and implement care pathways for patients with colorectal, lung and ovarian cancer to ensure effective clinical management, care and support
- Review and prioritise implementation of key components of the Cancer Services Framework
- Ensure Trusts complete a review of the care of patients who present to hospital with complications of cancer or its treatment by March 2012.
- Explore opportunities for the strengthening of acute oncology services across NI.
- Progress the implementation of the national Oncology/ Haematology 24 Hour triage toolkit for patients with complications.
- Work with Trusts to identify practical solutions for the prioritisation of acute oncology patients who present at A&E
- Complete GAIN audit of Neutropenic Sepsis Pathway being implemented across region

- Ensure tailored information is offered to colorectal, lung and ovarian cancer patients and their carers in line with regionally agreed pathways
- Work in partnership with Macmillan (and other key stakeholders including voluntary sector) to transform follow-up pathways for cancer patients in line with Trust bids
- Develop mechanisms to measure clinical quality and patient experience to provide feedback to the colorectal, lung and ovarian multidisciplinary teams
- Identify an IT system for Oncology and Haematology to replace the current system
- Explore the opportunities for utilising C-PORT for chemotherapy capacity planning across the region
- Agree standardised regional chemotherapy protocols
- Work to develop pathways for Teenage and Young Adult (TYA) Cancer Services and raise awareness of the needs of this group of patients with professionals
- Work with the NI Cancer Registry to monitor cancer incidence and survival rates and health inequality gaps in cancer in NI
- Work with the Voluntary Sector and key stakeholders to explore opportunities for a cancer event
- Ensure all urgent breast cancer referrals should be seen within 14 days
- Ensure 98% of cancer patients commence treatment within 31 days of the decision to treat
- Ensure 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

## 6.6 Palliative and End of Life Care

The vision for palliative and end of life care is to improve quality of life and meet the patient/carer needs 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.

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" has 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.

Palliative Care and acute care can co-exist in the provision of care for many people as the last few months, weeks or days may not be possible to identify.

The Palliative Care approach has traditionally been used for people mainly with a cancer diagnosis. Services to these patients have not been equally developed across the country to provide a palliative care response for all cancer conditions. It is estimated that two thirds of all deaths in N. Ireland (9,570) would benefit from the palliative care approach in the last year of life, but do not receive it. This approach is appropriate also 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.

We would also seek to support people to die in their preferred place of care, usually their own home (including nursing and residential homes). Approximately 50% of all deaths and 50% of all cancer deaths occur in hospital. We intend to develop



pathways and services which support people to die at home when that is appropriate and 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.

## **Key Priorities**

- Progress the development of information systems to measure progress on the implementation of the Palliative Care Strategy and to improve co-ordination between services
- Agree definitions for the implementation of palliative care provision
- Agree functions and support implementation of the key worker function
- Agree and support implementation of key prognostic indicators within respiratory, heart failure, cancer and renal secondary care specialties
- Agree/develop holistic assessment tools and advance care plans and support implementation
- Develop and support implementation of handover forms for OoH services
- Develop and support implementation of patient held passports
- Agree to use shared care notes in the home at the dying phase
- Develop disease specific specifications, in particular detailed self assessment service specifications for heart failure, renal failure, Cystic Fibrosis and cancer as per the respiratory service specification
- Support and progress the implementation of the Care of the Dying Pathway within acute hospitals and community services
- Develop a palliative care service specification for nursing homes

- Develop a palliative care service specification for GP services including Out of Hours
- Ensure advice and support contact points are in place in each LCG area for patients and carers out of hours through improved training, co-ordination and utilisation of existing services
- Work will be undertaken to co-ordinate services for Huntington's disease based on the Huntington's Disease Needs Assessment
- LCGs will measure baselines and develop plans in each area for the enhanced provision of a 24hr palliative care support service e.g. by reallocating resources from acute care particularly for patients with cancer who are currently admitted within 48 hours of death and for patients with cancer who wish to be discharged to die at home
- Local commissioners will develop plans to sustain palliative care co-ordinators beyond 2011/12 in each LCG area.

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## 6.7 Long-Term Conditions

Long-term conditions (LTCs) refer to any condition that cannot, at present, 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, although there are a number of significant public health challenges in delivering this objective. These 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.

For 2011/12 our focus will be on long-term conditions related to heart disease, vascular disease, respiratory disease, stroke, and diabetes in adults and children. Care should be provided close to home, with patients and their families being active participants in their care; supported by responsive secondary care services to deal with exacerbations or complications that cannot be managed at home.

### Key Priorities

- **Enhance primary care management of cardiovascular risk factors**

The HSCB/ PHA will develop and test a programme of enhanced primary care management of cardiovascular risk factors, in collaboration with local communities. This will start in areas of deprivation and with practices with below average performance on QOF. The aim will be to address health inequalities. The first programmes will be in place by March 2012.

- **Enhance patient self-management**

The HSCB/ PHA will review the impact of investments in patient education programmes to promote self management, remote monitoring and case/ disease management in people with COPD, heart failure and stroke. This will be undertaken during 2011. The HSCB/ PHA will review the content and format of existing patient self-management programmes, learning from effective chronic disease management models elsewhere.

- **Develop care pathways**

The HSCB / PHA will work with relevant stakeholders to develop care pathways for key conditions covered by the Cardiovascular and Respiratory Frameworks. These care pathways will help to reduce variations in care; provide a framework for providing high quality care based on good evidence of effectiveness and facilitate improved communication between HSC staff and patients/ service users. Three care pathways will be developed by March 2012.

- **Develop disease management programmes**

The HSCB/ PHA will work with Trusts and primary care to develop community disease management programmes, which aim to reduce acute unscheduled hospital activity. These programmes will have an emphasis on prevention, patient self-management, expert patient programmes and community development approaches to maximise health and well being. Three programmes will be identified for development during 2011/12.

- **Measure and improve clinical quality**

The HSCB/ PHA will develop/ revise existing systems to measure clinical quality routinely through quality improvement projects, supported where appropriate by clinical networks, other clinical forums, and/or the HSC Safety Forum. This will be linked to the work on the Service Frameworks, including the recommendations of the Cardiovascular Framework Health Impact Assessment, and associated timescales.

- **Measure patient experience**

The HSCB/ PHA will work with existing patient fora in Trusts, community/voluntary groups, clinical networks etc, and use standard tools to facilitate data collection and analysis. We will review the results with service providers and use the results to help in improving the quality of care. This work will be linked to the standards for communication and personal & public involvement in the service frameworks and associated timescales, with data collection starting during 2011.

- **Primary prevention – reduce obesity & smoking**

This will be taken forward through the Tobacco and Obesity action plans led by the PHA. However, the HSCB/ PHA will specifically review the existing support to smokers who are admitted to hospital with IHD, CVD, diabetes, and COPD to ensure that those smokers receive appropriate support and follow-up to stopping smoking. This review will be completed by March 2012.

The HSCB/ PHA will ensure that nursing, medical and AHP staff working in cardiology, respiratory and general medicine are trained in providing brief interventions to support smokers to quit. Training needs assessments will be carried out and a training plan will be implemented during 2011.

- **Familial hypercholesterolaemia (FH)**

The HSCB/ PHA will work with GPs and Trusts to identify ways to improve the detection of people with high cholesterol, due to FH, through active family tracing; as recommended by the Cardiovascular Service Framework.

- **Adult congenital heart disease (ConHD)**

The HSCB/ PHA will work with adult and paediatric cardiologists, through the Cardiac Network, to ensure that adults with major congenital heart disease receive specialist care, including access to a consultant specialist and appropriate diagnostic services; as recommended by the Cardiovascular Service Framework. The new arrangements will be in place by March 2013.

- **Invasive Cardiology**

The HSCB/ PHA will work with the Cardiac Network and service managers in all Trusts to review the allocation of resources for regional and local cardiac catheterisation services, with the aim of providing equitable and timely

access to cost-effective interventional cardiology services. We will look carefully at the results of the primary angioplasty pilot in the Belfast HSC Trust, and other evidence, and work with the Cardiac Network to identify an equitable service model for Northern Ireland. Review carried out, service model identified and action plan agreed by March 2012.

- **Insulin pumps**

The HSCB/ PHA will identify the resources to enable investment in additional insulin pumps for children and adults beginning in 2011/12; and phased over the next three to five years.

- **Stroke Awareness, Treatment & Care**

The PHA will launch a multimedia campaign "Act Fast" in 2011/12 to raise public awareness of the early signs and symptoms of stroke. The HSCB/ PHA and LCGs will work with trusts to ensure that patients with stroke and transient ischaemic attack (TIA) have access to treatment and care that meets national quality standards consistent with the recommendations of the review of stroke services in Northern Ireland. This work will be ongoing over the next 3 years.

- **Vascular Services**

The HSCB/ PHA will work with relevant stakeholders to develop a Northern Ireland vascular network and agreed patient pathways and protocols for patients with vascular disease; beginning with a care pathway for people with abdominal aortic aneurysm (AAA). The network and the AAA care pathway will be developed by during 2011.

- **Development of Community Respiratory Services**

The HSCB/ PHA will work with relevant stakeholders to develop community respiratory services in those areas where they currently are not available. This will include pulmonary rehabilitation, long term oxygen treatment assessment, early intervention and facilitated early hospital discharge services and palliative care.

The HSCB / PHA will identify the resources required to develop screening and diagnostic services for TB, to reduce health inequalities, in accordance with identified need. A

Service development plan will be in place by December 2011.

The HSCB/PHA will identify the resources required to develop paediatric asthma and allergy services in accordance with identified need and the standards set in the Respiratory Service Framework. A Service development plan will be in place by December 2011.

- **Diabetes Pilot Projects**

The HSCB/ PHA will review the pilot projects on pre pregnancy care and structured patient education (SPE) programmes for children and adolescents being run by the five trusts. These run until 2013 and at that stage a decision about future funding will have to be made.

- **Telemonitoring**

By March 2012, the HSCB/PHA will, together with Trusts, ensure that at least 1,800 people benefit from the provision of remote telemonitoring services.

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## 6.8 Maternity, Paediatrics and Child Health

There are currently nine consultant obstetric units in Northern Ireland. Three of these units have co-located midwife units, and there are a further two freestanding midwife units. In total these units deliver around 25,000 babies per annum. A DHSSPS review of maternity services is expected to report in 2011 which will provide key context and direction for the provision of maternity services in the future.

There are currently eight paediatric medical inpatient units in Northern Ireland. The only consultant obstetric unit that does not have a co-located paediatric inpatient unit is at the Mater Hospital in Belfast.

Our ability to provide the recommended level of staffing cover for intrapartum care and to sustain inpatient paediatric services across all existing sites presents challenges, particularly for smaller units. Future models of care which continue to support local access but with clear pathways to specialist support as necessary will need to be developed if we are to continue to meet quality and safety standards in these areas.

During 2011/12 and beyond, we shall seek to promote the normalisation of births, including securing a reduction in rates of caesarean section which vary considerably between units and are generally higher than in the rest of the UK. We shall also examine the continued appropriateness of existing arrangements for the transfer of obstetric emergencies from community settings.

We will also focus on the variance in pregnancy outcomes across socio economic groupings. Particular attention will be given to reducing the number of women who smoke during pregnancy, reducing levels of obesity in pregnant women, and increasing levels of breastfeeding. We will also seek to ensure that key recommendations from recent reports<sup>1</sup> published by the Centre for Maternal and Child Enquiries (CMACE)<sup>2</sup> are implemented.

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<sup>1</sup> Saving Mothers' Lives (2011), Perinatal Mortality (2010 & 2011), Maternal Obesity in the UK (2010).

<sup>2</sup> Now Maternal, newborn and child health clinical outcome review programme.



Priority will also be given to services for pre-school and school aged children, and the recommendations of the regional review of health visiting and school nursing will be important in this regard.

The Family Nurse Partnership programme provides intensive support to vulnerable first time parents and has been shown to make a significant difference to children's' health and well being. During 2010-11 a pilot commenced in the Western Trust, and in 2011-12 the programme will be offered to up to 100 teenage mothers.

Finally, we shall ensure that Trusts have in place appropriate arrangements to enable users to have an input to improving maternity services.

### **Key priorities**

- To establish appropriate arrangements to take forward the implementation of the recommendations of the regional review of maternity services
- To require each Trust to develop of an action plan to promote the normalisation of birth
- To review arrangements for the management and transfer of obstetric emergencies occurring in the community
- Through action plans led by the PHA introduce appropriate measures to reduce maternal obesity, improve pre-conception and pregnancy care for obese women, reduce smoking in pregnancy and improve breastfeeding
- To ensure that key recommendations from recent CMACE reports are implemented
- To deliver the Family Nurse Partnership programme to 100 teenage mothers who will be recruited up to the 28<sup>th</sup> week of pregnancy at the first test site
- To develop a clear commissioning framework for health visiting services
- To evaluate the stand – alone midwifery units in Downpatrick (2011) and Lisburn (2012)

## 6.9 Community Care, Older People and Physical Disability

### Older People

Our population is ageing and this demographic change will have significant implications for health and social care as older people are major users of services;

- The number of people over 65 has increased by 16% since 1999 and will show a similar increase from the current figure of 255,000 by 2015
- This will include a rise of 29% in the number aged over 85
- The number of people over 65 with dementia will increase by 30% from the current figure of 15,400 people to almost 20,000 by 2017.

If we are to meet the challenge of demographic change and build on progress to date the way in which services are perceived and delivered needs to be reviewed in order to achieve a balance between meeting the needs of the most vulnerable and promoting independence and self determination. This will impact on how the 19% (£616m) of the budget allocated for older people's services is spent and the balance within it for major areas of expenditure such as residential and nursing home provision (£190m), hospital care (£115m) and domiciliary care (£138m).

Delivering these priorities will require radical change. It will need us to shift the emphasis of from traditional service models to a partnership approach; optimising inter-agency working, enhancing the capacity and role of voluntary and community organisations to support self management and improving safeguarding arrangements. The current model of delivery, with its emphasis on the provision of community care to and for people rather than supporting their own independence and abilities does not meet this demand nor is it financially supportable in the long term.

Each year additional funding has been required to provide community care packages for a growing aged population. The budget for the next four years will not provide the same level of increase so we will have to change the way in which we assess

people for care packages and more actively promote healthy ageing and self management. In Northern Ireland we have a relatively high proportion of people living in care homes. This is at odds with the demand for greater independence and needs to be reduced substantially. Other significant initiatives will be the implementation of the Northern Ireland Single Assessment Tool (NISAT) as a way of delivering needs led services alongside the further development of regional safeguarding arrangements to protect those at risk of abuse or exploitation.

## **Key Priorities**

The Board and PHA would wish to progress the following priorities in relation to **Older People** in 2011/12.

- Incorporate Service Framework standards into Board commissioning and performance monitoring.
- Address the recommendations of the regional Dementia Strategy, in particular the needs of carers
- Introduce a Re-ablement model to promote rehabilitation, self care and independence.
- Increase access to targeted health and wellbeing improvement services, falls prevention services and action to reduce social isolation
- Extend the proportion of people cared for at home and reduce reliance on nursing home care by reviewing current assessment and discharge processes from hospital to home, patterns of demand and costs.
- From April 2011, work with Trusts to ensure that older people with continuing care needs wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.
- From April 2011, ensure that Trusts achieve the level of performance that no care management assessment should take longer than 8 weeks to complete; and the main component of the assessed care need – nursing home care, residential care or domiciliary care – will be delivered within 12 weeks of the assessment being completed.

## Physical Disability

It is estimated that between 17 – 21% of our population have a disability, affecting 37% of households. Recent research indicates that approximately 8,800 people have a visual impairment, 11,700 are hearing impaired and over 35,000 have a mobility problem. Whilst quite a small proportion of this population is in regular contact with HSC services, approximately 16,500 contacts are made with Trust disability services each year. 400 people are in nursing or residential care but the heaviest reliance is on community based day and domiciliary care, specialist equipment and therapeutic interventions. A high proportion (approx 32%) of the 1860 (at Jan 11) people receiving Direct Payments have a physical or sensory disability

A relatively small proportion of the Board's budget, 2.8% (£91m) is allocated to this programme. Domiciliary care accounts for 22% (£19m) of this figure, hospital care almost 15% (£13m) and residential/nursing care accounting for a similar expenditure (£14m). A significant proportion of this budget is spent on community staffing and support. Future funding pressures will be created by changing public expectations, technological advances, an increase in high cost care packages and transfer of budgetary responsibility to service users.

Until recently the reform agenda within disability services has been focused on specific services resulting in initiatives aimed at reforming Wheelchair services, prosthetics, brain injury services, sensory impairment provision and Thalidomide survivors. A more strategic approach will be adopted as a result of the new Regional Disability Strategy. The Board will work closely with service users and providers to consider how this will help to reshape services. It will be followed by the Report of the Joint Housing Adaptations Steering Group which is designed to improve joint working between HSC and Housing.

In relation to **People with a Physical Disability or Sensory Impairment** our priorities for 2011/12 are:

- Address the recommendations of the Physical Disability Strategy, in particular the needs of carers

- Work with DSD/NIHE to take forward the findings of the Joint Housing Adaptations Review.
- From April 2011 ensure that Trusts maintain the standard that 95% of lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate; and that minor urgent housing adaptations are completed within 10 working days.
- Maintain the level of performance in the provision of wheelchairs arising from the implementation of the regional Action Plan; specifically ensure that from April 2011, Trusts maintain the standard that there is a 13 week maximum waiting time for 95% of basic wheelchairs and 75% of specialised wheelchairs
- From April 2011, ensure that Trusts maintain a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment for acquired brain injury in 95% of cases.
- Promote robust service re-design of regional brain injury provision.
- Introduce a Re-ablement model to promote rehabilitation self care and independence.

In relation to **both Programmes** we will also seek to take forward the following areas:

- Support Primary Care Partnerships and LCGs in local service redesign, including reducing inequalities of access and outcome
- Update Adult Protection procedures and review the effectiveness of current safeguarding arrangements.
- By 31 March 2012, ensure that's Trusts increase the number of direct payment cases to 2,100 and other models of self directed support.
- Increase the availability of respite provision in support of service redesign and modernisation.
- Promote individualised care planning and improve the quality and coordination of assessment through implementation of the Northern Ireland Single Assessment Tool

- From April 2011 ensure that Trusts achieve a performance level of 90% of complex discharges from an acute hospital setting take place within 48 hours of decision to discharge; All non-complex discharges from an acute hospital setting take place within six hours of being declared medically fit (Standard 100%); and no discharge from an acute hospital setting takes longer than seven days (100% standard).
- From April 2011, ensure that Trusts achieve a performance level of 48% of care management assessments completed in relation to nursing home, residential or domiciliary care, recommend domiciliary care provision.

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## 6.10 Children and Families

This section relates primarily to services which are required through legislation and also considers circumstances where additional supports are required to assist families to care for their children.

The Service areas include:

- Family Support/ Early Years
- Child Protection
- Looked After Children including residential child care and foster care
- Adoption
- Leaving Care and After Care
- Children with a disability
- Child & Adolescent Mental Health Services (CAMHS)

The Board now leads a single integrated planning and commissioning process for services for children and young people across Northern Ireland, through a Chief Executive led partnership, the Children and Young People's Strategic Partnership (CYPSP). The CYPSP will provide an integrated plan, the Northern Ireland Children and Young People's Plan, setting out how Partnership member agencies will integrate their planning and commissioning in order to improve the lives of children and young people across Northern Ireland. The process is outcomes focused, with the joint outcomes being those set out in the NI Executive's Ten Year Strategy for Children and Young People, 'Our Children and Young People: Our Pledge'.

The Board will ensure that all of its commissioning decisions in relation to children and young people will contribute towards the Northern Ireland Children and Young People's Plan.

In addition, the CYPSP has decided that a key shared strategic objective is to focus efforts on early intervention. By this is meant addressing the needs of children and young people in the early years and at an early stage of any difficulty, at all ages. The Board's commissioning decisions in relation to children and young people will be consistent with this strategic objective. The CYPSP

will seek that the NI Executive designate Northern Ireland as an early intervention region to ensure that strategies and funding streams for early intervention are used with more consistency and less duplication of effort. The Board will play a lead role in seeking this joint approach to early intervention.

There is an onus on all stakeholders involved in the lives of children and their families to demonstrate what difference/benefits are accruing as a result of the services being offered. Contract monitoring and monitoring against PFA Targets will inform on progress being made. The voice of the user is also integral to this agenda and remains to the fore. It will also be important to have close working relationships with the service team looking at Maternity and Child Health as there are mutual areas of concern, specifically for children with a disability but also in the consideration of support services for families.

It has been recognised by a number of independent reviews that, compared to other parts of the United Kingdom, there is approximately a thirty percent under investment in children's services within Northern Ireland.

Although the economic climate will pose very real challenges going forward, it will be important to ensure that children and young people who have been unable to be looked after by their parents have their needs fully met in families / settings which can best meet their assessed need. Of equal importance will be the need to maintain an emphasis on early years support and intervention if children's needs are to be recognised, assessed and addressed at the earliest possible stage.

The overarching principle spelt out within the Children (N.I.) Order 1995 that children are best cared for within the family of origin will continue to shape interventions and service delivery. There will also continue to be a small number of children for whom this is not achievable and, in these circumstances, it is critical that decisions on permanency are informed by robust assessment and effected in a timely fashion to avoid further damage to the children involved.

There will continue to be an emphasis on working collaboratively with all stakeholders to inform needs assessment, to assist with planning services and provide opportunity to monitor and, if required, reshape service delivery.



## Key Priorities

- The Board will in conjunction with relevant stakeholders progress the development of the Regional Fostering and Adoption Recruitment and Training service. There will be a focus on securing placement as per assessed need and collaborative working
- The Board and PHA will progress a review of the Allied Health Profession Service in Special Schools to ensure equity of access and fit with the core service
- The Board will take forward a review of Trusts' Early Years Services to encompass the regulatory functions as well as the potential for skill mix and charging
- The HSCB/PHA will continue to progress the strategic direction as outlined within the Healthy Futures strategy
- The Board will conclude a Regional Review of Residential Child Care provision to provide greater differentiation. Account to be taken of Individual Funding Requests, some of which result in out of country placement
- The Board and PHA will undertake a review of the multi disciplinary teams for children with a disability. The review will focus on the quality and effectiveness of the teams and regional consistency
- The Board will progress the commissioning of an Inter-country Adoption Service within one lead Trust and explore the feasibility of this service being self financing
- The Children and Families Team will support RASDN, the Bamford Task Group and the Regional Acquired Brain Injury Groups to deliver on actions relating to children. This will include a review of the Family Trauma Centre
- The Board, in collaboration with other stakeholders, will progress a regional review of accommodation needs of Care Leavers and Young Homeless
- The Board and PHA will review the availability of provision for children with life limiting illness to consider hospice, children's community nursing and respite services.

- The Board and PHA recognise the importance of early intervention to provide much needed support when it matters most and will take cognisance of this in pursuing any review or service development
- The Board and PHA will take appropriate action to deliver, in cooperation with Trusts and other stakeholders, the following key targets and standards:
  - Ensure that at least 70% of all care leavers aged 19 are in education, training, or employment
  - Ensure children admitted to residential care have, prior to their admission: (i) been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process
  - Ensure that for every child taken into care, a plan for permanence and associated timescale is developed within six months and formally agreed at the first six-monthly LAC review
  - Provide family support interventions to 3,000 children in vulnerable families
  - From April 2011, all child protection referrals should be allocated within 24 hours of receipt of the referral
  - All child protection referrals should be investigated and an initial assessment completed within 10 working days from the date of the original referral being received
  - From April 2011, following the completion of the initial assessment, a child protection case conference should be held within 15 working days of the original referral being received
  - From April 2011, an initial assessment should be completed within 10 working days from the date of a child becoming looked after
  - From April 2011, 90% of family support referrals should be allocated to a social worker within 20 working days for initial assessment
  - From April 2011, all family support referrals should be investigated and an initial assessment completed within

10 working days from the date the original referral was allocated to the social worker

- From April 2011, on completion of the initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days.
- Ensure that at least 225 care leavers aged 18+ are living with their former foster carers or supported family.

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## 6.11 Mental Health and Learning Disability

This section proposes the significant reform, modernisation and standardisation of mental health and learning disability services beginning in 2011 and extending across the current Comprehensive Spending Review period.

To take forward the recommendations and actions arising from the Bamford Review ('Delivering the Bamford Vision, DHSSPS 2009) the Board and Agency, in partnership with Trusts, established a range of working groups across the region in partnership with Local Commissioning Groups. Within the Taskforce service users and carers have been incorporated as equal partners; this is reflected across the range of working groups.

Key in-patient service delivery areas in Mental Health are Acute Assessment and Treatment, Psychiatric Intensive Care beds, Low Secure/Forensic beds and Addiction beds. Key community service delivery areas are primary care based assessments and therapies such as structured counselling, Primary Care facing Psychological therapies e.g. Cognitive Behaviour Therapy. People with more acute needs are now increasingly having these met by crisis response/home treatment/community mental health resource services which aim to minimise admissions to hospital and promote recovery.

It is also agreed that there must both be a better access to primary care based services to reduce dependence on secondary care and work is also needed to implement more consistent and standardised service models across Trust areas.

Within Learning Disability services include assessment and treatment beds, multi-disciplinary community teams, supporting living options/residential and nursing homes and day opportunities to help support people live independent and inclusive lives.

The key focus for service delivery and modernisation in 2011-2012 will be the continuation and promotion of inclusion and independence in line with "Equal Lives". This will support people with a learning disability in the areas of housing, training, further education and employment opportunities.

People with a learning disability should be supported to live as independent a lifestyle as possible. At present there are still too many people living within hospitals in N.Ireland.

Too often the physical health of those with a learning disability falls below that enjoyed by the general population. People with a learning disability still can't access the full range of educational, training and vocational opportunities accessed by the wider population.

At the heart of the 'Bamford Vision' are the following key themes:

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers
- Providing better public services to meet people's needs
- Providing structures and a legislative base to deliver the Bamford Vision.

Some of the additional strategic drivers include

- 'Protect Life', Suicide Prevention and Promoting Mental Health and Wellbeing strategy
- New Strategic Direction for Drugs and Alcohol
- Psychological Therapies Strategy
- Personality Disorder Strategy
- Autism Action Plan.

In terms of improving health and social care services there is a need to improve access to community based services which allow people to live independently, address inequalities and promote citizenship, recovery and inclusion.

## **Targets and Priorities**

Trusts must work in partnership with the Commissioner to deliver a major programme of reform, modernisation and standardisation.

Within **Mental Health** services, the key four core strands will be:

- Stepped Care model – implement the agreed model of care
- Progressing Mental Health Promotion and Protect Life strategy implementation
- Crisis Resolution/Home Treatment – identify an evidence based high fidelity service model
- Acute inpatient care services – secure agreement regarding the overall configuration and size of Acute and PICU inpatient services
- Resettlement – all long stay patients in Mental Health hospitals will be resettled by 2014/15.

Within **Learning Disability** services, the key strands will be:

- Resettlement - all long stay patients in Learning Disability Hospitals will be resettled by 2014/15
- Day Services - continue to develop and implement a consistent model of provision
- Improved Physical and Mental Health - implementation of the Directed Enhanced Service for Learning Disability which provides annual physical and mental health checks in primary care for all adults with a Learning Disability in Northern Ireland
- Family Support - supporting families and carers who care for someone with a learning disability to live in the community.

The Board/PHA will work with Trusts and other stakeholders to ensure that the following targets and standards are delivered in 2011/12:

- From April 2011, no patient should wait longer than 9 weeks from referral to assessment and commencement of treatment for mental health issues, with the exception of psychological therapies for which no patient should wait longer than 13 weeks
- From April 2011, 75% of patients admitted as mental health or learning disability inpatients for assessment and treatment should be discharged within seven days of the decision to

discharge, with all other patients being discharged within a maximum of 90 days

- By March 2012, an additional [45] long stay patients should be resettled from learning disability hospitals to appropriate places in the community compared to the end March 2011 figure and should also reduce the number of delayed discharge patients by [15]
- By March 2012, an additional [45] long stay patients should be resettled from mental health hospitals to appropriate places in the community compared to the March 2011 total and should also reduce the number of delayed discharge patients by [10]
- From April 2011, no children should wait longer than 13 weeks for assessment for autism following referral and a further 13 weeks for commencement of specialised intervention.

## **Local Priorities**

The above regional priorities will be incorporated into LCG commissioning plans within the context of taking forward locally based service improvement. In addition, LCGs will also take forward the following priorities:

### **Mental Health**

- Northern LCG – to consider the strategic outline business case for the replacement of Holywell Hospital in partnership with Northern Trust
- Southern LCG – take forward and progress the further development of the Bluestone in-patient unit, i.e. additional new ward facilities;
- Belfast LCG – to consider proposals for the development of new build mental health in-patient services within a single site configuration based on the existing business case
- Western LCG - to develop proposals for the appropriate model of acute in-patient service provision for the Western area

- South Eastern LCG – to take forward and progress the existing business case for the development of acute in-patient services based at Lagan Valley hospital.

## Learning Disability

- Belfast/Northern/Southern Eastern LCGs - the development of plans for the resettlement of the remaining long stay population from the Muckamore Abbey Hospital site.
- Southern LCG - develop plans for the resettlement of the remaining long stay population from Longstone Hospital in Armagh. In addition, the development of new acute admission and treatment facilities in the Southern area.
- Southern / South Eastern LCG – consider plans for the development of new adult resource centres to replace existing centres.
- All LCGs - The development of a better understanding of the capacity of existing resources to deal with the needs of ageing carers. In addition, development of local community support options in partnership with local housing, employment, further education and leisure providers.



## 6.12 Prison Health Services

From 1<sup>st</sup> April 2008 the DHSSPS has had responsibility for Prison Health Services. The commissioning of Prison Health Services is now the function of the HSCB 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.

Healthcare services in Northern Ireland are delivered within three prison establishments: HMP Maghaberry with a branch at Crumlin Road Working - Out Unit; HMP YOC Hydebank Wood and HMP Magilligan. There are approximately 5,000 committals annually and approximately 1,500 prisoners placed within the prison estate at any point in time.

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.

There are particular challenges in delivering health care in an environment whose principal purpose is security.

A significant proportion (approximately 65%) of prisoners will have some form of personality disorder, with many being assessed as posing significant risk of harm to themselves or others (Psychiatric Morbidity among prisoners - Office of National Statistics, 1997).

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 an addiction problem.

New sentencing arrangements introduced in May 2008 have the potential to increase the prison population from 1480 prisoners (January 2010) to approximately 2000 prisoners by 2015.

The transfer of responsibility for Prison Health Systems is relatively recent and in many ways existing health structures represent systems in transition. Although many prison health staff are employed by the NIPS it is our expectation that the percentage employed directly by Health and Social Care will increase over

time. This mixed model of provision does however give rise to potential governance issues and to the need to clarify lines of responsibility to facilitate good governance and the quality assurance of systems.

The overarching aims for Prison Healthcare are to:

- Ensure that prisoners have at least 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
- Ensure best value for money is secured.

### **Key Priorities**

- Agreeing with the South Eastern Trust the appropriate numbers of qualified staff taking into consideration the need for specialist therapists in respect of all aspects of care and the transfer of staff to HSC and that future recruitment is to HSC
- Ensuring that the Trust has appropriate information systems and that there is improved healthcare information flows from prison to the community and vice versa
- Progressing the development of medical services and chronic disease management in line with the principal of equivalence
- The development of care pathways in and out of prison
- The introduction of the stepped care model providing a range of therapies at the various levels
- Working with the criminal justice system and prison health partners to ensure the identification of people with a learning disability early in the criminal justice system

- Ensuring that the South Eastern Trust identify the number of prisoners with a learning disability currently in the prison system
- The development of a Health Promotion Strategy

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## 6.13 Health and Social Wellbeing Improvement, Health Protection and Screening

### Health and Social Wellbeing Improvement

The focus of this section is on the broader public health agenda. Improving health and reducing inequality requires coordinated action across many different sections of government and delivery organisations. Such action also requires:

- i. Health and social wellbeing improvement to be embedded in the commissioning of services and;
- ii. Development of effective partnerships with other sectors that can influence the wider determinants of health.

Prevention of ill health and the promotion and maintenance of health and wellbeing is essential. This presents something of a paradox; 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. There is now good evidence that promoting good health and preventing ill health does save money<sup>3</sup>. Further, there are significant costs in not tackling health inequalities, estimated in England to be £31 – 33 billion loss in productivity, £20 – 32 billion in lost taxes and higher welfare payments and some £5.5 billion in additional NHS health care costs<sup>1</sup>. In Northern Ireland the Chief Medical officer estimated the total annual inpatient costs as a result of smoking to health and social services to be £22 million in 2000<sup>4</sup>. The total costs of hospital treatment for smoking - related diseases in Northern Ireland were estimated at £119 million per annum in 2008/09<sup>5</sup>. Some £24.5 million were estimated to have been spent on prescribed anti-diabetic medication alone in 2009<sup>6</sup>.

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<sup>3</sup> Using NICE guidance to cut costs in the downturn, NICE 2009

<sup>4</sup> The Health of the Public in Northern Ireland: Report of the Chief Medical Officer 2000. DHSSPS 2000

<sup>5</sup> RCP (2000) Nicotine Addiction in Britain: A report of the Tobacco Advisory Group of the RCP applied to 2008/09 HRG costs. In: Ten Year Tobacco Control Strategy for Northern Ireland Consultation Document

<sup>6</sup> N. Gallagher, Presentation QUB Centre of Excellence 2011, Source BSO

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 most of the public expenditure, building synergy of action at a local level. However, the lack of progress with the Review of Public Administration in other sectors has made partnerships working particularly difficult over the past number of years with the lack of certainty impacting negatively on clear direction and shared goals.

Finally, 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%).<sup>7</sup>The impact of this increase is now being experienced in different areas of service provision e.g. complications in pregnancy, increase in type 2 diabetes, coronary heart disease, stroke and a number of cancers. It is also known that obese children are more likely to become obese adults. A key goal is 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 that 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

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<sup>7</sup> NI Health and Social Wellbeing Survey 2005/2006, Information and Analysis Directorate, DHSSPS

- Develop partnership models which empower communities and which seek to address with others the determinants of health
- 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

## **Targets and Priorities**

In addition to specific actions identified across the commissioning teams, the PHA/HSCB will progress priorities within the PHA Health Improvement framework as follows:

### **Give Every Child and Young Person the Best Start in Life**

- Implement the Family Nurse Partnership Programme
- Develop evidence based breast feeding programmes in identified areas of low uptake and among young mothers
- Support HSC Trusts and Sure Start programmes to achieve and maintain UNICEF UK Baby Friendly Initiative accreditation
- Develop effective breast feeding coordination in each HSC Trust as recommended by NICE to the level of at least one full time equivalent post for every 3000 births
- Implement the Alcohol Hidden Harm Action Plan
- Extend the Roots of Empathy programme to a minimum of ten primary schools in the remaining three HSC Trusts
- Develop models of parents active participation in their children's education

### **Ensure a decent standard of living**

- Expand programmes which tackle poverty (including fuel poverty) and maximise access to a range of services and support
- Ensure current health and wellbeing programmes are tailored and focused to meet the needs of those at risk of poverty, including Travellers, Looked After Children, lone parents and homeless people

- Continue to implement the RAFAEL programme to increase the proportion of fresh, local and sustainable food procured into healthcare settings, supporting local economy, sustainability in healthcare and increasing the nutritional content of food on patient and staff menus
- Work with Health and Social Care organisations and a wide range of community and voluntary networks to support skills development
- Continue to develop effective working with the education sector using the school as a setting for holistic development

### **Build Sustainable Communities**

- Develop an integrated action plan for user and carer involvement and community engagement in health and social care organisations
- Health and Social Care organisations will implement the Community Development Strategy and Action Plan. A performance management framework will be incorporated into all PHA and HSCB plans
- Extend joint working with community networks, including rural support networks, to increase community participation in health and social wellbeing improvement
- Develop together with other services food cooperatives, community gardens/allotments at local level
- Support a wide range of programmes at local community level to improve health and wellbeing

### **Travellers and Migrant communities**

- Develop the newly established NI Travellers Health Forum, including implementation of the recommendations of the All Ireland Traveller Health Study
- Develop an integrated Action Plan to meet the needs of Travellers
- Establish a Migrant Health and Wellbeing Network as an information and good practice sharing forum for health and social care professionals
- Develop a clear action plan to meet the health needs of migrant communities Northern Ireland

## **Lesbian, Gay, Bisexual and Transgender communities**

- Ensure that health and social care services are accessible and sensitive to the needs of LGBT people
- Ensure programmes are in place for LGBT training and awareness for staff working across health and social care sector
- Continue to work with LGBT sector to identify health needs and appropriate responses

## **Make Healthy Choices Easier**

### **Tobacco**

- Develop a public information campaign targeted towards 16-24 year olds.
- Rerun existing public information campaigns at an intense, sustained level.
- Ensure smoking cessation services continue to be developed and provided to areas and populations with higher rates of smoking. A particular focus will be given to pregnant women and patients prior to elective surgery.
- As a minimum, maintain 2010/11 quit rates for people completing Cessation Programmes.
- Maintain the number of adults from areas of deprivation (bottom quintile) completing smoking cessation programmes and, at the least, maintain 2010/11 quit rates for people completing cessation programmes.

### **Promoting healthy weight and physical activity**

- Promote healthier eating and policy change with different sectors across a wide range of settings
- Expand the implementation of the community based nutrition education programme "Cook It"
- Implement the physical activity guidance at local level and in particular the physical activity referral programme and walking for health programmes



- Develop a consistent approach to providing weight management advice and support for young people (and their families) that are found to be obese during annual BMI assessment for year 8 pupils
- Review and develop enhanced support programmes for women in the preparation for, and during pregnancy

### **Alcohol and Drug Misuse**

- Contribute to the development of Phase 2 of the New Strategic Direction on Alcohol and Drugs 2011-2016
- Roll out the use of the Regional Initial Assessment Tool to improve consistent assessment and referral processes in relation to young peoples substance misuse
- Expand the development of brief intervention training programmes in primary care settings informed by the pilot programme to ensure that a minimum of 80 health and social care professionals will be trained in delivering brief interventions.
- Undertake a review of workforce education and training.
- Ensure drug and alcohol programmes are in place through multi-sectoral action at local level
- Consider the findings from the evaluation of the pilot one stop shop services and further development if appropriate.
- Promote a minimum price for a unit of alcohol

### **Mental Health and Wellbeing and Prevention of Suicide**

- Support the development of the new regional mental and emotional wellbeing strategy and work with key partners to develop an implementation plan
- PHA, HSCB and HSC Trusts will work together to ensure suicide cluster response plans are in place for each Trust/LCG area.
- Develop a new public information campaign and maintain existing programmes.
- The Deliberate Self Harm Register will be extended to all five HSC Trust areas and by 31 March 2012 the PHA and HSCB will ensure that 100% of new people, with injuries as a result

of self harm, presenting to A&E Departments are being added to the deliberate self harm registry.

- PHA, HSCB will ensure that Trusts and partners have delivered 100 'gatekeeper' suicide awareness prevention training sessions across the 5 Trust areas to a minimum of 1000 people.
- The PHA and HSCB will ensure that there is a 30% unprompted awareness of the Lifeline service.

### **Teenage Pregnancy and Sexual Health**

- Consolidate support programmes offered to young women during pregnancy and after birth.
- Implement the sexual health promoting strategy and in particular access to and delivery of sexual health services.
- Ensure health improvement programmes to promote good sexual health and reduce teenage pregnancy are in place in a range of arenas including school and youth settings
- Continue support and education programmes for Looked After Children
- By March 2012, as part of the implementation by the Public Health Agency of the Family Nurse Partnership pilot programme, the programme will be delivered to 100 teenage mothers who will be recruited up to the 28th week of pregnancy at the first test site

### **Accident Prevention**

- Development and implementation of the accident prevention action plan with a focus on home, workplace (including farms) and road. Falls prevention will be particularly important in relation to older people

### **Settings**

A coordinated approach will be developed to take forward health improvement in a number of settings including the workplace:

- Review the regional "Work Well" initiative

- Develop a comprehensive workplace health improvement model with a wide range of public, private, voluntary and community organisations
- Promote the health and social wellbeing of staff in health and social care organisations

## **Local Priorities**

Priorities at a local level will involve a local interpretation of regional priorities alongside meeting the specific needs of localities. In addition, action will be taken forward to:

- Asset map with communities – in the most disadvantaged areas as well as with specific groups such as LGBT, older people.
- Develop innovative use of green space with communities
- Develop programmes of community led activity
- Develop partnership approaches across a wide range of agencies and Influence the environment positively so that healthier choices become easier
- Communities to address local needs

## **Health Protection**

Health Protection includes Public Health Activities intended to protect individuals, groups and populations from infectious diseases or environmental hazards. It includes the need to have robust, tested emergency plans to respond to health protection emergencies.

### **Health Protection Service PHA**

The Health Protection Service in the Public Health Agency has a frontline role in protecting the Northern Ireland population from infectious diseases and environmental hazards and does this through:

- i. Surveillance and monitoring of infectious diseases.

- ii. Operational support and advice to a range of Health professionals/other stakeholders throughout the health and social care system.
- iii. Response to all adverse health protection incidents including outbreaks.
- iv. Education, Training and Research.

Health Protection is the first point of call in hours and out of hours for all Health Protection emergencies. In hours this service is provided from the Public Health Agency Duty Room and out of hours by an on call rota.

## **Health Protection – Work Programmes**

### **Immunisation programmes**

Immunisation against serious infectious diseases is one of the most effective Public Health interventions ever, in terms of preventing disease and prolonging life expectancy. The childhood immunisation programme and the influenza immunisation programme in Northern Ireland are the most successful in the United Kingdom. The Health Protection Service PHA has overall leadership responsibility for the implementation of immunisation policy across Trusts and Primary Care.

### **Healthcare Associated Infections (HCAs)**

Prevention of HCAs is a priority and a patient safety issue. DHSSPS set targets for Trusts to achieve reductions in Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile. HCAs cause morbidity and mortality, particularly for elderly people and those with at risk medical conditions. HCAs are associated with increased lengths of stay in hospital and negatively impact on the health economy.

### **Tuberculosis**

There are approximately 70 cases of Tuberculosis in Northern Ireland each year. The management of a Tuberculosis case requires a coordinated approach across Public Health, Primary Care and Trusts. Trusts need to have facilities for diagnosis and

treatment of these patients and appropriate infection control facilities available.

### **Blood-borne viruses and sexually transmitted infections**

Prevention and control of sexually transmitted infections and blood borne viruses requires work across Public Health services, Primary Care and Trusts. Trusts need to ensure they have services for diagnosis and treatment of sexually transmitted infections. Although numbers of HIV infection in Northern Ireland are low compared to the rest of the United Kingdom, we still see cases every year which require care by Trusts. New therapies for HIV have resulted in increased drug costs. The Hepatitis B (HBV) immunisation programme in Trusts is delivered for occupational health reasons, for immunisation of newborn babies who are born with or at risk from Hepatitis B infection and in GUM clinics. Appropriate services for diagnosis and treatment of Hepatitis C infection are also required.

### **Emergency Preparedness**

All Health and Social Care organisations in Northern Ireland are required to have robust and up to date tested emergency preparedness plans in place which cover major emergencies such as an influenza pandemic. A key aspect of these plans is business continuity planning to ensure that vital elements of service are preserved during the response to an acute emergency.

### **PFA Health Protection Targets for Trusts**

- Achieve 20% uptake rate of the seasonal flu vaccine by frontline Health and Social Care workers by 31 March 2012.
- Achieve 40% uptake of seasonal flu vaccine by pregnant women by 31 March 2012.
- From April 2011, the Public Health Agency and Trusts should secure a further reduction of 14% in MRSA and C. Difficile infections compared to the position in 2010-11.

### **Key Priorities**

- Work with Primary Care and Trusts to achieve good uptake for all immunisation programmes. In particular, ensure a strong focus on protecting the health of minorities and migrants from vaccine preventable diseases, and those in disadvantaged communities.
- Implement any changes to the childhood immunisation programme in 2011/12 and achieve high uptake levels.
- Ensure the mandatory Trust requirements for clearance of health care workers for serious communicable diseases are met. Roll out of the MMR immunisation programme for healthcare workers to continue.
- Trusts to ensure services in place for the diagnosis and management of HIV, Hepatitis B, Hepatitis C and Sexually Transmitted infections.
- Trusts to ensure the 4 dose programme for HBV Immunisation of babies born to HBV infected mothers.
- Trusts to ensure access to laboratory services for diagnosis of TB (IGRA and VNTR) as per NICE recommendations.
- Trusts to ensure services for assessment for post exposure prophylaxis for HIV occur within 72 hours of exposure -HSS (MD) 23/2010).
- Implementation of the Regional Tuberculosis Action Plan due to be published by PHA July 2011.
- Trust services for TB to meet the standards in the NICE Guidance, Respiratory Framework and DHSSPS HSS (MD) 22/2009.
- Trusts to meet the requirements of DHSSPS Policy in Changing the Culture 2010 and DHSSPS Controls Assurance Standards  
<http://www.dhsspsni.gov.uk/governance-controls>.
- Clostridium Difficile Infection (CDI) - the ribotyping programme, delivered through NI Ribotyping Service in Belfast Trust to be reviewed.
- The CDI testing protocol to be reviewed second half of 2011, informed by publication of findings of UK study of optimal testing protocols. PHA and Trusts to agree future CDI testing arrangements for Jan 2012.

- Trusts to deliver the Intensive Care Unit (ICU) Infection Surveillance and the CDI & MRSA/MSSA Surveillance programmes.
- Development of a regional action plan on for Antimicrobial Resistance.
- Trusts to develop and implement a programme of Antimicrobial stewardship.
- All HSC organisations to have in place up to date and tested outbreak and emergency preparedness plans.
- Undertake Seasonal Flu planning, including for an increase in admission of patients with seasonal flu or flu like/related illness during winter of 2011/12.
- Trusts to ensure laboratory reporting of organisms of public health interest to the Health Protection Agency (HPA England) is in line with HPA published guidelines for surveillance purposes/public health action and their associated targets –[www.hpa.org.uk](http://www.hpa.org.uk)
- Trusts to provide the necessary supports for outbreak investigation, including - microbiological input, laboratory resources and community staff to assist the PHA in outbreaks which could involve community facilities and schools.

## Screening Programmes

Screening is an important public health function that involves Health & Social Care inviting members of the public, who have no symptoms of a particular disease, to be tested to see if they have the disease, or are at risk of getting it. This is different from the usual type of health care in which a patient makes contact with the health service because he or she has symptoms or signs of disease.

Screening is a programme, not just a test. Screening programmes are subject to strict quality assurance and control. In this way the benefits of screening can be maximised and harms (such as false positive and false negative results) minimised. The elements of a screening programme include:

- Policy setting;
- Equipment procurement;
- Staff training;
- Workforce planning;
- Quality assurance;
- Identifying and inviting all eligible people;
- Information management;
- Public and professional communication;
- Taking and reading tests;
- Follow-up and failsafe;
- Diagnosis; and
- Interventions.

Most screening tests are not diagnostic tests and further diagnostic testing is required to establish the diagnosis. Screening tests sort a population of people into two groups – those who might have the disease being looked for and those who probably don't.

There are a number of issues and challenges relating to screening programmes. These include:

- The need to improve the performance of existing screening services to meet standards.
- The need to improve the performance of related diagnostic & treatment services to meet standards.
- The need to implement policy and current PFA targets for new screening programmes and developments in existing programmes.

## **Key Priorities**

### **Breast cancer screening**

- Prepare for the introduction of digital mammography.
- Plan for the NI Breast Screening Programme to undertake surveillance of women at high risk of breast cancer, in



accordance with guidance to be issued by the NHS Breast Screening Programme.

### **Cervical screening**

- Improve laboratory 'smear to result' turnaround times.
- Introduction of HPV triage into screening pathway (policy awaited) - will reduce number of repeat smears but may increase colposcopy referrals
- Improve uptake and coverage particularly in hard to reach groups.
- Establish direct referral from screening labs to colposcopy – timelier follow-up and improves failsafe.

### **Bowel cancer screening**

- Maintain timely access to diagnostic colonoscopy services for screen positive (asymptomatic) patients and to diagnostic endoscopy services for symptomatic patients.
- Full roll out of screening programme - dependent on endoscopy waiting times being addressed.
- Introduction of polyp surveillance programme.
- Improve uptake and coverage particularly in hard to reach groups.
- Establish QA structures & monitoring processes.

### **Cancer screening**

- Develop a strategy to improve uptake and coverage in the 3 cancer screening programmes; particularly in hard to reach groups.

### **Diabetic retinopathy**

- Review capacity of Diabetic Retinopathy Screening Programme within BHSCT
- Development of direct referral mechanism from screening services to ophthalmology.
- Monitor growth in diabetes cases and impact on services.

### **Abdominal aortic aneurysm (AAA) screening**

- Prepare for implementation of AAA screening in 2012.

### **Antenatal infection**

- Implementation of DHSSPS 2011 standards (implications for labs).
- Ensure specialist assessment for hepatitis B positive women within 6 wks of diagnosis.
- Ensure hepatitis B vaccination for all infants of hepatitis B positive mothers.
- Improve failsafe for the identification and follow up of missing screening results.

### **Newborn blood spot**

- Implementation of sickle cell screening.
- Improve a timely sample despatch & avoidable repeats.
- Address sustainability of regional services for follow-up of infants screen positive for PKU, CHT, CF & MCADD.

### **Newborn hearing**

- Establish QA structures & monitoring processes

# GLOSSARY

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## Glossary of Terms

**Health Inequalities** – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

**Quality Outcomes Framework** – a system under which the effectiveness of schemes and measures to improve health is measured against a set of agreed targets.

**Primary Care** – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

**Chronic conditions** – illnesses such as diabetes or heart disease that can affect people over long periods of their lives and need regular treatment and medication.

**Palliative Care** – services for people who are 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.

**National Institute for Clinical Excellence** – an expert organisation based in London that guides health care organisations across the UK on the effectiveness of new treatments, new drugs and other innovations.

**Bariatric Surgery** – a new type of hospital operation that enables some chronically obese people to reduce their weight by extensive surgery on their abdomen and digestive organs.

**Northern Ireland Block** – the total amount of financial support given to Northern Ireland by the Treasury in London.

**Locum doctors** – doctors whose work is based upon short term or temporary contracts.

**Local Commissioning Groups** – committees of the regional Health and Social Care Board that are comprised of GPs, professional health and social care staff such as dentists and social workers and community and elected representatives. Their role is to help the Board arrange or commission health and social care services at local level.

**The Bamford Report** – a major study commissioned by the Department of Health in Northern Ireland to provide a long term strategic plan for the development of mental health services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

**Public and stakeholder engagement** – the process of meeting, discussing and consulting with people and communities who use the health and social services.

**Evidence Based Commissioning** – the provision of health and social care services based upon proven evidence of their value.

**Managed Clinical Networks** – the provision of clinical services to patients through expert, closely linked and effective teams of staff.

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## Board Membership

### Health and Social Care Board Membership

Dr Ian Clements – Chair  
Mr John Compton – Chief Executive

#### **Non Executive Directors**

Mr Robert Gilmore  
Mrs Elizabeth Kerr  
Mr Stephen Leach  
Dr Melissa McCullough  
Mr Brendan McKeever  
Mr John Mone  
Dr Robert Thompson

#### **Executive Directors**

Ms Fionnuala McAndrew, Director of Social Services  
Mr Paul Cummings, Director of Finance  
Mr Dean Sullivan, Director of Commissioning  
Ms Louise McMahon, Director, Performance Management and Service Improvement

### Public Health Agency Board Membership

Ms Mary McMahon – Chair  
Dr Eddie Rooney – Chief Executive

#### **Non Executive Directors**

Ms Julie Erskine  
Dr Jeremy Harbinson  
Ms Miriam Karp  
Mr Thomas Mahaffy  
Councillor Cathal Mullaghan  
Councillor Stephen Nicholl  
Mr Ronnie Orr

#### **Executive Directors**

Dr Carolyn Harper, Executive Medical Director/Director of Public Health  
Mr Ed McClean, Director of Operations  
Mrs Mary Hinds, Director of Nursing and Allied Health Professions

## Local Commissioning Groups

### Belfast Local Commissioning Group

Dr George O'Neill (Chair)  
Mr Iain Deboys, Commissioning Lead  
Cllr. Tim Attwood  
Ms Gerry Bleakney  
Dr Grainne Bonner  
Mr Gerry Burns  
Ms Pat Cullen  
Dr Jenny Gingles  
Alderman Michael Henderson  
Cllr. Mervyn Jones  
Dr Terry Maguire  
Ms Joyce McKee  
Mr Danni Power  
Alderman Gerry Rice  
Ms Catriona Rooney  
Mrs Irene Sloan  
Dr Alan Stout  
Mr Mike Townsend

### Western Local Commissioning Group

Dr Brendan O'Hare (Chair)  
Mr Paul Cavanagh, Commissioning Lead  
Dr Kieran Deeny  
Dr Eugene Deeny  
Cllr Robert Irvine  
Mrs Jenny Irvine  
Dr Jackie McCall  
Dr Martin McCloskey  
Mr Seamus McErlean  
Mrs Clare McGartland  
Mrs Siobhan McIntyre  
Ms Loretto McManus  
Mr Eamon O'Kane  
Mr Martin Quinn  
Mr Graham Robinson  
Cllr Bernice Swift

### **Northern Local Commissioning Group**

Dr Brian Hunter (Chair)  
Mrs Bride Harkin, Commissioning Lead  
Cllr. David Barbour  
Dr Ian Buchanan  
Mrs Linda Clements  
Cllr. Adrian Cochrane-Watson  
Dr Fiona Kennedy  
Dr Una Lernihan  
Mr Laurence O’Kane  
Dr Terry McGowan  
Cllr. Thomas Nicholl  
Ms Sharon Sinclair  
Dr Turlough Tracey  
Mrs Corrina Grimes

### **South Eastern Local Commissioning Group**

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



## 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

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