

## **.Programme for Government 2008-2011**

The new Executive's first Programme for Government sets out plans and priorities for 2008-2011 together with some longer term aspirations and intentions.

The Draft Programme for Government was subject to extensive public consultation, was revised in light of that and was approved by the Assembly on 29<sup>th</sup> January 2008.

The Programme's over-arching aim is to build a peaceful, fair and prosperous society in Northern Ireland, with respect for the rule of law and where everyone can enjoy a better quality of life now and in years to come. Its priorities are to pursue an innovative and productive economy and a fair society that promotes social inclusion, sustainable communities and personal health and well-being. It will do this in ways that protect and enhance the physical and natural environment and use resources as efficiently and sustainably as possible.

### **Public Service Agreements**

To support the Executive's priorities and help realise its goal of a shared and better future, there have been developed a framework of 23 Public Service Agreements (PSAs). These confirm the key actions to be taken in support of the priorities, and the outcomes and targets to be achieved over the next three years.

### **Delivery Framework**

Many of the outcomes and goals set out under the priority areas and the PSAs are interdependent and will only be achieved where departments work closely together and co-ordinate their approach. To ensure that this is done, departments have put in place a delivery framework which establishes a robust and effective basis for the monitoring and reporting of progress at a strategic level to, and by, the Executive.

## **Delivery Agreements**

Each PSA is underpinned by a Delivery Agreement that has been drawn up collaboratively but under the leadership of the department with the preponderant share of the objectives and targets in the PSA concerned and published initially on that department's website. DHSSPS leads on three PSA Delivery Agreements, and shares leadership of a fourth:

- PSA 6 Children and Family
- PSA 8 Promoting Health and addressing Health Inequalities
- PSA 16 Investing in the Health and Education Estates (shared with DE)
- PSA 18 Deliver high quality Health and Social Services

All four are published on this page of the DHSSPS website. They are living documents, and will be developed, refined and adjusted as the planning and implementation processes evolve.

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## **PSA 6: CHILDREN AND FAMILY: DELIVERY AGREEMENT**

### **Vision**

Our overall aim is to ensure that all children are cared for, that they live in safety, are protected from abuse, receive the support they need to achieve their full potential, and grow into well-adjusted adults. Our broad approach is set out in the 10-year strategy for children and young people.

For most children, the family sustains that aim. Early childhood is of critical importance to the development and well-being of the child. Even in secure and stable family surroundings, some help may be needed to consolidate that framework and ensure that some young children, especially those from disadvantaged backgrounds, are not left behind or put at further disadvantage at the outset.

As part of their rounded development, we must also instil in our children a lifelong culture of enjoyment in sport and physical recreation.

Children are naturally vulnerable, and require the love and protection that comes with normal family life. Where that family support is at risk or lacking, it is the State's duty to try to strengthen or repair the family bonds. Where a child is suffering or is likely to suffer significant harm or neglect, the State must take action. This includes adding the child's name to the Child Protection Register and, where necessary, taking the child into the care of the State.

Children are often received into care at the request of or with the agreement of their parents. In such circumstances the State shares parental responsibility for the child, and takes on all the obligations that position brings, e.g. ensuring that the child is nurtured intellectually, emotionally and morally, and assisting the child's preparation for adulthood.

In Northern Ireland there are at present 1,600 children on the Child Protection Register (in relative terms, half as many again as in England). There are over

2,500 children in care at any given time (some of whom will also be on the Child Protection Register), and over 19,000 children (including some thought to be at risk) are annually referred to Social Services

Our vision is to significantly reduce the number of children in the care of the State over the period to 2010-11 by improving support to families so that fewer children need to come into care. For those who stay in care we want to improve their experiences, and we want to support them when they leave care so that outcomes for them are significantly improved over the early adult years. As part of that, we aim to increase the numbers of young people leaving care who continue to live with their former foster carer until they are aged 21, and to improve the range and availability of accommodation options for young people leaving care. Fundamentally, we want to ensure that our children and young people stay safe and secure; to this end we want to further improve child protection services and establish a Safeguarding Board for Northern Ireland.

### **Measurement**

#### **Objective 1: improve the outcomes and life chances of children and young people**

#### **Target: deliver targets as set out in the 10-year Strategy for Children and Young People**

Following a review of the current action plan, a three-year plan will be developed by Summer 2008. This action plan will set out what will be done by all eleven Northern Ireland departments, the Northern Ireland Office and the Northern Ireland Court Service to deliver on the aims of the strategy over the period 2008-2011. The effectiveness of the Strategy and associated action plan will be closely monitored through a range of mechanisms including:

- The Ministerial Sub-Committee on Children and Young People;
- A Strategy Planning and Review Group;
- A Parents Advisory Group;

- A mechanism to seek the views of practitioners;
- A Research and Information Group; and
- An Inter-Departmental Group (IDG).

OFMDFM will seek updates on the action plan every 6 months to measure progress and ensure delivery of the Strategy and associated targets. This action plan will be reviewed at the end of the three years to assess progress and inform the development of a further action plan.

**Target: re-establish the Ministerial Sub-committee on Children**

The first meeting of the Ministerial Sub-Committee will be held in late February/ March 2008 subject to Executive agreement. Subsequent meetings will be held quarterly.

**Target: by 2011, to have 125,000 children participating in sport and physical recreation**

The existing database for this target is the Continuous Household Survey. However this will be supplemented by a revised research framework for participation rates, to be initiated during 2008 that builds on the recommendations of Chief Medical Officers in the UK as to how frequently children should participate in physical activity to gain health benefits.

**Target: increase the number of children in the 11-16 age range accessing youth work services**

Measurement of this target will be informed by development of the following strategy documents: by September 2008, the Capital Investment Strategy for Youth; by February 2009, Northern Ireland Network for Youth; and, by March 2009, Priorities for Youth.

**Objectives: 2-4: reduce the number of children in care, improve the life chances of children leaving care, and provide a safer environment for children, both in the family setting and for those in foster care.**

Most of the basic data for the next three targets are collected in the Children Order Statistical Tables. These are produced annually by DHSSPS's Community Information Branch, and contain many important baseline figures for looked-after children and those in need of child protection services. As such, they are an invaluable gauge of the success or otherwise of existing or new policies. This data can be used as an accurate barometer of how we are doing and for determining if additional measures or resources are required to achieve our policy goals and targets.

Milestones en route to the PSA targets will be specified in the DHSSPS Minister's Priorities for Action 2008-2011 (PfA), and will be inserted in the Delivery Agreement once the PfA is published.

**Target: by 2011, reduce by 12% the number of children in care**

Given the benefits of family life, reducing the number of children needing to be taken into care is a self-evident target. We believe that the 12% reduction aimed for is a realistic and achievable one. With around 2,500 children in care at any given time, reducing this figure results directly in better prospects for many children and young people (and, indeed, for the adults concerned). It also reduces the avoidable burden on health and social care services and professionals and impacts on other agencies such as education, the courts service and the police (a higher proportion of children in care come into conflict with authority than children who are not in care).

**Target: by 2011, increase by 50% the proportion of care leavers known to be in education, training or employment at age 19**

Too many of our young people leave care with little or no educational attainment, training and indeed expectations to succeed in life. The latest figures for young people leaving care in Northern Ireland showed that only 9% left care with five GCSEs (Grades A-C) or higher, compared to almost two thirds (64%) of Northern Ireland school leavers, and more than half (55%) of care leavers had no qualifications whatsoever, compared with only 3% of all school leavers. Trusts are in contact with just under 90% of care leavers by the time they reach the age of 19; this figure needs to be improved upon. Additionally, in 2005-06, only 51% of care leavers aged 19 were known to be in education, training or employment (the comparable figure for England is 65%). We need to change this damaging and damning trend by working closely with children and young people and by having the same expectations for them as we would for our own children. By improving their employment prospects and their hopes for the future we are improving their overall prospects and life chances, and at the same time reducing the current and future burden on our health, social care and court services.

**Target: By 2011 increase by 25% the number of care leavers living with their former foster carers or supported family**

Parents continue to provide help and support to their children into early adulthood. On average across the UK, young people leave their parents' home to live independently at age 22. Historically, young people from care, who include some of the most vulnerable in our society, have left home at age 18. Two-thirds of children in care live with foster parents and a key objective for us is to continue to support care leavers who wish to continue to live with their foster families until aged at least 21. At present around 140 of our care leavers aged 18-20 are living with their former foster carers, i.e. around 1 in 4. It is obvious that many more of our young care leavers need support for longer to achieve the transition to independence and adulthood. This is especially true

for those who have experienced trauma and upset in their lives. Providing support and a secure family environment will enhance the outcomes for young people, reduce their isolation and vulnerability and help them mature into adulthood with confidence and reduced reliance on social services.

**Target: by 2011, reduce by 12% the number of children requiring to be placed on the Child Protection Register and who are looked after; and**

**Target: by 2011, provide family support interventions to 3,500 children in vulnerable families each year**

These targets are closely interconnected. The misery and suffering behind the statistics of children and young people placed on the Child Protection Register cannot be overstated, and reduction in these figures is imperative. The overall figures, and the unfavourable comparison with England, have already been noted. In 2006-07 1,200 children were registered and a further 200 who had previously been on the Register needed to be placed on it again. In any given year there are 300 children who are looked after but whose names must be kept on the Child Protection Register. We aim to reduce the need for children to be placed on the Child Protection Register and taken into care through improvements to training and awareness of all those involved in working with and caring for children and young people, through improved communication and co-ordination, and through the development of family support services. The aim is to prevent many children reaching the point where they need to be placed on the Register by supporting them and their families earlier, before the situation deteriorates, and also by improving services for children in care. The target, we believe, is realistic.

**Target: by 2009, establish the Safeguarding Board for Northern Ireland**

Without detracting from their important contribution, the current arrangement of four Area Child Protection Committees has acknowledged flaws (eg poor accountability and inconsistency of decisions across the four areas). We aim to

establish a Safeguarding Board for Northern Ireland by March 2009 to address these systemic shortcomings and further improve our services to vulnerable children and young people. We intend that the Safeguarding Board would take on a wider rôle in promoting the safeguarding of children and across a range of services provided to and for children and young people.

## **Delivery Strategy**

### **Objective 1**

#### **Target: deliver targets as set out in the 10-year Strategy for Children and Young People**

OFMDFM will engage key stakeholders in the review of the current action plan to help inform the development of a further three year action plan (2008-2011) by Summer 2008. To develop this action plan, OFMDFM will seek input from all departments, the Northern Ireland Office and the Northern Ireland Court Service to identify what they will be taking forward over the next three years that will contribute to the delivery of the targets set out in the 10-year strategy. OFMDFM will take responsibility for outlining these actions in a three-year plan which will be discussed by the Ministerial Sub-Committee and agreed by the Executive before publication.

#### **Target: re-establish the Ministerial Sub-committee on Children**

Ministers have agreed to the re-establishment of the Ministerial Sub-Committee. Subject to Executive agreement, the first meeting is scheduled to take place in late February/March 2008. It is expected that these meetings will be held quarterly and the terms of reference and priorities will be agreed at the first meeting.

#### **Target: by 2011, to have 125,000 children participating in sport and physical recreation**

The development of sport and physical recreation in Northern Ireland must take account of recent significant advances in sports development thinking. The main elements of our model deal with the development of Physical Literacy, Lifelong Physical Activity and Performance Sport. No single individual or organisation can deliver these components, so a genuine partnership approach to implementation will be essential.

The first link in the delivery chain is the Minister responsible for sport and recreation, who will champion the aspirations of the Strategy for Sport and Physical Recreation with Ministerial colleagues in other Departments.

The requirement of leadership in the context of partnership working will be provided by a Strategic Monitoring Group, overseeing the activities of several Implementation Groups that will draw on expertise and experience of those involved in delivery of sport at local level. These groups will be representative of departments, agencies and organisations with responsibility for sport and recreation, health, education, employment, the natural and built environments and social development.

Specifically the Strategy Implementation Groups will include representatives from Sport NI, Government departments and other agencies, District Councils, Education (pre-school, primary, secondary, tertiary levels), Health (planners, commissioners and deliverers), Sport (athletes, coaches and governing bodies), and the community and voluntary sector.

**Target: increase the number of children in the 11-16 age range accessing youth work services**

The three essential steps in delivering this target are: to adequately assess the needs of young people and prioritise the delivery of those services accordingly; to develop capital investment strategy for youth sector; and to ensure that young people have a voice in the services delivered to them, working with

Education and Skills Authority on the development of Northern Ireland Network for Youth.

### **Objectives 2-4, all Targets**

All relevant standards and targets set in the Programme for Government (PfG) are restated, together with any detailed adjustments and operationally necessary steps, in the DHSSPS Minister's 'Priorities for Action'. This document, published shortly after the PfG/Budget have been approved by the Executive and the Assembly, specifies the year-by-year requirements placed on Boards and Trusts in order to meet those targets

Performance against each target is monitored by the Department – at least quarterly and, in the case of targets judged to be critical for the overall standard of care in the HSC, monthly or even weekly. Where necessary, the Department will intervene directly to ensure that targets or milestones are not missed, that individual Boards and Trusts are playing their full allotted part in meeting them, and to provide support where that is needed. Each Chief Executive is held personally responsible by the Minister for achieving his or her organisation's share of the targeted improvements.

This system of performance management and accountability, now in its second year, has e.g. succeeded in reducing waiting time for hospital operations, cut time spent in A&E, reduced delayed discharges into the community, guided the resettlement of long stay patients from learning disability hospitals, tracked the increase in the number of foster carers, and monitored the reduction in smoking prevalence. It has proved itself fit for the purpose of delivering the DHSSPS-related improvements planned in the Programme for Government PSA 6.

The agencies of the State have considerable power to intervene in the lives of families to protect children. Those powers are statutory – set out in primary and secondary legislation with very detailed guidance and standards of service determining not only what Trusts can do but also in what circumstances and the

process for doing so. The use of these powers is closely scrutinized through systems of independent regulation and inspection not only to prevent abuse or inappropriate use of these powers but also to ensure that children do not come to harm should Trusts fail to use the powers at their disposal.

The elements of these services delivered to children are also subject to scrutiny by agencies such as the Northern Ireland Commissioner for Children and Young People (NICCY) and children's advocacy groups who will intervene in general or in individual cases to represent the interests of children. These elements are also governed by international treaties and conventions such as the Hague Convention on Adoption and the UN Convention on the Rights of the Child (UNCRC) – to both of which the UK Government is signatory. There are a number of areas of specialism, such as adoption, within these services which require particular expertise and where specialist interest groups representing particular stakeholders operate.

The effective discharge of their powers by Trusts requires close collaborative working with other agencies such as the police, housing (DSD, NIHE) and education (DE and DEL) and similarly close collaboration between the statutory and voluntary sector which delivers many of these services and/or represents the interests of various stakeholders. The nature of these services also means that the use of powers and decision making of Trusts is open to, and regularly subject to, legal challenge - typically on the basis of human rights and UNCRC compliance.

The underlying strategy for meeting the five targets for children at risk, in care or leaving care is as follows:

**Target: by 2011, reduce by 12% the number of children in care**

**Target: by 2011, reduce by 12% the number of children requiring to be placed on the Child Protection Register**

**Target: by 2011, provide family support interventions to 3,500 children in vulnerable families each year**

These targets will be addressed by strengthening family support services – earlier intervention, helping families to help themselves, engaging the child’s extended family to draw on a wider range of support and care. It is for HSC Trusts to identify the support needed in each case (all cases are different) and to commission what is needed (typically from the voluntary sector). These services will be designed and commissioned through children’s services planners ensuring a partnership approach between agencies and between the voluntary and statutory sector working with children and young people;

**Target: by 2011, increase by 50% the proportion of care leavers in education, training or employment**

Continuity contributes strongly to improved outcomes in young adulthood i.e. getting the looked-after person into education, training or employment. HSC Trusts will be working to see that this continuity is not lost at the juncture where the looked-after 18 year old leaves child care, by ensuring that the same social work team remains responsible for the individual from 13 years old onwards. A range of initiatives, some of them taken forward in partnership with DEL and DE, will be pursued to expand existing support to children in care (eg the ‘fostering achievement’ initiative) and focusing specifically on educational outcomes for children in care as well as their employment and training opportunities.

**Target: by 2011, increase by 25% the number of care leavers living with their former foster carers or supported family**

Continuity of foster care, and the growing bond of interest and affection that often comes with that, is of proven value in growing emotional and behavioural stability. It is for HSC Trusts to register foster carers, and support them, until the looked-after person is 21. This initiative will be promoted as part of the package of entitlements and support routinely on offer to young people in care and to foster carers; and

**Target: by 2009, establish the Safeguarding Board for Northern Ireland**

DHSSPS, in conjunction with HSC Boards and Trusts, is directly responsible for establishing the new regional Safeguarding Board for Northern Ireland.

The strategy for delivering these services and meeting these targets must take account of the already mentioned context of regulation, scrutiny and operational accountability. It requires the establishment of arrangements which bring together stakeholders to help plan services, develop guidance, consult and communicate with stakeholders and commission services. These stakeholders include Boards, Trusts, experts, voluntary sector and arrangements to take account of the voices of young people themselves. The sequence is:

Step: Establish infrastructure bringing together stakeholders to inform the planning of services. DHSSPS already has this infrastructure in place around care leavers, family support and young people in care.

Step: Assessment of need. Detailed plans for establishment of services must be based on assessed needs. There is already a considerable body of research and statistical evidence available. Further work will be needed in some areas to define and plan services.

Step: Map regulatory and statutory context to identify what changes may be needed to both.

Step: Develop guidance (and regulations) and standards for identified services.

Step: Identify which services can be commissioned from the non-statutory sector and develop commissioning plan.

Step: Develop communication strategy and materials for various stakeholders.

Step: Identify key performance indicators including quality measures

Step: Commission services including defining arrangements for monitoring and periodic review to complete loop.

DHSSPS will develop a number of key performance indicators monitoring inputs and outcomes to incentivize and support achievement of these objectives. This will be reinforced by the operation of the independent regulation and inspection of services which will provide information on the quality of services and adherence to standards by service deliverers. By identifying specific inputs and outcome measures and including these within delivery agreements, the Department will be able to monitor progress and address areas of concern with commissioners of services, who should in turn apply the same discipline to Trusts.

The accountability responsibility for these services sits with the relevant Director of Social Services in each Trust.

## **Risk Management Strategy**

### **Objective 1**

#### **Target: deliver targets as set out in the 10-year Strategy for Children and Young People**

The key risk associated with this target is the reliance on the co-operation of all government departments including the Northern Ireland Office and the Northern Ireland Court Service and their ability to deliver on the actions outlined in the Action Plan.

The risks will be managed by OFMDFM through:

- continuation of the Inter-departmental Group and the Strategy Planning and Review Group to oversee the implementation of the strategy and action plan and to identify any issues arising.
- The requirement for departments to produce progress reports to OFMDFM for review of progress against actions.

**Target: re-establish the Ministerial Sub-committee on Children**

The risk associated with this would be the additional pressure on Ministers time. If Ministers did not have the time available to attend the Sub-Committee meetings this could potentially prohibit the Sub-Committee from ensuring an integrated implementation of the priorities agreed. This will be managed by ensuring that OFMDFM liaise closely with diary secretaries to ensure meeting dates allow for majority representation and that meetings are limited to 4 per year.

**Target: by 2011, to have 125,000 children participating in sport and physical recreation**

The risk framework that will manage the mitigation of threats to the successful delivery of the Strategy will be built on the following key risks:

- Inadequate funding;
- Political instability;
- Sectoral buy-in;
- Management of partnership;
- Communication and promotion of strategic aims;
- Loss of end user confidence; and
- Marketing of 2012 potential.

Risk management arrangements across the delivery partnership will reflect these key risk themes.

**Target: by 2011, increase the number of children in the 11-16 age range accessing youth work services**

Identified risks to the delivery of this target include

- failure to clearly define a strategic vision for the future of these services;
- lack of stakeholder involvement/buy in;
- lack of human resources to deliver strategy;
- failure to assess need in developing plans;

- inappropriate service delivery based on historic delivery mechanisms
- Re-organisation of education structures

In order to minimise these risks the Department will

- Work with the youth sector to develop the priorities for youth, and with young people to determine their needs;
- Maintain the cross sectoral Youth Service Liaison Forum post ESA; and
- Review the delivery of youth services in line with policy development.

### **Objectives 2-4**

**Target: by 2011, reduce by 12% the number of children in care**

**Target: by 2011, increase by 50% the proportion of care leavers in education, training or employment at age 19**

**Target: increase by 25% the number of care leavers living with their former foster carers or supported family**

**Target: by 2011, reduce by 12% the number of children requiring to be placed on the Child Protection Register**

**Target: by 2011, provide family support interventions to 3,500 children in vulnerable families each year**

**Target: by 2009, establish the Safeguarding Board for Northern Ireland**

Identified risks to the delivery of the above targets in Objectives 2-4 include:

- failure to clearly define a strategic vision for the future of these services;
- lack of stakeholder involvement/buy in;
- failure to comply with NI, National and International law and standards;
- lack of human resources to deliver strategy;
- failure to assess need in developing plans;
- inappropriate service delivery with the wrong children coming into care and/or children who should be in care being excluded by

inappropriate use of thresholds in order to reduce the size of the care population;

- financial pressures on family and child care services within Trusts.
- re-organisation of HPSS structures

The strategy for managing the risks to services and related targets will be pursued in the context of regulation, scrutiny and operational accountability outlined earlier. It will be greatly strengthened by the arrangements which bring together stakeholders to help plan services, develop guidance, consult and communicate with stakeholders, and commission services. Thus, in order to minimise these risks the Department has:

- carried out public consultations on the Families Matter and Care Matters Strategies setting forth our strategic vision for these services;
- established arrangements to involve key stakeholders in the identification, planning and commissioning of services;
- been working with Boards to ensure that plans for service development must reflect assessed need;
- been reviewing the existing regulatory framework for these services;
- been including key input and outcome indicators as part of services already commissioned;
- worked with Boards and Trusts to clearly define standards of service and thresholds for intervention which will be regionally applied

## **Consultation**

### **Objective 1**

**Target: deliver targets as set out in the 10-year Strategy for Children and Young People**

OFMDFM will involve key stakeholders in reviewing and revising the action plan to deliver on the 10 year strategy for children and young people. A revised 3 year action plan will be considered by the Executive and the Committee for OFMDFM in Spring 2008.

**Target: re-establish the Ministerial Sub-committee on Children**

OFMDFM have sought agreement from Ministerial colleagues to re-establish the Ministerial Sub-Committee. The first meeting is scheduled to take place late February/early March subject to Executive agreement.

**Target: by 2011, to have 125,000 children participating in sport and physical recreation**

The production of the consultation draft of the Strategy for Sport and Physical Recreation 2007-2017 has been influenced by extensive desk research as well as consultations with a range of sectoral interests, key individuals, sports practitioners and the wider public.

**Target: increase the number of children in the 11-16 age range accessing youth work services**

**Objectives 2-4**

**Target: by 2011, increase by 50% the proportion of care leavers in education, training or employment at age 19**

**Target: increase by 25% the number of care leavers living with their former foster carers or supported family**

**Target: by 2011, reduce by 12% the number of children requiring to be placed on the Child Protection Register**

**Target: by 2011, provide family support interventions to 3,500 children in vulnerable families each year**

**Target: by 2009, establish the Safeguarding Board for Northern Ireland**

The responses to the consultations on Care Matters (the main strategy for children in care and leaving care) and Families Matter (the family support strategy) will be analysed and considered before determining the final policy which will then go for Ministerial and Executive approval. The consultation process included involvement of the public, statutory and voluntary sector organisations, political parties and families & children and young people. The Department has also consulted widely on its proposals for the future of adoption (Adopting the future) and on its proposals to establish a single regional Safeguarding Board for NI.

**PSA 6 - MEASUREMENT ANNEX**

**Target: deliver targets as set out in the 10-year Strategy for Children and Young People**

The Strategy aims to achieve progress after ten years and have evidence to indicate that children and young people are:

- Healthy;
- Enjoying, learning and achieving;
- Living in safety and with stability;
- Experiencing economic and environmental well-being;
- Contributing positively to community and society; and
- Living in a society which respects their rights.

There are multiple individual indicators associated with each of these 6 high level outcomes. Associated data sources and baseline information is also outlined in the strategy against each indicator with expected direction of change identified.

Progress reports will be published every 2 years on the Children and Young People's Unit web-site: [www.allchildrenni.gov.uk](http://www.allchildrenni.gov.uk)

**Target: re-establish the Ministerial Sub-committee on Children**

A measurement Annex cannot be provided for this target. Subject to Executive agreement, the first meeting of the Ministerial Sub-Committee is scheduled to take place in late February/early March 2008.

**Target: by 2011, to have 125,000 children participating in sport and physical recreation**

**Source of data** Young People's Behaviour and Attitudes Survey (conducted by NISRA).

**Frequency of reporting** Progress against target will be reported in 2008 and 2011.

**Baseline** **125,934 (March 2007)**

**Future data availability** 2010, 2013

**Availability of results** Survey normally conducted in November and results normally available 6 months later.

**Definitions**

Children People aged 11 - 16

Participation

- a) Participated in sport or physical activity on one or more days in the previous week. [Number of times in the last week participated in sport or physical activity]
- b) Did physical activity or played actively that made the participant out of breath or hot and sweaty for at least 60 minutes on one or more days in the last week [Number of days in the last week done physical activity or played actively that made participant out of breath or hot and sweaty for at least 60 minutes]
- c) Number of hours per week spent at PE/games in school

[measurement will take place in respect of a) and b) and c) from 2007/08 onwards]

### Baseline

	a)	b)	c)
2000	84/83%	n/a	n/a
2003	89/86%	n/a	n/a
Average	86.5%		

Based on participation definition a), the number of children participating is as follows:

2000	84/83%	x	161,000 = 135,240/133,630
2003	89/86%	x	158,000 = 140,620/135,880
Proj 2007	89/86%	x	150,000 = 133,500/129,000
Proj 2011	89/86%	x	143,000 = 127,270/122,980

It is important to note that this target is sensitive to demographic changes – ie the projected decreasing numbers of 11-16 year olds.

To meet the **target** of having 125,000 children participating in sport and physical recreation (under definition a) by 2011, there would need to be a participation rate of 87.5%.

**Minimum level of change to constitute improvement**      baseline + 2%

[this is the minimum % increase on the baseline which is statistically significant at 95% level, based on a YPBAS sample size of 6500]

**Minimum value which constitutes a maintained level**      84%

[this is the minimum value for which is not statistically significantly different  
(at 95% level) from the baseline, based on a YPBAS sample size of 6500]

**Data Quality Officer**

DCAL Research & Statistics Branch

**Notes:** None

<b>Target</b>	<b>By 2011 reduce by 12% the number of children in care</b>
<b>Data Provider</b>	Information and Analysis Directorate (IAD)
<b>Data set used</b>	Looked After Children statistical returns
<b>Baseline/Latest data</b>	<p>The baseline figure will be that for the number of children in care as at 31 March 2008. i.e. 2,324 children in care.</p> <p><u>Latest position (July 2008):</u> 2,338 children in care.</p> <p>The target is to reduce by 12% (i.e. to 2,045) the number of children in care by 2011.</p>
<b>Frequency of reporting</b>	Annually.
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	Eugene Mooney, DHSSPS Information Analysis Directorate (IAD)
<b>Minimum movement required for performance assessment</b>	Not applicable because not a sample

The LA (Looked After Children) returns are a set of 11 statistical returns which HSC Trusts submit to IAD annually. These returns detail information relating specifically to looked after children, including the numbers of children in care at 31 March each year. Definition of key terms – e.g. LA 1

<b>Target</b>	<b>By 2011 increase by 50% the proportion of former care leavers known to be in education, training or employment</b>
<b>Data Provider</b>	IAD
<b>Data set used</b>	OC3 annual statistical return
<b>Baseline/Latest data</b>	<p>Baseline year is 2005-06 – 51%. Progress will be measured by reference to what happens to the population in care as of 1 April 2008 who, having left care, turn 19 in 2010-11.</p> <p><u>Latest Position (Sept 2008):</u> Monitoring arrangements are being finalised.</p> <p>The target is to have 76% of former care leavers in education, training or employment by 2011.</p>
<b>Frequency of reporting</b>	Annual.
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	Eugene Mooney, IAD
<b>Minimum movement required for performance assessment</b>	Not applicable because not a sample

The OC3 is a statistical return which HSC Trusts submit to IAD annually. The return details information on the circumstances of former care leavers at the time of their 19<sup>th</sup> birthday. It covers a range of information, including contact with social services, economic activity and accommodation.

<b>Target</b>	<b>By 2011 increase by 25% the number of care leavers living with their former foster parents or supported family</b>
<b>Data Provider</b>	Northern Health & Social Services Board (NHSSB) on behalf of all four HSS Boards/IAD
<b>Data set used</b>	Regional leaving and aftercare project – A regional group funded by the Department to support those leaving care.
<b>Baseline/Latest data</b>	The baseline figure is 150 at 31 March 2008.  <u>Latest Position (Sept 2008):</u> Monitoring arrangements are being finalised.  The target is to have 188 care leavers living with their former foster parents or supported family by 2011.
<b>Frequency of reporting</b>	Monthly
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	Fergal Bradley, DHSSPS Social Policy Group
<b>Minimum movement required for performance assessment</b>	Not applicable because not a sample

<b>Target</b>	<b>By 2011 reduce by 12% the number of children requiring to be placed on the Child Protection Register and who are looked after</b>
<b>Data Provider</b>	Information and Analysis Directorate (IAD)
<b>Data set used</b>	Children Order Statistical return CPR 4
<b>Baseline/Latest data</b>	The baseline figure will be that for 31 March 2008. Baseline position to be confirmed.  <u>Latest Position (Sept 2008):</u> Monitoring arrangements are being finalised.
<b>Frequency of reporting</b>	Annually.
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	Eugene Mooney, IAD
<b>Minimum movement required for performance assessment</b>	Not applicable because not a sample

The CPR 4 is a statistical return which HSC Trusts submit to IAD annually. It details information relating specifically to the number of children on the child protection register at 31 March, by age and gender.

<b>Target</b>	<b>By 2011, provide family support interventions to 3,500 children in vulnerable families each year</b>
<b>Data Provider</b>	HSS Trusts
<b>Data set used</b>	To be developed
<b>Baseline/Latest data</b>	Baseline at 31 March 2008 is nil.  <u>Latest Position (Sept 2008):</u> Monitoring arrangements are being finalised.
<b>Frequency of reporting</b>	six monthly
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	Eugene Mooney, IAD
<b>Minimum movement required for performance assessment</b>	Not applicable because not a sample

<b>Target</b>	<b>By 2009 establish the Safeguarding Board for Northern Ireland</b>
<b>Data Provider</b>	Social Policy Group, DHSSPS
<b>Data set used</b>	Not applicable
<b>Baseline/Latest data</b>	Not applicable
<b>Frequency of reporting</b>	Not applicable
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	Fergal Bradley, Social Policy Group
<b>Minimum movement required for performance assessment</b>	Not applicable because not a sample

## **PSA 8: PROMOTING HEALTH AND ADDRESSING HEALTH INEQUALITIES - DELIVERY AGREEMENT**

### **Vision**

A healthy population is desirable in itself; it is also an essential element in helping to deliver a strong economy. DHSSPS will lead on a range of actions that will improve health and well-being. This will involve a strategy to ensure engagement with all key stakeholders including government departments, statutory, community and voluntary sectors, and business/industry – resulting in a population that is “fully engaged” in maintaining and improving its health and well-being. Achieving a fully engaged population, ie people who care and take responsibility for the health and well-being of themselves and their families, will also lead to a long-term reduction in demand for health services with a subsequent lessening of demand for scarce resources.

Key factors that affect the overall health and well-being of the population include tobacco use, risky or problem consumption of, alcohol and/or drugs; rising levels of obesity, teenage pregnancy, sexual health, mental health, rising levels of suicide, and uptake of screening and immunization programmes. The overarching purpose of the strategy is to create the social and environmental conditions for improved health and well-being while tackling the health inequalities that currently exist. The impact of the latter is illustrated by the fact that the difference in average life expectancy between the 20% most deprived areas and the NI average is currently 3.8 years for men and 2.3 years for women. Government has a clear duty to lead and direct this change process, and to create conditions in which all individuals, families and communities can make healthy choices. This includes development of a culture of lifelong enjoyment and success in sport for communities across Northern Ireland.

## Measurement

In order to test and demonstrate the extent to which the above vision is being realized, a number of key indicators will be utilised. The rate of progress will be measured by a variety of means, as set out in the Measurement Annex. In many cases bespoke surveys will be undertaken; for others, routine hospital data will tell us the position. Milestone targets will be set where that represents a useful means of measuring progress. The PSA targets and their underlying rationale are as follows.

### **Objective 1: promote uptake in screening and immunisation programmes to forestall avoidable disease and reduce mortality rates**

**Target: from September 2008, ensure that a comprehensive HPV immunisation programme is in place, with a view to achieving a long term reduction of 70% in incidence of cervical cancer**

Cervical cancer is the second most common form of cancer in young women - currently 80 new cases of cervical cancer are diagnosed each year. while 30-40 deaths also occur each year. HPV causes 99% of invasive cervical cancer, and is spread through sexual activity. Immunisation protects against the disease and is shown to prevent up to 70% of cervical cancers. This routine immunisation programme will offer vaccination to all girls in Year 9 of post-primary education.

**Target: From December 2009, ensure that a comprehensive bowel screening programme for those aged 60-69 is in place, with a view to achieving a 10% reduction in mortality from bowel cancer by 2011.**

Bowel cancer is the second largest cause of cancer death in Northern Ireland - there are 1,000 cases, and some 450 deaths, each year. Bowel cancer screening aims to detect the condition at an early stage, before the symptoms become apparent, when treatment is more likely to be effective. Research indicates

that, over the longer term, the bowel cancer mortality rate can be reduced by 15% through earlier diagnosis and treatment as a result of an effective screening programme. For Northern Ireland, that will eventually equate to 70 lives saved each year.

**Target: by 2009, extend the regional breast screening programme to cover those aged 65-70**

The basic aim is to reduce the suffering and burden associated with breast cancer through prevention and early detection. Extending the programme to this age group will mean that 45,000 more women will be screened, and this means of early detection, followed by appropriate treatment, will reduce mortality rates.

**Objective 2: promote smoking cessation and measures to tackle obesity and physical inactivity, particularly among children, and reduce health inequalities**

**Target: by 2012, increase average life expectancy by 2 and 3 years for women and men respectively, and facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the Northern Ireland average**

Average life expectancy, and the inequality gap, is used to measure overall levels of health and well-being in the population. The difference between average life expectancy for men and women in the 20% most deprived areas and the Northern Ireland average is currently 3.8 years for men and 2.3 years for women, as noted above. In respect of DSD's Neighbourhood Renewal Strategy, which targets the 10% most deprived areas in Northern Ireland (Neighbourhood Renewal areas), the life expectancy gap between these areas and the Northern Ireland average is even greater: 5.2 years for men and 3.1 years for women. The reasons for this gap are complex and multi-factoral, reflecting the many issues that associate deprivation and poor health, In large

measure, the narrowing of these gaps will be a sign of success on the other, more specific, public health fronts included in this PSA (smoking cessation, reducing obesity, the curbing of binge drinking etc).

**Target: by 2011, reduce to 21% and 25% respectively the proportions of adults and manual workers who smoke**

Smoking is one of the key contributors to Northern Ireland's mortality and morbidity rates, (ie deaths and illnesses). In Northern Ireland, tobacco contributes to approximately 15% of all deaths, claiming around 2,300 lives each year and accounting for one in three of all cancer deaths and 90% of lung cancers. In 2004-05 the prevalence of smoking ranged from 19% among professional/employers/managers to 43% among unskilled manual workers. Further interim targets are likely to be developed, in collaboration with DHSSPS's Information Analysis Directorate, as part of the current review of the Tobacco Action Plan. A reduction in smoking prevalence would be a clear indicator of how engaged people are in maintaining and improving their own health and wellbeing.

**Target: by 2011, halt the decline in adult participation in sport and physical recreation**

The NI Strategy for Sport and Physical Recreation 2007-2017 aims to deliver a culture of lifelong enjoyment and success in sport for the Northern Ireland community. It is evident from Continuous Household Survey Data that participation in sporting activities amongst adults is declining in Northern Ireland and a knock-on effect in health terms can be inferred. The Strategy will try to redress this decline and to measure the improvements against a revised research framework for participation rates, to be initiated during 2008. This framework will take account of the recommendations of Chief Medical Officers in the UK as to how frequently adults need to participate in physical activity to achieve health benefits. Sport NI is currently developing its proposals for this, in conjunction with DCAL.

### **Target: by 2011, halt the rise in obesity**

In Northern Ireland around 60% of adults have a weight problem, and almost 1 in 5 are obese - an increase from under 1 in 4 in 1997. This means that there are at present at least 300,000 obese adults and a further 500,000 who are overweight. In common with many other western societies, increasing disposable income, increasing access to processed energy dense foods, and increasingly sedentary lifestyles have led to obesity becoming one of the main public health problems in Northern Ireland. Obesity rates here have tripled over the last twenty years, with 1 in 20 schoolchildren now obese by the age of five. Evidence shows that obesity reduces life expectancy by approximately 9 years; increases the risk of succumbing to Northern Ireland's biggest killers, coronary heart disease and cancer; increases the risk of being diabetic – an obese woman is ten times more likely to become diabetic than one who is not overweight; and can impact on emotional/psychological well-being and self-esteem, especially among young people. Obese children are more likely to become obese adults, and children of obese adults are significantly more likely to become obese – creating the potential for a vicious circle of obesity. Research also shows that for both men and women those in the most deprived areas are more likely to be obese than those living elsewhere.

### **Objective 3: reduce binge drinking and illicit drug use, particularly among young people and vulnerable groups**

#### **Target: by 2010, ensure a 5% reduction in the proportion of adults who binge drink**

The misuse of alcohol brings immense social costs impacting on health and social services, on issues related to the wider economy such as illness, absenteeism and productivity, and on law and order. An issue of particular concern in Northern Ireland, as in other parts of the UK and elsewhere, is the harmful culture of 'binge drinking' - 43% of male and 33% of female drinkers

are currently reported as binge drinkers. A reduction in the prevalence of this habit would be an indication of the population taking a more positive approach to their way of life. The interim target for March 2009 is for a 1.5% reduction in the incidence of adult binge drinking in each HSS Board area.

**Target: by 2010, ensure a 10% reduction in the number of young people who drink and report getting drunk**

Adult patterns of drinking can be reflected in the drinking patterns of young people, i.e. those aged 16 and under, which in turn can be carried forward into adulthood. At present 2% of young people report drinking every day, with 13% of young drinkers reporting being drunk more than 10 times. A reduction in the proportion of young people getting drunk would be reflective of a more informed adult population and an indication that future drinking patterns would be less harmful. The interim March 2009 target is for a 3% reduction in the proportion of young people who drink and who report getting drunk.

**Target: by 2010, ensure a 5% reduction in the proportion of young adults taking illegal drugs**

There are many harms associated with drug misuse – to the individual, to his or her family, to the local community and to society as a whole. In many ways the prevalence of drug misuse, too, acts as an indicator of the extent to which young adults in particular will take greater control of their own lives.

Approximately 20% of 15-64 year-olds have taken illicit drugs at least once, and 19% of 16-24 year-olds have used at least one type of illicit drug in the past year. At the beginning of March this year 1,118 individuals were being treated for problems relating to drug misuse. The interim target for March 2009 is for a 1.5% reduction, in each HSS Board area, in the number of young adults (15-34 year-olds) taking illegal drugs.

**Target: by 2011, ensure a 10% reduction in the number of children at risk from parental alcohol and/or drug dependence**

There is a lack of research in Northern Ireland on this issue, but extrapolating from GB estimates it is reasonable to assume there could be as many as 40,000 children in Northern Ireland living in a family where there is an alcohol problem. There will also be a significant number of young people living with parents or carers who are problem drug users. As part of ongoing work on this issue, a key 2008-09 priority in this field will be the development of a baseline to fully scope out the situation in Northern Ireland. These young people are often a forgotten group, hence the term 'hidden harm'. A reduction in the number of these 'at risk' children would serve to show not only progress in addressing the harmful use of alcohol and drugs, but also the extent to which our services are dealing appropriately with the situation.

**Objective 4: reduce the incidence of suicide**

**Target: by 2011, achieve a reduction of at least 15% in the suicide rate**

Suicide can be seen as the ultimate manifestation of the poor mental health and well-being. Large increases in suicide have been reported across most regions of the world in the last few decades, and it is the third biggest cause of "years of lives lost" worldwide after cardiovascular disease and cancer. ('Years of life lost' is a statistical measure of premature mortality. It takes into account the age at which deaths occur by giving greater weight to deaths at younger age and lower weight to deaths at older age.) . Until recently there had been approximately 150 deaths by suicide in Northern Ireland each year but 2005 witnessed a significant increase to 213 (+46%) and the 2006 figure shows a further 36% rise to 291. There is little or no evidence to show why this should have happened. The DHSSPS R&D Office has therefore been commissioned to undertake an extensive piece of research into "The Underlying Causes of Suicide in NI".

## **Objective 5: improve sexual health and reduce the rate of teenage pregnancy**

**Target: by 2010, achieve a 40% reduction in the rate of births to mothers under 17**

Socio- economic disadvantage can be both a cause and a consequence of teenage parenthood. Socio-economically disadvantaged young people are those most likely to become teenage parents. Northern Ireland has among the highest rates of teenage pregnancy in Europe and rates are highest in areas of disadvantage. In 2005, there were 22,328 live births to women in Northern Ireland - of these 1,395 (6.2%) were to teenagers aged 19 and under.

Unplanned pregnancy leads to teenage mothers facing limited prospects in education and training and are often reduced to working in low paid, low status jobs or to unemployment and dependence on state benefits; the prospects for the children in question are equally problematic. A reduction in the rate of unplanned teenage pregnancy would show young women in this age group taking beneficial control of their own lives.

### **Delivery Strategy**

So far as the DHSSPS targets are concerned, the general position is that all relevant standards and targets set in the Programme for Government (PfG) are restated, together with any detailed adjustments and operationally necessary steps, in the DHSSPS Minister's 'Priorities for Action'. This document, published shortly after the PfG/Budget have been approved by the Executive and the Assembly, specifies the year-by-year requirements placed on Boards and Trusts in order to meet those targets

Performance against each target is monitored by the Department – at least quarterly and, in the case of targets judged to be critical for the overall standard of care in the HSC, monthly or even weekly. Where necessary, the Department will intervene directly to ensure that targets or milestones are not missed, that

individual Boards and Trusts are playing their full allotted part in meeting them, and to provide support where that is needed. Each Chief Executive is held personally responsible by the Minister for achieving his or her organisation's share of the targeted improvements.

This system of performance management and accountability, now in its second year, has e.g. succeeded in reducing waiting time for hospital operations, cut time spent in A&E, reduced delayed discharges into the community, guided the resettlement of long stay patients from learning disability hospitals, tracked the increase in the number of foster carers, and monitored the reduction in smoking prevalence. It has proved itself fit for the purpose of delivering the DHSSPS-related improvements planned in the Programme for Government PSA 8.

Given the variety of the health and social well-being objectives and targets, and their focus on the ingrained or cultivated habits of individuals throughout society, the delivery chain for the delivery of the PSA 8 is a complex affair. It involves a wide range of stakeholders, organizations, agencies and partnerships, working at the national, regional and local level – not to mention the East/West and North/South dimensions.

The roles and particular responsibilities of these are described generically below. In order to achieve effective co-ordination across the various outcomes which will aggregate up to achieve PSA 8 and contribute to PSAs 7 and 12, an established structure will be utilised centering on the current Ministerial Group on Public Health (MGPH) and the formal commissioning and monitoring arrangements within the Health and Social Care domain. Further details of this are provided at **Annex B**. The role of MGPH, where individual Departments report to the DHSSPS Minister, ensures that all other Government Departments and relevant agencies have a shared responsibility for PSA 8, and for relevant objectives in PSAs 7 and 12. MGPH meets every six months, and the outcomes from the relevant healthy lifestyle strategies, and the ongoing work of the various Departments, agencies, HSS Boards and Trusts are reported to the group at least annually. The respective Business Plans and 'key performance indicators' will reflect this. Such a process (illustrated in the flow diagram at

Annex B) ensures that there is a clear responsibility for all contributory outcomes, with an overarching reporting and monitoring process.

The development of sport and physical recreation in Northern Ireland must take account of recent significant advances in sports development thinking. The main elements of our model deal with the development of Physical Literacy, Lifelong Physical Activity and Performance Sport. No single individual or organisation can deliver these components, so a genuine partnership approach to implementation will be essential. The first link in the delivery chain is the Minister responsible for sport and recreation, who will champion the aspirations of the Strategy for Sport and Physical Recreation with Ministerial colleagues in other Departments.

There are imminent changes in the exact nature and responsibilities of certain structures within the Health and Social Care system, and other RPA-related decisions are likely to have implications for the future form and roles of local councils. At this stage, therefore, it is not possible to be definitive concerning delivery strategy.

Apart from the linkages within NI there are clearly defined reciprocal relationships with the UK Government, UK bodies and also in respect of North-South bodies and organisations.

In outline, the strategy for delivering the various objectives is as follows.

### **Objective 1**

**Target: from September 2008, ensure that a comprehensive HPV is in place, with a view to achieving a long term reduction of 70% in incidence of cervical cancer**

An HPV vaccination programme, targeting the 11,500 12/13-year old girls in Northern Ireland and comprising three vaccines to be administered over six

months, will be launched in September 2008. The Joint Council on Vaccination and Immunisation has recommended a school-based approach as being the most effective. DHSSPS is discussing detailed implementation with stakeholders.

**Target: From December 2009, ensure that a comprehensive bowel screening programme for those aged 60-69 is in place, with a view to achieving a 10% reduction in mortality from bowel cancer by 2011**

DHSSPS, HSS Boards and Health and Social Care Trusts are discussing how the screening programme can most efficiently and effectively be structured. This will be settled shortly, and Trusts will carry operational responsibility for delivering the service.

**Target: by 2009, extend the regional breast screening programme to cover those aged 65-69**

Breast screening is already being delivered to women aged 50-64. The extension of the existing programme to include more women will be project-managed and overseen by the Regional Advisory Group on Breast Screening.

## **Objective 2**

**Target: by 2012, increase average life expectancy by 2 and 3 years for women and men respectively, and facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the Northern Ireland average**

As noted earlier, progress towards this target will be a function not only of success on the other public health and health promotion programmes but also the work of other departments, agencies, district councils, the private and the voluntary sectors. MGHP will continue to oversee and monitor this work.

**Target: by 2011, reduce to 21% and 25% respectively the proportions of adults and manual workers who smoke**

In 2007 the DHSSPS introduced crucial legislation to curtail smoking. The Department, Boards, Trusts and other agencies collaborate in funding eg smoking cessation groups, engage trained smoking cessation facilitators (working in a range of settings such as the workplace and recreational venues) and promote smoking cessation initiatives in local communities.

**Target: by 2011, halt the decline in adult participation in sport and physical recreation**

Leadership will be provided by a Strategic Monitoring Group, overseeing the activities of several Implementation Groups that will draw on expertise and experience of those involved in delivery of sport at local level. These groups will be representative of departments, district councils, agencies and organisations with responsibility for sport and recreation, health, education, employment, the natural and built environments and social development.

**Target: by 2011, halt the rise in obesity**

The approach to combating obesity in children is set out in the 'Fit Futures' strategy. In line with this, schoolchildren are periodically weighed to broadly assess their physical condition, with GP interventions as necessary. DHSSPS is also entering into cross-departmental discussions to develop a framework within which to tackle adult obesity. This will contain actions that seek to increase participation in physical activity and encourage adults to have a healthy and nutritious diet. It is anticipated that this work will be completed by 2009. Future operational roles and responsibilities will also be decided in light of that work, and the PSA Delivery Agreement will updated as required. .

### **Objective 3**

**Target: by 2010, ensure a 5% reduction in the proportion of adults who binge drink**

**Target: by 2010, ensure a 10% reduction in the number of young people who drink and report getting drunk**

**Target: by 2010, ensure a 5% reduction in the proportion of young adults taking illegal drugs**

**Target: by 2011, ensure a 10% reduction in the number of children at risk from parental alcohol and/or drug dependence**

Regarding all four of the above targets, action to combat the incidence of problem drinking and drug abuse is being taken forward under the auspices of the comprehensive 'New Strategic Direction for Alcohol and Drugs' (NSD) policy. The NSD steering group, which meets twice a year and is chaired by the DHSSPS permanent secretary, comprises expert representatives from HSS Boards and other agencies. Reporting to the steering group are several sub-groups, each focused on a particular issue e.g. binge drinking, 'hidden harm', and drug abuse. A critical part of this co-ordinating mechanism is that the business plans of the relevant bodies (Boards, Trusts, Health Promotion Agency (HPA) etc) contain their respective actions for taking forward the overall strategy. The NSD Steering Group itself reports to the cross-departmental Ministerial Group on Public Health, which is chaired by the DHSSPS Minister.

### **Objective 4**

**Target: achieve a reduction of at least 15% in the suicide rate**

A round-the-clock NI Crisis Response Telephone Helpline is being established by DHSSPS, as one of a range of measures to tackle the suicide problem. The Helpline will be operated by full-time accredited counsellors, with back-up staff and the necessary levels of clinical supervision. Other measures include prevention, intervention, education and awareness raising initiatives undertaken by the Department, Boards, Trusts, the HPA etc.

## **Objective 5**

**Target: achieve a 40% reduction in the rate of births to mothers under 17**

Work to date has been guided by the Teenage Pregnancy Action Plan. DHSSPS together with HSS Boards, Trusts, HPA etc will be reviewing the Plan during 2008. A new Action Plan will complement and be integrated with the new Sexual Health Promotion Action Plan, which is due to be published in Spring 2008. Work to implement a new Teenage Pregnancy Action Plan will be taken forward in a partnership approach with other statutory, voluntary and community organisations

### **Risk Management Strategy**

Key risks to the achievement of outcomes include:

- policies and strategies as currently applied are not conceptually appropriate and have outcomes which are therefore mismatched to the purpose;
- the resources – human or financial - are either insufficient or allocated and utilised inefficiently;
- insufficient or a lack of engagement and/or commitment by key stakeholders and partners – within the statutory and non-statutory sectors and at all levels; and
- the public does not respond as anticipated to evidence-based interventions.

In a programme of this nature, it is inevitable that some of the salient risks should be beyond the control of the DHSSPS and other agencies. Examples include broad social, environmental and political movements and events; structural employment trends; business cycles; the individual's free-will and choices about how to live life; commercial failure (e.g. to produce/ deliver vaccines).

Allowing for that, the threats to achievement of the targets will be managed through an integrated process of risk management. This will ensure that each risk is assessed and addressed within the planning, delivery and evolution/review stages by all appropriate partners and key stakeholders through participation in the business planning process. This is diagrammatically shown at Annex C.

### **Consultation Schedule**

These targets were developed as a result of on-going consultation with a wide range of key stakeholders across the whole public health domain. This has involved meetings (groups/individual), questionnaires, focus groups, e-consultations.

The production of the consultation draft of the Strategy for Sport and Physical Recreation 2007-2017 has been influenced by extensive desk research as well as consultations with a range of sectoral interests, key individuals, sports practitioners and the wider public.

The health and social care-related stakeholders who were consulted (and continue to be consulted) are representative of the statutory and non-statutory sectors. They include:

- Boards and Trusts
- Other Government Departments and organisations
- Regional statutory organisations
- Regional and local non-statutory organisations
- Representatives from local communities
- Representatives of local 'pressure groups'

**PSA 8 – MEASUREMENT ANNEX**

<b>Target</b>	<b>Reduce by 70% the incidence of, and mortality from, cervical cancer and reduce by 15% mortality from bowel cancer. <i>[These are long term targets that will be tracked annually]</i></b>
<b>Data Provider</b>	General Register Office; IAD, DHSSPS
<b>Data set used</b>	Cancer Registry, GRO (NISRA), Bowel Cancer Screening Information Management System (when established), Pathology Laboratory Information Systems
<b>Baseline/Latest data</b>	<p><i>1. Reduce by 70% the incidence of and mortality from cervical cancer.</i></p> <p>The baseline for each form of cancer is the incidence/mortality rate for 2007-08. To illustrate the position, the latest official figures (2006) show, for Bowel approximately 1,000 new cases a year with over 400 deaths per year and, for Cervical Cancer, 80 new cases a year with 30-40 deaths per year.</p> <p><u>Latest position (Sept 2008):</u> Comprehensive HPV Immunisation Programme now in place and underway.</p> <p>The target is to deliver second dose of HPV vaccine to 90% of yr 9 girls by March 2009.</p>

*2. Reduce by 15% mortality from bowel cancer.*

Latest Position (Sept 2008):

Terms of reference and a project management structure have been established to plan and implement a comprehensive bowel cancer screening programme from December 2009.

**Frequency of reporting** Annual

**95% confidence interval  
at last outturn** TBC

**Data Quality Officer** Statistician, Information Analysis Directorate,  
DHSSPS

**Minimum movement  
required for  
performance  
assessment** TBC

**Target** By 2009, extend the regional breast cancer screening programme to cover those aged 65-70

**Data provider:** Quality Assurance Reference Centre (QARC),  
Central Services Agency.

**Data set used:** The Regional Breast Screening Information System

**Baseline/latest data:** Approximately 12,000 additional women to be screened annually.

Latest Position (Sept 2008):

Robust plans are in place to ensure the extension of the breast screening programme by the required date.

**Frequency of reporting:** Annual

**95% confidence interval as last outturn** N/A

**Data Quality Officer** QARC

**Minimum movement required for performance assessment** N/A

<b>Target</b>	<b>Increase average life expectancy by 2 and 3 years for women and men respectively, and facilitate a 50% reduction in life expectancy differential between the most disadvantaged areas and the Northern Ireland average</b>
<b>Data Provider</b>	General Register Office; IAD, DHSSPS
<b>Data set used</b>	Mid-year population estimates, Annual GRO deaths dataset
<b>Baseline/Latest data</b>	<p>1999-01: Male 74.8 years; Female 79.8 years Differential; Male 3.9 years; Female 2.7 years</p> <p><u>Latest position (2005):</u> Male 76.1 years; Female 81.0 years, years. Differential: Male 3.7 years; Female 2.5 years,</p> <p>Target by 2012: Male 77.8 years; Female 81.8 years. Differential; Male 1.95 years, Female 1.35 years.</p>
<b>Frequency of reporting</b>	Annual
<b>95% confidence interval at last outturn</b>	Approximate confidence intervals for both males and females at NI level +/- 0.3 years. Within deprived areas in NI the confidence interval is approximately around +/- 0.7 years

**Data Quality Officer**

Statistician, Information Analysis Directorate,  
DHSSPS

**Minimum movement  
required for  
performance assessment**

We can be confident of achieving the first part of the target, if recorded figures of 78.4 years for males and 82.3 years for females are achieved. Conversely, if the recorded figures for males and females are less than 77.2 years and 81.2, we can be confident that the target has not been met.

We can be confident of having halved the life expectancy gap differential if the recorded figures show a gap of less than 1.45 years for males and 0.85 years for females. Conversely, if the gap for males and females are higher than 2.45 years and 1.85 years then we can be confident that the target has not been met.

<b>Target</b>	<b>Reduce to 21 % and 25% respectively the proportion of adults and manual workers who smoke</b>
<b>Data Provider</b>	Central Survey Unit
<b>Data set used</b>	Continuous Household Survey
<b>Baseline/Latest data</b>	<p>March 2007</p> <p>Adult smokers 25%,</p> <p>Manual groups 33%.</p> <p><u>Latest position (March 2008):</u></p> <p>Adult smokers 23%</p> <p>Manual groups 30%.</p>
<b>Frequency of reporting</b>	Annual
<b>95% confidence interval at last outturn</b>	Adults: +/-1.4% Manual: +/-2.3%
<b>Data Quality Officer</b>	Statistician, Information & Analysis Directorate, DHSSPS
<b>Minimum movement required for performance assessment</b>	<p>We can be confident of achievement if the recorded levels are below 19.6% and 24.7% <b>respectively</b>.</p> <p>We can be confident that they have not been met if the recorded levels are above 22.4% and 29.3% respectively.</p>

**Target** **Halt the decline in adult participation in sport and physical recreation**

**Data Provider** DCAL

**Data set used** Continuous Household survey

**Baseline/Latest data** 53% 2006/07

Latest Position 2006/07

Same as baseline.

**Frequency of reporting** Annually

**95% confidence interval at last outturn** +/- 1.6

**Data Quality Officer** DCAL Research & Statistics branch

**Minimum movement required for performance assessment**

**Minimum level of change to constitute improvement**

	Baseline = 53.0%	
Decline	No change	Improve
<50.7%		>55.3%

The above table is derived from statistical significance tests conducted at the 95% level, based on a CHS sample size of 3700. A value of 55.3% or more from a future survey constitutes improvement on the baseline, whereas a value of 50.7% or less would constitute a decline. Intermediate values would constitute no change.

<b>Target</b>	<b>By 2011, halt the rise in Obesity</b>
<b>Data Provider</b>	Central Survey Unit, NISRA
<b>Data set used</b>	NI Health and Social Wellbeing Survey
<b>Baseline/Latest data</b>	2005/06 – Children aged 2-10 9.5%. It is assumed that there will continue to be an increase in the short-term from the baseline level of obesity with the rate of increase slowing each year until the figures level out. This is modelled to occur at around 10.2%.
<b>Frequency of reporting</b>	The NI Health and Social Wellbeing Survey is carried out every 4 years with the next planned survey being in 2009/10. In the interim years between surveys, childhood obesity levels are monitored using figures from the Child Health Survey
<b>95% confidence interval at last outturn</b>	NI Health & Social Wellbeing Survey +/- 2.5% The Child Health Survey is not subject to statistical error
<b>Data Quality Officer</b>	Statistician, Information Analysis Directorate, DHSSPS
<b>Minimum movement required for performance assessment</b>	Obesity figures are measured using the International Obesity Taskforce (IOTF) definition. Ultimate success will be assessed based on the 2009/10 Health and Social Wellbeing Survey results. A recorded figure of less than 7.7% would

mean that we are confident that the target has been met. Conversely a recorded obesity level of more than 12.7% would mean that we are confident that the target has not been met.

Supporting evidence from the NI Child Health Survey with respect to obesity levels in P1 and P7 pupils will also be considered in establishing whether the target has been met or not.

<b>Target</b>	<b>Reduce by 5% the proportion of adults who binge drink (i.e. to 36%)</b>
<b>Data Provider</b>	Drug and Alcohol Information and Research Unit
<b>Data set used</b>	Adult Drinking Patterns Survey in Northern Ireland
<b>Baseline/Latest data</b>	<p>The percentage of adults (aged 18-75 years) who have drunk alcohol in the week prior to the survey and have engaged in at least one binge drinking session is *38%, in 2005.</p> <p><u>Latest Position (Sept 2008):</u></p> <p>Performance to be established during next adult drinking pattern survey in 2011. Other, more timely proxy indicators being finalised.</p> <p>*Source – 2005 Adult Drinking Patterns Survey</p>
<b>Frequency of reporting</b>	Every 3 years.
<b>95% confidence interval at last outturn</b>	+/- 3.0%
<b>Data Quality Officer</b>	Statistician, Information and Analysis Directorate, DHSSPS
<b>Minimum movement required for performance assessment</b>	We can be confident of achievement if the recorded level is below 33%. Conversely, we can be confident that it has not been met if the recorded level is above 39%.

- The last survey was carried out in 2005 and the next will be carried out in 2008 and in 2011.

<b>Target</b>	<b>Reduce by 10% the proportion of young people who drink and who report getting drunk (i.e. to 50%)</b>
<b>Data Provider</b>	Central Survey Unit, NISRA
<b>Data set used</b>	Young Persons' Behaviour and Attitudes Survey
<b>Baseline/Latest data</b>	<p>* Baseline - The percentage of young people (aged 11-16 years) who have taken an alcoholic drink and have had so much alcohol that they have been drunk on at least one occasion is 55%.</p> <p><u>Latest position (Sept 2008):</u> Information will be available in January/February 2009 following the latest Young Persons' Behaviour and Attitudes Survey.</p> <p>* Source – 2003 Young Persons' Behaviour and Attitudes Survey (Summary Bulletin, June 2004)</p>
<b>Frequency of reporting</b>	Every 3 years**
<b>95% confidence interval at last outturn</b>	+/- 1.5%
<b>Data Quality Officer</b>	Statistician, Information and Analysis Directorate, DHSSPS
<b>Minimum movement required for performance assessment</b>	We can be confident of achievement if the recorded level is below 48.5%. Conversely, we can be confident that it has not been met if the recorded level is above 51.5%.

\*\* The first and second rounds of the survey were carried out in 2000 and 2003 respectively. The third round was due to take place in 2006, but the proposed fieldwork period coincided with another school-based survey which would have had a considerable impact on response rates so a decision was taken to postpone until 2007. It is anticipated that subsequent rounds will be carried out at 3 yearly intervals.

<b>Target</b>	<b>Reduce by 5% the proportion of young adults taking illegal drugs during the previous month (i.e. to 5.8%)</b>
<b>Data Provider</b>	Drug and Alcohol Information and Research Unit
<b>Data set used</b>	All-Ireland Drug Prevalence Survey
<b>Baseline/Latest data</b>	<p>*Baseline - The percentage of young adults (aged 15-34 years) who reported using any illegal drugs*** in the month prior to the survey is 6.1%.</p> <p>*Source – 2002/03 Drug Use in Ireland and Northern Ireland: Bulletin 1 (Revised June 2005)</p> <p><u>Latest position (2006/07)</u> 5.9%.</p>
<b>Frequency of reporting</b>	Every 4 years. Information will also be available from the Northern Ireland Crime Survey.
<b>95% confidence interval at last outturn</b>	Asymmetric CI: +1.8%, -1.5%
<b>Data Quality Officer</b>	Statistician, Information and Analysis Directorate, DHSSPS
<b>Minimum movement required for performance assessment</b>	We can be confident of achievement if the recorded level is below 4.3%. Conversely, we can be confident that it has not been met if the recorded level is above 7.6%.

\*\*\* ‘any illegal drugs’ refers to amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents





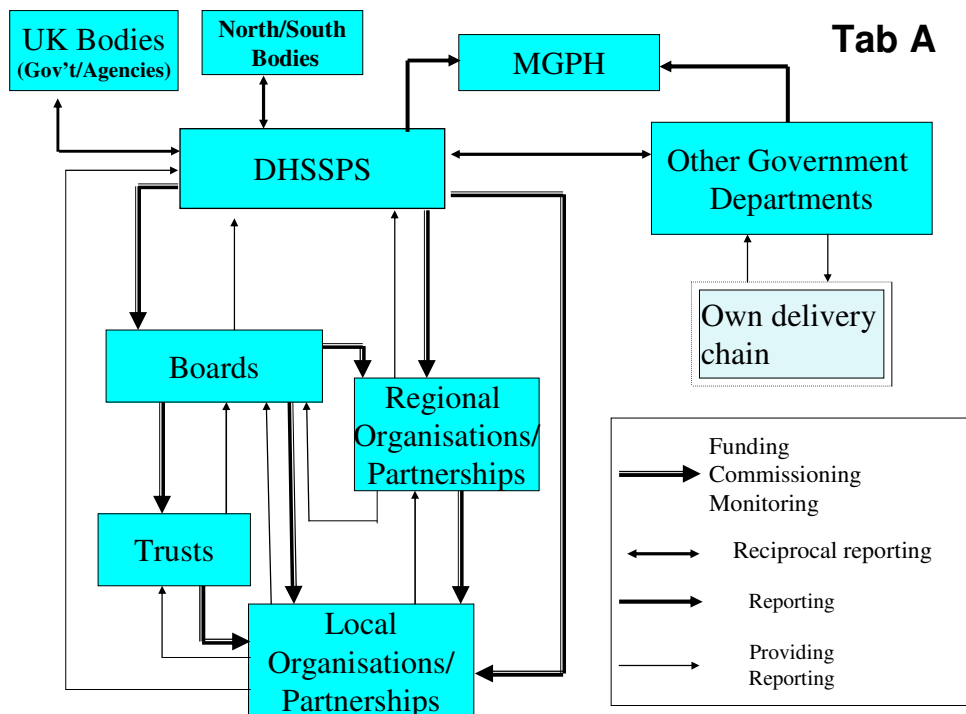
<b>Target</b>	<b>Reduce by 15% the average crude suicide rate</b> <i>[ie the number of suicides expressed as a proportion of the population without adjusting for different age and gender structures]</i>
<b>Data Provider</b>	General Register Office; IAD, DHSSPS
<b>Data set used</b>	Mid-year population estimates, Annual GRO deaths dataset
<b>Baseline/Latest data</b>	Baseline - 2004-2006 – 12.6 suicides per 100,000 population.  <u>Latest position (2005/07)</u> 14.3 suicides per 100,000 population.  The target is to reduce the average crude suicide rate to 10.7 suicides per 100,000 population by 2009/11.
<b>Frequency of reporting</b>	Annual
<b>95% confidence interval at last outturn</b>	This information is not subject to statistical error
<b>Data Quality Officer</b>	Statistician, Information Analysis Directorate, DHSSPS

**Minimum movement  
required for  
performance  
assessment**

The target average crude suicide rate is 10.7 suicides per 100,000 population.

<b>Target</b>	<b>Reduce by 40% the rate of births to girls under 17</b>
<b>Data Provider</b>	General Register Office; IAD, DHSSPS
<b>Data set used</b>	Mid-year population estimates, Annual GRO births dataset
<b>Baseline/Latest data</b>	1998–2000 – 4.1 births per 1,000 girls aged under 17 years –  <u>Latest Position:</u> 2004/06 – 2.9 births per 1,000 girls aged under 17 years. The target is to reduce to 2.5 births per 1,000 girls aged under 17 years by 2008/10.
<b>Frequency of reporting</b>	Annual
<b>95% confidence interval at last outturn</b>	This information is not subject to statistical error.
<b>Data Quality Officer</b>	Statistician, Information Analysis Directorate, DHSSPS
<b>Minimum movement required for performance assessment</b>	Target teenage birth rate of 2.5 births per 1,000 females aged under 17 years. ) The teenage birth rate expresses the number of live births to teenage mothers aged under 17 as a proportion of the total female population aged 13-16 years. “2.5 births per 1,000 females aged < 17 years” is the target figure

and represents a 40% reduction from the baseline figure.

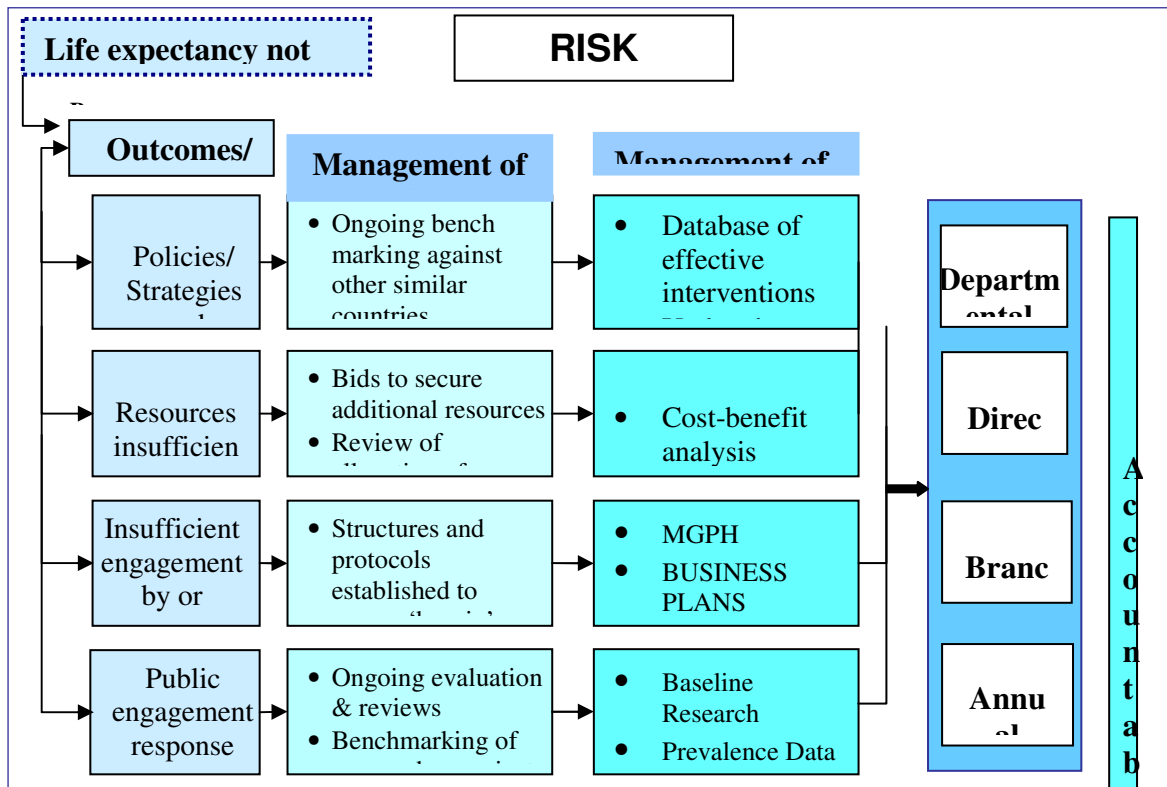


### Accountability and monitoring

The systems and protocols by which the work funded through the Department in support of PSA 8 will be targeted and monitored are as follows:

On an annual basis DHSSPS sets PfA targets – these can include specific measurable outcomes such as a reduction in a specific lifestyle behaviour and/or outputs such as a specific action plan. These are monitored by the Department and also form the basis of the annual accountability review. Boards also have to develop and submit Health and Wellbeing Investment Plans to the Department which again should demonstrate action against the stated objectives/outcomes/targets. Across the various ‘lifestyle’ issues although accountability and monitoring ‘structures’ may differ in detail they do have an overarching framework typically with an Implementation or Steering Group to which the key stakeholders report. This complements the Department’s own monitoring arrangements described above, as well as any other monitoring arrangements put in place by the Boards. In this regard it should be noted that in respect of certain health improvement issues, funding is allocated to the Boards on the understanding that agreed regional outcomes/targets are addressed. At the local level this is translated into

arrangements between the Boards and those organisations/agencies who provide an appropriate/relevant service. This process is also subject to regular monitoring by the Boards.



## **Delivery Agreement**

### **PSA 16: INVESTING IN THE HEALTH AND EDUCATION ESTATES**

#### **Note**

The delivery of this PSA will be described in detail in the relevant Investment Delivery Plans. What follows is an outline only of the approach to be adopted in providing a capital base for 21<sup>st</sup> century public services in health and social care and in schools.

#### **Vision**

Capital investment is critical to improvement in both health and social care and in education. It is essential to the health and social care reform and modernisation programme, developing an infrastructure that is capable of sustaining the best possible primary, secondary, specialist and community and mental health care, as well as providing state-of-the-art medical equipment and technology. This investment in improved facilities will ensure positive health benefits and outcomes for us all, and will cover the three key strands of the reform and modernisation programme:

- Primary and Community Care Infrastructure;
- Hospital Modernisation; and
- Public Safety and Technology.

A similarly wide-ranging education reform programme is underway to enable publicly funded schools deliver a modern high quality educational experience for school children. Aligned with this, and in support of it, is a long-term programme of investment encompassing school estate planning, improved procurement methods and processes, and improved delivery through the Education and Skills Authority (ESA). On completion of the Programme, it is expected that the following will have been achieved:

- The estate will more fully align with expected changes in need;
- Schools should be both educationally and financially sustainable; and
- Pupils and teachers will have modern safe facilities which support the delivery of the modern curriculum.

## **Measurement**

In line with DHSSPS's aims of securing better clinical outcomes and safer, high quality treatment and care, and achieving improved levels of morbidity, improved access and service responsiveness, the investment programme's effectiveness will be judged by its ability to create:

- a regional network of primary and community care facilities, bringing services into the heart of the community, improved access and service responsiveness and supporting greater integrated working;
- an acute hospital network that can deliver the best health outcomes using modern technology efficiently and supporting increasing medical sub-specialisation;
- information and communications technology to support seamless administration and care delivery between settings and services
- emergency and rescue services that are well integrated, and are equipped and deployed to deliver the highest response standards
- modernisation of the mental health service estate, and supporting a move away from long stay settings to care in the community.

In the education estate, key indicators of improvement over the 3-year period beginning in 2008-09 will include:

- Modern procurement arrangements;

- The establishment of the Education and Skills Authority by April 2009 and the commencement of area-based planning of education as envisaged in the Strategic Review of Education (the Bain Review); and
- Progress on renewal of the schools estate to address the substantial historical underinvestment.

### **Delivery Strategy**

DHSSPS has established a Programme Executive responsible for performance managing a range of Strategic Investment Groups for all Trusts and NDPBs, aimed at driving forward the programme on investment and reporting to the Infrastructure Investment Programme Board (IIPB) in the Department. This structure is designed to facilitate a robust performance management approach to the delivery of strategic outcomes.

The Department considers that it is important to structure its procurement arrangements to avoid reliance on any single procurement model, and so its procurement strategy actively promotes a range of procurement models to enable it to choose the best procurement route for any particular project. The Department's Health Estates Agency provides a centre of specialist professional and technical estate expertise which supports the development and maintenance of an efficient and effective estate for the delivery of health and social care.

There are two key reforms designed directly to improve the delivery of the schools estate:

- Establishing a “whole system” approach to planning and delivery, as manifested by the implementation of area-based planning; and
- Modernising procurement by putting it on a more strategic footing, with central support being provided locally to sponsored projects, manifested by the establishment of a single procurement service within the ESA.

The recommendations of the *Report of the Independent Strategic Review of Education* require a step change in the way the provision of school places is planned. The Report proposes an area-based planning approach and work is underway with the education sector to implement aspects of this approach.

The delivery chain will comprise the relevant divisions in DE, the support and professional development services of the Education and Skills Authority, the SIB, school management teams, the construction industry and strategic partners where appropriate. New arrangements under RPA will strengthen the accountability of schools to ESA and of ESA to the Department.

### **Risk Management**

The detailed arrangements for risk management in PSA 16 will be set out in the relevant Investment Delivery Plans (IDP). The IDP for DHSSPS will be published once a review of capital priorities – essential for the targeting of available resources for the maximum service impact – has been conducted. The expected date for completion of the review is September 2008.

## **PSA 18: DELIVER HIGH QUALITY HEALTH AND SOCIAL SERVICES**

### **DELIVERY AGREEMENT**

#### **Vision**

Our vision is to preserve life and allow people to live more productive and independent lives. We will tackle inequalities in access to services and we will ensure that services are built around the needs of the individual. We will reduce avoidable reliance on acute hospital services and institutional care through a range of flexible and more responsive care services closer to home. We will reduce long waiting times for care packages and delays in discharge from hospital for want of a care package. Where admission to hospital is appropriate, we will provide timely access to high quality treatment and care. We will also ensure that people are discharged as promptly as possible, with safe, accessible health and social care services supporting them, if necessary. We will ensure timely access to early intervention, assessment and treatment including access to new drug therapies. In order to realise this vision we need to ensure that hospital capacity is sufficient for anticipated increase in demand and that ambulance services are more responsive to the demands placed upon them. Once admitted to hospital we will ensure that the risk of infection is significantly lowered so that people can return to their homes more quickly and lead independent lives.

## **Measurement**

**Objective 1: promote independent living and a reduction in avoidable admissions to hospital.**

**Target: by March 2010, 45% of people with assessed community care needs supported at home.**

A consistent aim of the Health and Social Care (HSC) system is to provide services that enable people to live safely and with dignity in their own homes for as long as reasonably possible. In addition to the increasing role played by specialist early intervention services, assistive technology etc (see target below), significant improvements have been made in domiciliary care services over the past year in order to work towards this target. All these advances are essential if the aim, and the associated demographic pressure, is to be met. An interim target of 44% of people with assessed community care needs being supported at home has been set for March 2009.

**Target: from April 2008, no older person with continuing care needs will wait more than eight weeks for a completed assessment, with the main components of care met within a further 12 weeks.**

It is important that assessment for provision of community care packages and decisions about continuing health and social care needs are taken in the right environment and at the right time. That is why assessments of long term care needs should take place outside a hospital setting, and over a period of some weeks so that a clearer view of the person's longer term requirements can be obtained. Coupled with timely assessment, of course, is the need to ensure that, on discharge from hospital, people will have the support they require at home or in the community to prevent early re-admission to hospital.

**Target: by 2011, 50% reduction in unplanned hospital admissions for case-managed patients with severe chronic conditions (eg heart disease and respiratory conditions).**

If people receive better care in the community, often conditions will not deteriorate to a stage where hospital admission is the only option. We aim to do this through effective management of chronic disease using multi-disciplinary teams from primary, secondary and social care sectors, the increased use of telehealthcare and more effective medicines management. A 10% reduction is the provisional target for March 2009.

**Target: from April 2008, 95% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being declared medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support. All other patients will be discharged from hospital within six hours of being declared medically fit.**

A hospital is not an appropriate place for patients who have been declared medically fit and who no longer require the care provided by a hospital. Timely discharge is important to ensure the efficient flow of patients through the hospital system. Apart from the personal inconvenience, delays in discharging medically fit patients have a negative impact on both waiting times in A&E and on the timely provision of normal hospital care.

**Objective 2: shorter waiting times for access to specialist drugs, to a range of specialist hospital services, and to elective treatment.**

**Target: by 2011, ensure a 21-week waiting time for drug therapies for treatment of severe arthritis.**

There are currently waiting times of up to 2 years for access to anti-TNF therapy. There is clear evidence that this treatment brings significant improvements in quality of life for people with severe arthritic conditions and, in some cases, can help people remain economically active where that may not otherwise be possible. The 21-week target aims to provide more equitable access to anti-TNF treatment by bringing the maximum waiting time into line with that for inpatient or day case treatment.

**Target: by March 2009, no patient will wait longer than nine weeks for a first outpatient appointment, nine weeks for a diagnostic test, and 17 weeks for inpatient or day case treatment.**

For patients who can no longer be treated in Primary Care, it is important that all parts of the elective pathway (including assessment, diagnostic tests and actual treatment) are completed as quickly as possible to prevent deterioration in their condition and quality of life. This target shortens from 47 to 35 weeks the length of time that patients will wait, during each phase of their treatment. .

**Target: by 2009, 95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.**

Clinical evidence suggests that fracture patients' recovery is improved where the fracture is treated within 48 hours. The use of a 95% target for such patients reflects the clinical flexibility required in deciding how and when to treat.

**Target: by 2009, 98% of cancer patients will commence treatment within 31 days of decision to treat, and 95% of patients referred with suspected cancer will begin treatment within 62 days.**

The sooner patients commence treatment following diagnosis the better their chances for survival. The above target is consistent with practice elsewhere in the UK.

**Objective 3: improve outcomes and survival rates in key specialisms.**

**Target: by 2011, ensure a 10% reduction in mortality and disability from stroke.**

Stroke is the single biggest cause of severe disability in the UK. This target will be delivered through the treatment of patients in specialist acute stroke units and through the timely administration of thrombolytic drugs, where appropriate. These drugs are not, as yet, used to a significant degree for stroke sufferers in Northern Ireland, and it will require significant enhancement of the infrastructure needed to provide and interpret CT scans within 3 hours of stroke onset. That will take some time to put in place. 2-3 years. Given this starting point, a 10% improvement is a challenging target. The longer term Programme for Government goal is for a 15% reduction in stroke mortality rates.

**Target: by 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula, and no patient should wait longer than nine months for a transplant (reducing to six months by 2010).**

With rising levels of obesity and diabetes, and an ageing population within a general population increase, demand for renal dialysis will grow by approximately 10% year on year. The aim is to meet this demand, through modern procedures, while at the same time responding to the wish for transplants. The latter have, of course, the advantage that they obviate the need

for future dialysis and thereby relieve pressure on the service and bring a much improved quality of life.

**Target: by 2009, ensure a 10% in the number of hospital patients with staphylococcus aureus bloodstream infections (including MRSA) and a 20% reduction in cases of clostridium difficile.**

The level of healthcare associated infections (HCAIs) in our hospitals remains a matter of public concern. Although the chances of acquiring an HCAI (including MRSA and clostridium difficile) are relatively low – a UK-wide survey in 2006 found that Northern Ireland had a 5.5% rate – when it does happen it is extremely distressing for the patient and his or her family. HCAIs also are costly; they typically add 3-10 days to a patient's length of stay in hospital. Since eradication is not regarded as feasible, the aim is to reduce the incidence of HCAIs, and to measure the reduction using the mandatory surveillance schemes in place for MRSA and clostridium difficile.

### **Delivery strategy**

All standards and targets set in the Programme for Government (PfG) are restated, with any operationally necessary steps added in the DHSSPS Minister's 'Priorities for Action'. This document, published shortly after the PfG/Budget have been approved by the Executive and the Assembly, specifies the year-by-year requirements placed on Boards and Trusts in order to meet those targets.

Performance against each target is monitored by the Department – at least quarterly and, in the case of targets judged to be critical for the overall standard of care in the HSC, monthly or even weekly. Where necessary, the Department will intervene directly to ensure that targets or milestones are not missed, that individual Boards and Trusts are playing their full allotted part in meeting

them, and to provide support where that is needed. Each Chief Executive is held personally responsible by the Minister for achieving his or her organisation's share of the targeted improvements.

This system of performance management and accountability, now in its second year, has e.g. succeeded in reducing waiting time for hospital operations, cut time spent in A&E, reduced delayed discharges into the community, guided the resettlement of long stay patients from learning disability hospitals. It has proved itself fit for the purpose of delivering the improvements planned in the Programme for Government PSA 18. As part of the arrangements, commissioners will be empowered to secure services from alternative providers where existing providers are unable to meet targeted performance.

The performance management arrangements will focus on the following:

- Improving capacity in hospital services to deliver effective and timely treatments.
- utilising existing capacity at optimum levels ie efficient outpatient services; rapid access to diagnostics, effective utilization of theatres, maximising impact skill utilisation of staff.
- creating additional capacity where need is clearly demonstrated eg orthopaedic surgery.
- prioritising treatment for patients most likely to benefit ie consistent with best practice guidance.

## **Risk management strategy**

There are a number of risks to the achievement of the desired outcome

**Resources:** The achievement of the outcomes is critically dependent on the required resources being made available for this specific PSA and other related areas. Service interdependencies are such that failure to adequately resource the system as a whole will lead to bottle necks in the hospital system imparting on its ability to cope with the increasing demand.

**Tightening Labour Market:** Salaries may be uncompetitive in tightening labour market conditions, causing recruitment and retention problems and threatening the sustainability of care services.

**Property Market:** Increasing value of property market may lead to exit from nursing home sector and reduced capacity of this essential service.

**Staff:** New working practices will involve the development of multi-disciplinary team working with much greater integration of practice across the primary community and secondary care sectors. This is inherently difficult and will require significant leadership at service levels.

**Professional Commitment:** The change will require commitment to adopt new working practices and this commitment may well be dependent on wider issues eg pay policy.

**Competing priorities:** The ability to sustain the focus on specific disease areas in the face of emerging new (and unresourced) therapies, and powerful lobbies to do more elsewhere.

**Public resistance:** The reform and modernisation proposals will lead to bed reductions in the hospital sector and change in the residential care sector, this is likely to be unpopular and give rise to campaigns designed to retain such capacity.

**Latent Demand:** Expanded screening programmes and earlier intervention may identify additional demand which have not been tailored into projections.

**Global threats:** Services are not delivered in a vacuum. An outbreak of pandemic flu would seriously challenge capacity and restrict the services ability to respond to the demand from these disease groups.

To mitigate the identified risks the Departmental and HSC strategy will ensure that:

- resource and service planning are fully integrated and that for each organisation and the system as whole an appropriate balance is secured between planned service interventions and resources available;
- leadership (including clinical leadership) programmes are in place for each organisation and change in working practices are supported by formal organisational change programmes eg introduction of managed clinical networks;
- there is a clear focus on the delivery of Ministerial targets and that where competing priorities are identified these (and their resource consequences) are brought to the attention of the Department/Minister for resolution;
- where change in the profile of services is fundamental to the achievement of the desired outcomes, appropriate public consultation will be taken forward so that users and local communities fully understand the rationale behind the proposed change;

- performance monitoring arrangements provide for the early identification of demand and capacity trends so that these can be tailored into future plans with short term action plans implemented where appropriate;
- effective and tested emergency plans are in place to address global threats.

In order to sustain existing services the HSC will proactively engage with independent sector to secure their ongoing commitment. The proposals reflect the need to respond to the labour and property market trends by providing the additional resources deemed necessary to counter potential recruitment and retention difficulties by offering competitive rates of pay in the domiciliary sector and ensuring adequate rates to maintain and where necessary expand residential and nursing home capacity to address future demographic trends.

Change proposals will be subject to detailed stakeholder engagement and public consultation to ensure the fullest possible understanding of the underpinning rationale. An essential pre-requisite will be to ensure the new services are in place in the primary and community care sectors before change in the profile of hospital services is introduced. This will build public confidence and do much to counter the perception that change is being introduced for financial reasons.

Professional commitment will be pursued through active clinical leadership and a leadership programme is being developed to facilitate this. Detailed commissioning of new services, under RPA, is being devolved as close as possible to the service user and will be professionally led. This should ensure significant support at the front line for the proposals.

## **Consultation Schedule**

The strategic direction for the reform and modernisation programme was set out in the Department's Health and Wellbeing Strategy, *A Healthier Future*, and its primary care strategy *Beyond Tomorrow*. These were developed with significant stakeholder and user involvement and were subject to detailed public consultation.

Similarly, the proposals for revisions to the tariffs for domiciliary and residential care are based on detailed analysis of the actual costs of care provision undertaken by consultants. The independent sector was fully involved in the process.

Significant change in use of facilities over the period will be subject to detailed public consultation at the relevant time. The services identified reflect those attracting significant correspondence and media attention, and our major sources of user dissatisfaction

The above proposals already reflect significant consultation and interaction with key stakeholders. For example the cancer survival strategy reflects the results of detailed work in developing on Cancer Control Programme, and a Review of Lymphoedema; proposals for the effective care of stroke patients are derived from a recently completed strategy for stroke care; and proposals for renal dialysis reflect an assessment of the future needs and capacity requirements for such intervention.

All of this work has been taken forward through detailed engagement with relevant clinicians and service users and reflect best international practice. Such engagement is also a key component of future plans; the development of the Service Framework for Cancer and particularly the care standards is

professionally led and will include significant user involvement and public consultation.

## Measurement Annex

### PSA 18 - MEASUREMENT ANNEX

**Target**                      **45% of people with assessed community care needs to be supported at home.**

**Data Provider**            IAD

**Data set used**             Quarterly CC7 (define) information return

**Baseline/Latest data**     Percentage of Care Managed Clients Receiving Domiciliary Care at 30 June 2007

<b>Trust</b>	<b>% of Care Managed Clients Receiving Domiciliary Care</b>
Belfast HSC Trust	48%
Northern HSC Trust	44%
South Eastern HSC Trust	45%
Southern HSC Trust	42%
Western HSC Trust	37%
<b>Northern Ireland</b>	44%

Latest position (Sept 2008):

Monitoring arrangements being finalised.

### Calculation

- 1) Figures are based on the quarterly CC7 information return.
- 2) Information refers to care managed cases only. Care management refers to a total concept for providing care in the community, which includes the functions of addressing need, care planning, managing, coordinating and reviewing services.
- 3) The CC7 information return details; the number of people with continuing care needs who were in receipt of a community care package on the last day of the quarter, by Programme of care, main type care provided (residential, nursing or domiciliary care), and the provider of the care package (private, voluntary or statutory).
- 4) The target is calculated as the number of domiciliary care packages in effect as a proportion of all community care packages in effect, on the last day of the quarter.

#### Information Contact

Note: Community Information Branch (CBU) and Elderly Community Care Unit (ECCU) have recently re-issued guidance specifically on what should be counted under domiciliary care in the CC7 return. As a consequence, provisional information indicates that HSC Trusts are currently achieving the 45% target, with a few HSC Trusts exceeding 50%.

**Frequency of reporting**    Quarterly

**95% confidence interval at last outturn** Not applicable because not a sample

**Data Quality Officer** Information Analysis Directorate (IAD), DHSSPS

**Minimum movement required for performance assessment** Not applicable because not a sample

<b>Target</b>	<b>No older person with continuing care needs will wait longer than eight weeks for their assessment to be completed.</b>
<b>Data provider</b>	IAD
<b>Data set used</b>	Quarterly CC3 information return
<b>Baseline/Latest data</b>	<p>During Quarter Ending 31 March 2008, 99% (1741 out of 1763) of assessments of older people with continuing care needs were completed within 8 weeks.</p> <p><u>Latest position ( June 2008):</u> 98% of assessments of older people with continuing care needs were completed within 8 weeks.</p>

#### Calculation

- 1) Figures are based on quarterly CC3 information return.
- 2) Information refers to care managed cases only. Care management refers to a total concept for providing care in the community, which includes the functions of addressing need, care planning, managing, coordinating and reviewing services.
- 3) Information on the CC3 details; the number of completed assessments during the quarter, by Programme of Care and length of time waited from start of assessment, according to specific time bands.

4) In June 2007, the time bands on the CC3 return were amended to monitor this target.

**Frequency of reporting** Quarterly

**95% confidence interval at last outturn** Not applicable because not a sample

**Data Quality Officer** IAD

**Minimum movement required for performance assessment** Not applicable because not a sample

<b>Target</b>	<b>No older person with continuing care needs will wait longer than twelve weeks for the main components of their care package, following the completion of their assessment.</b>
<b>Data Provider</b>	IAD
<b>Data set used</b>	Quarterly CC5b information return
<b>Baseline/Latest data</b>	<p>During quarter ended 31 March 2008, 81% (151 out of 187) of older people waiting for the main components of their care needs to be met had been waiting less than 12 weeks.</p> <p><u>Latest position (30 June 2008)</u></p> <p>82% of older people waiting for the main components of their care needs to be met had been waiting less than 12 weeks.</p> <p><u>Calculation</u></p> <ol style="list-style-type: none"> <li>1) Figures are based on quarterly CC5b information return.</li> <li>2) Information refers to care managed cases only. Care management refers to a total concept for providing care in the community, which includes the functions of addressing need, care planning, managing, coordinating and reviewing services.</li> <li>3) Information on the CC5b details; the number of persons with continuing care needs waiting at the end of the quarter for the main components of their assessed needs to be met, by Programme of Care,</li> </ol>

length of time waited from the end of their assessment, and reason for the delay.

4) Main components refer to those components that deliver an effective care package which meets a high percentage of the assessed care needs.

Example: If a client has been assessed as requiring a domiciliary care package of 15 hours home help per week, and at the quarter's end is in receipt of 12 hours per week and is still awaiting a further 3 hours per week, this client should be excluded and categorised as no longer waiting because the components of this care package which are in place meet a high percentage of the assessed care needs.

**Frequency of reporting** Quarterly

**95% confidence interval at last outturn** Not applicable because not a sample

**Data Quality Officer** IAD

**Minimum movement required for performance assessment** Not applicable because not a sample

<b>Target</b>	<b>50% reduction in unplanned hospital admissions for people with severe chronic diseases (eg heart disease and respiratory conditions).</b>
<b>Data Provider</b>	Data is provided from all acute hospitals in Northern Ireland.
<b>Source of Data</b>	Hospital Inpatients System (HIS)
<b>Baseline/Latest data</b>	Baseline will be established when patients are identified. <u>Latest Position (Sept 2008):</u> Monitoring arrangements are being finalised
<b>Frequency of reporting</b>	Annual. Important to remember that we are working on the cohort which will be case managed (severe chronic condition) not the global figure (all). We know 146 070 people had an unplanned admission, and that the total number of unplanned admissions is 216 294. We need to know how many of the 146 070 had 2 or more admissions over this period and can therefore be classed as 'severe', and secondly how many admissions this group had. It is this figure which we need to reduce by 50% by 2011. This becomes the baseline figure against which each Trust should be reporting each month not annually.
<b>95% confidence interval</b>	Not applicable because not a sample

**at last outturn**

**Data Quality Officer**      IAD

**Minimum movement  
required for  
performance  
assessment**      Not applicable because not a sample

<b>Target</b>	<b>905% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being declared medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support. All other patients will be discharged from hospital within six hours of being declared medically fit.</b>
<b>Data provider</b>	Data is provided by those Acute Hospitals in Northern Ireland with a type 1 or type 2 Emergency Departments and Musgrave Park Hospital.
<b>Data set used</b>	Information will be sourced from the Discharged Inpatients Universe of the Departmental Data Warehouse.
<b>Baseline/Latest data</b>	Baseline to be established.  <u>Latest Position (Sept 2008):</u>  Monitoring arrangements are being finalised
<b>Frequency of reporting</b>	Annually
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	IAD
<b>Minimum movement</b>	Not applicable because not a sample

**required for  
performance  
assessment**

<b>Target</b>	<b>No patient should be waiting more than 21 weeks for drug therapies for treatment of severe arthritis.</b>
<b>Data Provider</b>	Health and Social Care Trusts via Hospital Information Branch
<b>Data set used</b>	Data will be sourced from a specific data return developed by Hospital Information Branch and Secondary Care Directorate (DHSSPS).
<b>Baseline/Latest data</b>	At September 2007, 396 patients waiting more than 21 weeks for drug therapies for treatment of severe arthritis.  <u>Latest Position (Sept 2008):</u> Monitoring arrangements being finalised.
<b>Frequency of reporting</b>	Quarterly
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	IAD
<b>Minimum movement required for performance assessment</b>	Not applicable because not a sample



1. *No patient will wait longer than 9 weeks for a first outpatient appointment.* - At April 2008 10,105 patients waiting longer than 9 weeks for a first outpatient appointment.
2. *No patient will wait longer than 9 weeks for a diagnostic test.* - At April 2008 1,411 patients waiting longer than 9 weeks for a diagnostic test.
3. *No patient will wait longer than 17 weeks for inpatient or day case treatment.* – At April 2008 7,481 patients waiting longer than 17 weeks for inpatient or day case treatment.

Latest position:

1. *No patient will wait longer than 9 weeks for a first outpatient appointment.* - At July 2008, 11,214 patients waiting longer than 9 weeks for a first outpatient appointment.
2. *No patient will wait longer than 9 weeks for a diagnostic test.* - At July 2008 1,724 patients waiting longer than 9 weeks for a diagnostic test.
3. *No patient will wait longer than 17 weeks for inpatient or day case treatment.* – At July 2008 5,958 patients waiting longer than 17 weeks for inpatient or day case treatment.

**Frequency of reporting** Quarterly

**95% confidence interval at last outturn** Not applicable because not a sample

**Data Quality Officer**      IAD

**Minimum movement  
required for  
performance  
assessment**      Not applicable because not a sample

<b>Target</b>	<b>95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.</b>
<b>Data provider</b>	NIAS
<b>Data set used</b>	Information will be sourced from the Fractures Database
<b>Baseline/Latest data</b>	At March 2008, 74% of patients were waiting less than 48 hours for inpatient fracture treatment. <u>Latest position (July 2008):</u> 71% of patients were waiting less than 48 hours for inpatient fracture treatment.
<b>Frequency of reporting</b>	Quarterly. Only patients who have surgery are included in the reporting of the Fracture Treatment Target. The first report will report the position as at 31 <sup>st</sup> March 2009 and will cover fracture waiting times over the month of March 2009. Reports will be provided for each subsequent quarter and will report the position over that quarter.
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	IAD
<b>Minimum movement</b>	Not applicable because not a sample

**required for  
performance  
assessment**



87% of patients referred with suspected cancer began treatment within 62 days.

**Frequency of Reporting** Official monitoring will be undertaken on a retrospective monthly basis. The target relates to all patients that have received first definitive treatment and that have an official ICD 10 code cancer diagnosis in the month ending 31 March 2008.

**95% confidence interval at last outturn** Not applicable because not a sample

**Data Quality Officer** IAD

**Minimum movement required for performance assessment** Not applicable because not a sample



**Minimum movement  
required for  
performance assessment**

**Target** At least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula, and no patient should wait longer than nine months for a transplant (reducing to six months by 2010).

**Data Provider** Regional Renal Centre, Belfast City Hospital

**Data set used** Renal Centre records

**Baseline/Latest data**

*1. By 2009 At least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula.*

Baseline to be established.

Latest Position (Sept 2008):

Monitoring arrangements being finalised

*2. By 2009 no patient should wait longer than nine months for a transplant*

Baseline to be established.

Latest Position (Sept 2008):

Monitoring arrangements being finalised

*3. By 2009 At least 60% of patients should receive dialysis via a fistula.*

Baseline to be established.

Latest Position (Sept 2008):

Monitoring arrangements being finalised

*4. By 2010 no patient should wait longer than six months for a live donor transplant*

Baseline to be established.

Latest Position (Sept 2008):

Monitoring arrangements being finalised

**Frequency of Reporting** Annual

**95% confidence interval at last outturn** Not applicable because not a sample

**Data Quality Officer** IAD

**Minimum movement required for performance assessment** Not applicable because not a sample

<b>Target</b>	<b>10% reduction in number of hospital patients with staphylococcus aureus bloodstream infections (including MRSA) and 20% reduction in cases of clostridium difficile, by 2009.</b>
<b>Data Provider</b>	Communicable Disease Surveillance Centre (CDSC) via Hospital Information Branch
<b>Data set used</b>	Data will be sourced from the Communicable Disease Surveillance Centre (CDSC) and will be provided to Hospital Information Branch for reporting.
<b>Baseline/Latest data</b>	<p>Incidence of each recorded case during 2006-07:  MRSA/MSSA - 591  C.Diff -1,012</p> <p><u>Latest position (April to July 2008):</u>  MRSA/MSSA - 173  C.Diff - 338</p> <p>Target for MRSA/MSSA is 531 and for C.Diff, 811 by March 2009.</p>
<b>Frequency of reporting</b>	Retrospective monthly basis
<b>95% confidence interval at last outturn</b>	Not applicable because not a sample
<b>Data Quality Officer</b>	IAD

**Minimum movement  
required for  
performance  
assessment**

Not applicable because not a sample