

# **PRIORITIES FOR ACTION**

**2010/11**

**19 May 2010**

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## INTRODUCTION

The overall aim of the Department of Health, Social Services and Public Safety is to improve the health and well being of the people of Northern Ireland. In pursuing this aim through the health and social care (HSC) system, the key objective of the Department is to improve outcomes through a reduction in preventable disease and ill health by providing effective and high quality interventions and services, equitably and efficiently, to the whole population.

Consistent with this aim and objective the Minister's expectation, for 2010-11 and beyond, is that – as far as possible within the resources made available by the Executive – the public will see continuing improvements to services across six key priority areas, namely:

- Priority Area 1: Improve the health status of the population and reduce health inequalities
- Priority Area 2: Ensure services are safe and sustainable, accessible and patient-centred
- Priority Area 3: Integrate primary, community and secondary care services
- Priority Area 4: Help older people to live independently
- Priority Area 5: Improve children's health and well-being
- Priority Area 6: Improve mental health services and services for people with disabilities.

In addition, Priorities for Action 2010/11 includes a seventh priority area which, particularly in the current financial context is critical, namely:

- Priority Area 7: Ensure financial stability and the effective use of resources.

It is inevitable that the substantial reduction in resources available for service developments as a result of the Executive's cut in the budget for health and social care will severely limit the progress that can be made across a number of the key PfA themes in 2010/11. However this document should nonetheless be taken as a clear signal to HSC organisations of the direction of travel in the short to medium term. It is more important than ever for commissioners and providers to ensure that every penny of the funding available to the HSC is spent economically, efficiently and effectively in pursuit of the Department's aim and objective as stated above. At the same time it must be acknowledged that within the funding available for health and

social care in Northern Ireland it will not always be possible to provide the local population with access to every new service that becomes available.

The remainder of this document sets out the strategic direction for HSC organisations across the seven key priority areas including the particular outputs and outcomes sought.

## **PRIORITY AREA 1: IMPROVE THE HEALTH STATUS OF THE POPULATION AND REDUCE HEALTH INEQUALITIES**

***Aim: to improve the health status of the entire population and reduce inequalities in health status between population groups and geographical areas.***

Improving health and wellbeing status remains one of the most fundamental ways of improving people's quality of life in Northern Ireland. The Department's aim is to maintain and improve the health status of the entire population and to reduce inequalities in health status between population groups and geographical areas.

With healthcare costs continuing to rise and chronic care consuming an ever increasing share of spending, it is essential that a step-change improvement is secured in relation to prevention and health improvement activities and interventions, leveraging all opportunities within the health and social care service and beyond to promote key public health messages. The Public Health Agency should ensure that all key stakeholder organisations and individuals – within the HSC family, other statutory sectors and the community and voluntary sector – are fully and appropriately involved and working in partnership to improve public health and address inequalities. All stakeholders must be clear about their respective roles and responsibilities and the Agency should establish appropriate oversight arrangements to ensure timely and effective delivery of real improvements.

Addressing lifestyle factors such as smoking, alcohol, diet and physical activity can both reduce the incidence of chronic disease and prevent premature death. The HSC must offer advice and support to help people to stay healthy by tackling these issues, and also help older people remain independent; there should be a particular focus on the early years of life, from conception to the age of three. Individuals should also be encouraged to take more responsibility both for their own health and the health of their children and must understand the impact of their behaviours, especially in terms of rising rates of chronic diseases such as diabetes, cancer and cardiovascular disease.

*Tackling inequalities*

A key priority for the Department is to reduce inequalities in health status between population groups and geographical areas. This will require the social determinants of ill-health (employment, housing, education, poverty (including fuel poverty), etc) to be addressed, and social capital to be built within communities, through partnership working with key stakeholders.

The Department will continue to work with other Government Departments to promote the use of health impact assessment to ensure their policies and strategies help address the social determinants of health and well being. The Department will also work towards the integration of planning, transport, environmental and health policies to address the social determinants of health. In 2011-12 the Department will publish its new Investing for Health Strategy.

In addressing health inequalities, including in due course taking forward the recommendations of the review of the Investing for Health Strategy, the Public Health Agency should, working with other HSC organisations and through wider partnership arrangements, provide support to evidence-based local initiatives to empower communities and individuals, encourage regeneration and reduce social isolation. In addition, the Agency should work with NIHE, local councils and other statutory and voluntary organisations to ensure the best use of public funds in relation to reducing fuel poverty.

### *Tobacco*

The prevalence of smoking in Northern Ireland has fallen only marginally in recent years, with little real improvement following the initial impact of the smoking ban in 2007. The Department's aim is to re-energise the drive to reduce smoking across Northern Ireland through a multi-component policy, community and societal level prevention approach. Particular focus will be given to those geographical areas with the highest rates of prevalence, and on pregnant women, manual workers and young people.

During 2010-11 and beyond, the Department will take forward a range of key actions to ensure an appropriate policy context for reducing the prevalence of smoking. Legislation will be introduced banning retail displays of tobacco products and the sale of tobacco products from cigarette vending machines, preventing point-of sales advertising for tobacco products.

During 2010-11 the Public Health Agency should introduce and sustain an intense, targeted public information campaign on smoking prevention and cessation. Working with Trusts, primary care and other providers the Agency should ensure accessible, effective smoking cessation services are provided, particularly targeting geographical areas with the highest smoking rates, pregnant women who smoke, manual workers and young people. The Agency will also be expected to work with local government to encourage effective local enforcement of smoking legislation. Finally the Agency should seek to involve communities identified as having high rates of smoking in reducing these rates and should engage with education partners to re-examine educational approaches with young people.

### *Alcohol and drugs*

Tackling the harm from alcohol and drug misuse will continue to be a key priority in 2010-11 and beyond. During 2011 the Department will review and update its strategy document – a New Strategic Direction for Alcohol and Drugs – focussing on a number of existing and emerging issues including the misuse of prescribed drugs, misuse of legal highs, reducing general alcohol consumption (not just binge drinking), encouraging recovery amongst clients, addressing cocaine misuse, and delivering support and information to parents and carers.

During 2010-11 the Public Health Agency should work in partnership with Trusts, primary care and other providers to expand training for professionals for brief intervention, to further develop specialist services and treatments, to ensure effective media campaigns and to take forward relevant actions within the New Strategic Direction for Alcohol and Drugs, the Young People's Drinking Action Plan and the Hidden Harm Action Plan.

The Agency should also work in wider partnerships with statutory, community and voluntary sector organisations to develop community-based programmes to address illicit drug use and problem alcohol consumption, and increase social capital.

### *Obesity*

Addressing obesity in children and adults remains a significant challenge. By October 2010 the Department will develop and publish a comprehensive framework to

prevent and address overweight and obesity across the whole life course. The framework will contain actions to improve nutritional intake, increase participation in physical activity, and improve the evidence base. The level of resources available to address this issue, along with the buy-in and support of key partners to address the obesity issues, will have a direct impact on the framework's effectiveness. The Public Health Agency should lead on the development and implementation of a comprehensive action plan to deliver the framework.

During 2010-11 the Department will continue to work with all Government Departments to address the obesogenic environment, including active travel, healthy schools and the built environment.

During 2010-11 the Public Health Agency should continue to promote and support breastfeeding by working with statutory, voluntary and community sector partners. The Agency should also seek to increase breastfeeding rates, by particularly targeting those least likely to breastfeed. The Agency should also continue to ensure that data are collected in schools on overweight and obese children and support provided for children identified through this process.

Working with other HSC organisations, the Agency should ensure the commissioning of effective services for the treatment and support of people who are overweight or obese. The Agency should also seek to promote Healthy Workplaces in HSC settings and promote physical activity and good nutrition for clients in different care settings e.g. long-term care.

In addition the Agency should continue to address adult and children obesity with actions and initiatives which cover food, nutrition and physical activity. This should include working with a wide range of partners and across all appropriate settings.

### *Mental health and suicide*

The Department's aim is to promote improved emotional well-being and reduce deaths by suicides by: building resilience within individuals and communities; reducing stigma; promoting the early recognition of signs of mental ill health; providing appropriate training (for HSC and non-HSC staff) and sign-posting to appropriate referral pathways; and, providing a range of high quality, responsive

services which are both available and accessible (including preventive initiatives and support for bereaved, both community-based and statutory).

During 2010-11 the Department will publish a new Mental Health and Wellbeing Promotion Strategy. This will place significant emphasis on early-years interventions to secure life-long improvement in mental wellbeing. The Public Health Agency will be expected to work with relevant statutory, voluntary and community partners to take forward this and the new Investing for Health Strategy in 2011-12.

During 2010-11 the Public Health Agency will also be expected to manage effectively the Lifeline Contract. The Agency should ensure effective linkages between regional and local suicide prevention arrangements – with tailored interventions for those areas with particularly high suicide rates, and that local research into the causes of suicide and deliberate self harm is undertaken. Finally, following the refresh of the Protect Life Strategy, the Agency should work with local suicide prevention implementation bodies to develop and deliver local Protect Life Action Plans.

#### *Sexual health and teenage pregnancy*

The promotion of good sexual health and wellbeing, and further reducing the overall rate of teenage pregnancy and variations in local teenage pregnancy rates are key priorities.

During 2010-11 the Public Health Agency should undertake further analysis of local data and evaluation of local interventions to identify and implement appropriate ways of delivering accessible and high quality contraception and sexual health services in primary and community settings. These services should be underpinned by an effective, targeted information campaign. During 2010-11, the Agency, working with the Sexual Health Improvement Network, should also take forward the implementation of the Sexual Health Promotion Strategy, to include co-ordinated actions to address teenage pregnancy and parenthood.

#### *Screening*

Screening plays a vital role in preventing illness before symptoms appear. A new screening programme for bowel cancer will be introduced on a phased basis during 2010-11 for men and women aged 60 to 69. The Public Health Agency, working with

the HSC Board, Trusts and other relevant organisations should ensure that this programme is implemented in a manner that is cost effective and meets quality assurance requirements. During 2010-11 the Public Health Agency should work with the HSC Board and Trusts to commence preparatory work for the phased introduction of screening arrangements for abdominal aortic aneurysm.

In the context of available funding, it will not now be possible during 2010-11 to proceed with the planned extension to the scope of antenatal screening for foetal anomalies. This and other new screening programmes will be looked at again for introduction in 2011-12, in the context of available funding and on the basis of recommendations from the UK National Screening Committee.

### *Emergency preparedness*

The purpose of planning for emergencies in the HSC is to ensure preparedness for an effective response to any emergency and to ensure that organisations fully recover to normal services as quickly as possible.

The Public Health Agency, the HSC Board, the Business Service Organisation, HSC Trusts, NIBTS and NIGALA should review, test and update their emergency plans, including building on the lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments for pandemic flu preparedness.

### *Business Continuity Planning*

Both emergency and business continuity plans are essential components of each HSC organisation's planning, commissioning and delivery of HSC services to the wider population. Each HSC organisation must have the appropriate structures and mechanisms in place to continue to meet its core objectives even whilst under sudden or sustained pressure, whether as a result of factors outside or within the organisation. Putting in place plans and testing and validating these arrangements in order to ensure an effective response to threats and hazards can be delivered needs to be given high priority.

All HSC organisations should ensure that they have a fully tested and operational Business Continuity Plan in place.

*Standards, targets and actions*

The specific standards, targets and actions to be achieved in 2010-11 are as follows:

- **Life Expectancy (linked to PSA 1.1):** by March 2011, the Public Health Agency should implement agreed actions contained in its Health Improvement Plan to address inequalities at regional and local level, including any actions arising from the Investing for Health Review.
- **Smoking (linked to PSA 1.2):** by March 2012, reduce to not more than 22% and 28% respectively the proportion of adults and manual workers who smoke. Consistent with the achievement of these outcomes, by September 2010 the Agency should take forward its action plan to improve access to smoking cessation services for manual workers. By September 2010, the Agency should also have in place arrangements for obtaining enforcement activity reports from local government and for analysing and reporting this information (including views on value for money) at least twice yearly to the Department. And by December 2010 the Agency and Trusts should establish additional support arrangements for pregnant women to help them to stop smoking.
- **Obesity (linked to PSA 1.3):** by March 2012, reduce to not more than 9% the proportion of children that are obese. Consistent with the achievement of this outcome, the Agency should throughout 2010-11 ensure timely and effective arrangements are in place in each Trust area to provide targeted support to children identified through the ongoing BMI monitoring process in schools. By February 2011, the Agency should produce an integrated action plan to take forward the obesity prevention strategic framework to address overweight and obesity across the whole life course.
- **Reducing the harm related to Alcohol and Drug Misuse (linked to PSA 1.4, 1.5, 1.6, and 1.7):** by March 2012, reduce to 29% the proportion of adults who binge drink, reduce to 27% the proportion of young people who report

getting drunk, and reduce to 5.5% the proportion of young people taking illegal drugs. Consistent with the achievement of these outcomes, the Agency should from April 2010 further develop and evaluate the brief intervention pilot designed to support primary care to undertake screening and brief intervention on alcohol misuse. By December 2010, the Agency should produce an effective training methodology and determine the feasibility of rolling this out across GP practices. And, from April 2010 the Agency in partnership with the HSC Board should, through the implementation of the joint Hidden Harm Action Plan, increase awareness of relevant services and ensure that more young people affected by parental substance misuse are effectively signposted to existing services.

- **Suicide (linked to PSA 1.8):** by March 2012, ensure that the suicide rate is reduced below 14.5 deaths per 100,000. Consistent with the achievement of this outcome, by September 2010 the Public Health Agency should ensure that a Deliberate Self Harm Registry pilot is established in the Belfast HSC Trust, and a first draft report produced by March 2011. By September 2010, the Agency should produce an action plan to implement recommendations arising from Mental Health Promotion / Suicide Prevention Training in Northern Ireland.
- **Mental Wellbeing (linked to PSA 1.8):** by March 2011, the Public Health Agency should produce an action plan to take forward the relevant regional and local elements contained within the Mental Health and Wellbeing Promotion Strategy.
- **Early years' intervention:** by March 2011, the Public Health Agency and Trusts should ensure that the updated child health promotion programme is fully implemented. The impact of the programme will be measured through the Child Health System and the introduction of a new schedule of visits to be undertaken by health visitors.
- **Births to teenage mothers (linked to PSA 1.9):** by March 2012, the Public Health Agency should ensure that the rate of births to teenage mothers under 17 is reduced to not more than 2.7 births per 1,000. Consistent with the achievement of this outcome, by December 2010 the Agency should

complete a review of the latest evidence of effective intervention for reducing teenage pregnancy, take forward agreed actions to secure further reductions in the rates of teenage pregnancy linked to the Sexual Health Promotion Action Plan.

- **Bowel cancer screening (PSA 1.11):** during 2010-11, the Public Health Agency, Health and Social Care Board and Trusts should establish on a phased basis a bowel screening programme for those aged 60 – 69 ( to include appropriate arrangements for follow up treatment).
- **Screening for abdominal aortic aneurysm:** during 2010-11, the Public Health Agency should work with the HSC Board and Trusts to commence preparatory work for the phased introduction of screening arrangements for abdominal aortic aneurysm.
- **Emergency Preparedness:** by March 2011, all relevant HSC organisations should review, test and update their emergency plans, including building on the lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments for pandemic flu preparedness.
- **Business Continuity Planning:** – by March 2011, each HSC organisation should ensure it has a fully tested and operational Business Continuity Plan in place.

## **PRIORITY AREA 2: ENSURE SERVICES ARE SAFE & SUSTAINABLE, ACCESSIBLE & PATIENT-CENTRED**

***Aim: to ensure that patients and clients have timely access to high quality services responsive to their particular needs and delivered locally where this can be done safely, sustainably and cost-effectively.***

### *Quality and safety*

The first dimension of quality must be that we do no harm to patients or clients.

A strengthened system of regulation and robust standards of care and treatment have been established through linkages with NICE and SCIE. Commissioners and Trusts must ensure that services are delivered to common agreed standards, and that there is no inappropriate variation in the care and treatment that people are receiving. Clinicians and practitioners will be expected to look closely at their own practice and ensure that it is fully in line with current best practice. Within the context of available resources, it is expected that patients will continue to have access to the majority of NICE approved drugs and technologies and approved vaccines.

During 2010-11, Commissioners and Trusts should ensure that appropriate clinical and social care governance structures are in place to ensure satisfactory progress is made towards the full implementation of all endorsed best practice guidance (NICE, SCIE, NPSA, GAIN). Trusts should evidence that they are participating in Safety Forum collaboratives and develop action plans for any learning sets.

A significant programme of work has been established to develop Service Frameworks for the major causes of ill health and disability. This programme has been assigned a high priority and the Service Frameworks implemented are expected to fundamentally underpin the commissioning and delivery of services across the HSC for the future.

Service Frameworks for Cardiovascular Health and Wellbeing and Respiratory Health and Wellbeing have been published for implementation whilst Service Frameworks for cancer, mental health and wellbeing, learning disability, the health

and wellbeing of children and young people and the health and wellbeing of older people are at various stages of development. HSC organisations are expected to continue to contribute to the development and implementation of this programme of work as a means of ensuring that services are commissioned and delivered to standards of quality that are evidence-based, safe and sustainable. Commissioners should ensure that the structures and processes for joint commissioning facilitate the timely and effective implementation of service frameworks.

It is also important that we learn from mistakes and minimise the risk of untoward events. *Safety First: A Framework for Sustainable Improvement in the HPSS* set an early strategic direction for Quality and Safety in the HSC, with a strong emphasis on robust incident reporting arrangements. Completion of this work has laid strong foundations in terms of quality, learning and patient/client safety in particular. In building for the future, all parts of the HSC are contributing to the development of a quality strategy for the next 10 years that will focus on three key components, namely safety, standards and the patient/client experience (with the latter embracing personal and public involvement). During 2010-11 the Public Health Agency in partnership with the HSC Board should establish effective arrangements to ensure that lessons learnt from adverse events are taken forward by Trusts, primary care and other providers.

During 2010-11, Trusts should continue to ensure satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash call rate, the prevention of venous thromboembolism and mental health inpatient care. Trusts should also during 2010-11 prepare quality improvement plans to implement WHO Surgical Checklists in 80% of cases by March 2011 and, in collaboration with the HSC Safety Forum, to promote initiatives aimed at reducing the incidence of falls and medication errors.

The Department also wishes to see evidence of improving clinical outcomes such as mortality and survival rates. From September 2010, Trusts will be expected to put in place arrangements to routinely review their standardised mortality rates, both over time and against comparator organisations in NI and GB. Trust review arrangements should include consideration at Trust board level.

It is also important to ensure that the healthcare environment is safe and clean and issues such as healthcare infection are tackled. *Changing the Culture 2010* aims to eliminate the occurrence of preventable, healthcare associated infections (HCAs) in all HSC settings. To date, work has focussed on secondary care; the main challenge for the medium term will be to tackle HCAs in the community. The Department expects to see year-on-year improvements in performance as measured by infection rates, infection numbers and other criteria; the infection-control performance of NI hospitals should be as good as high-performing comparable hospitals elsewhere in the UK.

General standards of hygiene and cleanliness are also essential to ensure public confidence. Trusts should ensure that effective arrangements are in place to provide ongoing assurance that the patient environment and levels of hygiene and cleanliness are meeting prevailing standards, as updated by the current review process being taken forward by the Department and Public Health Agency.

Ensuring effective decontamination of medical devices also forms an important part of protecting patients from infection risk: during 2010-11 Trusts should continue to take forward implementation of the regional decontamination strategy in accordance with agreed timescales.

### *Accessibility*

Ensuring that the population has timely access to high quality healthcare remains a key priority.

Significant improvement in waiting times had been achieved in recent years, but performance has slipped back in 2009-10 in a number of specialties. It will be a key priority for the HSC Board and Trusts in 2010-11 to ensure that, within available resources, in-house capacity is increased and as many specialties as possible are brought into recurrent balance, with the independent sector only being used in exceptional circumstances, and then only with the prior approval of the HSC Board. By March 2011 it is expected that all outpatients will be seen within nine weeks following GP referral; it is recognised that the current 13-week standard for treatment is not achievable across all specialties within the resources available in 2010-11, but nonetheless Trusts should ensure that maximum treatment waiting times are – at worst – maintained at March 2010 levels for all specialties being brought into

recurrent balance in 2010-11, and in the small number of remaining specialties, waiting times for treatment do not exceed the maximums stated later in this section.

Trusts should also ensure in 2010-11 that effective steps are taken to address the current delays in appointments for review patients.

Similarly, A&E performance against the 4-hour and 12-hour standards has been weak at nearly all larger hospital sites in 2009-10 and commissioners and Trusts must ensure that the achievement of these standards is given the highest priority in 2010-11.

In delivering timely access to elective and emergency care services, Trusts will be expected to further embed the reform agenda, including the improvement of hospital booking processes, reducing cancelled appointments and improving hospital utilisation. To drive up both quality and productivity and to improve care and outcomes for patients, it is vital that clinicians are actively engaged in determining the best clinical care pathway redesign processes that deliver improved outcomes. This applies equally to clinicians in primary, community or secondary care. The HSC Board and Public Health Agency should ensure that effective clinical engagement is a central plank of their commissioning processes.

In meeting all challenges faced by the service, the primary issue is how health and social care services are best configured to respond safely and effectively to the emerging needs of the individuals and populations they serve. As those needs and the technology to meet those needs develop, it may be right to provide some services on single sites or have them provided on a regional basis while other services may continue to be provided at local hospitals or in primary care. At all levels of care the goal must be to ensure that the services provided are safe and of a high quality, delivering effective outcomes for patients. Timeliness and ease of access remain as important issues and service planners and providers should recognise the need to consider the particular issues faced by the most vulnerable and disadvantaged service users with regard to accessing appropriate care.

Commissioner and Trust plans should outline the action to be taken to identify where and in what way services may need to be modernised or reconfigured to achieve higher quality and better outcomes. Services should continue to be delivered locally where this can be done safely, sustainably and cost effectively.

Remote populations remain concerned about access to life saving interventions in the event of a sudden emergency. Often proximity to acute facilities is perceived as the determining factor as to whether the local health and social care services will adequately provide for a population's needs. Increasingly however it is not the distance to the appropriate facility that may determine the outcome for the patient but the timeliness of the initial clinical intervention and the ability to provide appropriate care for the patient during a transfer to the most appropriate destination.

Commissioner and Trust plans should reflect the steps required to put in place supporting measures, for dispersed rural communities, for example, first responder schemes, improved ambulance services, etc. Plans should also reflect the further actions required to ensure effective arrangements are in place for the regional neonatal and paediatric transport service.

Hospital services are dependent upon those delivering primary and community care services to ensure that people are not inappropriately referred to hospital services where there is a safe and effective means of caring for the patient in the community. Primary and community services must also respond to the needs of patients following discharge from hospital to ensure patients have access to a range of services needed to support them in the community. The HSC should seek to achieve a closer integration of primary, community and secondary care with the aim of delivering comprehensive treatment and care across a variety of care settings, with care providers operating collaboratively as an inter-dependent care network. This is developed further under Priority 3 – Integrate Primary, Community and Secondary Care.

Other developments include the potential offered by ICT for improved communication with remote sites, between primary and secondary settings and transfer, in real time, of data, information and images. These developments in turn facilitate the establishment of managed clinical networks, provide for specialist advice to be made available remotely to smaller institutions, and contribute to enhanced care being delivered locally, enhancing the patient experience and avoiding many hospital visits and possibly hospital admissions.

Commissioners and Trusts must ensure NIPAC is fully implemented and utilised and should continue to support its development.

### *Ensuring services are person-centred*

Personal and Public Involvement (PPI) is about giving people and communities a say in the planning, commissioning and delivery of their health and social care services. Person-centred care means organising services around the needs of the individual patient, meeting their clinical needs, working in partnership and treating them with dignity and respect. It means providing timely and convenient services that help prevent – as well as treat ill-health.

Service users have a right to be treated with dignity and respect; they should be involved in discussions and decisions about their own healthcare and also in the development and consideration of proposals for changes to the way in which services are provided. Commissioners and Trusts should actively engage with those who use health and social care services, their carers and the wider public to discuss: their ideas, our plans; their experiences, our experiences; why services sometimes need to change; what people want from their services; how to make the best use of available resources; and how to improve the quality and safety of services.

To be effective, PPI must be seen as part of the job of all those involved in HSC organisations, integral and not incidental to their daily work. HSC organisations should therefore ensure that they comply with the requirements of Departmental guidance on PPI, and should continue to take forward appropriate actions at strategic and local level to ensure that PPI is mainstreamed within their organisation.

### *Standards and Targets*

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Specialist drug therapies for arthritis (PSA 2.2):** from April 2010, the HSC Board and Trusts should ensure no patient waits longer than nine months to commence specialist drug therapies for the treatment of severe arthritis.
- **Elective care (consultant-led) (PSA 2.3):** by March 2011, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks for a first outpatient appointment and 9 weeks for a diagnostic test, the majority of inpatients and daycases treated within 13 weeks and no patient waits longer than 36 weeks for treatment. During 2010-11, Trusts should take steps to

ensure review patients are seen in a more timely fashion; from March 2012, all reviews should be completed within the clinically indicated time.

- **Diagnostic reporting:** from April 2010, the HSC Board and Trusts should ensure all urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.
- **Elective care (AHP):** from April 2010, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks from referral to commencement of AHP treatment.
- **Fractures (PSA 2.4):** from April 2010, the HSC Board and Trusts should ensure 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.
- **Cancer (PSA 2.5):** from April 2010, the HSC Board and Trusts should ensure all urgent breast cancer referrals are seen within 14 days, 98% of cancer patients commence treatment within 31 days of the decision to treat, and 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.
- **A&E:** from April 2010, HSC Board and Trusts should ensure 95% of patients attending any A&E department are either treated and discharged home, or admitted, within four hours of their arrival in the department. No patient should wait longer than 12 hours.
- **Stroke services (PSA 2.6):** by March 2011, the HSC Board and Trusts should ensure 24/7 access to thrombolysis and that high risk transient ischemic attacks are assessed and treated within 24 hours. Trusts should also work towards a door to needle time of 60 minutes for thrombolysis by March 2011.
- **Renal services (PSA 2.7):** from April 2010, the HSC Board and Trusts should ensure all patients should continue to have timely access to dialysis services. From April 2010, at least 60% of patients should receive dialysis via a fistula. By March 2011, the Belfast HSC Trust should deliver a minimum of 50 live donor transplants.
- **Ambulance services (PSA 2.8):** from April 2010, the HSC Board and NIAS should ensure an average of 72.5% of Category A (life-threatening) calls are

responded to within eight minutes, increasing to an average of 75% by March 2011 (and not less than 67.5 % in any LCG area).

- **Healthcare associated infections (PSA 2.1):** in the year to March 2011, the Public Health Agency and Trusts should secure a further reduction of 20% in MRSA and C.difficile infections compared to the position in 2009-10.
- **Hygiene and cleanliness:** from September 2010, each of the five HSC Trusts should put in place arrangements to routinely review compliance with updated and consolidated regional standards of hygiene and cleanliness. Trust review arrangements should include consideration at Trust board.
- **Mortality:** from September 2010, each of the five HSC Trusts should put in place arrangements to routinely review the Trust's standardised mortality rates, both over time and against comparator organisations in NI and GB. Trust review arrangements should include consideration at Trust board.
- **Trust quality initiatives:** from April 2010, the Public Health Agency and Trusts should continue to ensure satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash call rate, the prevention of venous thromboembolism and mental health inpatient care. By July 2010, Trusts should submit to the Public Health Agency, for approval and monitoring, quality improvement plans to implement WHO Surgical Checklists in 80% of cases by March 2011, and in collaboration with the HSC Safety Forum promote initiatives aimed at reducing the incidence of falls and medication errors.
- **Patient Experience:** following the adoption of the Patient and Client Experience standards in 2009, Trusts should extend the clinical care areas monitored and increase the range of monitoring tools, and ensure appropriate reporting and follow-up, consistent with direction from the Public Health Agency.
- **Patient involvement:** by March 2011, the Public Health Agency in partnership with the HSC Board should: establish a regional Health and Social Care forum, with appropriate Patient and Client Council and public representation, to drive the PPI agenda; develop and implement a regional Health and Social Care Action Plan for PPI including arrangements to

promote and evidence active PPI; arrange for the publication of an annual summary of PPI activity across Health and Social Care Organisations.

- **Service Frameworks:** by March 2011, Commissioners and Trusts should have action plans in place to ensure the implementation of agreed standards from the Cancer Framework in accordance with guidance to be issued by the Department in October 2010.

### **PRIORITY AREA 3: INTEGRATE PRIMARY, COMMUNITY AND SECONDARY CARE SERVICES**

***Aim: to ensure greater engagement between secondary and primary care clinicians and practitioners to agree clinical pathways which reduce the use of hospital services and increase the capability of primary care to manage patients more locally.***

Ever increasing demands are being placed on hospitals. Patient flows must be more effectively managed so that patients are seen, diagnosed and treated in the right setting by the right person at the right time. Much of the care provided in hospital or other institutional settings could be delivered in community settings. Many referrals and unplanned admissions to hospital, outpatient appointments and diagnostic tests could be more appropriately managed in the community. Moving care from hospitals to community settings and patients' own homes should not only improve efficiency but should also drive improvements in quality.

A reduction in the use of acute services including mental health should lead to a managed reconfiguration of these services which focus on specialised interventions in support of enhanced locally based integrated care.

During 2010-11 Commissioners and Trusts should continue to build a continuum of responsive, integrated primary and community care that promotes good health, prevents ill health and focuses on people at risk, supporting them to live independent lives and reducing unnecessary and inappropriate reliance on hospitals and other institutional care.

The Department wishes to see greater engagement between secondary and primary care clinicians and practitioners to agree integrated clinical pathways which reduce the use of hospital services, increase the capability of primary care to manage patients more locally and ensure effective communication across organisational, professional and geographical boundaries. A good example of such an initiative is the current work on the development of an integrated pathway for the management of people with glaucoma. Trusts should support their clinicians and practitioners in facilitating the integration of primary, community and secondary care services.

During 2010-11, Commissioners should establish partnerships in primary care involving groupings of GPs and other health and social care providers, which incorporate integration along clinical care pathways and address the wider determinants of health. In particular, the partnerships should look at the potential for improvement in the care and support for patients with long term conditions, mental health problems, palliative care, families and children. In developing these partnerships, Commissioners should ensure that due regard is given to existing services provided by the voluntary/ community sectors and by other partners such as Councils, housing and education. Commissioners should also engage fully with PCC and service users to ensure proposed service models are responsive to client needs.

As part of this programme, and building on work in 2009-10, Commissioners and Trusts should continue to identify people with long term health conditions as early as possible and provide person centred care plans tailored to individual needs and wishes, supported through a case management approach that will improve the quality of local care and support available to users and their carers and enable people to better manage their conditions.

As medicines constitute a key aspect of care management, every effort must be made to optimise their safe, effective and economic use, including actions to secure further improvement in generic prescribing and the extension of repeat dispensing in line with the Pharmaceutical Effectiveness Programme. Commissioners should ensure that effective arrangements are in place for medicines management, including the introduction during 2010-11 of a NI medicines formulary and potentially expanding the role of community pharmacists within the primary care team.

During 2010-11, in developing partnerships in primary care, Commissioners should also explore the opportunities for primary care out-of-hours services to more effectively integrate with A&E and ambulance services in the provision of unscheduled care services, to include the physical co-location of out-of-hours services with A&E, single point triage, and the streamlining of management arrangements to maximise value from the complementary skill-sets and capacities and offer a more efficient, cost-effective service for patients. During 2010-11 Commissioners should also continue to progress work on the development of a regional out of hours service.

GPs are now expanding the services they provide and in some instances gaining more specialist expertise and training in specific areas. Subsequently the range and scope of healthcare that can and will be provided in local communities is likely to expand. Commissioners, working in partnership with relevant training agencies and other stakeholders, should facilitate specialisation, skills development and education in primary care. Commissioners should also explore the potential to use primary care information more effectively to proactively identify patients and families at risk of ill health and plan for their care.

Integrated care will require joint training as well as new skills to manage patients effectively along clinical pathways. Training agencies should be considering this and looking at ways of providing this. Agencies should also consider the generic skills and roles required at local levels to support integrated care. Commissioners should encourage the use of lay health workers to deliver healthcare in local communities.

Direct Payments also play an important role in facilitating independent living as they offer service users flexibility, choice and control over the purchase and delivery of the social care services that best support them. Trusts should continue to promote the use of Direct Payments as an alternative to traditional social care provision.

Consistent with the recently launched Departmental strategy, providers should ensure that each person identified as needing palliative care or end of life care is supported by a multi-disciplinary team on a 24/7 basis, which is proactive in working with private sector care home providers and carers to be able to offer people the choice of dying at home with dignity. These should be considered in the context of the Gold Standards Framework, (integrated) Care Pathway for the Dying and the best standards of multi-professional education as outlined in the Framework for Generalist and Specialist Palliative and End of Life Care Competency.

### *Standards and Targets*

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Pathway management:** by March 2011, the HSC Board should establish: (i) models of integrated care in community settings which incorporate integration along clinical care pathways and address the wider determinants of health; and (ii) models of unscheduled care in hospital settings which integrate primary care out-of-hours services with ambulance and A&E services.

- **Hospital discharges (PSA 3.1):** from April 2010, the HSC Board and Trusts should ensure that 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days. All other patients should be discharged within six hours of being declared medically fit.
- **Unplanned admissions (PSA 3.2):** by March 2011, the HSC Board and Trusts should further develop early intervention approaches to support identified patients with severe chronic diseases (e.g. heart disease and respiratory conditions) so that exacerbations of their disease which would otherwise lead to unplanned hospital admissions are reduced by 50%.
- **Direct payments:** by March 2011, the HSC Board and Trusts should increase the number of direct payment cases to 1,750.
- **Palliative care:** by March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.
- **Primary care access:** from April 2010, the HSC Board should ensure 70% of patients receive an appointment within two working days with a GP or appropriate practice based primary care practitioner, increasing to 80% from April 2011.
- **Medicines management:** by March 2011, the HSC Board should introduce a NI medicines formulary.

## **PRIORITY AREA 4: HELP OLDER PEOPLE TO LIVE INDEPENDENTLY**

***Aim: to ensure that older people are able to remain independent in their own homes and communities with a good quality of life for as long as possible.***

With life expectancy increasing, it is important that the HSC supports people to remain healthy both physically and mentally for as long as possible. During 2010-11 Commissioners and Trusts should continue to provide support to help older people live independent lives through ensuring local access to day care and respite services, together with the provision of targeted domiciliary care support, and effective management of long term conditions and end of life care.

Effective partnership arrangements should be established with DSD, local councils, voluntary, community and independent sector organisations to provide support to older people including initiatives to reduce social isolation, promote healthy life styles, develop more flexible transport arrangements and reduce fuel poverty. Commissioners and Trusts should continue to support this multi-agency approach.

Trusts should ensure that patients discharged from hospital are offered where appropriate active rehabilitation that reduces the need for residential care or domiciliary care. Planning for discharge should begin on admission and plans should be agreed with local integrated teams. Assessment of ongoing needs should take place at home or in intermediate care settings rather than in hospital. Consideration should be given to the needs of carers as part of the assessment process.

Providers should ensure that decisions on patients' long term care needs are made by all relevant professionals within the framework defined in the NI Single Assessment Tool to ensure that a consistent, comprehensive approach is taken in all cases. Patients, clients and carers should be appropriately involved in decisions being made about their community based health and social care. All patients should be provided with a copy of their individual care plan to enable them and their carers to understand the level of care to be provided and who to contact if difficulties arise with care package arrangements.

The vital role of carers and the contributions they make as expert partners and the support they need to fulfil this role should be recognised within care plans. Providers should ensure that carers are aware that they have a statutory right to an assessment of their own needs, and the Carer's Support and Needs Assessment component of NISAT provides an effective and consistent framework for this. Commissioners should plan for services to carers on the basis of the joint *Review of Support Provision for Carers* published in December 2009.

### *Standards and Targets*

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Supporting people at home (PSA 4.1):** from April 2010, the HSC Board and Trusts should ensure at least 45% of people in care management have their assessed care needs met in a domiciliary setting.
- **Assessment and treatment of older people (PSA 4.2):** from April 2010, the HSC Board and Trusts should ensure older people with continuing care needs wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.
- **Individualised Care Plans:** from December 2010, the HSC Board and Trusts should ensure any patient receiving a new care package at home is provided with a copy of their individual care plan to enable them to understand the level of care to be provided and who to contact if difficulties arise with care package arrangements.

## **PRIORITY AREA 5: IMPROVE CHILDREN'S HEALTH AND WELL-BEING**

***Aim: to improve the health and wellbeing of children, to protect vulnerable children, to help families stay together and to improve outcomes for children and young people including those leaving care.***

The Department's key policy priorities are set out in Families Matter and Care Matters both of which have now been approved by the Executive. The emphasis is on early intervention and prevention to help all families and parents to be confident and responsible in helping their children reach their full potential and reduce the number of children who have to be taken into care. The two strategies provide a continuum of support with Families Matter focusing on universal and targeted support and Care Matters focussing on higher level need.

During 2010-11, Trusts should continue to increase the use of family-friendly approaches such as family group conferencing and mediation and identify family-specific support packages to meet families' needs. The HSC Board and Public Health Agency, working with Trusts, should commission family support services in partnership with other key stakeholders, such as voluntary sector organisations.

### *Safeguarding vulnerable children*

The need for robust structures and systems to support safeguarding children practice has been repeatedly emphasised in child death inquiry reports, case management reviews, the DHSSPS Inspection Report, Our Children and Young People – Our Shared Responsibility and in recent RQIA inspection reports into child protection services. Over the next year, a key safeguarding priority will be to complete the transition from Area Child protection Committee arrangements, building on the establishment of the Regional Child protection Committee and laying the groundwork for a statutory and independently chaired Safeguarding Board for Northern Ireland.

The Safeguarding Board will have responsibility for broadening the approach to safeguarding children beyond child protection into a wider child welfare agenda. The Safeguarding Board will have three main objectives: to secure effective coordination of what is done to safeguard and promote the welfare of children by each person and agency represented on the Board; to ensure the effectiveness of what is done by

each agency and person for that purpose; and, to communicate the need to safeguard and promote the welfare of children to the wider community.

During 2010-11, the Department will update the Co-operating to Safeguard Children guidance in preparation for the planned establishment of the Safeguarding Board. The revised guidance will take account of structural challenges in the delivery of services to children and families brought about by the reform of public administration alongside the introduction of the Safeguarding Board and new Safeguarding Vulnerable Groups arrangements. The guidance will also reflect the work being taken forward on the promotion of infant and child mental health and wellbeing.

Trusts should continue to ensure the effectiveness of child protection arrangements and services to families through the operation of gateway teams and the production of high quality assessments of need using the UNOCINI single assessment tool. Trusts should also continue to ensure that supervision standards, information sharing protocols and recording standards are complied with on a consistent basis. Further work is needed to align other assessment tools with the UNOCINI framework and to develop existing IT systems to underpin the functioning of Gateway and Family Intervention Teams and the referral and assessment process. Commissioners and Trusts should also continue to work positively with police colleagues to play their full part in the operation of statutory public protection arrangements introduced by the NIO in October 2009.

The Department has recently issued new guidance on the use of child protection procedures for looked-after children; Trusts should apply this guidance from April 2010 onwards.

The Department expect the Reform Implementation Team – established in 2006 to drive forward a comprehensive change agenda for child protection services in NI in partnership across Commissioners, Trusts, police and education – to continue to progress key initiatives in 2010-11 including: the implementation of the public law outline; the development of a caseload management model; the development of policies and procedures for residential care; and, the development of an audit process to underpin RIT products.

*Vetting*

The Department is implementing a new Vetting and Barring Scheme, which is being put in place under the Safeguarding Vulnerable Groups (NI) Order 2007. The new scheme extends to those who work with children in both paid and voluntary capacities and for the first time will establish a register of those who work with both children and vulnerable adults. Trusts should take steps to ensure that their employment and recruitment practice complies with the requirements of the scheme as it is fully implemented including taking steps to prepare for the phasing in of their existing workforce into the scheme over the following five years.

### *Looked-after children*

While the best place for children and young people is nearly always with their families, sometimes the best interests of the child are served by their being looked after by health and social care services. At any one time, 2,500 children are looked after. The greater number of these young people live with a foster family with around 12% in residential care.

When health and social care services take on parental responsibility for children every effort must be made to provide them with stability, protect them from further harm and be ambitious for their futures. Trusts should work to achieve greater permanence for children in care – primarily through long-term foster/residential care, returning children home or through adoption. All children in care should have a plan for permanence by the time they have been in care for six months.

During 2010-11, Trusts should also implement Departmental guidance on delegated authority (issued in January 2010) with a view to giving more children in care the opportunity to live their lives without bureaucracy unnecessarily impacting negatively on routine, day-to-day decision making. Similarly, Trusts should make further progress in developing and implementing new arrangements to recruit more kinship foster carers. All Trusts should have dedicated kinship foster carer teams or dedicated kinship foster carers workers within their fostering teams. And all Trusts should prepare for the implementation of new and separate approval processes for kinship foster carers which will be in place by September 2010.

In relation to adoption, all Trusts should eliminate unnecessary delays in progressing adoptions and provide better support to all parties involved including birth families,

adopters and children and young people themselves. The Department expects to see significant progress in the year ahead in the move towards a lead regional Trust for a Regional Adoption Service.

#### *Improved outcomes for care leavers*

During 2010-11, the Department expects to see improvements in outcomes for children and young people in care or on leaving care. Trusts should ensure that young people in care from age 13 are able to participate in an accredited preparation for adulthood programme. Trusts should also encourage more young people in care and care leavers to seek and attain employment, education and training opportunities, working in partnership with other agencies such as the careers service. And Trusts should also ensure adequate provision is made for those young people who wish to have the opportunity to continue living in their foster home until they are aged at least 21, taking steps to improve therapeutic support to residential children's homes.

These initiatives are intended to underpin a longer term strategic focus on improved outcomes for 18-21 year old care leavers in line with the Care Matters agenda. All Trusts should now have Through-care Transition Teams in place as an essential mechanism to ensure the provision of dedicated support services and to provide a gateway to other key services. A range of other collaborative initiatives are also being progressed to support this objective, including the development of guidance and protocols on the accommodation needs of care leavers, employability schemes, and the prospective introduction of delegated authority for foster carers and kinship care. Trusts should support the relevant Departments and agencies in the development and implementation of these initiatives to provide a strong foundation for 2010-11. This will include the piloting of new standards for facilities accommodating care leavers aged 16-21 and some older children in care.

There has been considerable co-operation between the Department, the HSC Board, Trusts, DSD and the Housing Executive on the development of joint accommodation provision to provide housing and support for care leavers aged 16-21. Trusts should continue to ensure that they fully discharge their statutory responsibilities towards young people living within jointly commissioned accommodation. They should also continue to work in partnership with housing colleagues to meet the needs of homeless young people and ensure that they assess the needs of this population.

## *Standards and Targets*

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Children in care:** from April 2010, the HSC Board and Trusts should ensure children admitted to residential care have, prior to their admission: (i) been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process. For every child taken into care, a plan for permanence and associated timescale should be developed within six months and formally agreed at the first six-monthly LAC review.
- **Family support interventions (PSA 5.1):** by March 2011, the HSC Board and Trusts should provide family support interventions to 3,000 children in vulnerable families each year. By this date, Trusts should also have updated the Regional Information System with details of family support services which they provide.
- **Care leavers in education, training or employment (PSA 5.2):** from April 2010, the HSC Board and Trusts should ensure that at least 70% of all care leavers aged 19 are in education, training or employment.
- **Care leavers living with former foster carers or supported families (PSA 5.3):** by March 2011, the HSC Board and Trusts should ensure that at least 200 care leavers aged 18+ are living with their former foster carers or supported family.
- **Looked-after children on the child protection register (PSA 5.4):** by March 2011, the HSC Board and Trusts should ensure that the child protection status of all looked-after children on the current register is reviewed in line with Departmental guidance issued in April 2010.
- **Family group conferencing:** during 2010/11, the HSC Board and Trusts should ensure that at least 500 children and young people participate in a family group conference.
- **Assessment of children at risk and in need:** from April 2010, the HSC Board and Trusts should ensure the following:
  - Child protection (allocation of referrals) – all child protection referrals are allocated within 24 hours of receipt of the referral

- Child protection (initial assessment) – all child protection referrals are investigated and an initial assessment completed within 10 working days from the date of the original referral being received
- Child protection (pathway assessment) – following the completion of the initial assessment, a child protection case conference is held within 15 working days of the original referral being received
- Looked-after children (initial assessment) – an initial assessment is completed within 10 working days from the date of the child becoming looked after
- Family support (family support referral) – 90% of family support referrals are allocated to a social worker within 20 working days for initial assessment
- Family support (initial assessment) – all family support referrals are investigated and an initial assessment completed within 10 working days from the date the original referral was allocated to the social worker
- Family support (pathway assessment) – on completion of the initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days.

## **PRIORITY AREA 6: IMPROVE MENTAL HEALTH SERVICES AND SERVICES FOR PEOPLE WITH DISABILITIES**

***Aim: to improve the mental health of the population and to respond effectively to the needs of individuals with a mental health condition or a learning disability or physical/ sensory disability, and to support them to lead fulfilling lives in their own home and communities.***

### *Mental health services*

One in four people will suffer a mental health condition at some stage in their lives. Not only does this impact on the individual but also has a potential to have a profound social and economic impact on our society and on the lives of children and families.

The focus on mental health services should include the promotion of mental wellbeing and prevention of mental health conditions, where possible. During 2010-11, Commissioners and Trusts should ensure that the provision of services to people with a mental health need should be through a stepped care approach, recognising that the majority of services should be delivered in primary and community care settings through multidisciplinary and cost-effective approaches. Improving access to psychological therapies should be an integral part of a modern service and be incorporated within the stepped care approach. Inappropriate admission to hospital must be avoided and, where admission is necessary, a focus on access to therapeutic interventions is essential, and early discharge must be facilitated.

The key driver will be the Executive-approved Bamford Action Plan (October 2009). Bamford recognised the need for change – both societal and service change – with a focus on the creation of an emotionally resilient society, early intervention and a recovery ethos, where possible. For those with severe and enduring mental health conditions, there remains a need to provide specialist support and multiagency action. Strategic drivers will include the soon-to-be published Personality Disorder Strategy and Psychological Therapies Strategy, in addition to the recently published consultation on the Dementia Strategy. All of these documents will set strategic direction for future service developments recognising, of course, that enhanced

service provision will take some time to achieve. Such an approach is consistent with Bamford which identified that sustained development will be required over at least 15 years.

Mental health legislation is also an important driver for societal and service change. Preliminary Executive approval has been given to proceed with legislative change through the development of policy on a single Bill, encompassing mental capacity and mental health which, subject to Executive approval, will be enacted in 2012-13. Within this legal framework, change is needed to deliver a broader range of interventions and treatments. The legal framework will also include personality disorder in the definition of a mental disorder. In addition, the importance of advocacy for service users and carers will be recognised.

Risk assessment and management is a core element of mental health services and regional guidance in this regard has been issued, with piloting of supporting tools and associated training. Commissioners and Trusts should ensure this guidance is adopted during 2010-11 including implementation of supporting tools.

Regional principles to guide the provision of services for those in crisis and at risk of suicide or serious harm were published in January 2010. These principles should be taken into account by Commissioners and Trusts when developing crisis intervention services.

During 2010-11 and beyond, Commissioners and Trusts should ensure that progress is made in the following areas to improve mental health services and enhance mental wellbeing of the population:

- Promotion of early interventions including psychological therapies
- Strengthening of multidisciplinary community services, including crisis intervention services aligned to stated DHSSPS principles
- Continued development of the stepped care model across all appropriate mental health services
- Reconfiguration of acute inpatient facilities with a reduction in overall acute provision supported by step-up and step-down facilities
- Continued resettlement of long stay patients from hospital into the community

- Staged development of specialist services – including personality disorder services, and forensic mental health and learning disability services
- Development of regional low secure inpatient provision based on the Department’s scoping paper
- Focus on early intervention for women and children with the development of an integrated pathway for peri-natal mental health services and promotion of infant and family mental health and wellbeing
- Development of HSC workforce plans for mental health services, building on the recommendations of the Workforce Report commissioned by the Department, with particular reference to the need for enhanced skills in the community, and development of specialist skills to deliver a range of therapeutic interventions for those with severe and enduring mental ill health
- Commencement of implementation of the Dementia Strategy and associated action plan to be published later in 2010
- Development of a regional approach to the reduction of extra-contractual referrals in both mental health and challenging behaviour
- Further development of a regional approach to eating disorder services recognising the need for specialist provision, and a commitment to reduce the number of extra-contractual referrals
- Ensure full and appropriate involvement of social services staff in Multi-Agency Risk Assessment Conferences (MARACs) to reduce the risk of domestic violence
- Reduce the trauma of sexual violence by securing the establishment of the regional Sexual Assessment and Resource Centre, to be operational by early 2012
- Subject to Executive approval, commence preparations for a single Bill encompassing mental capacity and mental health to be enacted from 2012 onwards.

### *Learning disability services*

The focus for learning disability will be a “whole life approach” to early intervention, assessment, diagnosis, treatment, care planning and support. This requires a multi-agency approach at local and regional levels. The Department expects a greater

focus on “purposeful lives” which supports the individual to live as independently as possible. Changing demographics and improvements in treatment and care mean that not only will there be an ageing population of individuals with a learning disability but also an increasing number of people with more severe learning disabilities. At the same time the average age of those caring for them is also increasing. In developing community services, Commissioners and Trusts should ensure a co-ordinated whole life approach that values individuals as welcome members of society.

The aim for both learning and physical/sensory disability services will be to provide person-centred, seamless community-based services, informed by the views of service users and their carers. It is vital that people are supported to live in the community and that inappropriate admission to hospital is avoided. Where admission is necessary, Commissioners and Trusts must facilitate timely discharge.

Carers have an important role to play in providing community support. Innovative approaches to respite care should be adopted by Commissioners and Trusts as part of service redesign to promote “purposeful days” and social inclusion for the individuals with learning disabilities and support for carers.

Local and fully inclusive access to services for patients with a learning disability must also be increasingly available; people should be provided with services close to their own home and should not be excluded from mainstream services.

The improvement of services for people of all ages affected by autism is a key priority for the Department; the strategic direction for the next three years is set out in the ASD Strategic Action Plan published in June 2009. Implementation should proceed through the regional ASD network which should report progress via the HSC Bamford Taskforce.

During 2010-11 and beyond, Commissioners and Trusts should ensure that progress is made in the following areas to improve access to health and care, and to enhance outcomes for individuals with a learning disability and their carers:

- Continued resettlement of the long stay population and the development of innovative approaches to prevent delayed discharges
- Redesign of community infrastructure to care and support individuals to live fuller lives

- Development of holistic approaches to care planning using appropriate assessment tools for both individuals and carers
- Promotion of “purposeful respite” that encourages social inclusion and support for carers
- Delivery of innovative, multiagency approaches to supported living in the community
- Development of a stepped care approach to the delivery of learning disability services in the community, with particular reference to care in the community
- Implementation of a regional bed protocol for those patients requiring acute hospital admission, to be published later in 2010
- Development of HSC workforce plans for learning disability, building on the recommendations of the Workforce Report commissioned by the Department; with particular reference to the need for enhanced skills in the community
- Enhancement of autism spectrum disorder services with particular reference to multiagency approaches to support early intervention, diagnosis, treatment and care and promote the timely delivery of services to children and adults.

#### *Physical and sensory disability*

The key driver for physical and sensory disability services will be the forthcoming disability strategy which will be issued for consultation in late-2010. This will be complemented by the soon-to-be- published Acquired Brain Injury Action Plan and consultation on a new Speech and Language Therapy Action Plan for children. All of these documents will set strategic direction for future years recognising, of course, that implementation will take some time to achieve.

Key themes for the disability strategy covering both adults and children will include:

- Promoting health and wellbeing, early intervention and social inclusion
- Supporting people to live independent lives
- Supporting carers and families
- Providing better services to meet the need of the individual
- Development of the infrastructure to implement change.

During 2010-11 and beyond, Commissioners and Trusts should ensure that progress is made in the following areas to improve access to health and care, and to enhance outcomes for individuals with a physical and/or sensory disability and their carers:

- Development of an integrated care planning approach to those with physical and/or sensory disability
- Service innovation and redesign to enhance the provision of respite for individuals and carers that focuses on age appropriate interventions to support social inclusion and purposeful living
- Improved access to wheelchair services especially for those requiring specialist wheelchairs, through service redesign and innovative approaches
- Implementation of NI contribution to *UK Vision Strategy* and recommendations contained in “*Challenge and Change*” report for sensory disability, including an agreed approach to the identification and use of established sensory equipment budgets
- Commencement of implementation of the speech and language therapy action plan for children to support early intervention and co-ordinated care
- Implementation of the acquired brain injury action plan due to be published soon, and especially the delivery of co-ordinated services in the community for those with complex conditions
- Focus on multi-agency arrangements to support those with acquired brain injury to live purposeful lives and to reduce the need for extra-contractual referrals
- Take forward the provision of assessments required to allocate the additional support for Thalidomide survivors generated by provision of additional resources which have been made available by the Department to the Thalidomide Trust.

#### *Standards and targets*

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Unplanned admissions (PSA 6.1):** by March 2011, the HSC Board and Trusts should take steps to reduce the number of admissions to acute mental health hospitals by 10%.

- **Assessment and treatment (PSA 6.3):** from April 2010, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health issues with the exception of psychological therapies for which no patient should wait longer than 13 weeks.
- **Card before you leave:** from April 2010, the HSC Board and Trusts should ensure that all adults and children who self harm and present for assessment at A&E are offered a follow-up appointment with appropriate mental health services within 24 hours.
- **Resettlement of learning disability patients (PSA 6.4):** by March 2011, the HSC Board and Trusts should resettle 120 long stay patients from learning disability hospitals to appropriate places in the community compared to the March 2006 total. (Note: PSA target 6.2 for the resettlement of mental health patients has already been achieved.)
- **Discharge (both mental health and those with a learning or physical/sensory disability):** from April 2010, the HSC Board and Trusts should ensure that 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. All mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge.
- **Eating Disorders.** Further enhancement of a regional approach to eating disorder services recognising the need for specialist provision, and at least a 10% reduction in extra contractual referrals.
- **Respite – learning disability (PSA 6.7):** during 2010-11, the HSC Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 125 additional respite packages by March 2011 compared to the March 2008 total.
- **Respite – dementia:** during 2010-11, the HSC Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 1,200 additional dementia respite places by March 2011 compared to the March 2008 total.

- **Respite – physical/sensory disability (PSA 6.5):** during 2010-11, the HSC Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 110 additional respite packages compared to the March 2008 total.
- **Wheelchairs (PSA 6.6):** by March 2011, the HSC Board and Trusts should ensure a 13-week maximum waiting time for all wheelchairs, including specialised wheelchairs.
- **Housing adaptations:** from April 2010, the HSC Board and Trusts should ensure all lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate, and all urgent minor housing adaptations to be completed within 10 working days.
- **Autism:** from April 2010, the PHA, HSC Board and Trusts should continue to progress the ASD action plan, ensuring that all children wait no longer than 13 weeks for assessment following referral and a further 13 weeks for commencement of specialised intervention.
- **Acquired Brain Injury:** from April 2010, the HSC Board and Trusts should ensure a 13-week maximum waiting time from referral to assessment and commencement of specialised treatment.
- **Domestic violence:** during 2010-11, each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences (MARACs) held in their area during the year.

## **PRIORITY AREA 7: ENSURE FINANCIAL STABILITY AND THE EFFECTIVE USE OF RESOURCES**

***Aim – to ensure that all of the resources available to the NI health and social care service are used appropriately and effectively to improve the health and wellbeing of the NI population and to provide better treatment and care, and that the service lives within available resources.***

### *Finance and productivity*

The scale of the financial challenge facing the Department and the HSC in 2010-11 is unprecedented. Under existing CSR07 plans the HSC had been already required to deliver cumulative savings of £249m by the end of 2010-11; this requirement was recently increased by a further £105m following the Executive's decision to cut the planned 2010-11 budget for health and social care.

During 2010-11 Commissioners and Trust must protect and improve frontline services – consistent with the policy direction detailed earlier in this document – while at the same time making further productivity gains and taking forward key reforms. It is essential that the HSC ensures the best possible use of available resources and maintains strong financial control; this will be vital to the continued provision of high quality health and social care.

The focus should be on securing value for money for every pound invested, prioritising the most effective treatments, reducing errors and waste and keeping people healthy and independent for as long as possible. This will require innovation and radical thinking, as well as consistent sharing of best practice and the rolling out of the best examples of providing routine healthcare that is efficient and effective. As far as possible, reforms should be taken forward on a robust, consistent, co-ordinated basis across the HSC.

Continuing and further improved collaborative working is essential and advice should be taken from across HSC, including the views of staff, senior clinicians, patients and managers. This will complement more detailed local planning to put in place patterns of services that are sustainable, and delivers to the values and key priorities set out in this document. All organisations and individuals need to work together, to look at

own practice to ensure that it is fully in line with best practice, and to take responsibility for the best possible care along the whole pathway.

Further to this there needs to be a commitment to innovation and the promotion and conduct of research to improve the current and future health and care of the population. In the more challenging financial environment, research and innovation is even more important in identifying new ways of preventing, diagnosing and treating disease that are essential if we are to continue to increase both the quality and productivity of services into the future.

It is expected that further improvements in productivity, as expressed in both throughput and effectiveness of care, resulting from the changed professional working practices will be delivered across all programmes of care.

To deliver the required savings and efficiency improvements and deliver contracted activity levels in 2010-11, and secure break-even in March 2011, it is essential that the HSC Board and Trusts have effective programme planning arrangements in place.

### *Workforce*

HSC services are delivered by people: over two thirds of HSC costs are staff-related. The Department and HSC are fully committed to staff engagement and working in partnership with Trade Union Side ensuring that organisational expectations are met and that staff at all levels are equipped with the resources and skills required to deliver.

It is essential that Commissioners and Trusts take full account of workforce implications in the development of their commissioning and delivery plans. Plans should include a robust risk assessment to identify any potential workforce capacity and capability issues, including the need to comply with the European Working Time Directive. Commissioners should offer constructive challenge to providers about the workforce assumptions in their delivery plans.

Developing staff, ensuring they are equipped with the skills they need to support changes and improvements in patient and client care and enabling them to progress in their careers is essential to the ambition of providing high quality patient centred

services in addition to underpinning successful organisational performance. All Trusts should have in place comprehensive learning and development plans, aligned with the Department's Workforce Learning Strategy, setting out a development programme for staff across all professional groups and at all levels.

Trust learning and development plans should have clear priorities – including the widening of access and increased participation in learning – supported by appropriate policies and an implementation plan. Plans should ensure sufficient investment to support the redeployment of staff into new ways of working, especially those moving to new roles and settings. Plans should also ensure all staff undertaking managerial roles have appropriate training for the role, and that managers undertake responsibility for development of their staff

Commissioners and Trusts will be expected to encourage multi-professional development through making the best use of current multi-disciplinary fora and, where necessary, the development of new processes to ensure all undergraduate and post graduate healthcare and social work students participate in multi-disciplinary working.

Commissioners and Trusts should also prepare for the introduction of medical revalidation in 2011 to help organisations deliver better quality of care and patient safety by ensuring that doctors remain up to date throughout their career. Commissioners should be seeking assurance that the clinical workforce is appropriately regulated to ensure patient safety. In tandem, Trusts should ensure that the necessary processes have been developed to ensure that appraisals are carried out on doctors in line with Trusts appraisal cycles to support the revalidation of medical staff.

All HSC organisations should support staff health and wellbeing by providing effective, targeted support for staff who present with ill health, being proactive in tackling the causes of ill health (both work and lifestyle related) and where there are clear benefits, providing early intervention services. HSC organisations will be expected to put in place organisational health and wellbeing strategies including being pro-active in improving the quality of and speeding up access to occupational health services, and strengthening board accountability for the management of sickness and absence.

### *Estate and equipment*

A high quality service demands modern, fit for purpose facilities and equipment. Within the available resources, action is underway to renew or replace significant elements of the health and social care infrastructure across NI. In parallel with this major new-build capital programme, it is essential that Trusts have effective ongoing arrangements for identifying and responding to emerging risks to the current infrastructure to ensure that adherence to minimum statutory requirements and to reasonable expectations of patients, the public and HSC staff.

During 2010-11 the Department, working with Commissioners and Trusts will undertake a review of capital priorities. The resulting capital plan will complement and support the strategic direction set out in this document, will provide value for money and will be affordable in terms of both capital budgets and associated revenue requirements. Work will continue in 2010-11 on rationalisation of the existing estate with a view to delivering efficiencies and releasing surplus assets.

### *Standards and targets*

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Financial Breakeven (PSA 7.1):** during 2010-11, the Department and all HSC organisations should live within the resources allocated and achieve in-year financial breakeven and establish a medium and longer-term financially sustainable position.
- **Efficiency savings (PSA 7.1):** from April 2010, the HSC Board and Trusts should establish effective arrangements to ensure the full delivery of agreed efficiency savings during 2010-11.
- **Hospital productivity (PSA 7.2):** each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.
- **Daycase rate (PSA 7.2):** each Trust should secure improvements in daycase rates for a defined range of procedures in accordance with Departmental targets for March 2011.

- **Pre-operative length of stay (PSA 7.2):** each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2011.
- **Absenteeism (PSA 7.2):** each Trust should reduce its level of absenteeism to no more than 5.2% in the year to March 2011.
- **Greater use of generic drugs (PSA 7.2):** the HSC Board should ensure the level of dispensing of generic drugs increases to at least 64% by March 2011.
- **Cancelled operations:** from April 2010, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.
- **Staff health and wellbeing:** all HSC organisations should put in place organisational health and well being strategies including being pro-active in improving the quality of and speeding up access to occupational health services, and strengthen board accountability for the management of sickness and absence.

## **ANNEX 1 – PSA TARGETS**

### **PFA Priority 1: Improve the health status of the population and reduce health inequalities – Related PSA Targets 2008-11**

1.1 By March 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 NI average.

1.2 By March 2011, reduce to 21% and 25% respectively the proportion of adults and manual worker subset who smoke.

1.3 By March 2010, halt the rise in obesity.

1.4 By March 2010, ensure a 5% reduction in the proportion of adults who binge drink.

1.5 By March 2010, ensure a 10% reduction in the proportion of young people who drink and who report getting drunk.

1.6 By March 2010, ensure a 5% reduction in the proportion of young adults taking illegal drugs.

1.7 By March 2011, ensure a 10% reduction in the number of children at risk from parental alcohol and/ or drug dependency.

1.8 By March 2011, achieve a reduction of at least 15% in the suicide rate.

1.9 By March 2010, achieve a 40% reduction in the rate of births to mothers under 17.

1.10 By 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.

1.11 By 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.

1.12 By March 2009, extend the regional breast cancer screening programme to cover those aged 65-70.

### **PFA Priority 2: Ensure services are safe & sustainable, accessible & patient-centred – Related PSA Targets 2008-11**

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

2.2 By March 2011, ensure a 21-week waiting time for drug therapies for treatment of severe arthritis.

2.3 By March 2009, no patient will wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 17 weeks for inpatient or day case treatment, working towards a total journey time of 25 weeks by March 2011.

2.4 By March 2009, 95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.

2.5 By March 2009, 98% of cancer patients will commence treatment within 31 days of decision to treat, and 95% of patients urgently referred with suspected cancer will begin treatment within 62 days.

2.6 By March 2011, ensure a 10% reduction in mortality and disability from stroke

2.7 By March 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 live donor transplant (six months by 2010).

2.8 By March 2011, NIAS to respond to 75% of life-threatening calls within eight minutes.

### **PFA Priority 3: Integrate primary, community and secondary care services – Related PSA Targets 2008-11**

3.1 From April 2008, 90% 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, from April 2008, be discharged from hospital within six hours of being declared medically fit.

3.2 By 2011, 50% reduction in unplanned hospital admissions for case managed patients with severe chronic diseases (e.g. heart disease and respiratory conditions).

**PFA Priority 4 – Help older people to live independently – Related PSA Targets 2008-11**

4.1 By 2010, 45% of people with assessed community care needs supported at home.

4.2 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.

**PFA Priority 5: Improve children’s health and well-being – Related PSA Targets 2008-11**

5.1 By 2011, provide family support interventions to 3,500 children in vulnerable families each year.

5.2 By 2011, increase by 50% the proportion of care leavers in education, training, or employment at age 19.

5.3 By 2011, increase by 25% the number of care leavers aged 18-20 living with their former foster carers or supported family.

5.4 By 2011, reduce by 12% the number of children requiring to be placed on the child protection register.

**PFA Priority 6: Improve mental health services and services for people with disabilities – Related PSA Targets 2008-11**

6.1 By 2011, ensure a 10% reduction in admissions to mental health hospitals.

6.2 By 2011, ensure a 10% reduction in the number of long-stay patients in mental health hospitals.

6.3 By 2009, ensure a 13-week maximum waiting time for defined psychotherapy services.

6.4 By 2011, ensure a 25% reduction in the number of long-stay patients in learning disability institutions.

6.5 By 2011, improve access to physical/sensory disability care by providing an additional 200 respite packages a year.

6.6 By 2011, ensure a 13-week maximum waiting time for specialised wheelchairs.

6.7 By 2011, improve access to learning disability care by providing an additional 200 respite packages a year

**PFA Priority 7: Ensure financial stability and the effective use of resources – Related PSA Targets 2008-11**

7.1 By 2011, reduce administration costs within the health and social care system by £53m a year.

7.2 Improve productivity, efficiency and effectiveness in the HSC as measured by such indicators as:

- Patient throughput per bed
- Ratio of day cases to inpatient cases
- Use of more effective drug therapies
- Greater use of generic drugs
- Improved procurement practices
- Proportion of people with community care needs supported at home
- Staff absenteeism.

7.3 Ensure the timely modernisation of the HSC infrastructure to include:

- By 2009, Downe Enhanced Local Hospital due to be completed.
- By 2010, Ulster Hospital Phase A due to be completed.
- By 2011, first stage of Altnagelvin Phase 3 due to be completed.
- By 2011, Royal Phase 2 B due to be completed
- By 2008, Craigavon Crisis Resource Centre due to be completed
- By 2009, Castlereagh Community Treatment and Care Centre due to be completed
- By 2010, Portadown Health & Care Centre due to be completed
- By 2010, Gransha Mental Health Crisis Centre due to be completed
- By 2010, Regional Adolescent Psychiatric Unit & Child and Family Centre due to be completed
- By 2011, Health & Wellbeing Centres Phase 2 due to be completed

- By 2011, delivery of PACS to be completed.