Transforming Your Care

Draft Strategic Implementation Plan

October 2012

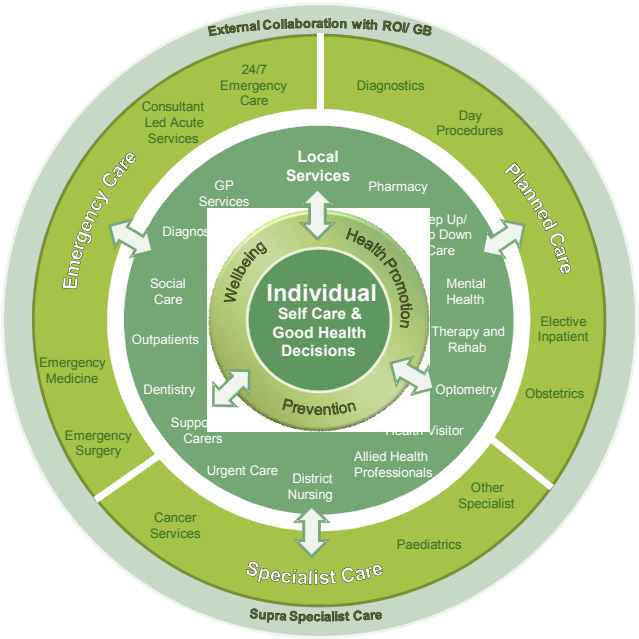
Health and Social Care Board

Contents

1 Executive summary

'Transforming Your Care: A Review of Health and Social Care' (TYC) was published by the Minister on 13 December 2011 and sets out 99 proposals for the future health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform. The review proposed a model of health and social care which would drive the future shape and direction of the service and puts the **individual at the centre** with services becoming increasingly accessible in local areas. This transformation will result in a significant shift in the way services are provided across hospitals and the community, with some provision moving from hospitals to the community, where it is safe and effective to do this.

'Transforming Your Care'
Model of health & social care



This draft Strategic Implementation Plan (SIP):

- Describes a planned approach for the delivery of the TYC proposals over the next 3 years.
- Reflects the shared ambitions and commitments of the TYC programme leadership and is intended for everyone involved in leading and managing delivery of any part of the TYC transformation programme across the health and social care system in Northern Ireland.
- Contains plans to enable engagement and public consultation. However, it is not the consultation document itself; that will be published in October 2012.
- Sets out the key commitments and the major changes which will drive service transformation in Section 4.2.

- Presents the big themes for each of the Programmes of Care over the next 3 years across the 5 Local Commissioning Group (LCG) areas (Section 4.4). At the heart of this are the draft 5 local Population Plans, which provide the building blocks for this draft SIP. These have been developed over the last 3 months and set out in detail the service transformation initiatives for delivery of the TYC proposals for each of the 5 local areas.

How we will collaborate to deliver

The draft SIP provides a coherent, controlled and managed framework which brings existing programmes together and adds new ones, in a well-integrated way, to deliver these proposals. We have developed an integrated planning approach which *aligns whole system planning, regional workstream planning and LCG area planning*. In bringing together our plans, *reducing health inequality* will be built into the heart of our design and implementation of the programme.

Alongside our aligned delivery strategy will be a robust collective *monitoring and learning* framework. This will include: integrated monitoring of delivery; assessing impact; spreading innovation and developing capabilities and supporting delivery and recognising system drivers.

The overall objective is to enable managed change from the existing service delivery model to one which encapsulates Transforming Your Care.

Recognising the importance of the transformation and its challenges, the Minister has stated his full support for TYC, particularly given the exciting opportunities its implementation presents.

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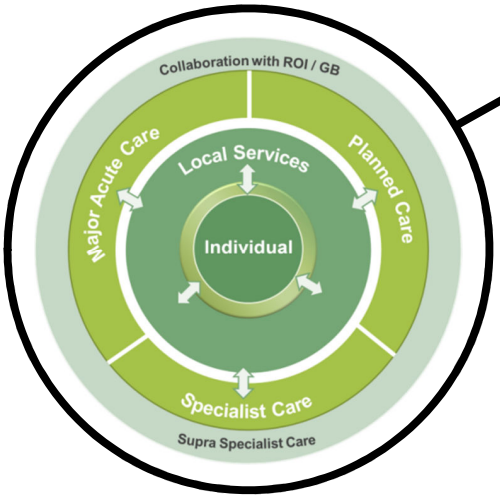
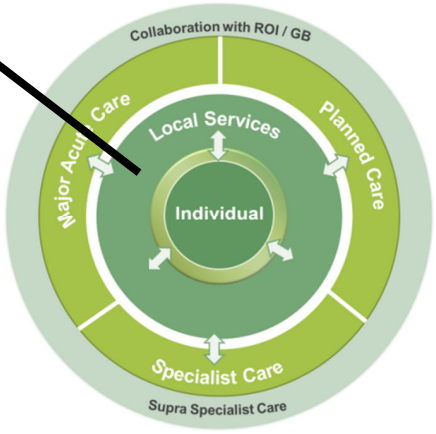
The major initiatives and drivers of the transformation are summarised below (presented in greater detail in Section 4 of this Strategic Implementation Plan):



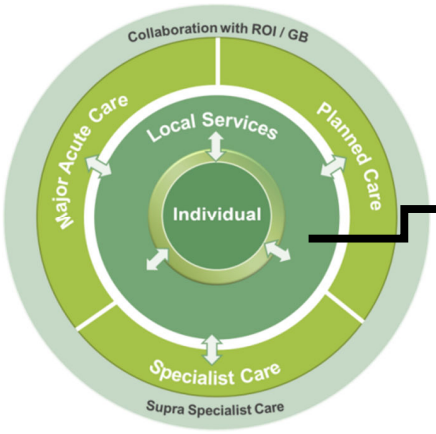
Population health & well-being

- **Implement the new Public Health Strategic Framework**
- Expand / introduce evidence-based programmes to support **parents and families**
- Extend the **Roots of Empathy** programme in primary schools
- Implement **Fitter Futures for All** to reduce obesity, and the **new tobacco strategy** to reduce smoking rates.
- Tackle alcohol and drug misuse

Local Services - At home and in the community



- **17 Integrated Care Partnerships** – bringing together health and social care providers, to work as collaborative networks, improving care pathways focusing initially on Older People and aspects of Long term Conditions; namely Diabetes; Stroke Services and Respiratory disease. Benefits include:
    - *Supporting a more co-ordinated, person-centred approach to how treatment and care are planned and delivered for specified Long Term Conditions;*
    - *Reducing ED attendances and admissions for Older People*
- **Reablement** – promoting greater independence for older people at home using planned short-term support services following a hospital admission or health or social care crisis at home
- **Falls prevention** programme to identify those at risk of falls and fragility fractures and provide targeted interventions
- **Personalised care**, with individual budgets to promote patient/client control over care and services
- Reduction in statutory residential care homes for older people
- Increase support for carers and improved access to respite care



Family and child care

- **Fostering schemes** for children hardest to place
- Embed **family support hubs** to focus on early intervention
- Reduce reliance on residential care homes.
- Develop Child and Adolescent Mental Health Services.

Mental health

- **6 Admissions units** – one in each 5 of local areas plus one more unit in the Western area
- **Significant reduction in institutional care** and the number of inpatient beds across the region by 2015
- **Improved focus** on community-based treatment.

Physical disability and sensory impairment

- **Care closer to home**, keeping as many people with a physical disability out of hospital where possible, improve rehabilitation
- **Enhance links** between community and voluntary services, create broader range of respite

Learning disability

- Move **clients into community based options** such as supported housing, and as a consequence reduce the number of people in institutional care
- The service will **resettle** all people with a learning disability living in hospital by March 2015 to community living options with appropriate support.
- Provide **support for families and carers** including short breaks/respite and day opportunities to enable people with a learning disability to remain at home with appropriate support.

Maternity & child health

- All children to be offered **universal child health programmes** as a means of supporting them and their families to have the best start in life.
- Safe and sustainable maternity services
- Development of **MLUs with effective links to consultant led care**
- Provide women with choice and promote normalisation of births
- Implement **Family Nurse Partnerships** to improve the health and well being of children and families

Palliative care & end of life

- **Public and staff involvement** and awareness of Palliative and End of Life care (End of life care refers to the last year).
- Identification, assessment and **advance care planning**
- **Co-ordination of care** across organisational Boundaries
- Improving the **availability** of services
- Increase the number of **staff confident and competent** in core principles of palliative and end of life care

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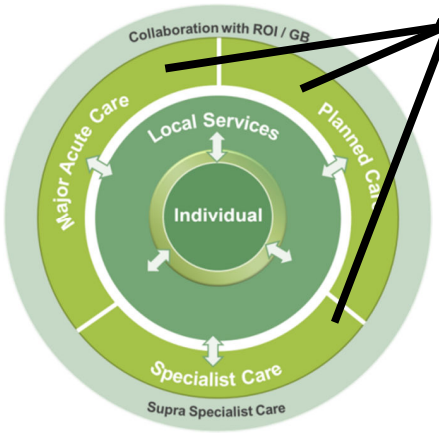
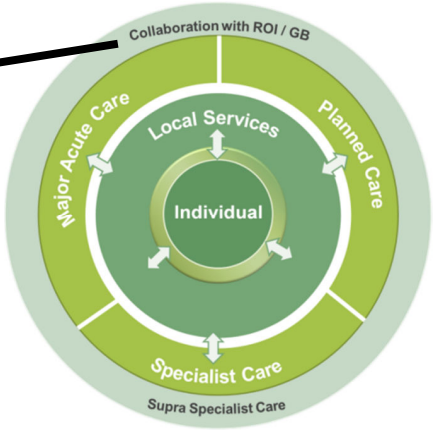


Acute care

- **5 – 7 networks** to guarantee safe and sustainable services – Address fragility of services in terms of throughput and staffing levels. Changes to services provided at hospitals, localising services where possible, centralising services where necessary, creating centres for major acute services and elective services for local populations.
- 1 **regional trauma centre** for Northern Ireland
- 24/7 access to safe sustainable **cardiac cath labs**, with an investment of £8m
- a **review of paediatric services** will be undertaken in 2012/13 to take account of the recommendations as outlined in the Maternity and Child health section of TYC. This review will focus on the commissioning and provision of effective and sustainable hospital and community services, and will also incorporate paediatric palliative and end of life care.
- Ensure safe, sustainable arrangements are in place for the provision of **Paediatric Congenital Cardiac Surgery** and **Paediatric Interventional Cardiology** for the population of Northern Ireland
- Modernisation of **pathology**
- Expansion of **orthopaedic services** in Southern, Western and Belfast Trusts with an investment of up to £7m revenue over the next 3 years
- Enhanced **ambulance services** bringing patients to destination with best outcomes - Introduction of "111" urgent care number; neo-natal retrieval service for babies below 1500g

Increase our collaboration with our colleagues in ROI and GB

- Where we do not have the volumes to support specialist services we will access quality services in neighbouring health services.
- Further details are set out in Section 4.2.11.



Delivering the service model - Detailed workforce and financial planning

The initiatives contained in the draft SIP and the Population Plans are focused on describing the service model. Further detailed planning concerning the workforce, the financial and capital implications of the service model is required and will be completed over the coming months. This localised costing and planning of all the initiatives will aim to identify in a detailed way the reinvestment in each Locality Commissioning Group (LCG) area and affirm the affordability of the new model of care. This exercise will provide the evidence base to support the implementation of the initiatives.

Supporting our workforce and engaging others in the transformation

With such significant transformation in how we will deliver health and social care services, we need to help create an environment which is receptive to and supports the transformation required to deliver TYC. We are committed to supporting those impacted upon by the changes and enabling our staff to take forward and deliver the change. Citizens and our workforce are the key to making change happen. The chosen model is based on evidence of what makes transformation successful. We do not underestimate the challenge ahead and are committed to investing in our capability and engagement approach.

- **Evidence based workforce modelling** to ensure that we know what skills will be required to deliver services.
- **Investment in the workforce** to ensure they have the right skills to support our journey. Our health and social care service will attract the best people offering opportunities to play a key part in its transformation.
- **Leadership and capability development** - For this unprecedented change, our leaders at all levels need enhanced skills and capability. We will invest in our people with the skills to deliver change, and establish a programme of training to support their development.
- **Continuous and tailored engagement and communication** with everyone impacted by TYC, to listen and act upon their views, and ensure that everyone has a voice in the way forward.

Next Steps: Quality Assurance and Public Consultation

This Strategic Implementation Plan and the Population Plans which support it are in draft form. Following submission to the Minister at the end of June 2012, a period of consideration and quality assurance has taken place, and this will then be followed by a 14 week period of public consultation commencing October 2012. We are committed to engaging in an informed and meaningful debate about the content of this plan to inform and influence the final shape of our Plans.

It is quite right that documents of such importance with proposals that will impact on such a wide range of people, are given due consideration and everyone is given the opportunity to have their say.

2 Context and background

2.1 Purpose of this document

This document describes the draft Strategic Implementation Plan (SIP) for the delivery of the TYC proposals over the next three years. It contains our shared commitments for what the programme will deliver together with the delivery strategy for how we will work together to achieve these.

It also describes the strategic components of the TYC transformation programme and associated responsibilities.

This document:

- Reflects the shared ambitions and commitments of the TYC programme leadership and is intended for everyone involved in leading and managing delivery of any part of the TYC transformation programme across the health and social care system in Northern Ireland.
- Contains plans for engagement and public consultation and forms a basis for this. It is not however intended as the consultation document itself.
- Sets out our Key Commitments - the major changes which will drive service transformation and acute service reconfiguration (Section 4.2).
- Presents how each of the Programmes of Care will evolve over the next 3 years across the 5 LCG areas (Section 4.4) along with an overview of the Regional Programmes.

2.2 Background to the TYC transformation programme

In June 2011, the Minister for Health, Social Services and Public Safety, announced the need for a review of HSC services. The key objectives of the Review were to:

- Undertake a strategic assessment across all aspects of health and social care services;
- Undertake appropriate consultation and engagement on the way ahead;
- Make recommendations to the Minister on the future configuration and delivery of services; and
- Set out a specific implementation plan for the changes that need to be made in health and social care.

The Minister's vision for the HSC Review was to drive up the quality of care for clients and patients, improving outcomes and enhancing the patient and client experience. In addition there is a need to improve productivity and make sure that every penny is spent effectively. The Minister emphasised the importance of promoting greater involvement of frontline professionals in decision making and service development and the crucial role which more powerful local commissioning and community and voluntary sector providing services could play in driving change and innovation.

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'Transforming Your Care: A Review of Health and Social Care' was published by the Minister on 13 December 2011 and sets out proposals for the future health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform. The figure below across outlines the core challenges and pressures for transformational change.

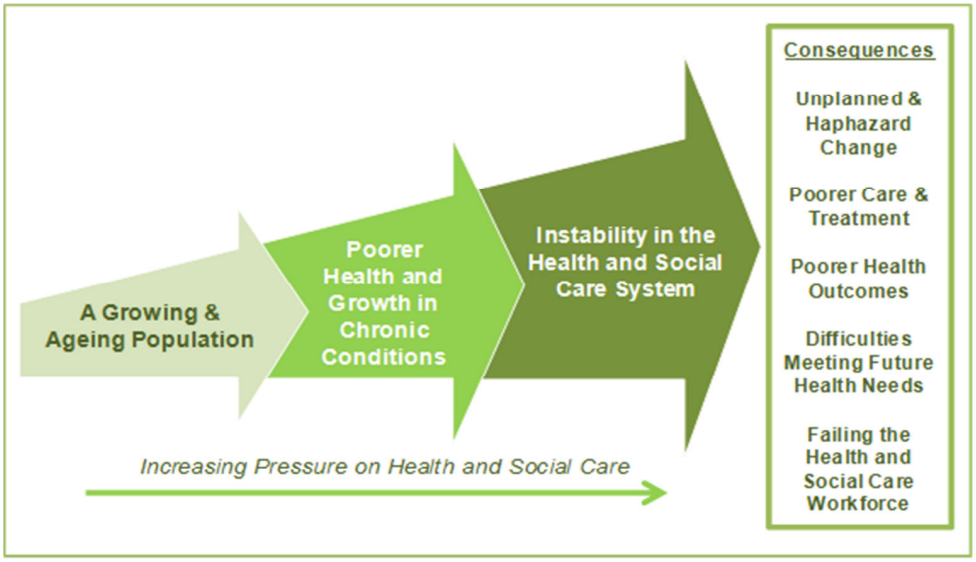

Figure 1: Summary of Pressures & Consequences for Health & Social Care Change

Responding to these pressures, the Review identified eleven key reasons for change.

Reason 1:	The need to be better at preventing ill health
Reason 2:	The importance of patient centred care
Reason 3:	Increasing demand in all programmes of care
Reason 4:	Current inequalities in the health of the population
Reason 5:	Giving our children the best start in life
Reason 6:	Sustainability and quality of hospital services
Reason 7:	The need to deliver a high quality service based on evidence
Reason 8:	The need to meet the expectations of the people of NI
Reason 9:	Making best use of resources available
Reason 10:	Maximising the potential of technology
Reason 11:	Supporting our workforce

'Transforming Your Care' also proposes a model of health and social care which would drive the future shape and direction of the service and puts the individual at the centre with services becoming increasingly accessible in local areas. This transformation will result in a significant shift in the way services are provided across hospitals and the community, with some provision moving from hospitals to the community, where it is safe and effective to do this – this service transformation is generally known as the "S*hift Left*".

Briefly described the model means:

- Every individual will have the opportunity to make decisions that help maintain good health and wellbeing. Health and social care will provide the tools and support people need to do this;
- Most services will be provided locally, for example diagnostics, (where volumes/ throughput and skill mix make it safe and sustainable to do so), outpatients and urgent care, and local services will be better joined up with specialist hospital services;
- Services will regard home as the hub and be enabled to ensure people can be cared for at home, including at the end of life;
- The professionals providing health and social care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care for patients;
- Where specialist hospital care is required it will be available, discharging patients into the care of local services as soon as their health and care needs permit; and
- Some very specialist services needed by a small number of people will be provided on a planned basis in the ROI or further afield.

'Transforming Your Care'
Model of health & social care

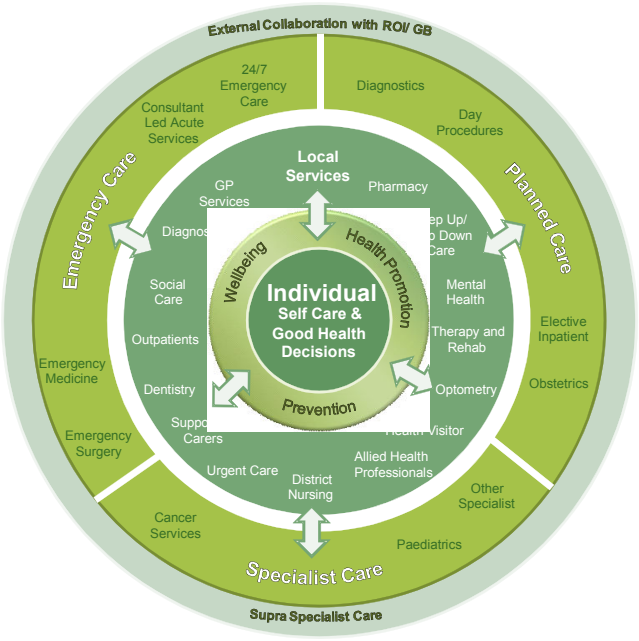

Figure 2: Transforming Your Care Model of Health & Social Care

Shift left in health care will require a combination of a greater focus on a preventative approach, including high quality management of Long Term Conditions, like COPD and heart failure, to reduce the frequency of acute exacerbations and need for hospital care, 7-day acute-care-at-home services to enable people to be looked after at home and thereby reduce admission numbers and the length of time people spend in hospital, and finally, intensive treatment of people who do need hospital care, including more services available 7-days a week.

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The Review considered and presented the methodology to make the change over a 5 year period. It initially describes a financial remodelling of how money is to be spent indicating that a 5% shift (which is approximately £83 million in the current budgets) from hospital services would need to be re-invested into primary and community and social care services by 2014/15. The pace of change will be influenced by our financial circumstances. Ideally, this would be a 3 to 5 year horizon for the implementation; however, implementation may be achieved slightly quicker, or indeed we may need to go at a slightly slower pace, depending on the level of resources available. We will need to be supported by Transitional Funding over a three year period to enable the new model of service to be implemented. This is a fundamental enabler in the change process.The Review re-affirmed there are no neutral decisions and there is a compelling need to make change. The choice is stark: managed change or unplanned, haphazard change.

There are a total of 99 proposals resulting from comprehensive engagement with a wide range of stakeholders, and analysis of the current provision of care. Together these represent a fundamental change in how we deliver services with overarching focus being on quality of care and care provided as close to home as practical. The key proposals are summarised below.

Quality and outcomes to be the determining factors in shaping services.
Prevention and enabling individual responsibility for health and wellbeing.
Care to be provided as close to home as practical.
Personalisation of care and more direct control, including financial control, over care for patients and carers.
Greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector.
New approach to pricing and regulation in the nursing home sector.
Development of a coherent regional programme for 0-5 year old children, to include early years support for children with a disability.
A major review of inpatient paediatrics.
In GB a population of 1.8million might commonly have 4 acute hospitals. In NI there are 10. Following the Review, and over time, there are likely to be 5-7 major hospital networks.
A changing role for general practice working in 17 Integrated Care Partnerships across Northern Ireland.
Recognising the valuable role the workforce will play in delivering the outcomes.
Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups.
Population Planning and local commissioning to be the central approach for organising services and delivering change.
Shifting resource from hospitals to enable investment in community health and social care services.
Modernising technological infrastructure and support for the system.

As part of the "Roadmap for the Future" set out in the Transforming Your Care report, a strategic approach to the implementation of the 99 proposals is set out. It is aimed that this

will primarily be delivered through the commissioning process and the development and implementation of Population Plans. These 99 proposals have been formally reviewed and accepted by the Minister and DHSSPS.

Alongside this, Health and Social Care in NI faces a considerable financial challenge over the next three years. The NI Budget settlement for the four year period 2011 to 2015 will result in £4.65bn by 2014/15 being available for Health and Social Care deployment. Managing resources in Health and Social Care is always contentious but it is clear that a significant funding gap will emerge in the years ahead if no change to and transformation of services is made.

To address this challenge, a number of opportunities have been identified to reduce cost whilst improving quality – the Quality Improvement and Cost Reduction Programme (QICR). Critical to this is the planning and delivery of the necessary reforms in an integrated fashion. It is intended that TYC's regional and local projects will be brought together with QICR, working in an effective consistent manner to support the financial challenge.

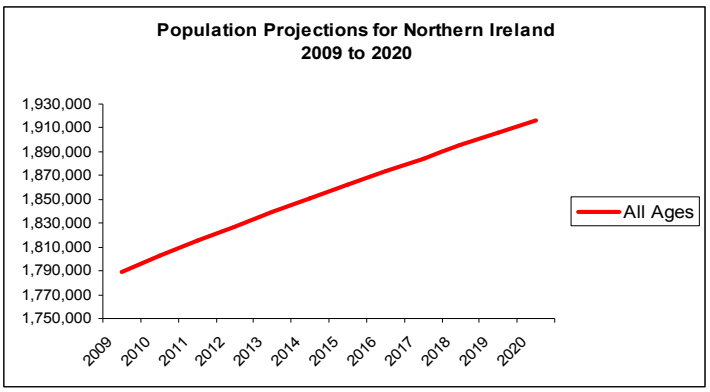
Significant investment is required in public health programmes to prevent ill health in the first place. There are 4,000 premature deaths per year in NI and 61,000 potential years of life lost through preventable illnesses. Stop smoking services, public information campaigns on obesity prevention, brief advice on alcohol and drug misuse, early recognition of and support for mental health problems, early access to GUM (genitourinary medicine) services, infection control, screening and immunisation are just some examples of highly cost-effective public health programmes which would prevent ill health or allow earlier diagnosis, more simple treatment and better outcomes for patients. Service Frameworks and a range of other documents, for example, on nutrition, patient experience, and perinatal mental health, set the standards that need to be met.

Even greater reductions in the need for health and social care would come through more support for parents in the early years of a child's life, from enhanced services for all parents to intensive support for those in the most difficult circumstances. Some parenting programmes reduce the likelihood of alcohol and drug misuse, mental health problems, and smoking later in life and have been shown to pay for themselves within 4 years.

Furthermore, to ensure that people in Northern Ireland continue to have access to new drugs and new technologies, significant resources are required to fund NICE-approved drugs and guidelines and meet good practice standards for care as set by DHSSPS. Greater investment in high quality care, and preventive care, is not just good for patients, clients and the public, it is cost-effective. However, to enable that greater investment to happen, current services need to change at a scale that enables funding to be released from inpatient services for reinvestment in the types of public health, primary and community services outlined above. Simply re-providing acute care elsewhere is not sufficient as it will not fundamentally improve the health and wellbeing of people in Northern Ireland.

2.3 Regional assessment of strategic need

Population plans have all detailed the projected changes in the demographic profile in Northern Ireland and also the projected increases in incidence of Long Term Conditions, as detailed in the diagrams below.



Projected Total Population Change by LCG Area 2009-2020

- Belfast***+2%***
- South Eastern ***+6%***
- Northern ***+7%***
- Southern ***+15%***
- Western ***+6%***

Figure 2 Population Projections
Source: 2008 Based Population Projections, NISRA

By 2014 there will be approximately 50,000 more people in N.Ireland than there are today and more than half of these will be over 65 years old.

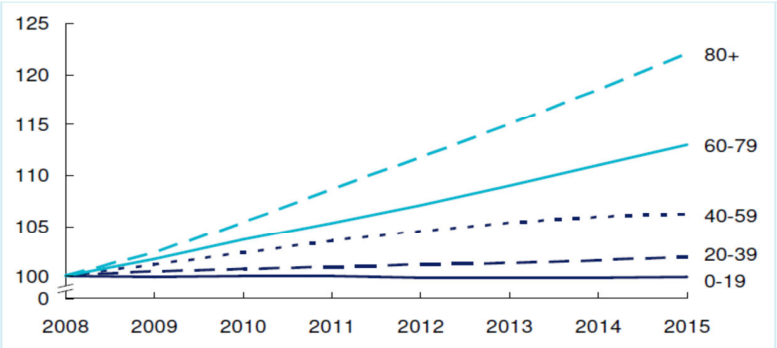


Figure 3 Projected Growth of 85+
Source: 2008 Based Population Projections, NISRA

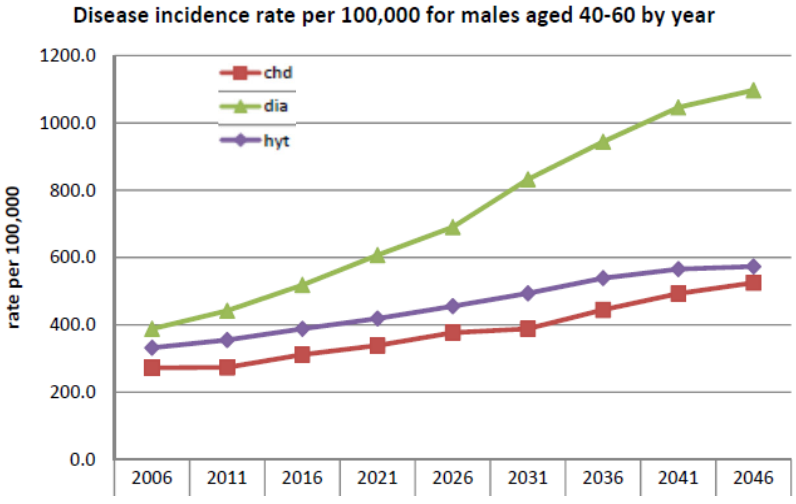


Figure 4: Estimated growth of the incidence rates for Coronary Heart Disease (CHD), Diabetes and Hypertension for males aged 40 to 60.
Source: National Heart Forum: Obesity Trends for Adults. Analysis from the Health Survey for England, (2010)

Advancements in modern treatments should be celebrated, but the implications on health and social care provision need to be recognised and planned for accordingly. In addition to an ever increasing older population, health and social care is also required to respond

effectively to the growing incidence rate of chronic conditions such as hypertension, diabetes, asthma and obesity. A study in Northern Ireland predicted a 10% increase in adults with hypertension between 2007 and 2020, and a 40% increase in adults with diabetes over the same period[1]. The Quality and Outcomes Framework (QOF) information published by the DHSSPSNI also demonstrates that these conditions have all shown an increase between 2007 and 2012[2].

The incidence rate (new cases) is influenced in part by lifestyle choices and government and personal action is required to make healthy choices easier. The 2010/11Health Survey of Northern Ireland demonstrated, although through a relatively small sample of 4000, 72% of respondents felt that they could do something to make their own life healthier, with males (74%) more likely to indicate this than females (71%)[3]. In addition, the prevalence rate (total number of cases) is influenced by survival rates. Early diagnosis and modern treatments reduce mortality and increase the need for services to manage chronic conditions in the long term; increasingly, this includes people with cancer.

The preference for the location of services differs depending on the type of care required. An Omnibus survey (2011), found that over 80% of those surveyed would prefer long term care to be closer to home. Alternatively for short term episodes of care, the Patient Client Council found that people are prepared to travel to get the right treatment quickly. Health and social care services will be required to adapt to new ways of working in order to provide services of the highest quality consistent with the needs and expectations of patients and clients.

It is estimated that the demand for services could grow by around 4% per year by 2015[1]. Examples of the potential consequences without change are listed below:[2]

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 8,000 extra nursing home weeks; and
- 40,000 extra 999 ambulance responses.

In addition, there is clear evidence of health inequalities in Northern Ireland, the consequences being poorer health outcomes observed in the most deprived areas than in the region generally such as:

- lower life expectancy;
- 33% higher rates of emergency admission to hospital;
- 72% higher rates of respiratory mortality;
- 59% higher incidence rates of lung cancer;
- 82% higher rates of suicide;
- self harm admissions at more than twice the Northern Ireland average;
- 55% higher rates of smoking related deaths; and
- 124% higher rates of alcohol related deaths.

[1] Reshaping the System (2010) McKinsey
[2] NI Confederation for Health and Social Care: Areas for Action for Health and Social Care in Northern Ireland 2011-2015

2.4 Transformation programme brief

The Minister and the DHSSPS have established a Whole System Planning approach to the planning and reform of health and social care. This encompasses the following:

- The Programme for Government, Investment Strategy for Northern Ireland and the Northern Ireland Economic Strategy;
- The new Public Health Strategic Framework;
- The Quality 2020 Implementation Plan;
- The TYC Transformation Programme;
- Commissioning Plan(s) (including LCG Plans);
- Quality Improvements and Cost Reduction Plans;
- Trust Delivery Plans; and
- Infrastructure Development (Capital) Plans.

The Minister for Health Social Services and Public Safety sets out the priorities for health and social care in an annual Commissioning Plan Direction to the Health and Social Care Board (HSCB). The Minister's priorities are set in the context of wider policies and strategies embracing the full range of health and social care services in Northern Ireland. The HSCB responds to the Direction by working with the Public Health Agency (PHA) to develop an agreed Commissioning Plan for Northern Ireland. Local Commissioning Groups, play an important role in assessing the particular needs of local populations in the context of the Minister's priorities and ensuring that they are properly represented in the Commissioning Plan. These arrangements are set out statute.

The proposals in Transforming Your Care impact on a wide range of health and social care services and will require a great deal of work to plan and deliver. In recognition of the size and importance of this service modernisation agenda, the Minister has asked the HSCB, working with the PHA and service providers, to draw up local population plans and an overall strategic implementation plan to ensure that all stakeholders have a clear understanding of what TYC proposes and how it will be delivered. These strategic proposals will be the subject of public consultation, as will the individual service changes that flow from them.

On conclusion of the strategic consultation process, the Minister's decisions will be reflected in future Commissioning Plan Directions along with other priorities not directly connected to Transforming Your Care. This will ensure that the important changes are taken forward within the existing legislative framework and fully in concert with all relevant policies and strategies for health and social care in Northern Ireland.

As part of this, the Minister and DHSSPS have devolved responsibility for many of the TYC outcomes to the HSC Board who will take the lead, working alongside the 5 local commissioning areas in delivery.

The 99 proposals contained in the TYC Report are wide-ranging and the draft Strategic Implementation Plan and Population Plans are not intended to cover all aspects of the Proposals. A number of proposals in the TYC report are not addressed through the draft Plans. This includes, for example, policy development work to be determined by the Department for Health, Social Services and Public Safety. The scope of these documents is

purely to provide summary details of the intended response to proposals that the HSCB and PHA have responsibility for.

The TYC programme defines transformational changes and service reform across the whole health and social care system and is designed to ensure that both service delivery and reform are managed and delivered in a coherent and co-ordinated way. The TYC Programme Initiation Document describes how the transformation programme has been established and is organised, managed and governed.

2.5 TYC Transformation Programme objectives

The objectives of the TYC transformation programme are the following:

- Implement the Transforming Your Care proposals for which the Health and Social Care Board has responsibility, by March 2015.
- In doing so, contribute to the outcomes set out in the Transforming Your Care Review Report, inter alia.
  - Shift of 5% (circa £83m) from current hospital spend and its reinvestment into primary, community and social care services by 2014/15.
  - Improvements of the quality of service.
  - Build resilience of service, against a backdrop of increasing demand and clinical workforce supplies difficulties.
  - Greater levels of productivity and value for money.

2.6 Desired outcomes from the TYC transformation programme

The desired outcomes from the TYC transformation programme are the following:

- People will get support to stay healthy, make good health decisions or manage their own conditions.
- More services will be provided locally with opportunities to access specialist hospitals where needed.
- More people will be cared for at home, where it's safe and appropriate to do so.
- People will have more choice and greater control over the types of services they are able to access.
- Investment in new technology will help people stay at home or receive care locally rather than in hospitals.
- Doctors, nurses, social workers and everyone providing care will work together in partnerships to help keep people healthy and prevent them going to hospital when that's not necessary.
- Any decisions about how we do things should be driven by evidence that it will be better for patients and users, and be better quality.
- Everyone working in health and social care services will be supported in helping to make the changes set out in TYC.

The new model of care will build on evidence of what produces good outcomes, and supports the resilience and flexibility of the health and social care system for the future. The draft Population Plans and SIP are supporting documents in the consultation process. Implementation Plans will be developed, which will include Key Performance Indicators and accountability arrangements to secure the desired outcomes.

2.7 Next steps: Quality Assurance and Public Consultation

This draft Strategic Implementation Plan and the draft Population Plans which support it are in draft form at the moment. Following submission to the Minister at the end of June 2012, a period of consideration and quality assurance has taken place. After this, the Minister intends to launch a 14 week period of public consultation from October 2012 to January 2013. As well as discharging relevant statutory duty to consult, we are committed to engaging in an informed and meaningful debate about the content of this plan to inform and influence the final shape of our Plans.

Quality assurance and consideration of the draft Plans has been carried out between July and September 2012. This has allowed the programme team to:

- Further validate the proposals with colleagues from DHSSPS, HSCB and PHA and from across the provider organisations, including the Trusts. In particular this has further considered the cross-boundary impacts of the proposed service change initiatives; and
- Further validate and consider the alignments between the proposals set out in the draft Population Plans and this draft Strategic Implementation Plan, policy, the vision set out in Transforming Your Care and other regional initiatives.

3 Delivery strategy

3.1 Purpose of this section

This section describes the strategic approach to implementation of the Transforming Your Care proposals.

It also describes the strategic components of the TYC transformation programme, associated responsibilities and the key ways we will work together to deliver the benefits of the TYC proposals.

3.2 Strategic principles

The following strategic principles guide the strategy for delivery of the transformation programme objectives.

- **Patient/user focus**

  An unrelenting focus on the outcomes and benefits set alongside the experience for patients/users will be at the centre of all that we do. This will be reflected in the individual being at the heart of re-designed services; planning for improvements as close to the point of delivery as possible; a clear 'line of sight' of how all programme activities are evidence-based; improve outcomes and services for patients/users; address inequalities; and finally, patients, users and staff engagement plans being the foremost consideration in securing commitments to change.

- **Clinical leadership and commitment**

  The uniquely challenging context of implementing a radical change programme, together with the financial context faced by HSC organisations, places a particular demand for leaders to create the conditions for change, role modelling the shared purpose, vision and values and engaging others to act. The programme will require collaborative system-wide leadership across all parts and at all levels with the health and social care system. This will be evident through a collaborative approach to planning and delivery, recognition of system drivers of change, and supported by effective capability and engagement plans.

- **Rigorous delivery**

  A programme as large and complex as this will not achieve rigorous and effective delivery of the scale and pace of improvements without genuinely shared commitments, a coherent overall plan and well managed delivery.

  This draft SIP is intended to provide high level planning coherence: combining and co-ordinating a portfolio of regional and local commitments, plans and processes with a shared timetable. The emphasis on localisation and ownership allows local service areas and their populations to shape change and realise benefits, with local leadership being supported at a regional level. In order for this to be successful, the plans will be underpinned by appropriate local and regional delivery capability and support.

3.3 Delivery strategy overview

TYC provides a coherent, controlled and managed framework which brings existing programmes together and adds new ones, in a well-integrated way, to deliver TYC proposals.

The draft SIP has been developed as a response to local Population Plan requirements and lessons, which are in turn based on the TYC proposals. In this way, the draft SIP provides a cohesive strategic response to TYC based on a collaborative local and regional dialogue and clear mutual expectations.

This collaborative approach to integrated planning provides a basis for strong aligned delivery and collective monitoring and learning, as shown in the diagram below:

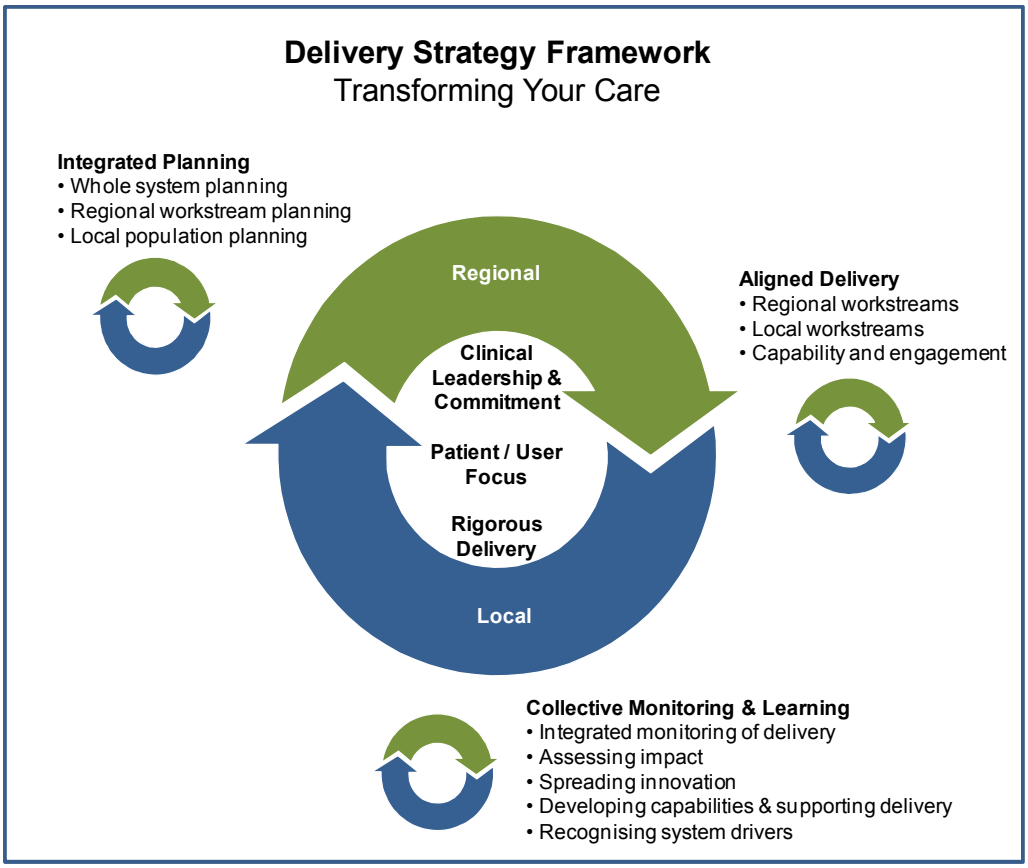
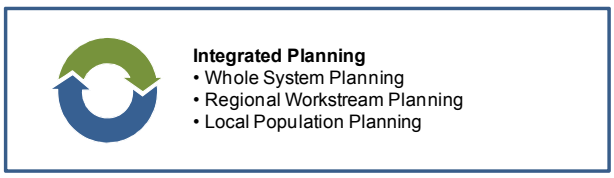


Figure 3: Transforming Your Care Delivery Strategy Framework

3.4 Integrated planning

This section describes the planning framework within which the TYC transformation programme workstreams (a workstream is defined as an area of focus, such as acute care) will be specified, collective commitments agreed and interdependencies managed across whole system plans, regional plans and local plans.



3.4.1 Whole system planning approach

Transforming Your Care, which focuses on reshaping how services are to be structured and delivered in the future so as to make best use of resources, is not being taken forward in a policy vacuum. It is set within a very robust policy context. For example, the *Quality 2020* strategy, published in 2011, preceded TYC and was designed to ensure that we can effectively protect and improve quality of services going forward in all we do. The key principles underpinning the approach in *Transforming Your Care* are all reflected in *Quality 2020*. Other key Departmental strategies and policies, such as the Public Health Strategic Framework, also have important links and help shape and influence the implementation of *Transforming Your Care* and ultimately positive health outcomes for all.

The Transformation Programme will look to the DHSSPS to ensure any policy and legislative changes are in place to support TYC.

The Transformation Programme will work closely with and report to the DHSSPS Strategic Planning Group (SPG).

3.4.2 Regional workstream planning approach

The HSCB will lead on the TYC transformation programme. In this regard, the Strategic Implementation Plan, along with the Population Plans will be incorporated into the commissioning process. In developing their draft Population Plans, Local Commissioning teams were required to having cognisance of all commissioning specifications and all major change initiatives which will deliver the shift left. The Programme Initiation Document will also be refreshed to reflect any changes to how the TYC transformation programme is organised, managed and governed.

The regional workstreams are defined in Sections 4.3 and 4.4 and have been identified or developed based upon:

- An understanding of the portfolio of existing or planned regional programmes that are either underway or committed, that are expected to have a direct impact on achievement of TYC proposals
- A response to common demands across programmes of care identified through the Population Planning process
- Analysis of coverage of TYC proposals of the local Population Plans combined with existing or planned regional programmes. We expect that there might be a small number of cases where TYC proposals are not, or not adequately, covered by current plans – resulting in a small number of potential additional new regional programmes.

We expect that the scope and accountability of regional programmes will change over time as they mature to reflect transformation decisions and responsibilities for delivery.

Health and Social Care Board

Equality

One of the key objectives of the Transforming Your Care future service model is the reduction of health inequality, and the transformation programme is committed to building this aim into the heart of our design and implementation of the programme and the specific projects and initiatives which will be taken forward as part of this. We believe that undergoing screening exercises and impact assessments will help to inform what we do, to ensure that we are improving services for our users, staff and the public.

In addition, Section 75 of the Northern Ireland Act 1998 requires the HSCB to "have due regard" to the need to promote equality of opportunity between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without. The HSCB is also required to "have regard" to the desirability of promoting good relations between persons of a different religious belief, political opinion or racial group.

In keeping with the overall aim to reduce health inequality and improve access to health and social care services, the above statutory obligations, and the guidance produced by the Equality Commission for Northern Ireland, equality and human rights issues will be specifically addressed through a number of activities:

- A preliminary equality screening exercise on the draft Strategic Implementation Plan which has taken place over the quality assurance period during the summer months, and in advance of public consultation. This has followed the HSCB's standard screening template. This provides evidence of the equality considerations that have already been taken into account in the development of the draft Strategic Implementation Plan and the supporting draft Population Plan documents. This will be published as part of the consultation period due to be launched in October, and determines whether a further examination of the issues is required through the conduct of an equality impact assessment (EQIA)
- As we move into later years of the TYC transformation programme, the Population Plans and Strategic Implementation Plan will be integrated with Local Commissioning Plans, Trust Delivery Plans and Quality Improvement and Cost Reduction Plans (QICR). . This will include service modelling and planning at increasing levels of detail based on data analysis of projected user demand. Enhanced data gathering on Section 75 categories will be built into this process to augment the quantitative data already available to assess who is affected and therefore inform the screening of later plans.
- As individual service changes and projects are initiated and embark on their implementation processes, they will be subject to their own equality screening, and if appropriate a full Equality Impact Assessment to address equality and human rights issues of the specific change due to take place.

Transitional Funding

The Transforming Your Care Report identified the need for transitional funding to enable the new model of service to be implemented and underpin the changes required. This transitional funding will be particularly focused on the following areas:

- Integrated Care Partnerships
- Service Change
- Implementation Funding
- Voluntary Redundancy / Voluntary Early Retirement Schemes

3.4.3 Local Population Planning approach

The draft local Population Plans will feed into and be integrated with Local Commissioning Plans, Trust Delivery Plans and Quality Improvement and Cost Reduction Plans (QICR).

The draft Population Plans were developed during May and June 2012 by the Local Commissioning Groups working closely with their Trust and other stakeholder colleagues. Given the need to develop a comprehensive understanding of TYC at a local level, the focus of this process was to identify the key initiatives which would support the delivery of the TYC proposals. In particular the local teams focused on articulating how their services would be transformed to reflect the "Shift Left" and that greater prevention in how Health and Social Care is delivered.

It is recognised that further detailed analysis of the service initiatives in the draft Population Plans, in terms of workforce and financial implications, is still to be completed to inform the implementation in 2013. As with any service changes, a comprehensive public consultation document on the initiatives described within this draft SIP has been developed.

The key features of the recent Population Planning process were as follows:

- Describing the Vision and Context for the Population Plan, including:
  - Current services provided and financial status
  - Challenges – why the local services needs to change
- Assessing the strategic needs of the local population based on demographics and population health trends analysis
- Articulating how the local area will respond to the TYC proposals under each of the Programmes of Care:
  - Identifying prioritised initiatives at a local level for each Programme of Care
  - Describing the impacts of the initiatives on quality and productivity
  - Presenting key success factors for each Programme of Care
- Setting out the Enablers for Implementation, including: Outcomes and Quality Measures; the Implementation structure; plans for building capacity and capability; engagement with stakeholders; and key considerations

Plans have been drafted to reflect and respond to TYC proposals, and also complement current strategic documents such as the Public Health Strategic Framework. They are also cognisant of Commissioning Specifications for each of the service areas mentioned in the following sections. Where there are variations in numbers, for example where an LCG has indicated that their plans will achieve a different percentage change in a particular service area compared to another LCG area, it should be noted that each draft plan has undergone

due scrutiny to ensure that each individual LCG's figures are as robust as possible. Whilst population needs for each area will all feature the same high level themes, such as prevalence of Long Term Conditions, each LCG area will have emphasised what they believe will do most to improve their particular baseline position.

When considering the implications of the initiatives in the draft Population Plans, it is critical that they take into account unfunded residual demand. Together with the service model changes which are articulated in the Population Plans, it is anticipated that medical advances, changes in clinical practice, and the development of new technologies and medicines will contribute significantly to the cost associated with providing modern health and social care services in Northern Ireland.

The draft Population Plans completed to date focus primarily on the nature of the services changes. The implications for the workforce in terms of skill mix have not been worked up. Detailed discussions on nursing, midwifery, allied health professionals and doctors requirements to support the initiatives will be required over the coming months.

In terms of the changes in capital infrastructure needed to fully implement TYC, the Population Plans will require a detailed working up of the capital implications and requirements over the three year planning period.

The approach to the 'Shift Left' included in Population Planning and plans for implementation

Section 3 of the draft Population Plans details the new service models across 10 Programmes of Care. Across the five local Population Plans, the transformation in how care is delivered focuses on:

- Care delivered closer to or in the home
- Reconfiguration of acute services across 5-7 hospitals networks, in line with best practice and professional guidelines, including access to specialist services
- Contracts with users and personalised care/budgets
- Reduction in residential and institutional care
- An enhanced role for primary care, pharmacy and medicines management
- Strong emphasis on prevention
- Increased use of community and social care services to meet people's needs
- Outreach of acute services into the community.

Over the next three years, the transformation of services is expected to result in funding shifting from the current hospital services budget and reinvested into the primary, community and social care services. TYC identifies a 5% reduction in the hospital services budget by 2014/15 equating to a recurrent shift of resources of circa £83m pa. This reduction is to be accompanied by a corresponding increase in spending broadly in the following areas:

- £21m increase in spending on Personal Social Services (2% increase in that budget by 2014/15)

- £21m increase in spending on Primary Care / Family Health Services (3% increase in that budget by 2014/15)
- £41m increase in spending on community services, namely health and social care services that are provided in a community setting, (9% increase in that budget by 2014/15).

Initial estimates of the share of the TYC 5% reduction in hospital spend that each LCG is likely to be required to deliver, is currently under development.

Guidance will be issued to LCGs in order to appropriately monitor and report on the shift of resources from hospital spend into personal social services, primary care, Family Health Services and community services.

Following quality assurance activities of proposed changes in services, we will build on the analysis done to date and complete a detailed localised costing and planning of all the service initiatives to identify: the reinvestment in each LCG area; the affordability of the new model of care; and to start the process of service and workforce planning.

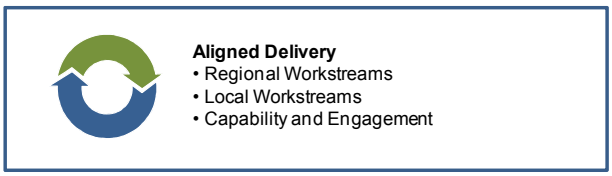
Detailed bottom up costing of the service models would form part of the consideration of a long term financial planning model for each LCG area. This approach allows the LCG area to assess how the initiatives they have developed for both QICR and TYC work together to result in financial balance for the LCG area.

The key initiatives by Programme of Care for each of the draft Population Plans are summarised in Section 4.5.

3.5 Aligned delivery

TYC provides a coherent, controlled and managed framework which brings existing programmes together and adds new ones, in a well-integrated way, to deliver TYC proposals.

This section describes the delivery workstreams and how they will be aligned to maximise delivery of programme benefits.



3.5.1 The regional workstreams

The regional workstreams comprise a series of regional programmes and regional enabler workstreams. The regional workstreams are further described in this document in Section 4.3.

1. **Regional programmes:**

These are a portfolio of either existing/planned or new programmes which require integration of existing regional accountabilities and processes - to align with and maximise delivery of TYC proposals, details are provided in Section 4.3. These programmes will be focussed on the regional reforms necessary to achieve transformation, which will have local dimensions and require local integration with delivery of Population Plans. As these programmes mature, responsibilities for delivery may change and will be agreed across regional projects and local Population Plans either through the annual planning processes or as regional programmes reach key milestones. Initiatives detailed below are HSCB/PHA programmes and workstreams, to progress the objectives of TYC.

2. **Regional enabler workstreams:**

These enable other regional programmes or local Population Plans to be delivered and are a strategic response to the collective requirements across these local and regional programmes. The regional enabler workstreams include Finance and workforce planning; Capital/Estates; Capability and Engagement; ICT; and Programme Management Office (PMO).

3.5.2 The local workstreams

The local workstreams comprise the initiatives contained in the draft Population Plans for each of the 5 local areas; further details are provided in Section 4.4.

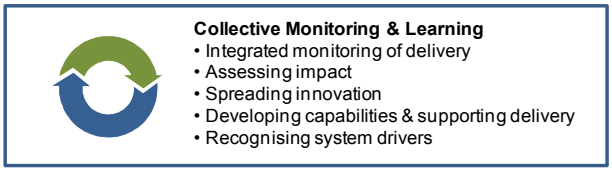
The draft Population Plans describe the local plans for delivery of those TYC proposals that have been locally developed through the planning process. Each plan has been drafted according to a consistent approach described earlier, access to insight, sharing of plans and ideas across local areas and external challenge.

Summaries of the 5 draft Population Plans across the Programmes of Care are presented in Section 4.4.

3.6 Collective monitoring and learning

TYC provides a coherent, controlled and managed framework which is not only enabled by integrated planning and joined-up delivery, but also supported by collective monitoring and learning.

This section describes the collective monitoring and learning arrangements that we will need to support a transparent collaborative approach to managing delivery across the portfolio of programmes and relentlessly focusing on benefits for patients.



3.6.1 Integrated monitoring of delivery

A programme as large and complex as this will not achieve rigorous and effective delivery of the scale and pace of improvements required without well managed collaborative delivery of coherent regional and local plans. The emphasis on localisation and ownership allows local teams and their populations to shape change and realise benefits, with local leadership being supported at a regional level in an environment of trust, mutual challenge and support. A successful collaborative approach to integrated monitoring of delivery will depend on:

- The identification and development of a small TYC PMO team with clear responsibilities for managing and monitoring delivery across local areas, regional workstreams and the TYC programme management office. This will be a close-knit mechanism for information sharing, transparent monitoring and reporting of delivery performance to plan, and applying and refining the best common standards and approaches to programme delivery.
- The establishment of common TYC good practice standards in programme management.
- Clear and aligned use of existing governance arrangements with aligned transparent programme reporting and support requirements.

3.6.2 Assessing impact

An unrelenting focus on the outcomes and benefits for patients and users will be at the centre of all that we do. This will be reflected in a clear 'line of sight' of how all TYC transformation programme activities are evidence-based, improve outcomes and services for patients and address inequalities. A robust approach to assessing impact through the identification and monitoring of transformation programme benefits (quality and productivity) will be developed during 2012.

- This will be based on a coherent framework of transformation programme benefits across the portfolio - that enables a common approach to mapping of activities by programme of care (programme workstreams or local initiatives) to associated benefits and to TYC proposals.
- Integrated transparent monitoring arrangements will be established using existing mechanisms wherever possible, either regionally or locally, and co-ordinated in a regular systematic way across the programme management community. For each benefit, a means of measurement (indicator) will need to be confirmed together with a baseline measure and its means of application.

3.6.3 Spreading innovation

The TYC case for change, combined with the challenging financial context faced by HSC organisations, places a particular demand for leaders to create the conditions for change and innovation. In order for the TYC transformation programme to be able to rapidly identify and spread ideas that work it will be important to enable teams to access new ideas. We will do this by:

- Actively managing a process of identifying programme ideas that work - and sharing, disseminating and scaling these rapidly across local teams.
- Establishing practical enablers of innovation across regional and local programme team activities. These can include events/forums to share know-how and approaches, improving access to external best practice expertise and insight, targeted use of management information (insights through benefits management), connectedness across teams, and the use of rewards/prizes.
- Supporting leadership development to create the conditions for innovation, such as supporting the vision and spirit of innovation, attitudes to risk taking and learning, engagement of patients and front-line staff, and the willingness to collaborate across organisational boundaries.
- Establishing a Skills Transfer Programme, whereby staff who have been involved in design and delivering a change initiative or project in one locality or organisation is offered the opportunity to transfer to another project to share what they have learnt through a structured programme of activities.
- Developing an 'intelligence hub' to provide access to the latest thinking and space to discuss and explore innovation with others from across the HSC system and beyond.

3.6.4 Developing capabilities and supporting delivery

The skills required implementing a radical change programme, together with the nature, scale and imperative of the TYC case for change, means a dedicated Programme Team will be required to support the core business in delivering against this challenge. A dedicated team has been set up to:

- Provide support for LCG / Trust teams to develop and deliver Population Plans and undertake service modelling and planning
- Instigate and deliver sustained, co-ordinated and focused engagement, communication and involvement with all key stakeholders, to secure the support of the public and their political representatives, clinicians and other partners for the required changes
- Inject pace and momentum into the transformation programme, and facilitate the acceleration and deliverability of timescales
- Minimise the risk of disruption to the service; it is critically important that frontline services are not adversely impacted by reforms
- Reduce the risk of overstretch of one team in terms of concurrently spreading their resource and expertise across numerous work strands / localities / clients
- Provide a mixed economy of experience, expertise and support to the overall planning and implementation process
- Maintain effective control throughout the implementation process via clarity of policies, processes and procedures, and transparency of roles, responsibilities and accountability for the delivery of outcomes

3.6.5 Recognising system drivers

The TYC transformation programme will require collaborative system-wide leadership across all parts and at all levels with the health and social care system, with particular demands for clinical leaders to create the conditions for change and role model the shared purpose, vision and values, thus engaging others to act. This will translate not only through fostering a collaborative approach to planning and delivery, but also through recognition of system drivers of change. The programme will support development of this understanding in particular through leadership capability development.

Also, the annual planning process will explicitly provide the opportunity to challenge the delivery strategy through collective review and involvement of external expertise, in particular to address any problems in delivery and challenge:

- The essential mechanisms by which the transformation programme will deliver change and benefit citizens across the programme portfolio
- Current assumptions regarding the levers of change, the importance of clinical leadership and whether important levers are being ignored or mis-used
- Options for alternative delivery strategies across programmes of care
- The desired impacts on citizens and their role in shaping change and realising benefits
- Whether the roles across regional workstreams and local teams are optimised.

4 Implementation commitments

4.1 Introduction

This section provides a summary description of the regional and local TYC workstreams to deliver the TYC proposals. It also provides a current statement of declared commitments for achievement of each workstream over the 3 year timeframe of the TYC transformation programme The HSCB will ensure that robust programme governance workstreams exist to further develop plans and monitor the progress against them. It is possible that the responsibility for these workstreams may change as plans move ahead. Where this is the case, this will be clearly detailed in all plans and governance arrangements.

At concept stage, detail on proposed initiatives is not always available but further detail will be developed at Implementation stage and will form part of the Project Initiation Documentation for each initiative.

This section is structured as follows:

- Section 4.2 describes overarching TYC key commitments.
- Section 4.3 describes the regional workstreams that contribute to the achievement of TYC proposals. These are a combination of existing and new programmes as well as a number of TYC enabler programmes.
- Section 4.4 describes how each of the Programmes of Care will evolve over the next 3 years across the 5 LCG areas.

4.2 TYC's key commitments

TYC presents Northern Ireland with an unprecedented opportunity to transform our health and social care service. With transformation of such scale there will be difficult times ahead and challenging decisions to be made – it is important to remind ourselves this transformation is about people and services, rather than buildings. Some projected gradual changes in use of resources are indicated in this section and these are picked up in some of the Population Plan details summarised in Section 4.4. Some LCG areas have detailed a percentage change anticipated and where this is so, this has been as a result of in-depth engagement between Trust and LCG teams, focusing on current and best practice, and informed by information on practice elsewhere as provided by the external consultants who were engaged to support the production of the draft Population Plans. Recognising the importance of the transformation, the Minister has stated his full support for TYC, particularly given the exciting opportunities it presents.

The key commitments across the Programmes of Care are summarised below:

4.2.1 Integrated Care Partnerships – a new way of providing primary and community care

Key to the delivery of the new model of care proposed in Transforming Your Care is a more integrated approach to service planning and delivery. The TYC report recommends the establishment of 17 Integrated Care Partnerships which would join together the full range of

health and social care services in each area, including GPs, health and social care providers, hospital specialists and representatives from the independent, voluntary and community sector.
ICPs would be developed as collaborative networks of service providers. Their aim would be to focus on the 'Shift Left', ensuring that services are delivered as close to patients'/users' homes as possible, are personalised and seamless; empower patients and promote health and prevent illness where possible.

Improving how providers work together to the benefit of patients and service users would mean challenging existing systems and processes that impede effective health and social care in order to ensure:

- A multi-disciplinary approach to the planning and provision of treatment and care, co-ordinating how care would be planned and delivered;
- The individual would be placed at the centre of care and promoting partnership working, both with individual service users and within and across the statutory, independent, voluntary and community sectors;
- Better communication, including detailed, accurate and timely information flow;
- Safe, high quality treatment and care through taking a holistic approach to improving services;
- Improved speed of operational decision making; and
- The effective deployment of resources.

The development of ICPs would be based on a number of key principles, including;

(i) ICPs would be a collaborative alliance with membership that would include statutory, independent and voluntary and community practitioners and organisations. A key consideration would be the inclusion of the voluntary and community sector in the work of ICPs;

(ii) ICPs would <u>not</u> be established as separate legal entities but would be a networked group of service providers within the existing HSC structures;

(iii) The aim of ICPs would be to focus on identifying how the blockages and barriers to the integration of services might be overcome through re-designing care pathways and improving how services are planned and delivered to the benefit of patients and clients;

(iv) ICPs would not have a commissioning role. Responsibility for commissioning and funding services would continue to lie with the HSCB and its LCG committees;

(v) ICPs would be established around natural communities (approximately 100,000 people) and would evolve from and replace the 17 Primary Care Partnerships;

(vi) ICPs should be clinically led and be based on multi-disciplinary working. It is envisaged that General Practitioners would have a key leadership role to play; however, clinical leadership should not be seen as exclusive to General Practitioners and opportunities for leadership development will be inclusive and available to other health and social care professionals

(vii) ICPs should be operated and regulated in a way that ensures equity of service across all regions.

It is anticipated that initially much of the focus of ICPs would be on the frail elderly and aspects of long term conditions, namely diabetes, stroke care and respiratory conditions. However, it is envisaged that over time ICPs would have the scope to address local priorities for service delivery improvement in line with identified local need and the direction of the Local Commissioning Group.

ICPs would operate in line with guidelines developed by the Health and Social Care Board and agreed by the Department of Health, Social Services and Public Safety.

- ICPs would be a key vehicle in working towards achieving improvements in 3 areas:
  - 20% reduction in ED admissions for Older People
  - Reduction in ED attendances of 20% for Older People
  - Reduction in unscheduled admissions of 10% for people with Long term Conditions, and a reduction of 18% in LOS
- ICPs would play a key role in supporting people to manage their Long Term Conditions, for example in medicine management and community pharmacy. ICPs would also expand the role for community pharmacy in terms of health promotion and medicines management. Effective clinical pharmaceutical practice will significantly improve quality and safety leading to improved health outcomes as well as generating efficiencies.

4.2.2 Older people

- We will support Older People and those with Long Term Conditions to maintain their own independence and manage the functions of daily living in their own home or assisted housing, as opposed to in an acute setting or long term care.
- Significant change and benefits of TYC will be realised over the next 3 years, including:
  - Provide 24/7 district nursing services and social inclusion programmes to help older people remain active.
  - Due to improved availability of community-based alternatives, it is expected that demand for statutory residential homes will further decline. The proposal is to close at least 50% of current statutory residential homes over the next 3 to 5 years. As part of the transitional process towards this, we will consider whether to restrict future admissions in some instances.
  - Reduction in admissions resulting from falls of 5%. A falls prevention programme will be rolled out to identify those at risk of falls and fragility fractures, to educate and raise awareness and provide targeted interventions, including raising awareness of the need to ensure good vision health to reduce the risk of falls.
  - A reduction in acute hospital bed days and emergency department attendances of 20% for Older People.

  - Reduction of 10% on unplanned admissions by implementing telehealth, telecare and telemedicine solutions which increase the variety of ways in which services can be provided, in particular for people with Long Term Conditions.

- Reablement - We will provide a wider range of focused programmes of therapeutic care and support interventions to individuals referred from the community or from hospital, and support them to become as independent as possible.
  - In line with our Reablement strategy, we will develop effective Rehabilitation Services and reduce readmissions.
  - We will provide planned, short-term, intensive care and support services to people in their own home, following a hospital admission or when they have experienced a health or social care crisis at home.
  - As a result of Reablement, we can expect to reduce the number of newly referred older people who need a long term domiciliary care service by up to 45%.
  - We will further develop intermediate care, which will include the use of bed based facilities focused in fewer settings.
- Carers play a well established and critical part in the overall care and wellbeing of older people in the community. There will be continued commitment to improve the quality of life of and support for carers including new models of respite and short breaks.
- Improvements in access times to cataract surgery and audiology services to support living at home.
- The NISAT assessment process allows community services to identify more carers who are then offered the opportunity to have individual assessment using NISAT carers' assessment documentation. Carers are pivotal to the delivery of the 'shift left'. This will involve designing new enablers to support carers such as new forms of respite care and technology to support arms length care
- Implementation of the NI Dementia Strategy. Integrated Care Partnerships will be central to proactively manage people with dementia in primary and community care settings. Working closely with the community/voluntary/independent sectors people with dementia admitted to hospital with medical needs will be supported by staff well equipped to meet their needs in acute and non-acute hospitals settings.
- Services will also develop their safeguarding aligned with the regional policies and procedures and associated operational changes.

4.2.3 Long Term Conditions.

- Develop new LTC 'Care Pathways' –those responsible for or involved in providing health care services would develop simpler ways to access services, often through a GP or specialist nurses at home. This will sometimes mean easier direct admission to hospital rather than going through the Emergency Department first.

- Develop 'risk profiling' using the latest clinical evidence, which will help those providing care to target specific support for those most at risk of an acute episode who may need a hospital admission to help to prevent them needing to go to hospital at all.
- Supported delivery of education for patients on how to manage their condition so that they can more easily identify when they are getting worse, their medication may need to change and when the right time to seek help is.
- Appropriate follow-up and regular review of patient's condition by the GP or practice nurse. This would mean a change in the way hospital specialists work and mean that patients get more follow up care.
- The pharmacist would play a key role in helping patients understand their condition and how to manage their medication effectively.
- Investment in 'telemonitoring' where this is appropriate to the patient's situation.
- Putting the range of initiatives set out in the plans in place would mean there are fewer emergency visits to hospital and a reduction in the average length of stay associated with an acute episode.

4.2.4 Ensuring our acute hospital services are safe and sustainable

As we develop our acute services over the coming months and years, there are particular service developments which will drive change across how our services are configured:

- Implementation of one regional trauma centre for Northern Ireland based in the Royal Victoria Hospital, as a key responsibility for Belfast Trust. The development of regional protocols and procedures for ambulance services would support this development.
- Making sure everyone has 24-hour access to safe, sustainable cardiac catheterisation laboratory services – including the introduction of an (emergency) primary Percutaneous Coronary Intervention service, which is a milestone of the Northern Ireland Executive's Programme for Government – with an associated investment of up to £8m over the next three years. Two sites would be developed: one in Altnagelvin Hospital and the other in Royal Victoria Hospital.
- Expansion of orthopaedic services in Southern, Western and Belfast Trusts with an investment of up to £7m revenue over the next 3 years, to significantly reduce waiting times for fracture and other orthopaedic services for patients.
- To ensure safe, sustainable arrangements are in place for the provision of Paediatric Congenital Cardiac Surgery and Paediatric Interventional Cardiology for the population of Northern Ireland.
- The DHSSPS will be carrying out a review of paediatric services, with a view to beginning consultation within 6 months. A review of palliative and end of life paediatric services will follow.
- Our Ambulance services will continue to develop new protocols which support "right care, right place, right time, right outcome". Protocols will be outcome-driven and

reflect best practice. They will provide alternatives to going to hospital, support people to safely manage their health at home (where appropriate), and take patients without delay to the most clinically appropriate destination.

This means that sometimes you may not go to A&E but are taken directly to a facility you have been to before, or you may go to a hospital which is not the one closest to you but one that specialises in treating your condition.

Key initiatives include looking at the feasibility of:
- A "111" urgent care service sitting alongside "999" – simplified access to urgent care 24/7 with real-time clinical advice and direction/support in accessing healthcare
- Hospital-at-home protocols with suitably trained and equipped ambulance, hospital and community based clinicians organising and providing clinical assessment and treatment in settings other than hospital.

- Enhance the dedicated paediatric and neonatal transport services throughout Northern Ireland.
- Modernisation of pathology.

Below we set out the direction of travel planned for acute hospitals:

- Creating hospital networks and reorganising acute services - No hospital will work in an isolated way and the existing infrastructure will form part of a network, contributing to the provision of services to the population in its area, and where appropriate adjacent areas.
  - Guaranteeing the future sustainability of our hospitals by ensuring all acute services adhere to best practice in terms of quality outcomes, infrastructure and staffing.
  - We will address fragility in our hospital services by ensuring volumes are sufficient to support best outcomes and staffing levels are in line with best practice, with activity directed to component parts of the network to achieve this outcome.
  - Through the creation of 5-7 hospital networks, the role of some hospitals will change as they become part of a network working together with their partner providers to provide comprehensive services to their local population. Individual hospitals will all be part of a network.
  - In developing our hospital networks and reconfiguring our acute services the following configurations are proposed, subject to public consultation:
- In **Belfast** the hospitals, comprising Royal Victoria Hospital, Belfast City Hospital, the Mater Hospital and Musgrave Park Hospital, would operate as one network with clinical services dispersed across the sites in the best configuration available. Specifically recent consultation recommends one emergency surgery centre at the Royal Victoria Hospital. Emergency department configuration across the network will be consulted on in 2012.

- The principal hospital in the current **Northern** network is Antrim. It would continue to deliver all core general hospital services – surgery, medical, emergency department, maternity, renal etc. – responding to its natural population area. A large number of people using Antrim Area Hospital live in the greater Belfast area. Network arrangements need to reflect this and ensure appropriate links with Belfast Hospitals. The need to ensure that acute hospitals are providing safe and high quality services and the natural population flows in the area means that change will occur on the Causeway site in terms of its core in-patient services. There would be access to 24/7 emergency/urgent care on both Antrim and Causeway sites, which would be doctor led. We need to responsibly manage this change over the next 3-5 years.
- In the **Southern** area, there is already strong evidence to suggest that changes have occurred across Craigavon Area Hospital and Daisy Hill Hospital which demonstrate robust networking. This includes a network of medical staff which supports the provision of safe, quality care for more acutely ill patients in the High Dependency Unit in Daisy Hill Hospital, through 'virtual wards rounds' with specialist medical staff based in the Intensive Care Unit in Craigavon Area Hospital. They use new technology which means that the specialist is involved in clinical decision making and can talk to patients and families, as if they were physically present. There is also a networked approach to Emergency Departments to ensure that service is safe and sustainable on both sites at all times through shared protocols and management. This model is to be supported and encouraged, and it is expected that further sensible changes will occur to maximise the effectiveness of this network in line with the criteria for acute care.
- In the **South Eastern area** there is a principal hospital network encompassing the three hospitals – Ulster Hospital, Downe Hospital and Lagan Valley Hospital with clinical activity dispersed across the 3 sites. The Ulster Hospital will have 24/7 Emergency department and the full range of normal acute hospital services. The urgent care model operating at Downe Hospital covered by GP out of hours would continue and it is proposed that this would be extended to Lagan Valley Hospital.

  Of equal importance is the network between the South East and Belfast. This is most obvious in a flow from Lisburn to Belfast and from east Belfast to the Ulster Hospital. This networking is to be supported and encouraged. Looking to the future the evolving network will continue to use the criteria to shape service provision.
- The **Western area** has two acute hospitals – the new South West Acute Hospital in Enniskillen and Altnagelvin in Londonderry. The South West Acute Hospital will reflect the needs of its population areas including the dispersed rural population and provide all general hospital services. Altnagelvin Hospital will in future provide a wider range of specialist regional services, including Orthopaedics, Cardiology and Cancer Services from 2016. Altnagelvin will continue to network with Causeway and Antrim Area Hospital as appropriate.

  The South West Acute Hospital would network strongly with both Altnagelvin and with Craigavon Area Hospital in the Southern area. This reflects natural population flows and takes account of planned specialist service developments. No change in the management arrangements is proposed.

4.2.5 Palliative and End of Life care

- Include local and regional raising awareness initiatives for public and staff across the patient journey: Identification, Assessment and Advanced Care Planning.
- Develop trust information systems to quantify and identify those approaching the end of life as per regionally agreed prognostic indicators and placed on GP registers and the trust information system.
- Have care plans developed and continually reviewed for those in the last year of life. (These should include DNAR wishes, place of care and referral for carer's assessment).
- Ensure that people identified as being in the last year of life have been offered the opportunity to have advance care plans developed. Ensure that all people, on admission to a nursing home, have been offered the opportunity to have an advance care plan developed.
- Ensure that there is a standardised approach, such as the Care of the Dying Pathway (e.g. LCP) is implemented, according to quality standards, across all care settings.
- Promote effective co-ordination of care across organisational boundaries - implement the regionally agreed key worker function and the use of multi-disciplinary records in the home and out-of-hours handover.
- Reduce the number of people admitted to hospital inappropriately during their end of life phase and ensure people are given the choice to die at home, with particular focus on those who die within 48 hours of admission.. There will be an increase in the number of people who are facilitated to die in their preferred place of care as recorded in their care plan. By year 2014 -2015 we will have a 10% reduction in the number of people who are admitted to hospital during these last hours.
- Right size community nursing and other support staff to ensure people receive palliative care across all community settings. Scope existing arrangements with the nursing home sector for delivery of palliative care services in terms of value for money and quality of outcomes. Provide support to nursing homes to meet the standards currently being developed in conjunction with RQIA. (End of 2014).
- Increase access to specialist palliative support out of hours and enhanced links between specialist and generalist services.
- Increase the number of staff confident and competent in the core principles of palliative and end of life care.
- Increase generalist palliative care services available in the community including medical services, personal care services, access to pharmacy services, AHP services, supported by specialist palliative care as required across settings.
- End of Life and Palliative Care standards should be met for those with long term conditions, such as cancer, heart failure, renal disease, stroke and respiratory disease by March 2014.

- Significant progress against these standards should be demonstrated for those with other chronic conditions, such as dementia and for the frail elderly who are recognised to be at the end of life.
- Work with NIAS to develop out of hours services to reduce ED attendances; working with nursing homes and NIAS to avoid unnecessary admissions from nursing homes, including for end of life care.
- Implementation of 'Living Matters: Dying Matters: Palliative and End of Life Care Strategy for Adults in Northern Ireland'.

4.2.6 Mental health services

- Mental health services will focus on their community teams' interface with primary and secondary care. This integration can then be developed into the ICP structures as the model matures across the region, for example in rolling out the stepped care approach in partnership with primary care with an emphasis on early interventions. The services will also explore the use of technology to aid mobile working and create a stronger network with primary and secondary care, enhancing home treatment models.
- Across the region, there will be a focus on resettling those people in the community who are living in long stay hospitals. This will involve close working with voluntary sector providers.
- Mental health services will ensure that no patient is required to live in a hospital after their treatment has been completed. Therefore mental health services providers will ensure the resettlement process for all people currently living in mental health hospitals has been completed by March 2015.
- As part of this community work the teams will also seek to form closer working ties with the voluntary sector to integrate where possible, their resources into the transformation initiatives and send service users to the most appropriate care provider.
- In continuing to focus on personalised care of service users, increasing the uptake of self-directed and individual budgets can be achieved with the involvement and support of carers.
- Carers play a well-established and critical part in the overall care and wellbeing of people with mental health needs. There will be continued and committed support for carers ensuring they have access to community-based interventions which enhance their quality of life, for example employability and emotional wellbeing.
- Regionally there will be a reduction in the number of acute mental health inpatient beds over the next three years to a point on March 31st 2015 where:
  - No patient will be living in a long stay mental health hospital setting.
  - 6 in-patient acute mental health units for those aged 18+ are developed. There would be one site in the Northern, Southern, South Eastern and Belfast areas, with two in the Western area. In order to reduce stigma and ensure there is good access to acute care, it is necessary to locate mental

health hospitals close to acute hospital provision, recognising that this may not be possible in all circumstances. These principles would imply that the second location in the Western LCG area would in proximity to the new South West Acute Hospital rather than Omagh as previously planned.

- Regionally the CAMHS service will focus on developing its service. It will implement the RQIA recommendations in relation to CAMHS. This will involve cross boundary co-operation.
- LCGs will continue to tackle suicide through implementation of the Refreshed Protect Life Strategy 2012.
- The transformation of mental health care will be progressed through the implementation of the stepped care model, the Mental Health Services Framework, Regional Psychological Therapy Strategy and related NICE Guidance. These have been designed to enable the reorganisation of services across the primary, community, and secondary care systems by matching service intervention with a person's presenting needs. Integral to the model is the emphasis on prevention, early intervention and the development of integrated care pathways which will simplify and promote better access to care across each LCG locality. Integrated Care Partnerships (ICP) will likely be critical in the delivery of these objectives.
- Improving access to psychological therapy is a fundamental component of recovery and is critical to the successful implementation of the Stepped Care Model for people with common mental health problems. It is within this context that each LCG locality will establish a dedicated Primary Care Psychological Therapy Service with the capacity to provide through a single gateway, facilitated self help, group therapy, and/or one-to-one counselling or Cognitive Behavioural Therapy for common mental health problems.
- Substance misuse services will implement existing Health Improvement strategies which aim to increase population awareness of alcohol/substance misuse related harm in partnership with community and voluntary sector. LCG Localities will support the implementation of the regional Integrated Care Pathway for substance misuse and ensure practice reflects such care across steps 3 & 4. This will also involve working with primary care and other community based services to undertake agreed 'screening and brief intervention' programmes.
- Advocacy services' standards will be improved in line with the 2012 Guidance for Commissioners. Services will be in place to provide support for women with serious psychiatric conditions in pregnancy and the post-partum period.

4.2.7 Learning disability services

- The service will aim to reduce the number of people in institutional care by moving them into community-based options through the continued development of self-directed support and individual budgets and the supported living model. This will take full account of the complex family dynamics in this area.
- Learning disability services will continue efforts to be more resettlement focused. It is the intention that this process will be complete by March, 2015.

- There will be continuing focus on reducing delayed discharge from hospital with investment in community infrastructure. Challenging behaviour services and alternatives to hospital based assessment and treatment will be further developed in order to shorten lengths of stay and reduce the number of service users being admitted to acute beds unnecessarily.
- The regional services will improve access to respite provision and provide a wider range of non-facility based respite for both service users and carers to help the development of self/carer care and reduce the number of service users being admitted to acute beds. It is vital that carers continue to be involved in care planning and service planning to bring their experience to bear on these functions.
- A Regional Day Opportunities Model for Learning Disability will be developed and implemented across all localities.
- The physical wellbeing and mental health of people with a learning disability will be improved through the Directed Enhanced Service in Primary Care for adults with a learning disability.
- Advocacy Services Standards will be improved in line with the 2012 Guidance for Commissioners.

4.2.8 Physical disability and Sensory Impairment services

- The services will conduct a review of daycare provision with a view to establishing the level of access to such services regionally, with the objective of enabling more care closer to home. Some areas have already moved to public consultation on this reform. Service users with complex needs will remain in the statutory sector where this is most appropriate to their needs, with flexibility of service provision to other service users with a less complex profile of need. The overall aim is to ensure that people with physical disabilities do not have to be admitted to hospital where day case provision is a viable alternative.
- Multi-agency and multi-disciplinary collaboration will improve the choice of services for people with physical disabilities and as a result improve rehabilitation, create an increased and broader range of respite options across the region and increased the capacity to meet supported housing needs.
- In line with the personalised care agenda, the proportion of people with self-directed and individual budgets will increase.
- Examine the potential for the development of specialist supported living options, for example for those people with acquired brain injury.
- Services will also develop their safeguarding aligned with the regional policies and procedures and associated operational changes.

4.2.9 Population health & wellbeing

- Ensure that support is in place for pregnant mothers with risk factors such as smoking, obesity, mental wellbeing, alcohol and drug use.

- Implement the 'Fitter Futures for All' framework to address obesity, and the Tobacco Strategy to reduce smoking rates.
- Expand the Roots of Empathy Programme in primary schools to improve the social and emotional wellbeing of children.
- Expand and/or introduce a range of evidence-based programmes to support parents and families and expand training for professionals and key community workers on infant mental health
- Expand breast feeding peer support programmes.
- Expand programmes which tackle poverty (including fuel poverty) and maximise access to benefits, grants and a range of services.
- Establish programmes that address employability and the needs of long term unemployed people with a focus on skills development and opportunities for training and employment within the health and social care sector.
- Strengthen workplace health programmes to improve the health and wellbeing of the workforce and ensure that staff provide appropriate information to HSC service users, to their own families and social networks.
- Incrementally expand capacity in providers of contraceptive and sexual health services specifically tailored to the needs of young people, and providers of sexual health services, particularly for groups at high risk of HIV and STIs.
- Expand community capacity to respond to potential suicide clusters.

4.2.10 Family and Child Care

- Northern Ireland has a unique opportunity to position itself as an early intervention region for generational change to support the improvement of life chances for children by achieving better outcomes. This focus on early intervention will require a multi agency/partnership approach to prevent children having to be separated from their families and enable some children to remain safely with their families.
  - Embed Family Support Hubs across the area to focus on early intervention. This will include delivery of Step 1 'Targeted Prevention' services and Infant Mental Health supports.
  - Support to families and parenting skills.
- Children are best cared for within the family of origin, or where that is not possible, within family settings where appropriate. Plans regarding the provision of residential childcare must be made on the basis of the assessed need of children and young people and the availability of suitable alternative placements such as foster care. Key aspects include:
  - Increase in the number of foster carers and in particular specialist foster carers.

  - Engage with Strategic Regional Review of Residential care services for Children and Young People to take forward recommendations of local review in line with regional recommendations.
  - Reduce the reliance on residential care homes.
  - The development of a fostering schemes for children hardest to place.
- Develop Child and Adolescent Mental Health Services: reduce the number of children waiting for service and a reduction in waiting times.

- Increase availability of emergency CAMHS cover to avoid acute admissions.
- Child and Adolescent Mental Health services will continue to implement the recommendations outlined in the RQIA CAMHS review (February 2011) and the DHSSPS Policy Guidance 'Child and Adolescent Mental Health Services: A Service Model' (July 2012). This guidance provides a basis for reshaping service provision and will require each LCG locality to establish a Primary Mental Health Team and Crisis Resolution and Intensive Treatment Teams as part of CAMHS service provision. Trusts will also be required to take steps that further integrate CAMHS, Child Development and Behavioural Services into a more coherent system of care.

4.2.11 Maternity & Child Health

- In the Belfast area, a freestanding midwife-led unit would be developed in the Mater Hospital, with one consultant-led obstetric unit in the Royal Jubilee Maternity Hospital. We also plan to provide an 'alongside' midwife-led unit in the new regional maternity hospital.
- In the Northern area, initially the current services will remain at both Causeway and Antrim Hospitals. The volume of activity in the consultant obstetric unit in the Causeway Hospital will be reviewed to ensure it meets the required standard. Given the likely number of births at the Causeway Hospital it is probable that there would be change in obstetric services at the Causeway Hospital over the next 3 to 5 years as it is not likely to be possible to maintain a safe and sustainable consultant-led service there.
- In the South Eastern area, there would continue to be a consultant-led obstetric unit and an 'alongside' midwife-led unit at the Ulster Hospital, with freestanding midwife led units in Downe and Lagan Valley Hospitals. These units are to be reviewed over the next 3 to 5 years to ensure their continuance is demonstrably supported by mothers choosing to use them.
- In the Southern area, there would continue to be a consultant-led obstetric unit and an 'alongside' midwife unit at Craigavon Hospital, and a consultant-led obstetric unit in Daisy Hill hospital. The level of medical cover for the consultant-led obstetric unit in Daisy Hill Hospital would continue to be reviewed to ensure it meets the required standard. An 'alongside' midwife-led unit would also be developed at Daisy Hill Hospital.
- In the Western area, there would continue to be consultant-led and midwife-led units in both Altnagelvin Hospital and the South West Acute Hospital. The level of medical

cover for the consultant-led obstetric unit in the South West Acute Hospital would be reviewed to ensure it meets the required standard. It is likely there will be additional activity from the Republic of Ireland.

- Progress regional plan to support mothers with serious psychiatric conditions.
- Keep first pregnancy and labour normal to reduce interventions and promote normalisation of birth - bring ante-natal and post-natal visits into line with NICE guidance. Reduce LOS and attendances at outpatients and foetal assessment units.
- Provision of antenatal care in the community: increase the percentage of women having their ante-natal care in the community.
- Support Healthy Pregnancy and early parenting to promote good parent/child relationships in the early years.
- Improved facilities for children who need acute in-patient treatment with extended community services involving GPs - care closer to home.
- Establish Family Nurse Partnership Programme pilots in the 3 specified areas (Western, Southern and Belfast), to improve the health and well being of our most disadvantaged children and families, thus preventing social exclusion. The Partnerships will be rolled out to other areas following the Pilot stage. Family Nurse Partnership Programmes will be offered to all first time teenage mothers within an area.
- It is recognised that as well as Family Nurse Partnership Programmes, a number of initiatives, for example the Child Health Promotion programme, Healthy Child, Healthy Futures, are working to to deliver improvements and give the best start in life. It is acknowledged that there is a need to introduce evidence-based programmes to support parents and families.
- Establish the neonatal managed clinical network

4.2.12 Increased collaboration with our colleagues in ROI and GB

- Where we do not have the volumes to support specialist services we will access quality services in neighbouring health services. Through these service arrangements, our population will have access to the highest quality specialist services not currently available in Northern Ireland. We will have better quality outcomes as a result.
- To progress this, the HSC Board and the Service Delivery Unit in the Department of Health (Republic of Ireland) have been discussing opportunities for engagement on major strategic issues. Terms of Reference are currently being finalised. Areas of collaboration suggested to date include the following:
  - Patient flows between hospitals on both sides of the border. Initial ideas of Trusts and hospitals involved include:
    - CAWT Out of Hours project
    - South Western Hospital (Enniskillen); Altnagelvin (Derry) and Daisy Hill Newry

- Southern Trust (in relation to Dundalk/Drogheda); Western Trust (in relation to Letterkenny)

– The provision of specialist services, for example:

- ROI patients accessing tertiary services in Belfast Trust
- Access for ROI patients to CATH Labs in Northern Ireland
- Collaboration on the provision of cancer services

– Consideration of collaboration around CAMHS, acknowledging that there is much demand for this specialist resource on both sides of the border.

4.2.13 Developing our workforce to support our transformation

- It is essential that there is sufficient staff available to manage the 'shift left'. Transitional funding will be required to ensure that services are maintained in the acute sector, while staff are undergoing retraining where redeployment may be necessary, and additional skills are being established in the primary and community sectors, We will ensure our TYC transformation programme supports those in transition.
- Critical Workforce changes:
  – We will invest in our people to ensure they have the right skills to support our journey. Our health and social care service will attract the best people offering opportunities to play a key part in its transformation.
- Leadership and capability development:
  – For this unprecedented change, our leaders need enhanced skills and capability. We will invest in our people, in particular our leaders, and establish a programme to support their development.

4.2.14 Procurement

- Greater diversity of service provision, particularly non-institutional services, using the community, voluntary, social enterprise and independent sectors - with consequent major changes in the residential sector.
- Standardisation of procurement of domiciliary services and residential and nursing home places.

4.2.15 Technology

Many of the proposals in TYC draft plans will be supported and enabled by new investment in ICT and Connected Health and some of the specific areas where there may be change are:

- Increased sharing of patient information across HSC organisations where this supports clinical decision making about your diagnosis or treatment. For example, a GP in the community should be able to send information about a patient's condition

directly to a consultant based in an acute hospital to enable a decision to be taken without the need for the patient to visit hospital.

- Everyone will have an Electronic Care Record.
- Connected Health uses technology to provide healthcare remotely and encompasses telehealth, remote care (such as home care), disease, and lifestyle management. While it is not limited to managing chronic diseases it can contribute to management of these, and should lead to reduced unplanned admissions to hospital (along with associated cost savings), and improved outcomes for patients and their families.
- Community Information Systems should be able to consistently generate minimum data sets that can be shared appropriately to facilitate effective service provision.
- The introduction of a web based portal' - this will be equivalent to the NHS Choices website but for the HSC. It would include information on prevention, self-management of illness, signs and symptoms, investigation and treatment of a range of conditions. It would also include a directory of local GP, community and hospital services.

4.2.16 Finance

- Financial remodelling of how money is to be spent indicates a 5% shift from current hospital spend estimated at £83million and its reinvestment into primary, community and social care services by 2014/15. The pace of change will be influenced by our financial circumstances. Ideally, this would be a 3 to 5 year horizon for the implementation; however, implementation may be achieved slightly quicker, or indeed we may to need to go at a slightly slower pace, depending on the level of resources available.
- The initiatives contained in the draft SIP and Population Plans are focused on describing the service model. It is recognised that further detailed planning around the workforce and financial (including capital) implications of the service model is required to be completed over the coming months. This localized costing and planning of all the initiatives will aim to identify the reinvestment in each LCG area and the affordability of the new model of care. This exercise will provide the evidence base to support the implementation of the initiatives.
- In addition, we recognise the need for capital investment in our infrastructure. At the moment our current capital budget between 2011/12 and 2014/15 is £962million which is used to cover a range of projects.
- Looking ahead, the draft Investment Strategy for Northern Ireland provides for an indicative allocation of £1.47bn from 2015/16 - 2020/21 against an estimated need of £2.3bn, leaving a projected shortfall of over £800m some of which may be addressed by revenue financing solutions such as Public Private Partnership (PPP).
- In this context, it is increasingly likely that without additional sources of capital funding, the scope to take forward major modernisation projects will need to be phased to take account of budgetary availability.
- Transitional funding is critical to enable the new model of service to be implemented. This transitional funding will be particularly focused on the following areas:

  - Integrated Care Partnerships
  - Service Change
  - Implementation Funding
  - Voluntary Redundancy / Voluntary Early Retirement Schemes

- Residual demand will need to be taken into account during the financial modelling of the initiatives. Together with the service model changes which are articulated in the draft Population Plans, it is anticipated that medical advances, changes in clinical practice, and the development of new technologies and medicines will contribute significantly to the cost associated with providing modern health and social care services in Northern Ireland.

Health and Social Care Board

4.3 Regional programmes

TYC provides a coherent, controlled and managed framework which brings existing programmes together and adds new ones, in a well-integrated way, to deliver TYC proposals.

The regional programmes described in this draft SIP are the portfolio existing/planned programmes together with new programmes - which require integration of existing regional accountabilities and processes - to align with and maximise delivery of TYC proposals. These programmes will be focussed on the regional reforms necessary to achieve transformation, which will have local dimensions and require local integration with delivery of Population Plans. As these programmes mature, responsibilities for delivery might change and will be agreed across regional projects and local Population Plans either through the annual planning processes or as regional programmes reach key milestones.

4.3.1 Existing regional programmes

No	Regional programme [TYC Recommendation addressed]	Summary of case for change	Programme Scope	Dependencies	3 year commitment (by March 2015)	1 year commitment (by March 2013)
1	Implementation of the Bamford Action Plan 2012 – 2015 **[52,56,57,58,60,62]**	The Review of Mental Health and Learning disability (commonly referred to as the Bamford Review) set out to reform the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review completed its work in 2007, however a revised action plan is due in 2012 and its recommendations need to be implemented.	The programme scope should cover the recommendations of Bamford and be cogniscent of the commissioning intentions across Mental Health and Learning Disability.	▪ Publication of the Bamford Action Plan forthcoming Autumn 2012	▪ Full implementation of the recommendations of the 2012 Bamford Action Plan	▪ Implementation of the 36 Year 1 commitments in the Mental Health and Learning Disability Commissioner Specifications, pertaining to the Bamford Action Plan
2	Implementation of the DHSSPS Maternity strategy 2012-2018 **[34,36,37,38,39]**	This six year strategy (published in July 2012) replaces the previous DHSSPS policy on maternity services issued in 1996 and focuses on six main outcomes: ▪ Giving every baby and family the best start in life ▪ Effective communication and high quality maternity care ▪ Healthier women at the start of pregnancy (preconception care) ▪ Effective, locally accessible antenatal care and a positive experience for prospective parents ▪ Safe labour and birth (intrapartum care) with improved experiences for mothers and babies ▪ Appropriate advice and support for parents and babies after birth	Project infrastructure will need to be put in place to ensure the strategic objectives are implemented. The required elements that are to be addressed in the strategy will be 1) Pre-conception care, 2) Antenatal care, 3) Intrapartum care, and 4) Postnatal care	▪ Forthcoming Regional Review of Paediatric Services ▪ Forthcoming Public Health Strategic Framework	Full implementation of the Maternity strategy by March 2018 a regional action plan to implement the maternity strategy will be developed by the PHA and the HSCB and submitted to the DHSSPS by 31 January 2013. This will include interim milestones with outputs and outcomes which will improve health outcomes for women and children,	▪ Ensure that a phased regional Action Plan has been developed and strategic objectives for Year One outlined in the commissioning plan are taken forward. ▪ bookings and risk assessment carried out by 12 weeks and ▪ receive their maternity hand held record ▪ Trusts to implement their Normalising Birth Action Plans with a resultant increase in the percentage normal births and reduction in unexplained variation in intervention rates

Health and Social Care Board

No	Regional programme [TYC Recommendation addressed]	Summary of case for change	Programme Scope	Dependencies	3 year commitment (by March 2015)	1 year commitment (by March 2013)
3	Implementation of the Physical Disability and Sensory Impairment strategy **[28,29,30]**	One of the key issues identified for urgent action by the NI Executive following devolution was the promotion of social inclusion for all citizens and particularly for those groups or individuals who are, or may feel, marginalised or disadvantaged in society . The goal of the strategy is to increase the empowerment of people with physical disabilities and or sensory impairment so that their disability does not stop them from participating in society.	Programme scope is delivery of the strategy vision and objectives, namely to ensure: ▪ The support of disabled people to become well informed and expert in their own needs; ▪ The promotion of health, wellbeing and maximizing the potential of individuals; ▪ Encouragement of the social inclusion of disabled people and work to address the stigma associated with disability; ▪ Encouragement of the family and person-centered services and the promotion of independent living options, such as using self-directed support and Direct Payments. ▪ Ensuring that practical supports such as suitable housing, necessary equipment or access to employment, are tackled.	▪Development of agreed partnership models with ALL key stakeholders, integrated working across ALL Government departments, effective interfacing with other regional groups developed to take forward Actions contained in the Strategy, e.g., Self-directed support and individual budgets, etc; meaningful service user engagement.	Full implementation of the Physical Disability and Sensory Impairment strategy	▪ Develop Infrastructure, Membership & Reporting Arrangements & necessary Processes commence work on priority issues across the key themes of Promoting Positive Health, Supporting Independent Living and Information & Training (there is a need to ensure actions adhere to TYC proposals for Physical Disability and sensory impairment), Carry out a Baseline Scoping Exercise, Develop a Rights Based Approach to the Strategy and develop an agreed Outcomes Framework for commissioning of services for people with physical and sensory disabilities ▪ Fully engage with service users, and careres in both development of services and evaluation of outcomes.
4	Modernisation of pathology services **[78]**	Around 70% of diagnosis in the HSC depend on pathology test results; as learnt form other areas of the UK, any HSC redesign must take account of the services that underpin its ability to provide high quality patient care. The recommendations of the Pathology Review are still relevant today; however molecular diagnostics spans all pathology disciplines and is the fastest growing area of medicine and in future will become widespread in disease management. It is now widely recognised that it is prudent to plan for a large increase in its use. A broader pathology transformation programme that takes account of the Pathology Review of 2007 and emerging	The core team leading the established federated network is a lead clinician and a network manager (to take up the post in July 2012). The programme is at a very early stage of development. The dept agrees that this should be taken forward within the existing network. Next steps should be: > To fully articulate the case for change > Develop a programme plan > Implement a major review of how services are delivered, building on "The Future of Pathology Services in NI" report from 2007. This should include appropriate local services, combined with a centralised regional laboratory.	▪ Support from the DHSSPS , commissioners and local trusts ▪A clear strategic plan for changes of clinical service delivery ▪Older technologies and processes need to be de-commissioned to make way for the new demands. ▪This transformative programme should be effectively managed at a regional level rather than locally if it is to bring maximum benefit to patients and make best use of HSC resource. ▪This should also take into account the need for a planned investment in ICT to support pathology modernisation.	Full implementation of technological transformation to support molecular pathology techniques, with the potential to exploit academic and business partnerships to make programme self-sustaining.	▪ TYC programme to commission the Pathology Network Board to develop and provide a strategic implementation plan by (e.g.) December 2012 covering the detailed case for change, a designed programme of change and an implementation plan by (e.g.) December 2012.

Health and Social Care Board

No	Regional programme [TYC Recommendation addressed]	Summary of case for change	Programme Scope	Dependencies	3 year commitment (by March 2015)	1 year commitment (by March 2013)
		priorities such as molecular pathology is required to embrace technological advances in testing in all pathology disciplines.				
5	Implementation of 'A Fitter Future for All: Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland, 2012 - 2022 **[1]**	In the most recent Health Survey Northern Ireland's (2010-2011), h 59% of adults measured were either overweight (36%) or obese (23%). The health impacts of obesity include an increased risk of type 2 diabetes, coronary heart disease, stroke, some cancers and complications in pregnancy. It is also known that obese children are more likely to become obese adults. A significant challenge is faced in reducing the proportion of the population who are overweight or obese.	The scope of the programme is to implement the actions needed to tackle obesity set out in the Fitter Future for All Framework. This involves a wide-ranging, multi-sectoral, long-term and integrated approach through the different stages of life. It includes supporting the individual to develop the knowledge and skills to make healthy lifestyle choices and creating an environment that supports and promotes healthy eating and physical activity.	▪ Partnership working with the voluntary and community sector ▪ Partnership working across other government departments (e.g. DE, DCAL, DRD) ▪ Partnership working at local level with all sectors – e.g. local government, schools ▪ Ensuring that funding that has been identified in the Programme for Government is realised	Implementation of the 2015 short-term outcomes/outputs outlined in 'A Fitter Future for All'	▪ N/A
6	Introduction of a reablement model of care **[10,11,14,17,19]**	The ageing population of NI will place increasing pressure on health and social care services, with the number of people over 65 set to increase by 16% (including a rise of 29% in the number aged over 85) by 2015 and a 30% in the number of people with dementia 2017.	The programme will introduce a reablement model which promotes greater independence and reduces unnecessary reliance on statutory services. This increases the capacity of the voluntary and community sector and promotes healthy ageing. This model will shift the emphasis from traditional service models to a partnership approach, optimising inter-agency working, enhancing the capacity and role of voluntary and community organisations to support self management.	▪ Partnership agreements between Trusts, other statutory agencies and the community and voluntary sectors to maximise the use of existing resources in the community. ▪ A regional Performance Management Framework which can continuously monitor Trust activity/performance. Production of regional protocols and tools needed to operate a full-scale reablement programme. ▪ The establishment of ICPs will likely be a major enabler for this ▪ Require an Action Plan for workforce over next few years, especially AHP ▪ Review and re visit policy circulars - Intermediate Care particularly as there are different views on what this means in different areas, and in light of ICPs.	Full implementation of the reablement model of care	▪ Production of Trust business plans ▪ Establishment of performance baseline information Establishment of Trust project teams ▪ Achievement of diversion targets following assessment
7	Implementation of the Dementia Strategy **[9,19,21,22,54,56,58]**	There are an estimated 19,000 people living with dementia in Northern Ireland, 1,000 of whom are under the age of 65 years. Numbers are expected to grow to 23,000 by 2017 and 60,000 by 2051. In recent years there have been numerous publications worldwide that have documented the economic and social cost of dementia to the middle of this century. Likewise, over the past decade, there have been important developments in addressing dementia however, lack of resources and insufficient funding for research have restricted progress.	The programme scope is to implement the 44 recommendations within the Action Plan arising from the dementia strategy ("Improving Dementia Services in NI" launched in Nov 2011) over a period of 3 years through a regional steering group and a number of multi agency/disciplinary workstreams with input from people with dementia and their carers/advocates.	▪ £6m - £8m in funding is required for full implementation of the recommendations ▪ Dependency on recommendation 59: the further shift of the balance of spend between hospital and community, with re-investment of any hospital savings into community services	Full implementation of the Dementia Strategy and achievement of its stated objectives of dignity and respect; autonomy; justice and equality; safe, effective; person-centered care; care for carers and skills for staff	▪ Programme kick off June 2012
8	Regional expansion of Radiotherapy Services	Radiotherapy services are currently only provided for Northern Ireland Patients at the Regional Cancer Centre at Belfast	The programme scope is to deliver a solution for the future provision of radiotherapy services for NI which takes full account of	▪ Need to ensure that workforce requirements are properly considered and planned for the region	Expansion of radiotherapy capacity in NI to meet the growing	▪ Approval of Western Health and Social care trust outline business

Health and Social Care Board

No	Regional programme [TYC Recommendation addressed]	Summary of case for change	Programme Scope	Dependencies	3 year commitment (by March 2015)	1 year commitment (by March 2013)
		City Hospital. Whilst a sub regional centre at Altnagelvin is necessary to secure sufficient radiotherapy capacity for the region from 2016 onwards, more immediately there is a need for additional capacity in the cancer centre from April 2012. The number of radiotherapy fractions being given per annum at the Cancer centre is increasing each year by an average of 5% and the current existing linear accelerator capacity will be insufficient to meet the rising demand.	service needs, infrastructure, staffing and resources.		needs of the population	case (OBC) 2
9	Transforming Cancer Follow Up – Macmillan Survivorship Programme **[21,22]**	There are increasing numbers of Cancer survivors across the UK, rising by 3.2% per year with 4 million by 2030. NI has 51,000 cancer survivors. As a result of this, and the failings of the current system such as crowded clinics, overly clinical focus, responsiveness of test results etc. services will need to change to accommodate post-cancer support.	The programme scope should focus on the development of a risk stratified model of follow-up in line with the national cancer survivor initiative. This should address both the increasing numbers of cancer patients as well as their health and well being needs. Partnership working with the voluntary sector is likely to enable this model. Programme objectives are 1) to improve patient experience of care 2) effective resource utilisation and 3) streamline services	▪ Funding to support local bids ▪ Macmillan cancer support working in partnership with HSCB/PHA ▪ Collaboration with other cancer charities	A robust external evaluation of the regional breast cancer pathway will be complete. Mechanisms for sustaining transaformational chance will be identified	▪ Self directed after care pathways will be in place for at least 30% of breast cancer patients ▪ Mechanisms for remote monitoring PSA tracking will be identified ▪ New prostate pathways will be developed
10	Implementation of Living Matters Dying Matters Palliative and End of Life Care Strategy [**80,81,82,83**]	There is a need for raised awareness and understanding of palliative and end of life Care including increased knowledge and skills of health care professionals in respect of palliative and end of life care; health and social care professionals enabled to identify individuals who could benefit from palliative or end of life care;	The strategy refers to supports for adults from the point of diagnosis of a life-limiting illness, to death and bereavement.	▪ Appropriate identification and addressing of education/awareness needs of staff ▪ Effective quantification of service needs and provision of supply to match those ▪ Effective identification of patients who need targeted with support ▪ Practical and flexible supports are available for patients and carers to allow delivery of effective care	See Living Matters Dying Matters Strategy Action Plan	▪ See Living Matters Dying Matters Strategy Action Plan
11	Evidence based population screening and immunisation assessment, and implementation of new programmes **[1,3,35,40]**	Population screening programmes enable the early detection of disease. Screening allows earlier intervention which contributes to improved outcomes for individuals. Key priorities, as outlined in TYC are to maintain and expand existing programmes and to introduce new programmes where there is good evidence they can be effective.	The programme needs to determine from an evidence based viewpoint where new screening and immunization programmes need to be rolled out, and which existing programmes need to be reviewed.	▪ A new overarching strategic direction for public health is being developed (by the DHSSPS) UK national screening committee advises on all aspects of screening policy based on best available evidence	Full implementation of population screening and immunisation assessment that has been based on a rigorous evidence based approach	▪ Commencement of data gathering process to build evidence base

Health and Social Care Board

No	Regional programme [TYC Recommendation addressed]	Summary of case for change	Programme Scope	Dependencies	3 year commitment (by March 2015)	1 year commitment (by March 2013)
12	Public Health Strategic Framework **[1,2]**	In general , the health of the NI public has been improving over time, however not everyone has been able to benefit from this process. Health inequalities persist, with poorer health outcomes disproportionately concentrated amongst particular population groups and amongst those living in deprived areas, I	The framework proposes an updated strategic direction for public health bringing together actions at government level to improve health and reduce health inequalities, and which will guide implementation at regional and local level. Improving and strengthening the health system will make a growing contribution to health and wellbeing.	• Public health and wellbeing placed firmly at the centre of the system with greater emphasis on prevention, early intervention and support for vulnerable people, and greater focus on tackling health inequalities. • Partnership working across other government departments (e.g. DOJ, DSD, DE, DOE) • Partnership working with the voluntary and community sectors • Partnership working at local levels with all sectors, e.g. local government, schools ▪	▪ Implementation of outcomes agreed for 2012-15.	Implementation processes to be agreed
13	Healthy Child, Healthy Futures (HCHF)	The 0 – 17 aged population is set to rise by 3% by 2020 and existing and emerging evidence overwhelmingly supports early intervention to improve health and social outcomes for children and young people. The publication of Healthy Child, Healthy Futures in 2010 provides a strategic direction to ensuring a co-ordinated approach to supporting children and their families and the programme will continue to be developed.	Healthy Child, Healthy Futures is provided to all children and young people aged 0 – 19 years irrespective of need. In addition some children and their families will receive a targeted service dependant on their individual need. The programme offers: • A universal service with a number of set contacts • Holistic assessment • Screening and surveillance • Early and progressive intervention	• Work streams established as part of implementation process rely on close working between primary/community care and secondary care • Workforce and training issues identified required funding and support • ICT support required to enable monitoring of programme through an electronic record which will include the child health record and work is ongoing to develop a Family Needs Assessment database.	This will be informed by the audit of the outcomes and the compliance with implementation.	An audit of outcomes in relation to Healthy Child, Healthy Futures; An audit of the implementation of Healthy Child, Healthy Futures; An increase in the number of ante natal home visits; An ante natal home visit to all teenage expectant parents;
14	Autism Strategy	There is a recognised need to ensure a new approach to the delivery of autism specific services. It recognises the need to improve commissioning and provision of ASD services, training and education so that there is earlier recognition, intervention and support for people with an ASD and their families. A Regional ASD Network has been launched to oversee and ensure the implementation of the action plan developed in response to the strategy.	• service redesign to improve ASD care; • performance improvement of ASD services; • training and raising awareness; • improving communication and information for individuals and families; • effective engagement and partnership working.	The Action Plan recognises that important work is being carried out by Health and Social Care organisations and other Government Departments. The DHSSPS Action Plan on ASD acknowledges that effective coordination and sharing of information and best practice with other agencies and sectors is essential.	▪ Rodney to comment ▪ Consolidation of the Childrens' Pathway ▪ Implementation of the Adult Care Pathway ▪ Establishment of local cross-sectoral improvement groups..	▪ Young Person's Pathway to be consolidated.
15	Implementation of the New Strategic Direction for Alcohol and Drugs Phase 2 **[1]**	Research has shown that alcohol misuse costs Northern Ireland up to £900 million every year and almost £250 million of these costs are borne by the Health and Social Care Sector. If we were to add in the costs of drug misuse this would be over £1 billion.	• The scope of the programme is to implement the actions needed to reduce the harm related to alcohol and drug misuse in Northern Ireland, through the outcomes set out in the New Strategic Direction for Alcohol and Drugs Phase 2 (NSD). This involves a wide-ranging, multi-sectoral, long-term and integrated approach through the different stages of	▪ Partnership working with the voluntary and community sector ▪ Partnership working across other government departments (e.g. DE, DSD, DoJ. DoE, etc ▪ Working across the UK, RoI and Europe ▪ Partnership working at local level with all sectors – e.g. local government, schools Ensuring that related funding is used to	▪ Implementation of the short-term outcomes/outputs outlined in the New Strategic Direction for Alcohol and Drugs Phase 2 ▪	▪ N/A

Health and Social Care Board

No	Regional programme [TYC Recommendation addressed]	Summary of case for change	Programme Scope	Dependencies	3 year commitment (by March 2015)	1 year commitment (by March 2013)
			life. The NSD seeks to direct action across five pillars: prevention and early intervention; harm reduction; treatment and support; law and criminal justice; and monitoring, evaluation and research	commission effective services		

Health and Social Care Board

4.3.2 New regional programmes emanating from TYC

The new regional programmes, described below, are subject to formal programme initiation.

No	Regional programme [TYC recommendation addressed]	Summary of case for change	Programme Scope	Dependencies	3 year commitment (by March 2015)	1 year commitment (by March 2013)
1	Development of ICPs **[5,15,60,65,76,86]**	The creation of ICPs is a key recommendation of Transforming Your Care – A Review of Health and Social Care in Northern Ireland (December 2011).	The ICP workstream comprises 4 main stages; Design, Initiation, ICP maturity and Ongoing development. The goal is the achievement of a care model in which individuals will have the opportunity to make decisions that maintain their health and wellbeing. Services will potentially be better co-ordinated and provided locally where safe and appropriate (with the home as the hub).	▪ Stakeholder engagement and buy in of the ICP Guidance Notes and Implementation Plan, including HSCTs, GPC, DHSSPS, etc). ▪ Completion and sign off of Population Plans ▪ Securing transition funding Development of ICP policy document by DHSSPS to be implemented by HSCB	▪ Establishment and effective operation of 17 ICPs.	▪ ICP initiation on a local basis by phased initiation in 2012/13.
2	An assessment of respite requirements by PoC and sourcing of investment required for implementation **[13,19,31,33,67,70]**	Respite care has been shown to help sustain family/caregiver health and wellbeing, avoid or delay out of home placements and reduce the likelihood of abuse and neglect. The ARCH outcome based evaluation pilot study showed that respite may also reduce the likelihood of divorce and help sustain marriages.	The programme scope should cover clear identification of the capability and capacity investment needed in order to provide increased respite to carers across PoC's. In addition, the programme should consider 'local day placement' opportunities that are age appropriate across PoC's.	▪ Carers strategy implementation groups ▪ Reallocation of resources to the community ▪ Dependent on overhauled financial model	▪ Greater support to carers by way of full implementation of an increased suite of respite opportunities	▪ Mobilisation of regional process
3	Develop, and create awareness of information resources for people with a learning disability **[69]**	In general, service users and carers consider it remains difficult to access information on the services available for people with a learning disability. Information on housing options was highlighted as an issue within TYC. Many carers are also unaware of their right to a carers' assessment and access to support to meet their physical and emotional needs	This programme scope should focus specifically on resources for those people with a learning disability from both a resource quality and awareness perspective. In addition, the programme should involve a 'joined up' approach with the PHA in its overall 'population health and wellbeing awareness' campaign.	▪ Build links with the Department of Education ▪ Bamford Action Plan: Dependency on DHSSPS to work with HSCB to make more use of the DHSSPS website and NI Direct website ▪ Dependency on BSO to provide guidance and policy on the use of social media and apps'	▪ Widespread availability and accessibility of information resources for those people with a learning disability	▪ Set up intra organisational joint working group (HSCB/PHA/DHSSPS) to take this forward
4	Implementation of a regional approach to the provision of self-directed support and individual budgets **[16,17,22,28,29,60]**	The provision of self-directed support and individual budgets is seen as a way in which the TYC agenda of 'Promoting independence and personalisation' can be taken forward. TYC has stated that this should be implemented at a regional level.	The programme scope should include provision of self-directed support and individual budgets (if desired) to older people who need support and individuals with physical disabilities, learning disabilities or mental health issues. As a minimum, clear information on the financial package available should be given to those using the service.	▪ Link to publication of Advocacy Strategy May 2012 ▪ Consideration to be given to setting up a self-directed support and individual budgets Steering Group ▪ Links to reablement programme with HSCB	▪ Increase uptake among older people, those with LTCs physical and ;learning disabilities of self-directed support and individual budgets	▪ Mobilisation of regional process
5	Implementation of a single number (111) for Urgent Care **[93]**	A single number (111) for Urgent Care will help people to access local health services when they need medical help or advice fast, but it is not an emergency. This will improve both the delivery and future planning of local healthcare. Callers using 111 will be assessed, given advice and directed straightaway to the local health service which best meets their need – such as A&E, out of	The programme scope is to develop and implement a single number (111) for Urgent Care operating on a 24/7 basis alongside and integrated with the 999 system, linked to a common clinical triage system and dynamic electronic directory of local and regional services which makes it easier for people to access the most appropriate service in the most appropriate, consistent	▪ Seamless linkages to 999 system to ensure safety and confidence ▪ Dynamic electronic directory of local and regional services ▪ Common clinical triage system for both 111 & 999 (such as NHS Pathways or NHS Scotland developments) ▪ Social work Out of Hours (OOH) system being developed needs to be inclusive	▪ Simplified, robust 24/7 access to urgent and emergency care via 111/999 with clinical triage and disposition which is regionally consistent and locally sensitive	▪ Scope of project to include key dependencies (Directory of Services; 111 Call-handling infrastructure; 999 interface; GPOOH interface; etc) ▪ Development of static

Health and Social Care Board

No	Regional programme [TYC recommendation addressed]	Summary of case for change	Programme Scope	Dependencies	3 year commitment (by March 2015)	1 year commitment (by March 2013)
		hours GP, Urgent Care centre, community nurse or pharmacist. 111 will work alongside and be integrated with the 999 emergency services to ensure there is no delay for emergency callers whichever number they use. Calls will be answered by highly-trained call advisers, supported by experienced clinical professionals. This number has already been piloted by the NHS in the North East of England, and is part of the NHS programme to ensure people receive the right care, from the right person, in the right place, at the right time.	and timely manner.	▪ Regional Strategic Framework for GP OOH's is currently with Minister" ▪ Engagement with relevant stakeholders and HSC Trusts to populate and further develop directory of services with local and regional health services (such as crisis response teams for social work, mental health, nursing, etc; pharmacy; dental; Out of Hours GP)		Directory of Local and Regional Services (as basis for developing dynamic directory)
6	Development of a suite of clear regional patient transfer/bypass protocols throughout the healthcare network **[72, 89 also thematic]**	The reconfiguration of services brought about by the implementation of TYC will act as a driver for clear protocol definition for patient transference throughout the healthcare system (both for major trauma and non emergency). Patient transfer/bypass protocols are currently partially defined, but not fully.	Working with the Northern Ireland Ambulance Service, the programme should clearly define and develop patient /bypass protocols throughout the healthcare network This should include arrangements for adults and children.	▪ The configuration of acute services and clinically agreed protocols	▪ Clearly defined regional protocols for patient transfer throughout the NI healthcare network	▪ Review of Regional trauma
8	Implement effective partnership working to maximise outcomes for children and their families in the early years **[41,63]**	It is widely acknowledged that early intervention produces positive dividends for children and families. The learning and experiences from the Sure Start model which targets 'children who will benefit most' and other similar initiatives needs to be understood and extended where benefit can be demonstrated, early intervention to support the development of young children is one of the most cost-effective aspects of social care.	The programme scope will cover integrated working between the HSCB/PHA to maximise outcomes for 0-5 year olds. The programme objectives need to be clearly defined.	▪ Dependency on DHSSPS to provide clarity on how this should be taken forward ▪ Dependency / strong links with Department of Education ▪ Dependency on ongoing AHP review	▪ Tangible benefits arising for 0-5 year olds versus 2012 baseline based on the programme objectives	▪ Set up joint working group between HSCB/PHA/DHSSPS (possible involvement of the community and voluntary sector)
9	Set up dedicated chronic condition management programme for those people who wish to be enrolled **[21]**	It is stated within TYC that the review should take account of extant statements of policy approved by the Minister including (as a major theme) the quest for better intervention and chronic condition management.	The scope of the programme that would need to be set up would be to identify and evaluate the current baseline of patient education and self management support programmes that are currently in place in each LHE area and then implement the necessary condition management to close the gap to best practice.	▪ This may be assisted by the establishment of ICPs ▪ Policy Framework on LTCs to be published April 2012 but this is focused on adults rather than children	▪ To be defined during programme initiation	▪ To be defined during programme initiation
10	Develop a model of non surgical oncology service which best addresses acute oncology requirements and makes most effective use of the multiprofessional workforce [**74. 77, 79**]	The development of a radiotherapy service in Altnagelvin changes the current outreach model of oncology and will impact on patient pathways and service provision in other trusts. There is a need to develop robust Acute Oncology Services to enhance patient safety in line with National Chemotherapy Advisory Group recommendations. The	To undertake a review of the current non-surgical oncology outreach model and drawing on work to date, identify which model enables the development of robust acute oncology services. The review would need to ensure maximum use is made of skill m ix in the development of new patient pathways which take account of local and	▪ Establishment of a sub regional radiotherapy centre in Altnagelvin ▪ Transforming Cancer Follow Up ▪ Establishment of Acute Oncology Services	▪ Robust workforce identified for staffing the radiotherapy unit	▪ Identified model and quantified requirements ▪ Project Plan for roll out of Acute Oncology Service, reduction in oncologist travel and multiprofessional

Health and Social Care Board

No	Regional programme [TYC recommendation addressed]	Summary of case for change	Programme Scope	Dependencies	3 year commitment (by March 2015)	1 year commitment (by March 2013)
		NICaN Chemotherapy service review (2010) identified the need for service reform & workforce modernisation.	regional requirements.			workforce plan

4.3.3 Regional enabler workstreams

These workstreams enable other regional programmes or local Population Plans to be delivered and are a strategic response to the collective requirements across programmes. They also enable TYC programme plans, supported by effective programme management arrangements, to be aligned with other regional programmes within whole system plans.

Enabler workstream	Existing/New	Summary description	Regional programmes enabled by the workstream	Key milestones to March 2015
Finance and workforce planning	Existing	The finance programme has been set up to: > Enable key programme workstreams by the provision of financial expertise to support the detailed work up of workstream plans > Ensure that the financial implications of all workstreams are reported through the TYC TPB and that appropriate actions are taken > Ensure financial stability is maintained during the implementation of transformation / TYC plans > In addition to the finance aspects, detailed workforce planning will need to be undertaken to ensure the correct skills mix exists in the newly reconfigured healthcare world.	▪ This enabling workstream cuts across all potential new and existing regional programmes.	▪ Validate that the agreed shift in expenditure out of hospital services and into alternate community and primary care based service provision has taken place recurrently by March 2015 ▪ Ensure that appropriate funds and resource flows are put in place to put into effect the agreed shift in the provision of care ▪ Ensure that the HSC maintains financial stability during 2012/13 -2014/15 by delivering on both TYC and QICR financial objectives
Capital/Infrastructure	Existing	The Health Infrastructure Board (HIB) considers the capital investment requirements for HSC. > The workstream will work closely with projects/initiatives for service change requiring capital investment > The workstream will work with the ICT programme to maintain oversight of ICT capital investment A comprehensive infrastructure investment programme is to be developed that will incorporate investment in the primary and community based infrastructure network and on improving the delivery of integrated GP and Trust-led primary care services. This includes the delivery of a range of Primary and Community Care Centres (PCCCs).	**New:** ▪ Development of ICPs ▪ Development and creation of information resources for people with a learning disability ▪ Evidence based population screening and immunisation assessment, and implementation of new programmes ▪ Service changes requiring capital investment in equipment **Existing:** ▪ The full suite of programmes identified	▪ Key infrastructure investments to support "Shift left" ▪ Q3 2012, validate capital requirements to enable TYC ▪ Q2 2013, 2 hub schemes going through the procurement process (successful developer will be able to extract revenue from the commercial aspect of the 'hub') ▪ Instigate investment appraisal of the infrastructure programme and proceed to procurement of approved projects by March 2015.
Capability and Engagement	Existing	The objective of the Capability and Engagement workstream is to help create an environment which is receptive to and supports the	▪ This enabling workstream cuts across all potential new and existing and regional programmes	▪ Validation of proposals for 4 key capability programmes (Leading Transformation, Building Capability to Deliver, Skills Transfer and Intelligence hub) by December 2012

Health and Social Care Board

Enabler workstream	Existing/New	Summary description	Regional programmes enabled by the workstream	Key milestones to March 2015
		transformation required to deliver the vision set out in 'Transforming Your Care' and the benefits set out in this draft SIP. In order to achieve this we will ensure that key groups are receptive in terms of their willingness to adopt new behaviours and support the delivery projects ('engagement'), and that they have the ability to do so ('capability'). This workstream will both directly manage some programme level engagement and capability activities (Appendix 1 of this document provides more detail on these activities), and will provide tools, templates and support to projects and initiatives taking place throughout the TYC Programme to build consistency of approach and ownership at a local level.		▪ All capability programmes completion by March 2015 in line with other key Programme milestones (i.e. the completion of the capability programmes will be aligned with Programme milestones to provide support as long as it is needed) ▪ Validation of Engagement approach and plan, and updated Regional Communications Strategy by September 2012 ▪ Delivery of engagement activities as per plan with completion in March 2015 in line with other key Programme milestone (i.e. the completion of engagement activities will be aligned with Programme milestones to provide engagement activities as long as they are needed) ▪ Evaluation Reports and updated capability and engagement plans to ensure alignment with objectives at March 2013 and March 2014
HSC ICT Programme	Existing	This is a programme of projects that has been running for several years. There are dozens of projects contained within the programme, as far as TYC is concerned the most relevant project is Electronic Care Records. There are also a number of emerging requirements from TYC, e.g. the need to increase the bandwidth for the network that supports GP practices (e.g. to give G.P.'s access to video conferencing and online collaboration tools etc). In addition, there is an understanding that there are additional TYC requirements that need to be addressed, namely ICT support for risk stratification. The HSCB will work collaboratively with Trusts and other stakeholders to meet specific IT challenges arising from emerging business requirements under TYC. There will be further development of NIPACS to enable a more networked approach to service delivery.	▪ This enabling workstream cuts across all potential new and existing and regional programmes	▪ Workshop between ICT and Trusts to further establish requirements (input from TYC programme team required) Aug 2012 ▪ First phase of ECR available to all trusts by March 2013 ▪ By March 2015 have fully integrated community information systems in Belfast and Southern Trusts with project also well underway in the Western trust ▪ Agreement with GPs on data warehousing project specification by October 2012
PMO	Existing	This workstream will be responsible for the delivery of effective integrated programme management arrangements to support the TYC programme for its duration. It's key responsibilities will be for: Delivery of the programme management arrangements in an efficient and systematic way to co-ordinate effective overall programme delivery. These will critically cover integrated programme plans, delivery monitoring, risk management and governance support and reporting. Development of a regional programme management community working together in close collaboration to deliver the above. Development and deployment of an approach to monitoring benefits of the TYC programme. Development and co-ordination of the Equality Impact Assessment programme. • Co-ordination and delivery of a plan to actively support the management of innovation during the programme.	All regional and local workstreams will be supported by the PMO activities. Particular activities supported by the PMO are: ▪ Benefits management. ▪ Programme delivery and risk management monitoring / reporting. ▪ Equality Impact Assessment programme. ▪ TYC innovation management	Commencement of a TYC benefits framework by Dec 2012. ▪ Equality Impact Assessment planning & awareness – July/December 2012

Health and Social Care Board

4.4 Draft Population Plans

The draft Population Plans are the local strategic articulation of Transforming Your Care. They describe models of care which are aligned to the TYC proposals. The draft Population Plans address the health and social services needs of a population over the next three years, and are founded on a number of core principles:

- Commission safe, resilient and sustainable personalised health and social services which meet the needs of a population, achieve greater integration of care between organisations and settings, and brings care closer to home.
- Improved access, quality and choice of health and social services in a LCG locality which achieves efficiency and enhances the patient experience.
- Integrated programmes of care across primary, community and secondary care.
- Improve morbidity, mortality and health inequalities.
- Improved quality of mental health and learning disability services by meeting the resettlement targets for 2015 and encourage independence and self-care.
- Identified acute productivity opportunities in the hospitals services system seek to reduce the need for admissions and to plan more effectively for discharge and length of stay.
- A transformation in the workforce, in terms of skills development and realignment will enable the delivery of Transforming Your Care in each LCG locality.
- Overall, the draft Population Plans aim to reduce activity in the acute system by shifting care into the community. This will require growth in community care, and an enhanced primary care system.

The draft Population Plans have been developed by each of the Local Commissioning Groups in consultation with their provider colleagues. They describe the Local plans for delivery of those TYC proposals that have been locally shaped and developed through the population planning process. The draft Population Plans have been designed to be consistent in terms of how they address the issues that exist for their populations; this has been checked through the quality assurance process. The plans and anticipated timescales will continue to be reviewed over the 3 years to consider the affordability. This could speed up the pace of implementation or indeed we may need to go at a slightly slower pace, depending on resources available.

The journey over the next years of how each of the Programmes of Care will evolve and change is summarised below for each local area starting in Year 1 2012/13. It is important to note that the following are summaries and that more detail can be found by reading these in conjunction with each draft local Population Plan. The Programmes of Care set out in Section 4.4 reflect those used in the 'Transforming Your Care: A Review of Health and Social Care in Northern Ireland'. This may differ in some instances from the official statistical definition of Programmes of Care.

Health and Social Care Board

4.4.1 *Older people*

Older People	Regional Strategic Direction – *Reduce residential care beds and establish services to support independent living*		
	Year 1	**Year 2**	**Year 3**
Northern	• Build on the established in-house re-ablement service to ensure that 90% of people requiring a new domiciliary care package are admitted to re-ablement. – 90% of new referrals to domiciliary care admitted to Reablement. – 20% of people going into Reablement will leave with no service required.	• Implement reduced number of specialised intermediate care units (to 6 in Phase 1 – beds from 143 to approx 111) throughout NHSCT to ensure best possible service user outcomes and optimum use of resources. – Increase Occupancy rates to from 85% to 90% and reduce Length of Stay in the service from 31 days to 28 days across all Intermediate Care beds.	• Develop a range of Housing Support services including Sheltered accommodation, Supported Living, Floating Support and Peripatetic Housing Support Services. – Increase by 250 the number of service users using alternative Housing Support Services.
Western	• Re-tender the provision of domiciliary care provision, re-align and reduce statutory homecare to focus on own home Reablement. • Develop an assessment and liaison model to save excess bed days through rapid access to community based teams. • Develop a memory service to increase the length of time from diagnosis to long term care dependency and associated dependency.	• Therapy led goal setting will optimise independence. • A range of housing with care models focusing on addressing the growth in dementia related demand. • Bed numbers can be reduced.	• Reduced residential care placements made and cessation of statutory residential care. • Delivery of long term care through the lower cost based independent sector.
Belfast	• Develop a re-ablement gateway service for people requiring community care which provides intensive assessment and support to maximise independence. • 20% of people going into Re-ablement will	• Further develop supported housing schemes jointly with NIHE and housing associations and avoid the need for residential care. • Closure of 2 homes currently occupied by	• Reduction in nursing home and residential home placements. • Increase in home based respite. • Excess residential home beds closed. • Excess beds within acute hospitals

Health and Social Care Board

	leave with no service required.	20 residents in total.	reduced to plan.
South Eastern	• Reduce ED attendances by 5%, unplanned admissions by 10% and LoS by 2%. • Develop co-ordinated service model and care pathway for Falls. • Reduce statutory residential care capacity by 40 beds.	• Further reduce ED admissions, LoS and statutory residential care capacity for Older People. • Expand Mobile Working pilot across the South Eastern locality to deliver a further 2,547 client contacts.	• Further develop Reablement service to reduce referrals long term domiciliary care support by 45%. • Further enhance telecare service to reduce the number of domiciliary visits required for Older People.
Southern	• Therapy led re-ablement services will be rolled out across the southern area - Increase from a baseline of 3 to 7 localities. Demand for mainstream domiciliary care services will be maintained against demographic growth. • Work will continue with NI Housing Executive to secure development of supported housing across the area including addressing the growing demand for housing with care opportunities for people with dementia.	• The number of people able to live independently in their own homes will increase and specifically there will be an increase in the number of people availing of telecare or other technology based solutions and personalised budgets. • There will be an increase in the number of referrals accepted to reablement (improve upon the 74% figure of April 2012. • Rapid response community services will be in place to safely avoid admission to hospital or reduce length of stay in hospital where admission is required resulting in a reduction in non-acute hospital beds. • Programmes to support the physical and emotional wellbeing of older people including promoting social interaction and targeting falls prevention, will be in place.	• Access to specialist community based support and treatment services for people with dementia will be improved including redesign of statutory day care. • There will be a diversity of providers of domiciliary care including social enterprises with a reduced percentage of domiciliary care provided by statutory services. • As a result of enhanced supported living opportunities, provision of statutory residential homes will reduce by a minimum of 2 homes and will cease over time.

Health and Social Care Board

4.4.2 Population health & wellbeing

Population health & wellbeing	Regional Strategic Direction – *A renewed focus on health promotion and prevention, with particular emphasis placed on smoking, obesity and alcohol consumption*		
	Year 1	**Year 2**	**Year 3**
Northern	• Tobacco Control – services will be targeted at pregnant women and their partners who smoke; those with long term conditions and pre operative patients- 5% of the smoking population will have accessed services in each year. • Obesity – children and young people will be assessed in school and will be referred to obesity management programmes if appropriate. • KPIs - Year 1 / 8 Obesity & Overweight Levels; Regional Obesity Prevalence; Obesity in pregnancy data. • Drugs, Alcohol, Substance Misuse – a range of preventative, early/brief intervention and treatment services will be available across the NLCG area. • KPIS - Increased uptake in preventative services; Increased range of preventative/early intervention services; Decreased substance misuse prevalence; Decreased admissions to ED with alcohol/drug effects.		
Western	• Under the Public Health Strategic Framework implement joint working and multidisciplinary pilots on- lifestyle management programmes aimed at tackling alcohol and drug abuse, smoking in pregnancy, obesity, CHD, falls and diabetes.	• Reduction in smoking in pregnancy by 30%. • Halt in the rise of obesity in families. • Reduction in harmful drinking and improved lifestyle behaviour: reduced STIs. • Reduced demand for acute services.	• Reduced residential care placements made and cessation of statutory residential care. Delivery of long term care through the lower cost based independent sector. • Reduction in hospital attendance and outpatient capacity. • Delivery of AHP and community pharmacy led programmes. • Reduced numbers of continuing care packages.
Belfast	• Higher awareness amongst the BME communities. • Improvement in nutrition to residents of	• Increased uptake of weight management, smoking cessation and cardiac rehab. • Gradual reduction in referrals at Unocini	• Improvement in breast feeding rates and increased dental registrations.

	nursing homes.	levels 2 and 3. • Reduction in the cost of oral nutrition. • Reduction in ED attendances.	• Reduced referrals to secondary care. • Improvement in the cardio vascular health of the population through specific indicators. • Reduction in incidents of dental decay in children and lower cost of interventions. • Reduction in ED related admissions.
South Eastern	• Reduce long-term demand for acute, primary and social services by promoting physical and mental wellbeing. • Establish 'Roots of Empathy' programmes in 30 primary schools to encourage better health and social outcomes. • Provide 12 paid and 12 unpaid apprenticeships for young people leaving care. • Reduce rates of smoking rates during pregnancy by 5% through targeted midwife interventions.		
Southern	• Tobacco Control services will be targeted at pregnant women and their partners, who smoke, long term conditions and pre operative patients. • Weigh to Health programme for obesity will be promoted in the community. • Services to promote and support mental wellbeing, including community development and training will be made available across the area.	• The public will have easier access to stop smoking services in a range of settings by 2014. • A pilot programme of referral to commercial weight management programmes will be undertaken and evaluated. • There will be increased community engagement and development around mental health issues.	• 5% of the smoking population will have accessed services in each year. • A range of preventive, early intervention and treatment services for drug, alcohol and substance misuse will be available. • Enhanced community capacity for mental health services will be in place provided by a range of organisations including the voluntary and community sector.

Health and Social Care Board

4.4.3 Long term conditions

Long term Conditions	Regional Strategic Direction – *Focus on primary and secondary prevention and personalisation of care planning, with assistance from technology and pharmacies to reduce hospital admissions.*		
	Year 1	**Year 2**	**Year 3**
Northern	• Application of reliable Risk Stratification model and tailoring of interventions accordingly across all care providers. • Redesign existing and develop new LTC Care Pathways for all chronic conditions across all settings leading to a reduction of admissions, and overall acute bed days. • Establish case management and community based teams to support complex patients and those with multiple LTCs. • Establish self care and preventive programmes across all LTCs.	• Develop ICPs to provide integrated, accessible healthcare services by clinicians who are accountable for addressing the large majority of personal healthcare needs on a 24/7 basis. • Continue the development of new LTC Care Pathways for all chronic conditions across all settings leading to a reduction of admissions, and overall acute bed days. • Provide support for self-care, transitional points and proactive case management. • Optimise the use of Telehealth.	
Western	• Through ICPs and PC federations develop LTC pathways for all chronic conditions to ensure support for self care and contact between GPs and consultants. • Additional GP nursing and phlebotomy will result in reduced A&E demand, admissions and OP appointments. • Prevent 5% of referrals and 10% of emergency admissions.	• Develop the use of Tele-health and NPT for LTCs. • Establish personalised plans managed by ICPs with escalation protocols. • Enable the review of acute capacity as productivity of district nursing improves.	• As referrals, admissions reduce and LOS improve medical systemic bed numbers can be reduced. • Investment in technology and ICP teams will enable robust out of hospital care infrastructure.

Health and Social Care Board

Belfast	• 8 multi-disciplinary primary care teams (IPACTs) to be established on a 'hub and spoke' model (2 per ICP), inc GPs, Community Pharmacists, OT, Nursing, S Worker. • Dynamic risk stratification of disease registries – supported by data warehouse and risk stratification tool as basis for deployment of stratified interventions in the IPACTs. • Develop telehealth; community nursing and community-based diagnostics, where volumes/ throughput and skill mix make it safe and sustainable to do so, and integrated pathway for older people: Target Diabetes; Heart Failure; Atrial Fibrilation; CHD and COPD.	• Integrated care pathways fully developed and operational. • Personalised plans and a named worker in place. Reduction in ED attendances. Reduced referral to secondary care. Reduction in beds commences.	• Patients managed within community. • Reduced admissions for LTCs. • Reduction in beds in acute settings complete. • Reduce unplanned admissions of adults (18-64) with a Long Term Condition as a primary diagnosis. • Reduce unplanned admissions of people aged 65 and over with Long Term Conditions as a primary diagnosis.
South Eastern	• In Year 1 the Trust will work with the SELCG and GP Practices to ensure that practice registers for a COPD, diabetes, stroke and dementia are accurate including patients with a history of multiple hospital admissions and co- morbidities, and that the information is shared. A process of risk stratification will be undertaken to determine those at greatest risk of rehospitalisation requiring case management and those who will benefit from supported self management. • Year 1, 50 patients in Virtual Ward in Down sector (160 admissions saved and 800 bed days). Year 2, 70 patients on Down Ward (192	• Year 2 and 3 will demonstrate that telehealth contributes to reducing hospital admissions, total bed days, ED visits, ambulance call outs, nurse to home visits and patient visits to GP by 10% per year for all patients on the virtual ward. • Increase the number of people on telemonitoring by 50% each year from the baseline of n = 100.	• After years 2 and 3 to include other LTC's such as Dementia as part of a widening ICP network within Primary Care. • Through case managing 10% of GP Register Respiratory patients in year 2 and 20% in year 3, we will reduce GP attendances by 10% each year. • Based on 4659 COPD patients, the 10% reduction will be 1864 GP appointments in Year 2 and 3727 appointments in Year 3.

Health and Social Care Board

	admissions and 960 bed days) and Year 3, 100 patients on Down Ward (320 admissions and 1600 Bed days).		
Southern	• By March 2013, ensure that at least 2,200 patients with long term conditions locally are availing of remote Telemonitoring services through the Telemonitoring NI contract. • Integrated care pathways supported by risk profiling will target support at those most at risk of multiple hospital admissions, for example, implementation of the NI COPD Integrated Care Pathway by March 2013. • Enhanced training and support will be available within primary and community settings.	• The number of children and adults with type 1 diabetes who have access to insulin pumps that improve their outcomes will increase. • The proportion of patients with confirmed ischaemic stroke who receive thrombolysis will have increased.	• Unplanned admissions to hospital for people with long term conditions will have significantly reduced and more people will be confident in managing their condition at home. • NICE guidelines for a range of long-term conditions will be implemented.

Health and Social Care Board

4.4.4 People with a physical disability and/or sensory impairment

People with a Physical Disability	Regional Strategic Direction – *A system that focuses on personalisation, independence and control, providing the right care in the right place at the right time*		
	Year 1	**Year 2**	**Year 3**
Northern	• Continued promotion of the use of self-directed support and individual budgets across the Trust that increases uptake whilst promoting choice and independence. • Continued development of creative day opportunities including access to employment, leisure and educational activities that promote independence and choice. • Continue to move people as appropriate to need from adult centre day care to independent sector day opportunities provision.	• For building based day care, we will continue to review current provision ensuring needs are met in the most appropriate setting. Consult and Implement changes to provision Sept 14. Increased numbers of people receiving day support through a range of day opportunities • In partnership with the Housing Executive and Independent sector maximise adapted housing options as well as the further development of floating support and peripatetic services to maintain people in the community. • Increased use of technologies and specialised equipment for people with progressive illnesses to remain at home. • 85 clients across the Trust (still at Adult Centres for part of their week), remain to be transferred completely to Day Opportunities. • 23 clients in transition from education are currently referred for Day Opportunities.	
Western	• Development of step down rehabilitation in Spruce will increase utilisation of capacity. • Re-design of traditional day support means that more people with PD will access day opportunities.	• Provide different models of person centred respite linked to carer assessed needs promoting increased choice and accessibility.	• Improved capacity efficiency and savings through retendering of domiciliary care. • Increased self-directed support and individual budgets.

Health and Social Care Board

Belfast	• Develop a Joint Plan for services for people with a disability involving. • Users and carers; Community & Voluntary sector providers and other agencies which increases. • Choice and provides a signposting, advocacy and support service. • Reduced numbers of people with complex conditions living long term in hospital and nursing homes.	• Enable choice through increased personalised budgets. • Increased number of people with personalised budgets.	• Reduction in number of people with complex conditions living long term in hospitals. • Reduction in use of intensive services. • Reduction in hospital and nursing home beds.
South Eastern	• Increase number of self-directed support and individual budgets to carers to promote care in the home. • Engage with local communities to prevent dependence and redirect care to more appropriate options. • Further roll out NISAT to increase the number of assessments by AHP and Nursing staff. • Enhance multi-disciplinary working to improve rehabilitation. • Develop a broader range of respite provision across the Health and Social Care sector. • Increasing level of engagement of people with Physical Disability in programmes focusing on increasing physical activity levels. • Ensure people with continuing care needs are assessed within 8 weeks and have the main components of their care met within a further 12 weeks.		
Southern	• Review of current day service programme and re-profile existing 'building based' provision to community based services and day opportunities on individual case by case basis. • Targeted engagement strategy to scope community opportunities with a view to extending current provision and/or adding additional capacity with new providers. • Review and refocus statutory day care provision to focus on 'unmet' need. • Reduce the number of statutory day care centres across the Trust in line with the development of the new day opportunities service model.		

Health and Social Care Board

4.4.5 Maternity & child health

Maternity and Child Health	Regional Strategic Direction – *Provide continuity of care and throughout pregnancy, focussing on the reduction of ill health, the normalisation of birth and connecting support from ante-natal care into early parenthood*		
	Year 1	**Year 2**	**Year 3**
Northern	• Develop optimum service configuration to meet minimum standards and promote choice. • Implement midwife led antenatal clinics. • Increase capacity of midwife-led clinics for low risk expectant mothers: 1 additional midwife-led clinic per week by Sept 2012. • .	• Develop midwife led community care for postnatal support. • Reduce caesarean section rate. • Develop improved dedicated in-patient paeds facilities. • Develop 6-hour discharge for normal delivery: ALoS from 2.3 to 1.9 days by April 2013.	• Intra-partum Care: Introduce quality and service improvement programme within obstetrics services including a focus on reduced interventions and improved productivity and efficiency. • Reduce caesarean section rate from 30% to 28% by April 2014.
Western	• Normalisation of Child Birth: Bring ante-natal and post-natal visits into line with NICE guidance 1) Reduced LOS 2) Reduced attendances at outpatients and foetal assessment units. • Development of community based specialist paediatric nurse for long term conditions for example: Diabetes, asthma, continence and epilepsy 1) Reduced acute paediatric attendances 2) Reduced admissions 3) Reduced demand on GP's and decrease in consultant referrals. • Family Nurse Partnership Programmes: Expansion of current scheme to support all appropriate pregnant women to support maternal and child health 1) Reduce ED admissions due to accidents 2) Referral to secondary care and tier 2 and 3 social services subject to license and agreement of the PHA, . • Development of paediatric specialist nurses for LTCs will reduce ED attendances and demands on GPs and consultant referrals. • Improved acute paediatric facilities and extended community services involving GPs and other professionals in providing services locally		

Health and Social Care Board

Belfast	• Provision of antenatal care in the community: Increase the percentage of women having their ante-natal care in the community by 30%. • Increase in midwife led births. • Sustainability of neonatal services examined. • Provide care closer to home. • Improved dental registration for children. • Specialist paediatric networks developed. • ICPS develop pathways and schemes.	• Reduction in intrapartum interventions. • Reduction in unnecessary interventions. • Reduced length of stay. • Common data set across maternity services established. • Reduced hidden harm. • Reduced referrals at Unocini levels 2 and 3. • Implement paediatric networks. • Attendances to paediatric ED reduced. • ICPs to work with Belfast Outcomes Group to support Healthy Child, Healthy Future and establish Family Support Hubs (cross ref Child Health) and multi-agency Locality plans. •	• Normalisation of labour. • Sustainable neonatal services. • Reduced antenatal clinics in hospitals. • Sustainable specialist paediatric services. • Improving life chances for children. • Disease levels in children reduced. • Admissions to paediatric services reduced.
South Eastern	• Transfer of antenatal care from Acute hospital site into community setting. • Normalising child birth as per Normalising Child Birth Action plan. • Development of paediatric diabetic outreach service. • Promoting and sustaining free standing MLUs.	• Deliver 1,270 births in the community. • 60% of all births will be normal births. • reduction in LOS to 6-24 hrs for 60% of mothers with normal deliveries (currently 31 hrs). • 30% of all Trust births in MLUs (currently 23%).	• Reduce admissions, waiting times and LoS. • Reduction in LOS for disorders in the NNU to 4 days.

Health and Social Care Board

Southern (including Children's Services)	• There will be a renewed focus on supporting healthy lifestyle choices for women and their families and access to Day Obstetric services will increase. • A care bundle to reduce infant mortality by addressing smoking and obesity in pregnancy and promoting breast feeding will be in place. • Early intervention programmes will be in place for children with known health risk factors such as low birth weight and a Family Nurse Programme will be implemented to support young first time parents and their children. • Ambulatory services will be further developed to avoid the need for children to be admitted to hospital and plans to provide acute child-only services up to 16 years through a networked approach across our hospitals will be taken forward in the context of the proposed Regional Review of Paediatric services. • Effective transfer and communication arrangements will continue to be in place with regional paediatric services.	• The volume of midwife led clinics within the community and the number of births in the Midwife Led Unit will increase. • The number of normal deliveries for first pregnancy will increase with a reduced number of interventions including C-sections. • By March 2015, increase from 10 to 14 midwife led clinics within the community per week. • By March 2015, increase in percentage of normal deliveries to 75%. • "Wraparound" community integrated teams will be in place to improve care and outcomes for children with specialist health needs and/or disabilities (March 2015).

Health and Social Care Board

4.4.6 Family & child care

Family and Child Care	Regional Strategic Direction –*Provide a service that focuses on early intervention, family support and foster care*		
	Year 1	**Year 2**	**Year 3**
Northern	• Reduce reliance on residential care homes for children and young people and increase the number of foster carers - Transfer 5 children out of independent sector care. • Develop intensive family support social services to aid those children on the edge of care for intervention, to escalate efforts at that point aiming to avoid admission to care. • Increase foster care capacity.	• Reduce 6 IFA placements. • Develop intensive family support social services to aid those children on the edge of care for intervention, to escalate efforts at that point aiming to avoid admission to care. • Increase foster care capacity.	• Reduce reliance on residential care homes for children and young people and increase the number of foster carers - Close 1 children's home. • Reduce basic foster carers by 15. • Increase foster care capacity.
Western	• Single point of access for children with behavioural and psychological difficulties. • Early intervention family therapy service to be initiated and will prevent more intensive resources being necessary. • Introduction of skills mix into early years service and self evaluation to ensure compliance with statutory processes.	• Reduced under 18 admissions to adult psychiatric care through intensive home treatment centre. • Development of respite for children with learning disabilities. • Development of short stay paediatric assessment units will prevent admissions. • Further development of family support hubs will include step up step down protocols to ensure signposting. This will reduce referrals to the gateway service.	• . • Investment in the Strengthening families programme will reduce childcare admissions through delivering preventative support.

Belfast	• Implement protocols for appropriate Gateway referrals. • Reduced referrals at UNOCINI Level 3. • Enable increase in foster carers. • Reduced need for residential care; reduction in length of time of permanency.	• Reduced need for referral at UNOCINI Level 2 and 3 services. • The Trust will support the development of Crisis Resolution & Home Treatment (CRHT) services and primary mental health services. • Reduced demand for step 3 provision, inpatient beds. • Cessation of use of adult beds for younger people under 18.	• Ensure that children who cannot live with own families have alternative permanent care arrangements in place that meets their needs and is provided n a timely way. • Reduction in length of time for permanency. • Reduced number of children requiring residential care.
South Eastern	• Development of Family Support Initiatives (Family Support Hubs and Outcomes Board) to provide early intervention\prevention strategies to children and their families 1) Increase in the number of children attending school 2) Deliver more than 1300 packages of care and support to families. • To deliver a quality early years child care service in the area: To have no waiting list for the registration and inspection of provision. • To reform the Child Protection service: To reduce the number of children on the Child Protection Register (currently – 529).		

Health and Social Care Board

Southern (including Children's Services)	• Family support hubs will be embedded across the southern area to ensure easy and early access to coordinated advice and support across a range of service providers. • Further develop the community infrastructure to support children & families access early support services. • Centralise all referrals to CAMHS services to one location to facilitate closer working arrangements with Primary Care. • Implementation of central co-ordination function for all referrals TO CAMHS: Target:1827 referrals (2011/12 activity) centralised.	• Intensive and frontline fostering provision will increase and demand for mainstream children's residential care will start to reduce. • The number of children missing paediatric and Child and Adolescent Mental Health (CAMHs) appointments will be reduced making best use of available resources. • Pathways will be agreed with primary care to enable more children and young people to be safely cared for at home. • 5% reduction in referrals to the Gateway Services. • 10% increase in FIT activity in high level family support casework to prevent family breakdown & admissions to care.	• Review of Specialist Child Health & Disability Short Break Services across SHSCT. • Review mainstream statutory residential care services for Looked After Children with a view to reducing numbers of children resident in these facilities and also reducing the numbers of children being admitted to residential units. • Primary care will have enhanced access to specialist advice and support from paediatric and CAMHS staff. • Demand for core family intervention teams will reduce and support will be reinvested into community family support services.

Health and Social Care Board

4.4.7 People using mental health services

People using mental health services	Regional Strategic Direction – *Promote early intervention, independence and the personalisation of care, providing the right care in the right place at the right time and reducing institutional care*		
	Year 1	**Year 2**	**Year 3**
Northern	• Continued development of a stepped care approach, with an emphasis on early intervention through the development of effective integrated care pathways – reducing acute LOS. • Develop community based alternatives for services. • Complete resettlement of service users currently in Inver 3. Reduce 8 beds. • Develop more effective use of supported living and ensure tenants are facilitated to move on to more independent accommodation.	• Consider full roll out of psychiatric liaison service. • Develop an early Intervention in Psychosis Service targeted at those aged 16 to 35. • Develop more effective use of supported living and ensure tenants are facilitated to move on to more independent accommodation.	• Progress the Holywell replacement development. To include 102 acute, 28 non-acute beds and 38 beds for people with dementia. • Develop more effective use of supported living and ensure tenants are facilitated to move on to more independent accommodation. • 40% of remaining long stay patients (16) will be resettled by March 2015.
Western	• Re-design of inpatient addiction services with independent sector providers will enable re-provision of addiction beds. • Reform of acute psychiatric services including alternatives to admission. • Develop a network of inpatient provision to maximise economies of scale.	• Development of acute day care in the southern sector will reduce admissions. The reduced LOS will enable a reduction in acute admission beds from 66 to 56.	• More readily accessible community based mental health services developed in liaison with GPs utilising a primary care intervention model.

Health and Social Care Board

Belfast	• Improved support for emotional resilience. • Improved access to support for recovery. • Urgent mental health services developed in support of emergency departments. • Implementation of single system of level 2 and 3 services.	• Reduced use of level 2 and level 3 care. • Further development of home treatment and day support services. • Appropriate resettlement options provided.	• Provide for the resettlement of long stay patients from Knockbracken: Close 3 wards by March 2015. 71 supported housing placements over a 3 year period. • Re-configure acute mental health from three sites to one to be located at the Belfast City Hospital and increased input of therapeutic care: Reduce acute beds from 106 to 80 by 2015. •
South Eastern	• Community Mental Health Service Mapping and CAPA : 10% reduction in baseline LOS and a 10% reduction in admission rates.	• Resettlement of Long Stay patients leading to the closure of remaining Continuing Care Wards: The Trust will seek to reinvest £75k savings released from years 2 and 3 of the Resettlement Programme to enhance and support a Care Management Budget. • Community Mental Health Service Mapping and CAPA: Reduce DNA rates to 5% for new appointment and 8% for review.	• Reform acute mental health inpatient services to create a single acute mental health inpatient unit with integrated PICU provision: upon the realisation of a single acute inpatient unit the Trust will seek to reduce admission rates by 8% and a reduction in the average LoS, commensurate with the regional average.

Health and Social Care Board

Southern (Mental Health & Disabilities)	• Work will continue with NI Housing Executive to secure development of supported living accommodation across the area. • The numbers of people with mental health and disabilities using personalised budgets will continue to increase alongside increased diversity of provision outside health and social care services. • Resettlement of 8-10 patients from St Luke's Long stay to supported living accommodation by March 2013 (pending business case).	• Enhanced local addiction services will be developed within the community and the need for inpatient addiction beds will reduce. • New day opportunities and a wider range of non-building based respite support will be in place and the number of statutory day care centres will reduce. • Specialist local services for eating disorders will be in place to support local care and avoid the need for some people to receive their care outside NI. • Secure availability of placements for resettlement of remaining individuals from St Luke's, Armagh: 10-16 people resettled from St Luke's by March 2014.	• All long-stay hospital based care at Longstone and St Luke's Hospitals for people with mental health needs and learning disabilities will cease. • The Protect Life Action Plan will be implemented with the intent of reducing suicide rates in targeted areas of deprivation.

Health and Social Care Board

4.4.8 People with a learning disability

People with a learning disability	Regional Strategic Direction – *Promote early intervention, independence and the personalisation of care, providing the right care in the right place at the right time and reducing institutional care*		
	Year 1	**Year 2**	**Year 3**
Northern	• Remaining 85 service users across the Trust (still at Adult Centres), to be Transferred completely to Day Opportunities. • 23 service users in transition from education to be absorbed within current provision. • Undertake resettlement of institutionalised service users through the development of supported living options and specialist day support to suit the individual needs of people. • Resettle 22 service users.	• Review the provision of statutory daycare services for those who needs cannot be met through day opportunities. • Develop specialist local services (to include short-term community based assessment and treatment interventions including crisis services) designed to reduce hospital admissions. • Undertake resettlement of an additional 10 service users.	• Undertake resettlement of an additional 3 service users.
Western	• Review respite services to offer greater flexibility and accessibility and capacity. • Develop integrated pathways for LD including dementia and autism will increase productivity.	• Lakeview Hospital will be reconfigured; current 19 beds to provide 8 mental health and 4 challenging behaviour beds: Reduction in admissions and a refocus on treating people with mental health and challenging behaviours.	• Increased productivity and capacity for domiciliary care provision. • Increased respite capacity.
Belfast	• Improve the physical and mental health of adults with LD in partnership with ICPs and other stakeholders, through the development of prevention strategies and with early intervention strategies.	• Develop supported housing services in line with the resettlement agenda and community accommodation pressures associated with ageing parents. • Increase of percentage of people receiving	• Increased number of people receiving mental health care in the community. • The number of people accessing respite breaks increases. • There is an increase in the number of

Health and Social Care Board

	• Increase by the number of people receiving their mental health treatment within the community.	supported housing.	people receiving supported housing. • Close lone stay hospital wards. • Provide for the resettlement of long stay patients from Muckamore Abbey Hospital: Close 7 wards by April 2015. 69 supported housing placements over a 3 year period.
South Eastern	• The resettlement of people with Learning Disabilities from long stay hospital beds into the community - to be completed by March 2015: Resettle 40% of long stay population by March 2013. • All adults receive annual GP mental and physical health check to reduce referrals. • Effective arrangements in place to enable access to secondary care services in line with GAIN Guidance.		• Close remaining long-stay hospital beds: Yr 2 and 3 targets will be determined regionally and will be dependent on progress of retraction model and which wards are to be closed. 100% resettlement by March 2015. • Fewer admissions, outpatients and Primary Care interactions. • Complete re-design of day care services in North Down and Ards.
Southern (Mental Health & Disabilities)	• LD Resettlement of remaining people from Longstone to vacant residential, nursing home and supported living placements / return to parental home: Resettlement of 10 people from Longstone by March 2013.	• LD Resettlement of remaining people from Longstone to vacant residential, nursing home and supported living placements / return to parental home: Resettlement of 2 people from Longstone by March 2014. • LD Remaining Longstone resettlements: – The Heathers – Phase 2: 4 people resettled from Longstone. – Granville: 24 Resettled from Longstone.	

Health and Social Care Board

4.4.9 Acute care

Acute Care	Regional Strategic Direction – *Provide clear protocols for the point of contact for emergency care and deliver more planned care closer to home, using technology to facilitate this*		
	Year 1	**Year 2**	**Year 3**
Northern	• Continue work in progress to secure staffing levels, and meet minimum service requirements. • Open redesigned A&E and rehab ward at Antrim area hospital. • Complete programme of efficiency and quality improvement.	• Strengthen and develop specialty networks across site. Profiling services to make effective use of staff skills and rotas etc. • Ensure greater use of technology to support networks. • Continue to pursue improved efficiency, throughputs and adopt best practice. • Develop long term condition management in community settings ('shift left'). • Establish, effective Integrated Care Partnerships and joint local working with GPs. • Continue to review the acute services profile on each site to maximise local access, achieve required standards and use of skilled staff.	
Western	• Develop end to end pathways for musculoskeletal indications, diabetic foot ulcers and varicose veins. This will reduce waiting times and allow shift from DC to OP. • Through ICPs extend GP minor surgery – retaining 500 patients. 350 day cases carried out in primary care. • Application of new/review ratios and clinical productivity planning assumptions. • Urgent care pathway will coordinate between GP s and OOH to reduce ED attendances and minor treatments. • Implementing rapid response nursing will	• Develop North West urology service across Western and Northern Trusts which will decrease FU appointments, elective and non elective admissions. • Reduction in procedures of low clinical value will move 850 procedures to a lower cost setting of stop them altogether. • Implement a fracture liaison and falls prevention service delivering early intervention to reduce falls and improve patient outcomes. • Development of alternative to hospital initiative.	• Implement NICE guidance on varicose veins will reduce OP and DC referrals by 20%. • Services to be established with clear protocols and pathways for minor surgical cases. • Development of an elective surgical unit will reduce excess bed days as it will streamline the pathway and improve utilisation and pre-op assessment. • Reductions in DNAs, improved theatres utilisation and day case rates • Reduced admissions and length of stay

	maintain patients at home. Achieve the 4 hr A&E target.		will enable a reduction in IP beds. • Established virtual liaison and direct referral approach between GPs and consultants will reduce admissions.
Belfast	• Establish ICPs. • Pathways for unscheduled care developed and defined. • Protocols for managing unscheduled episodes established. • Single point of access established. • Consult on ED configuration. • LoS improvement initiatives in the hospitals. • Develop patient focussed pathways for common conditions. • Establish pathways for various specialities such as ENT, Orthopaedics, pain management and dermatology. • Increased proportion of patients treated as day cases. • Improve theatre efficiency. • Establish integrated primary care teams.	• Patients treated closer to home. • Reduction in ED attendances. • Reduction in unscheduled admissions. • Provision of urgent/emergency outpatient slots. • Provide clinics, diagnostics - where volumes/ throughput and skill mix make it safe and sustainable to do so, and minor treatments in the community. • Reduce referrals to the hospital clinics. • Provide specialist clinics in community.	• Patients and carers fully involved in planning. • Structures in place to support return to home. • Reduction in beds in acute settings. • Reduction in new and follow up appointments in the hospitals. • Reduced waiting times in hospitals.
South Eastern	• 40% shift in sexual health services from consultant to specialist nurse/ GP/ Practice Nurse. • Reduce ED attendances and LoS and increase discharge rates.	• 10% reduction in admissions and LoS amongst patient with Diabetes. • Through active disease management achieve a 10% reduction in outpatient activity.	• Over the three year period, achieve a 20% shift of review and memory clinic work into primary care. • 10% reduction in admissions and LoS amongst patient with Diabetes.

Health and Social Care Board

	• Redesign respiratory pathway. • Work with NIAS to refine ambulance protocols. • Target nursing home referrals by redesigning rapid response and district nursing support.	• By Year 2, the Trust will reduce the admission rate in UHD/Ards MIU/Bangor MIU to 20% in line with the regional benchmark. • 10% reduction in respiratory admissions. • Reduce ED ambulance attendances by 5%. • Reduce nursing home referrals by 10%.	• 10% reduction in outpatient activity. • Working with NIAS, reduce ED attendances and achieve a 10% reduction number of ED attendances by ambulance. • Reduce ED attendances and LoS and increase discharge rates, e.g. 10% reduction number of ED attendances by ambulance. • Over the three year period, achieve a 50% reduction in nursing home attendances to ED. • 20% reduction in respiratory admissions. • Reduce nursing home referrals by 20%.
Southern	• Enhanced capacity will be in place to address recognised current capacity gaps and improve local access to services including trauma and orthopaedics, cardiology, general Surgery, gynaecology and ENT. • Clinical escalation, and regional bypass and transfer protocols will be developed to enhance quality of care. • There will be a rebalancing of some elective services across CAH and DHH. • Ambulatory pathways will be in place for the most frequent diagnoses to reduce attendances at ED and avoid admissions.	• Provision of acute services will continue to be reviewed in the context of commissioner requirements and emerging standards of care to ensure they remain “fit for purpose”. • Clinical management pathways will be in place with GPs to support care for patients within primary care and reduce the need for them to attend hospital for outpatient consultation and greater use will be made of technology to support remote consultations. • The length of stay in hospital will be optimised with timely access to diagnostics, proactive clinical management of care plans, increased numbers of patients admitted on the day of their surgery and increased procedures delivered as day cases. • The number of patients needing to be reviewed in a hospital setting will reduce and the number of people missing hospital appointments will reduce. • The number of inpatient beds at both acute hospitals will reduce releasing capacity and resource to deliver required savings and support reinvestment in alternative services in primary and community settings.	

Health and Social Care Board

4.4.10 Palliative & end of life care

Palliative and End of Life Care	Regional Strategic Direction –*Improve the overall quality of life in the last year of life and, by early identification and planning, reduce the level of inappropriate admissions to hospital for people in the dying phase of an illness*		
	Year 1	**Year 2**	**Year 3**
Northern	• Increased numbers of staff competent in the core principles of palliative and end of life care. • Reduce the number of people admitted to hospital during the end of life phase. To be achieved the development of palliative care tools and improved awareness raising. • Develop palliative and end of life care register. • Support Nursing Home sector for end of life care. • Reduce inappropriate hospital admissions for people in the dying phase of an illness.		
Western	• Establish a specialist palliative care service with balance between primary and secondary care. Implement a care of dying pathway in all care settings. Will reduce acute admissions and LOS.	• Implement advanced care planning to increase skills in palliative care in primary care to reduce acute admissions.	
Belfast	• Train existing staff within the community to deliver end of life care. • Establish integrated pathways of care. • Develop information infrastructure to support palliative care in community.	• Make available generalist and specialist palliative care in the community. • Expand care to nursing homes. • Reduced ED attendances.	• Reduced admissions for patients on end of life care pathway. • More number of patients on end of life pathway choose home as their preferred location.
South Eastern	• Implement regional communication strategy around death and dying reform of the patient pathway to prevent inappropriate ED	• Work across the interface of primary and secondary care to prevent inappropriate ED attendances having undertaken a case	• Reduce nursing home attendances to ED by 50%.

Health and Social Care Board

	attendance and provide alternatives in the community. • Establish project group, secure finance, work with LCG localities and stakeholders regarding the bid and business plan inc. workforce requirements and skills set.	review of patients who have died within 48hrs of admission and established a baseline for taking this work forward: reduce inappropriate end of life attendances to ED by 5% in year 2. • Reduce no. of patients receiving End Of Life Care in hospital by 10%: Based on 1353 deaths per year in hospital this will be a reduction in 135. • The Trust is developing a proposal for the Ards Hospital site which will be a community facing model which would enable assessment of palliative and end of life patients in a single centre. The Trust would see this "Hub" as contributing to reducing the number of hospital admissions and will provide an enhanced experience for patient and families at the end of life; Year 2, establish the "Hub".	• Further reduce ED attendances by 5%. • Hub fully staffed and operational and robust evaluation plan in place. • Reduce no. of patients receiving End of Life Care in hospital by 10%: Based on 1353 deaths per year in hospital this will be a reduction in 135 and a further 10% Year 3. • The trust's intention would be to reduce end of life admissions to acute hospital by 20% by year 3.
Southern	• A Macmillan Palliative Care Service Improvement Lead will be in place to support the development of action plans – October 2012.	• Access to specialist palliative support will be enhanced out of hours and there will be enhanced links between specialist and generalist services – March 2014. • Community palliative care multi-disciplinary teams (e.g. consultant, AHP / specialist nursing etc.) will be in place – March 2014	• A southern area Palliative & EOL Service Improvement Plan will be fully implemented. • The number of patients who are admitted to hospital from a nursing home and die within 48 hours will reduce. • Reduce inappropriate hospital attendances and admissions at EOL. This includes training for staff and

Health and Social Care Board

			enhanced support – 5% targeted reduction by March 2015. • The number of staff in health and social care and in private nursing homes who have been awareness trained on palliative and EOL care will have increased.

5 Implementation programme timelines

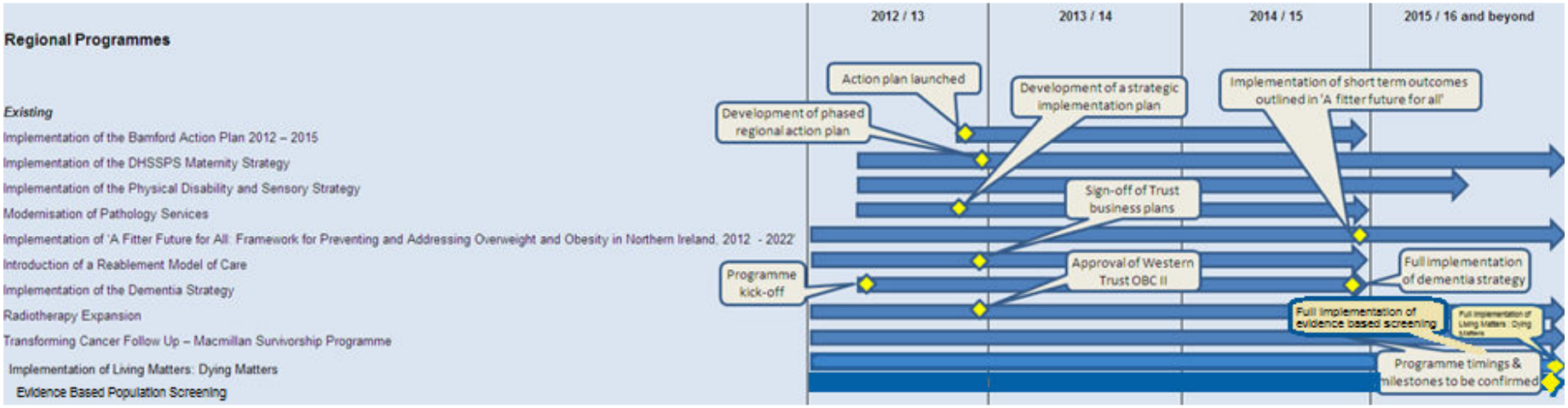
5.1 Introduction

This section provides a high level overall timeline of programme workstreams and key milestones for which HSCB/PHA have responsibility. In defining implementation timelines it is acknowledged, that for significant investments, appropriate approvals will need to be sought through the existing business case process. Greater detail and clarity will be required to allow any initiatives proposed to proceed and this detail will be provided before any plans can move ahead to implementation stage. This detail is important and largely operational therefore not necessarily appropriate for the SIP. Initiatives detailed below are at varying stages of development in the local areas, and therefore detail provided in the plans for those areas shows some variability. The plans and anticipated timescales will continue to be reviewed over the 3 years to consider affordability. This could speed up the pace of implementation or indeed we may need to go at a slightly slower pace, depending on the resources available.

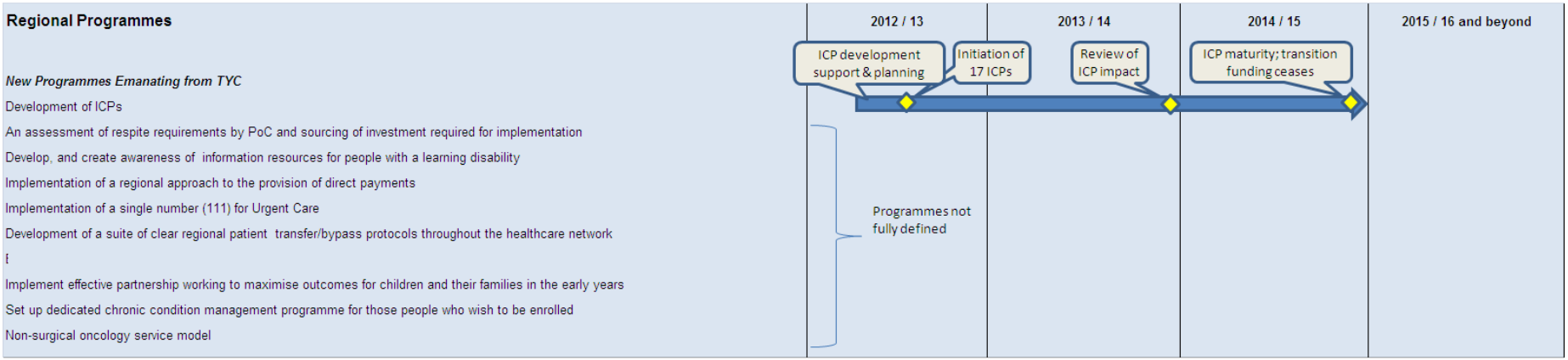
It should be noted that access to transitional funding will be to enable duplication of service to guarantee no detriment to patient safety and to provide confidence that the alternative services are in place before reconfiguration of existing services. All change plans will demonstrate a clear sequence to deliver each of the recommendations in an integrated and cohesive fashion, rather than in isolation from other initiatives.

5.2 High level programme timelines

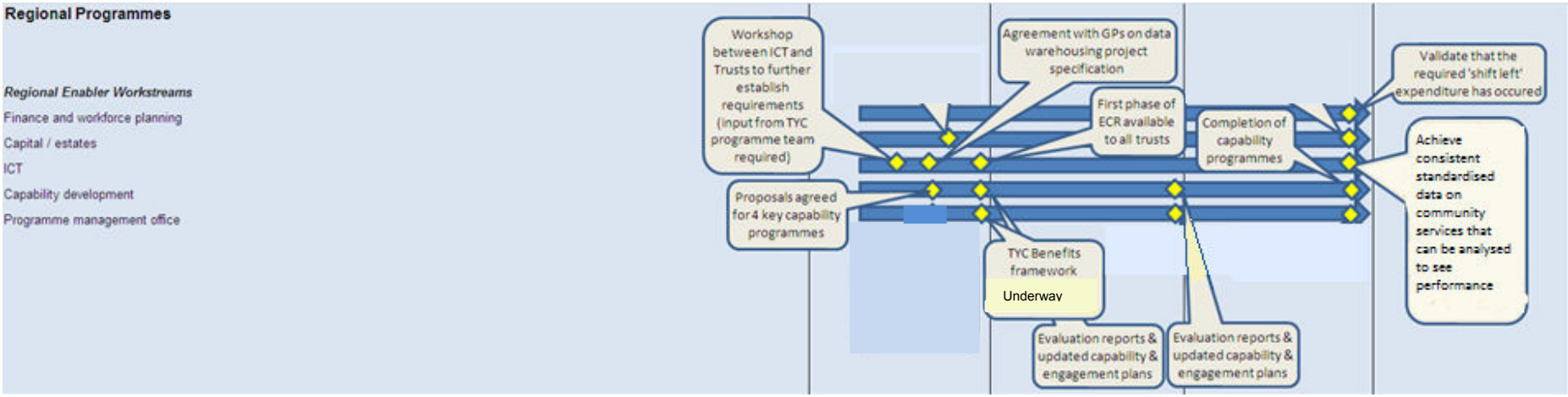
5.2.1 Existing regional programmes



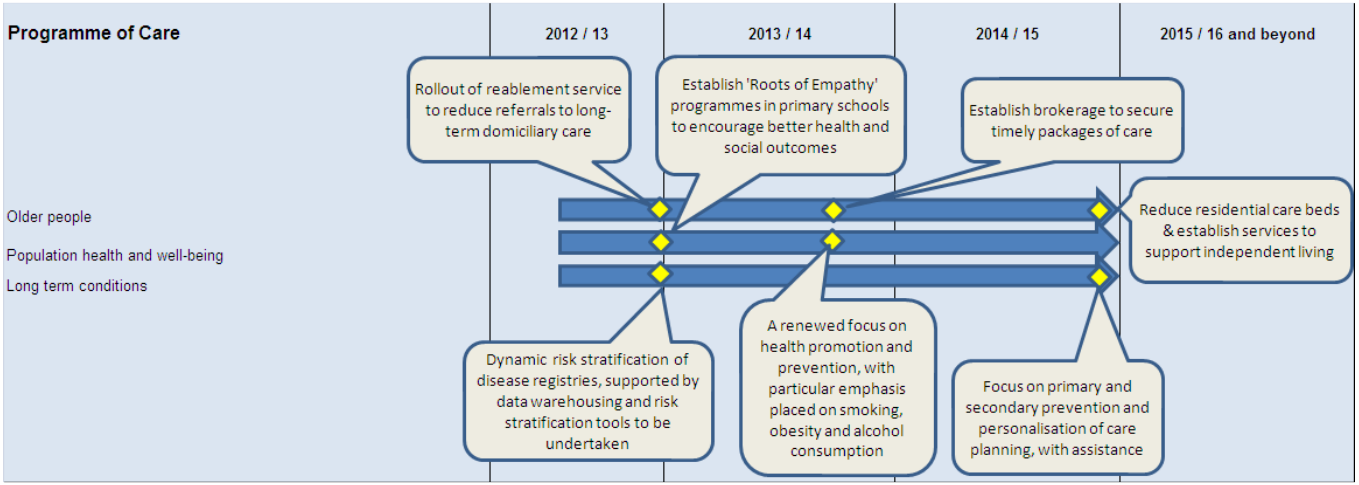
5.2.2 New regional programmes emanating from TYC

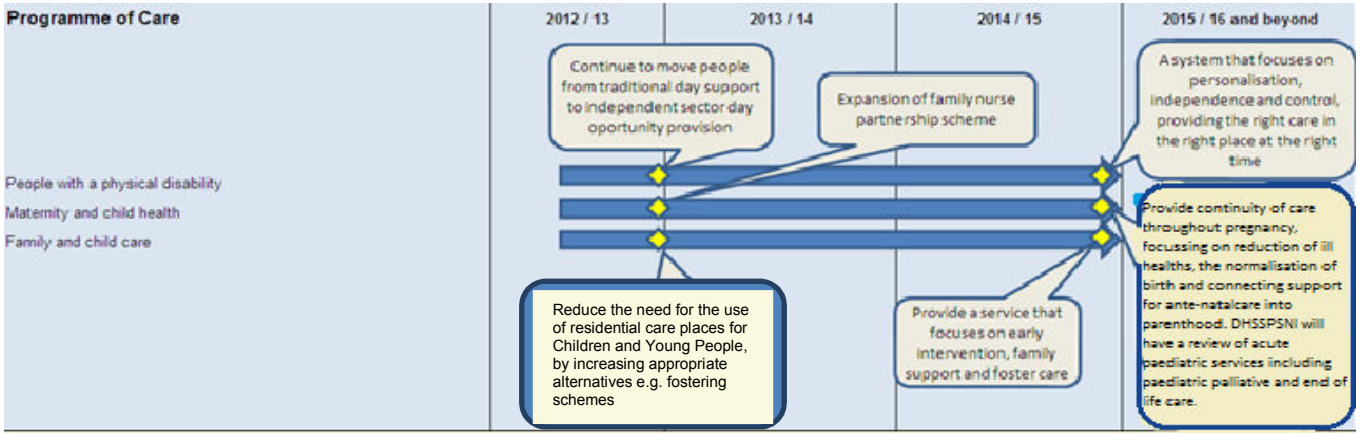


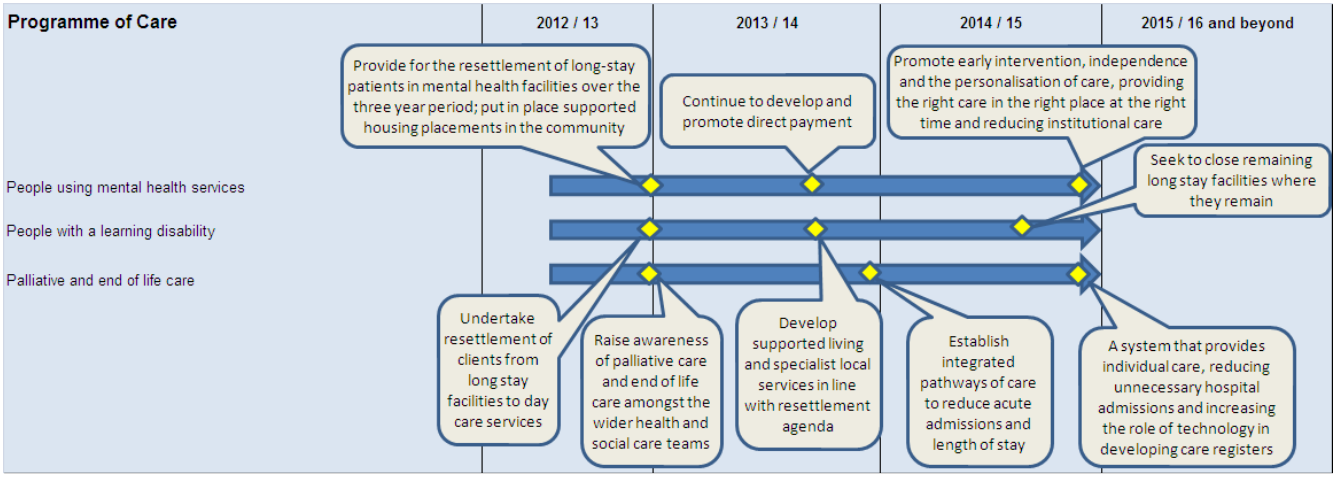
5.2.3 Regional enabler workstreams

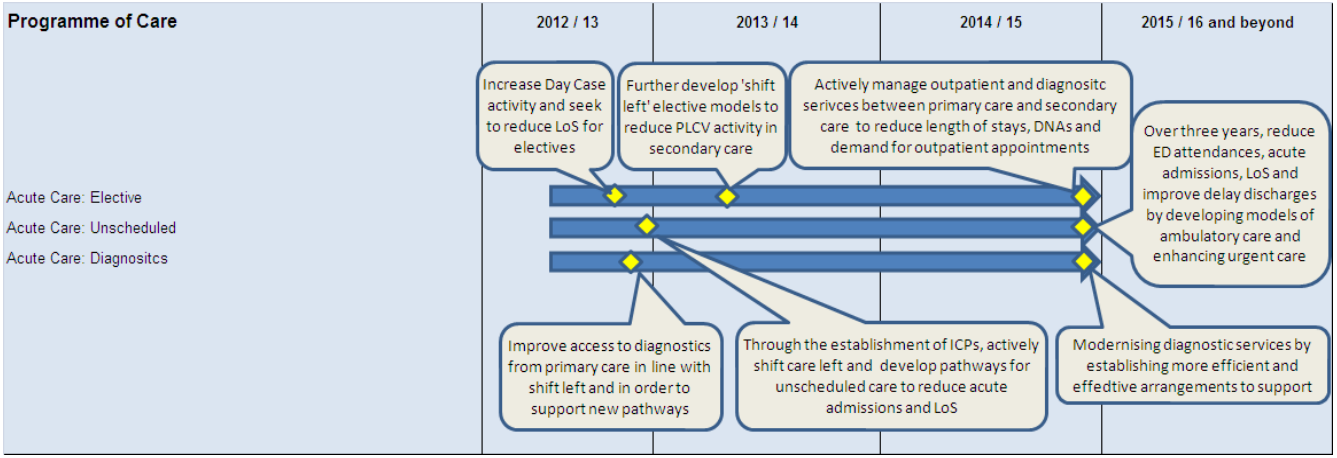


5.2.4 Programmes of care summaries of Population Plans




Programme of Care
2012 / 13
2013 / 14
2014 / 15
2015 / 16 and beyond
Continue to move people from traditional day support to independent sector day opportunity provision
Expansion of family nurse partnership scheme
A system that focuses on personalisation, independence and control, providing the right care in the right place at the right time
People with a physical disability
Maternity and child health
Family and child care
Provide continuity of care throughout pregnancy, focussing on reduction of ill healths, the normalisation of birth and connecting support for ante-natalcare into parenthood. DHSSPSNI will have a review of acute paediatric services including paediatric palliative and end of life care.
Reduce the need for the use of residential care places for Children and Young People, by increasing appropriate alternatives e.g. fostering schemes
Provide a service that focuses on early intervention, family support and foster care


Programme of Care
2012 / 13
2013 / 14
2014 / 15
2015 / 16 and beyond
Provide for the resettlement of long-stay patients in mental health facilities over the three year period; put in place supported housing placements in the community
Continue to develop and promote direct payment
Promote early intervention, independence and the personalisation of care, providing the right care in the right place at the right time and reducing institutional care
Seek to close remaining long stay facilities where they remain
People using mental health services
People with a learning disability
Palliative and end of life care
Undertake resettlement of clients from long stay facilities to day care services
Raise awareness of palliative care and end of life care amongst the wider health and social care teams
Develop supported living and specialist local services in line with resettlement agenda
Establish integrated pathways of care to reduce acute admissions and length of stay
A system that provides individual care, reducing unnecessary hospital admissions and increasing the role of technology in developing care registers


Programme of Care
2012 / 13
2013 / 14
2014 / 15
2015 / 16 and beyond
Increase Day Case activity and seek to reduce LoS for electives
Further develop 'shift left' elective models to reduce PLCV activity in secondary care
Actively manage outpatient and diagnositc serivces between primary care and secondary care to reduce length of stays, DNAs and demand for outpatient appointments
Over three years, reduce ED attendances, acute admissions, LoS and improve delay discharges by developing models of ambulatory care and enhancing urgent care
Acute Care: Elective
Acute Care: Unscheduled
Acute Care: Diagnositcs
Improve access to diagnostics from primary care in line with shift left and in order to support new pathways
Through the establishment of ICPs, actively shift care left and develop pathways for unscheduled care to reduce acute admissions and LoS
Modernising diagnostic services by establishing more efficient and effedtive arrangements to support

5.3 Public Consultation

Following a period of quality assurance and consideration, the Minister intends to launch a period of public consultation. As well as discharging relevant statutory duty to consult, we are committed to meaningful engagement and consultation to inform and influence the final shape of our plans.

- . This period of consultation will include: Publication of a consultation document setting out how we propose to deliver TYC over the next three years, based on this Strategic Implementation Plan
- The source documentation (including the draft Population Plans and this Strategic Implementation Plan) used in the development of the above mentioned consultation document will be available to everyone
- A series of workshops and public meetings across the region to support awareness and information about TYC, and support public's motivation and ability to respond to the consultation document
- A series of communications to support awareness and information about TYC, and support public's motivation and ability to respond to the consultation document

It is anticipated that the period of consultation will be complete in early 2013, thereafter the plans will be finalised and submitted to the Minister for approval.

Health and Social Care Board

Appendix 1: Glossary of Terms

Term	Meaning
AHP	Allied Health Professionals
ALoS	Average Length of Stay
BHSCT	Belfast Health and Social Care Trust
C +V	Community and Voluntary Sector
CAMHS	Child and Adolescent Mental Health Services
CATH Lab	Catheterisation Laboratory for diagnostic and interventional cardiac procedures
COPD	Chronic obstructive pulmonary disease
CPD	Continuing professional development
DHSSPS	Department of Health Social Services and Public Safety
DNA	Did not attend
DVT	Deep Vein Thrombosis
ECR	Electronic Care Record
ED	Emergency Department
ELCOS	End of Life Care operation system
ENT	Ear, Nose and Throat
EOL	End of Life
EPAU	Early Pregnancy Assessment Unit
Family Nurse Partnership Programme	Intensive home visiting from early pregnancy until the child is 2, designed to support young mums
Family Support Hubs	Network of agencies (voluntary/community and statutory) who work with families not meeting the threshold for statutory social work support.
HSC	Health and Social Care
HSCB	Health and Social Care Board
ICP	Integrated Care Partnerships
ICT	Information Communication Technology
IP	Inpatient
LCG	Local Commissioning Group
LD	Learning Disability
LGB&T	Lesbian, Gay, Bisexual and Transgender
Local Commissioning Group	Responsible for the commissioning of health and social care by addressing the care needs of their local population
Long Term Condition (LTC)	Chronic ailment from which there is no cure but will require long term treatment or monitoring
LOS	Length of Stay
MLU	Midwife Led Unit

Term	Meaning
MSK	Musculoskeletal
NDA	North Down & Ards Locality
NHSCT	Northern Health and Social Care Trust
NICE	National Institute for Health and Clinical Excellence
NISAT	Northern Ireland Single Assessment Tool - for use when planning home care for older people
NNU	Neo-Natal Unit
OOH	Out of Hours
PC	Primary Care
PCP	Primary Care Partnership
PD	Physical Disability
PHA	Public Health Agency
Population Plans	Document outlining key proposals for how TYC will be implemented, developed by each LCG in conjunction with respective HSC Trust.
QICR	Quality Improvement Cost Reduction
QOF	Quality & Outcomes Framework
Reablement	Programme of support to assist people in getting back to independent living
Resettlement	Shift from long term institutional care to living in the community
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust
Shift Left	Change in service delivery from an acute setting to community-based delivery; also a shift to greater emphasis on prevention of illness rather than response to exacerbations.
SHSCT	Southern Health and Social Care Trust
SSPAU	Short Stay Paediatric Assessment Units
Strategic Implementation Plan	Framework for the delivery of the TYC programme over the next 3 years.
Telehealth, Telecare, Telemedicine	Use of telecommunications to facilitate an independent lifestyle, includes alarm systems and monitoring systems
Third sector	Voluntary sector
Trust	Provider of Health and Social Care Services to a particular population
TYC	Transforming Your Care
UNOCINI	Understanding the Needs of Children in Northern Ireland
WHSCT	Western Health and Social Care Trust

Appendix 2: Capability and engagement

1. Purpose and objectives of the capability and engagement workstream

The overall objective of the Capability and Engagement workstream of the TYC Programme is to help create an environment which is receptive to and supports the transformation required to deliver the vision set out in 'Transforming Your Care' and the benefits set out in this draft Strategic Implementation Plan (SIP).

In order to achieve this we need to ensure that key groups are receptive in terms of their willingness to adopt new behaviours and support the delivery projects ('engagement'), and that they have the ability to do so ('capability'). At the centre of both this willingness and ability is the need to work towards a common goal, and that we have the right skills mix across the HSC system now, and into the future.

As with any complex transformation of this kind, the levels of engagement and capability will vary for different groups, as the changes will impact on them in a number of ways, at different times. Furthermore, the systemic wide-ranging nature of the transformation set out in TYC will mean that improvement activities will be taking place and embedded throughout the Health and Social Care system, rather than delivered in a 'top down' manner from a central Programme. It is vital therefore that the approach taken to capability and engagement for TYC is flexible and adaptable, and can operate at a number of levels.

The Capability and Engagement workstream, and the approach set out in this Appendix of the draft SIP, is closely aligned to the delivery strategy described in Section 3, and explicitly explores the activities which will be required at both regional / programme and local / project levels.

> *At the core of the approach is that each change project or initiative would be empowered to manage the specific engagement or capability impacts of their own project or initiative, facilitated and supported by the TYC Programme Team. Experience shows that this approach to change management is more successful and more likely to be sustainable in the long term as it is owned by those involved in implementation, rather than 'done to them'.*

It also explicitly recognises that capability and engagement activities are ongoing throughout the system all the time – the approach set out herein is intended to complement and augment these ongoing activities for the purposes for TYC, rather than duplicate, replace or conflict with them. It is important to align with workforce planning to ensure that the capability needs for TYC are supportive of, and feed into system-wide skills development plans.

In this section of the Strategic Implementation Plan, we set out the proposed approach for the Capability and Engagement Workstream, with the aim of informing debate and discussion before we finalise detailed plans based on the draft Population Plans and SIP.

2. Change principles

The change approach set out here adheres to some core change principles, which are based on experience from both large transformational programmes and small strategic

changes that affect a specific workforce or team. These align to the overall programme delivery approach and include:

- **A focus on the individual** – understanding the impacts on specific people and how their day to day role may be affected in future by the TYC programme, supporting these individuals to understand and effectively operate, not only in the new model of care provision and also during the transition to make the change process as smooth as possible. The engagement and capability strategy enables this through the tailoring of programme messages based on "what does it mean for me?", and a capability approach which aligns skill development to individual needs.
- **Leadership and commitment at all levels** – empowerment for leaders of change through a programme of support and learning, ensuring they have opportunities to develop skills and encouraging shared learning through specific and targeted approach.
- **Integrated approach** – between engagement and capability as pillars of support which will enable success for individuals and teams working on TYC. These 'workstreams' have been aligned deliberately to ensure this link is maintained through the life of the programme.
- **Alignment** – coordination between change occurring at programme and local levels, working collaboratively and at pace towards the same goals but with a different focus and purpose at the different levels. This alignment is supported by a robust cross-programme branding strategy which enables the programme to 'speak with one voice'.

3. The change impact of 'Transforming Your Care' on key groups

Before embarking on any change approach or developing a plan for capability or engagement, it is vital to understand the impact of the changes. This ensures that you are addresses the needs of those to whom engagement and capability activities are directed, and therefore has a greater chance of being meaningful, valuable and sustainable.

As we move into the implementation phase following consultation, and the change initiatives and projects are agreed and known, it is expected that a more detailed change impact analysis would be conducted for each one to support the engagement and capability planning for each initiative or project.

For the purposes of this statement of approach, a high level view can be developed based on the TYC vision, and what this will mean in implementation terms as set out in this Strategic Implementation Plan. The table below sets out this high level view with the key impacts and proposed key messages for on some of the key groups/stakeholders. The detailed stakeholder and capability plans will build on these.

Health and Social Care Board

Key Groups	Impact of TYC	Key Messages
Public including Patients and Carers	Each Programme of Care will bring specific impacts and there are many different types of patient and user. In general however, an impact may be felt due to the following: • More care closer to home in primary or community settings and a reconfigured hospital network – how you access or receive care services may be different • More control over your own care budgets through Direct Payments • Increased diversity and choice in terms of the types of heath service provision • More control and responsibility for self-management for some • Clarity on and encouragement to take responsibility for our own health and wellbeing	• Patients, clients, users and carers are at the heart of all that we do • Providing the right care in the right place at the right time = better outcomes • Safe, quality and resilient service based on assessment of our population's needs and evidence on the best care pathways • More choice and control – promoting independence and personalisation of care • More care closer to home where it's safe and appropriate to do, and so less hospital admissions • Clarity on how you access HSC services – we all have a collective responsibility in how we use HSC services, and to manage our own health and wellbeing • Reducing health inequality and having equitable access to services where it is most appropriate
HSC Staff, including HSCB and Trusts Healthcare Staff outside HSCB and Trusts, including GPs, Dentists and Pharmacists	• A shift of activity from an acute to a community and enhanced primary care setting • Delivery of care in a more integrated manner across primary, secondary and community care may mean a change in role and location for some staff • Enhanced role for some of our independent health care provider partners may require enhanced training and regulatory frameworks • Development of acute networks across an area may mean a change in working patterns or organisational structures • New care pathways may mean staff work in different ways, have a different skills mix, and build enhanced interfaces with other parts of the service	• Patients, clients, users and carers are at the heart of all that we do • Committed to supporting workforce through the transition • Workforce planning integral to planning and delivery of reforms: right people, right place • We want to engage in a meaningful way with staff, unions, the voluntary, community and independent sectors to ensure an integrated approach to workforce planning • Training, retraining and capability development is a key enabler for making TYC successful • Get involved in the design of the new service models and care pathways – you know the system and what needs to be done to make it better

Health and Social Care Board

Key Groups	Impact of TYC	Key Messages
Voluntary and Community Groups	• More care in the community where safe and effective to do so • A focus on prevention, wellbeing and tackling inequalities will need greater partnership across all sectors • Greater choice and a mixed economy for service provision, underpinned by the personalization of care • An overhauled financial model for procuring services to support our new ways of working together • Different roles for residential care and nursing homes, and the promotion of re-ablement and independent ageing • Greater V&C involvement in joint planning service provision, such as disabled people, and mental health • Strong recognition of the role of carers, including practical support and respite • Population planning – providing a 3 year view of population health and social care needs enabling you to plan your own services better	• Patients, clients, users and carers are at the heart of all that we do • You need to think about how your organisation can respond to the changing model of health and social care provision • We will support your ability to build longer term business and delivery plans • The need to build capacity and capability in the V&C sectors to support the shift to care closer to home • Get involved in the design of the new service models and care pathways – you have great insight into the needs and preferences of patients and their carers • Be innovative – seeking the best solution to respond to population needs
Professional Groups and Staff Representative Bodies, including TUS	There are two types of impact of the programme on these bodies 1. You may be directly involved in the Programme or one of the Projects / TYC Initiatives to input to *a.* the design of care pathways and service model from a clinical perspective – *what the future will look like* b. the design of the implementation and rollout – *how we will get to the future* 2. As a body who represents your members interest, there will be an impact as it is likely some initiatives and project will lead to changes to members' working practices and skills mix due to the move of some care provision from hospitals into primary and community settings	• Patients, clients, users and carers are at the heart of all that we do • Committed to supporting workforce through the transition • Workforce planning integral to planning and delivery of reforms: right people, right place • We want to engage in a meaningful way with professional groups and representative bodies to ensure an integrated approach to workforce planning • Training, retraining and capability development is a key enabler for making TYC successful • Get involved in the design of the new service models and care pathways – you have clinical expertise and insights into areas for improvement • We want your support and advocacy to make implementation as smooth as possible for your members and ensure their voice is heard
TYC Leadership (including Programme Board, and key leaders in delivery of TYC	• Be able to develop, articulate and role-model the vision for Transforming Your Care • Leading the design, planning and delivery of the changes 'on the ground' whilst ensuring safe, high quality services continue to be delivered	• Patients, clients, users and carers are at the heart of all that we do • Opportunity to shape healthcare services for the future, make real changes with real outcomes • This is challenging and complicated, and won't be without its difficulties • Complex systemic transformation requires a different set of behaviours

Key Groups	Impact of TYC	Key Messages
Programme)	• Empowered to make change happen in own organisation, but within an overall delivery and monitoring framework as an effective leadership team to avoid haphazard change and inconsistency • Will be expected to work in different ways across the boundaries of their organisations and through a different level / type of engagement with internal and external groups • There will be an impact on the overall shape and nature of the organisations they lead, and this may require a different strategic approach / structure etc which would not necessarily be addressed through a single project	and new mindsets to what we may have used in the past • A positive leadership influence will be critical to empowering and motivating the organisation to deliver TYC • Detailed service modelling and evidence based approaches will be vital to ensure we meet our users' expectations and can be resilient and sustainable • The TYC Programme team is to support you in the delivery of changes on the ground, bring a consistency and alignment across the region and ensure benefits are realised
Clinical Leaders from across HSC and external organisations	• Designing, planning, delivering and sustaining the changes 'on the ground' will require the buy-in support and advocacy of clinical leaders across the system. • Clinical leaders will be asked to get involved in the development of new models of care and pathways • Clinical staff may be asked to take more of a leadership role in the new models, particularly in primary and community settings	• Patients, clients, users and carers are at the heart of all that we do • Opportunity to shape healthcare services for the future, make real changes with real outcomes • This is challenging and complicated, and won't be without its difficulties • Opportunity to learn new skills and competencies, which will help your career development and build your networks. In some cases this may lead to accreditation or CPD recognition • You will be provided with training and support along the way
TYC delivery teams, including Regional and Local project teams	Designing, planning, delivering and sustaining the changes 'on the ground' will mean: • Working in a different way to what you are used to • Working across traditional organisational boundaries, and with new people • An opportunity to be innovative and think differently about the delivery of health and social care services • Some staff will have the opportunity to work in a different organisation for a while to 'transfer' what they've learnt to the next team undertaking a similar project	• Patients, clients, users and carers are at the heart of all that we do • Opportunity to shape healthcare services for the future, make real changes with real outcomes • Get involved in the design of the new service models and care pathways – you have great insight into the needs of patients and what is required to achieve the best outcomes • Lead and show advocacy for the new models and ways of working, support younger members of your profession • This is challenging and complicated, and won't be without its difficulties • Opportunity to learn new skills and competencies, which will help your career development and build your networks. In some cases this may lead to accreditation or CPD recognition • You will be provided with training and support along the way

Figure 4: Change Impact and Key Messages for key groups

4. A model for transformational change

There are a number of change models that can be employed to support transformational change, and experience demonstrates that the most successful are those which have been designed or adapted by the system undergoing the change itself. This ensures there is ownership for the model, collective understanding of what it means for the HSC system in NI, and that it is appropriate to the unique nature of the TYC.

Once we have a clear and agreed picture of the key changes and commitments over the next 3 years, through the consideration and quality assurance of the draft SIP and the draft Population Plans that support it, and wide-ranging consultation with the public, we will seek to work together with leaders at all levels to build our own model of change for TYC.

However in the meantime, we do know there are a consistent set of behaviours and capabilities which are at the core of leading and delivering successful and sustainable change. Therefore as a starting point a proposed model, strongly based on the NHS Change Model is set out in Figure 5 below.

This model is based on a proven approach and evidence of what makes transformation successful. One of the underpinning principles of this model is the need to ensure there is alignment between the elements of change, and those responsible for defining and delivering the change. Without this alignment the overall transformation can be undermined by unintentional consequences, and significant effort wasted.

Figure 5: The NHS Change Model (from NHS Institute for Innovation and Improvement)

More information on each of the components above is available from the NHS Institute for Innovation and Improvement.

5. Proposed capability and engagement approach

Taking into account the objectives of this workstream, the delivery strategy of the Programme as a whole and the change principles, there are four key components of the Capability and Engagement Approach for the TYC Programme.

These are set out in Figure 6 below, and are described in more detail in the table in Figure 7 overleaf.

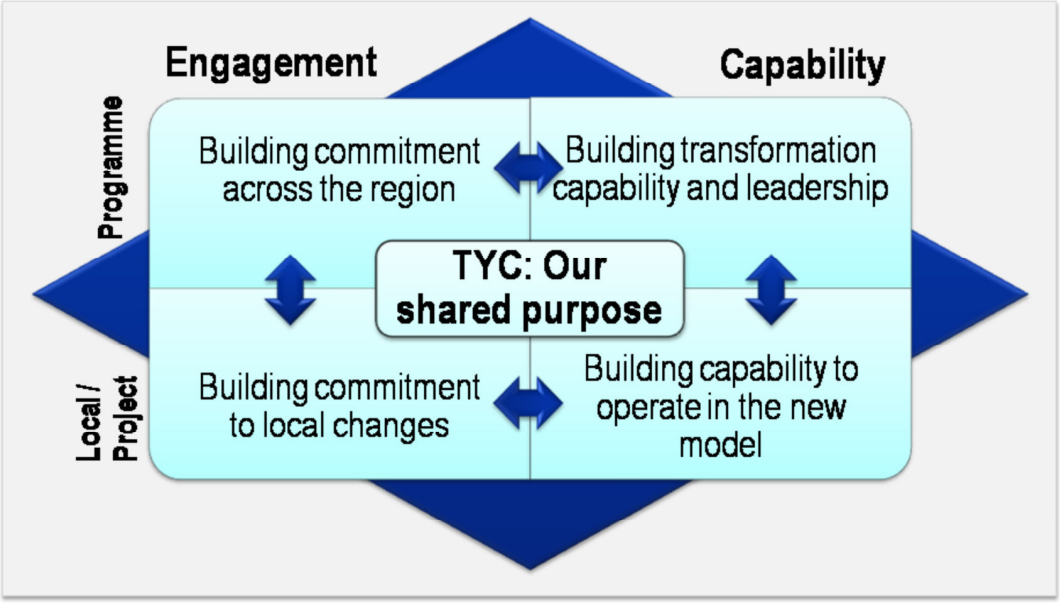


Figure 6: Key components of the Capability and Engagement Approach

The future capability and engagement states need to be defined in order to not only develop a clear vision and direction, but also a clear plan towards these goals. A simple maturity model framework can provide aspirational, but realistic and achievable phasing by which the organisation will move towards the desired future state. From this, the development plan can be developed and socialised with relevant stakeholders across TYC.

Figure 7: Summary of Proposed Capability and Engagement Approach

	Engagement	Capability
Programme level	***Building commitment across the region*** ***What:*** Rigorous Programme level stakeholder engagement and communications to establish, build and sustain common awareness, understanding and support for the TYC vision as a whole, both internally within HSC and with external organisations and the public. ***Why:*** Transformation of this scale requires a sustaining and coherent vision and narrative, which is both compelling and clear. The activities in this quadrant set the context for, and mobilises commitment to, the projects to make the changes happen on the ground. Without wide-ranging programme level commitment, delivery challenges will easily de-rail the overall transformation. ***Who leads:*** The Programme Team, working alongside with the HSCB and DHSSPS Teams, and interfacing closely with local leaders and communications teams, programme workstreams and individual projects as required	***Building transformation capability & leadership*** ***What:*** Support leaders of change at all levels to develop the skills and behaviours required to develop a vision and strategy to make the changes real, and see them through to implementation and delivery of the benefits, and mobilise and support others through the transformation. This includes three key target audiences: • The Senior Leaders responsible for TYC • Delivery teams (regional and local level) planning and delivering the changes • Clinical staff who will work alongside and within the Delivery Teams ***Why:*** TYC is a complicated whole system transformation which is unprecedented in our HSC system. We need to equip those who will be tasked with taking forward these changes to think and operate in different ways, to maximise learning available from outside our system, and to work together to manage the challenges which will arise as cohesive high performing teams. ***Who leads:*** The Programme Team, working alongside with HSC Leadership Centre and local L&D teams
Local / Project level	***Building commitment to local changes*** ***What:*** Rigorous local level stakeholder engagement and communications to establish, build and sustain common awareness, understanding and support for how TYC will impact locally (either as a geographical area impacted by a range of initiatives within that Trust / LCG boundary, or as distinct stakeholder groups impacted by a specific project). This may target stakeholders both internally within HSC, and with external organisations and the public. ***Why:*** As planning for improvements should as 'close to the point of delivery' as possible, so too engagement and conversations about such improvements and changes should also be as 'local' as possible. Feedback and evidence to date has shown that people want to be engaged about 'what does it mean for me'. Therefore this quadrant of activity complements Programme level activity by providing this detail within the context of consistency in messaging for TYC. ***Who leads:*** Given the nature of these activities, each of the local areas and projects will take the lead, with support from the central Programme Team.	***Building capability to operate in the new model*** ***What:*** Support local teams and staff to identify and develop change plans, and learning & development / training required to ensure that staff are supported and have the abilities to operate with the new processes, systems and ways of working put in place by a specific change to be implemented. This could include for example, the re-training of staff increasingly delivering care in a primary or community setting, or the re-training of nursing home staff in relation to Palliative Care. To work with each project to identify the long term skills mix required (and gaps) to promote transformation and ensure this is fed into workforce plans and training. ***Why:*** The activities in this quadrant will bring smooth and coordinated transition, reduced risk (including clinical risk), ensure we have a clear view of long term skill gaps, and maximise benefits by ensuring all staff are equipped and confident, and feel supported in the delivery of their roles. ***Who leads:*** The workstream / project (whether at local or regional level) responsible for implementing the change will take the lead for any training requirements arising from their project / workstream, supported by the L&D teams in their organisation and the central Programme Team, and working with DHSSPS

6. Engagement approach

Appropriate engagement and communications will play an extremely important role in ensuring that groups and individuals are fully informed of the direction of change; are involved and feel part of that change. It is essential that engagement builds confidence in the health service and that Transforming your Care (TYC) becomes synonymous with positive, powerful and innovative change. Failure to effectively engage and communicate could have a detrimental effect on ability of the HSC system to deliver meaningful change.

The TYC Programme requires a clear, targeted and considered stakeholder engagement approach at both regional and local levels to ensure:

- Impacted groups and individuals are appropriately identified and engaged through all phases of the programme.
- Communications are developed and delivered in a consistent and coordinated way through the life of the programme, and at different 'points of delivery'.

Stakeholder engagement covers a wide range of activities designed to build people's willingness to support and be committed to delivering TYC. It goes beyond but is closely integrated with 'communications' in its traditional sense. Therefore this approach is closely aligned with the Regional Communications Strategy, which is one way in which engagement activities are delivered, but also encompasses activities such as one to one meetings, workshops and presentations by the Programme Team.

The TYC Programme Capability and Engagement Team will be responsible for:

- developing the overall engagement plan
- developing content for communications materials in conjunction with the Regional Communications Team
- setting up and delivering a series of engagement events to promote buy-in to the vision of TYC both internally and externally
- supporting projects and initiatives in their stakeholder engagement processes
- measuring the effectiveness of engagement activities for TYC

The Regional Communications Group (comprising of senior communications staff from all HSC organisations, led by the HSCB Communications Manager) will be responsible for:

- developing the overall regional communications strategy and plan
- design and delivery of major external and internal communications channels (such as e-Briefs, articles, interviews)
- all engagement with the media in relation to TYC
- developing and maintaining electronic communications channels such as the website, twitter and social media
- co-ordinating and building consistency across the HSC

6.1. Principles and objectives for engagement

The success of this engagement strategy relies on a number of key principles. These are aligned with the Regional Communications Strategy.

- Ensure clear, timely consistent and effective engagement and communications at a regional and local level to fully support the Minister's vision of enhancing the quality of care for clients and patients, and improving outcomes and patient experience.
- Activities must be planned in harmony with the strategy that is adopted by the overall TYC programme.
- Speak with one voice but tailored for the stakeholder group
- Strong editorial direction and governance to provide swift and decisive sign off for approach and content
- Existing channels, media and standards will be leveraged where possible, utilising established formal and informal communication processes.
- Role-model and demonstrate new processes or behaviours to make it real to reinforce the message
- Rigorous measurement is essential to ensure the key messages are getting through to stakeholder groups and being correctly interpreted, and allow adjustment of messages to meet emerging needs

The approach for stakeholder assessment, engagement and communications is summarised in Figure 8 below:

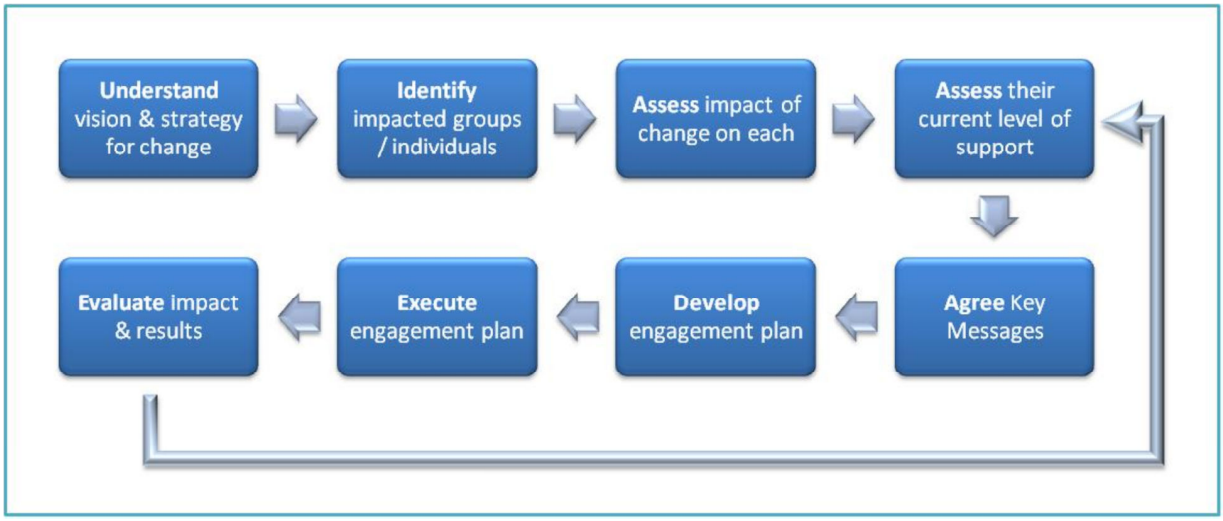


Figure 8: Key Steps in the Engagement Approach

It is anticipated and expected that each organisation and project will have its own plan at varying levels of detail, however, this strategy aims to provide a strategic and co-ordinated approach for all HSC organisations.

Therefore this approach, together with tools and templates to support its use, will be made available to each change initiative or project (whether at local or regional level). The Programme Capability and Engagement Team will also provide support and guidance to

project teams in how they go about assessing development or training needs arising from their project, and how they can build this into their plans from the outset. This will promote consistency to the approach taken to capability development across the TYC Programme, and help to ensure the smooth implementation and sustainability of the change.

6.2. Stakeholder analysis

Stakeholder analysis and mapping provides any programme, particularly one of this size and complexity with some clarity around who the key stakeholders are (based on the Impacted Groups set out in Section 6.3) and how to engage them, thereby allowing prioritisation and focus.

The TYC programme manages stakeholders and engagement activity using a proven approach. Stakeholders are mapped against simple matrix below which assesses both influence and interest of each stakeholder, and these can then be integrated at both programme and local / project levels.

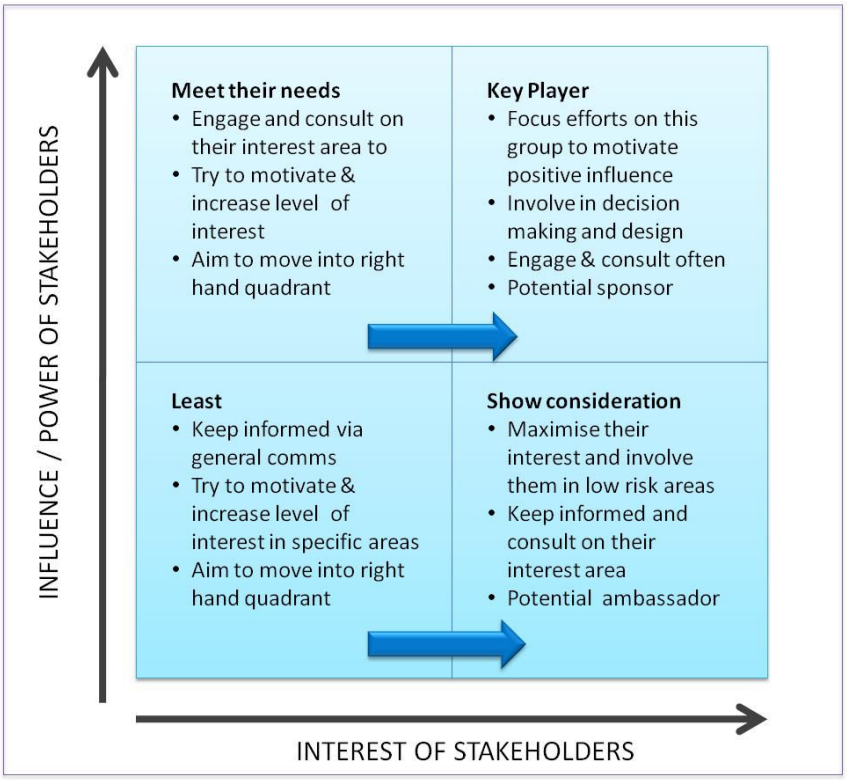


Figure 9: Stakeholder Analysis matrix

6.3. Key messages

Once the stakeholder mapping analysis is undertaken, the key messages for each stakeholder can be developed. It is recognised that these will, and should, be revised on a regular basis, particularly at a local level. It is also recognised that the messages for different groups or individuals will be different at various points throughout implementation. This addresses one of the core principles of engagement: to focus on the needs of the

individual and tailor our messages accordingly to support meaningful engagement based on "what does it mean for me?"

We have started to set out some of the key specific messages for defined groups in Figure 4 above. However, as set out in the Regional Communications Strategy, the key 'generic' messages, which can be tailored for the specific group or individual will broadly fall under three main categories:

We are listening

- It is vital that everyone joins the debate on what they want their health service to look like.
- There will be formal consultation processes in relation to any significant changes to services and key stakeholders and wider public will be able to have their say.
- It is essential that frontline professionals are involved at the core of decision making and service development; and there continues to be powerful local commissioning.

We are changing

- The proposals offer an unparalleled opportunity to provide Northern Ireland with safe, sustainable and accessible care services well into the future.
- There needs to be a shift in care currently carried out in hospitals, into the community with patients being treated in the right place, at the right time, and by the right people.
- It will be necessary to stop doing what does not work, become more assertive in challenging out of date practices, and acknowledge that some of today's services and their current design are no longer sustainable.
- The proposals will offer a wider range of accessible and quality services closer to home

We are delivering

- This is what we have achieved/are achieving (including good news stories and examples of best practice).
- This is when and how you can keep updated on what we are delivering, and how it impacts you

6.4. Branding

Branding is of critical importance for a programme such as TYC. Effective branding enables a programme (and the organisations and projects within the programme) to:

- Create awareness and common understanding of the programme and promote its impact and benefits in NI, speaking with 'one voice'. This is achieved through a constant link back to vision or goal statement within the branding and strapline.
- Generate an emotional connection for those involved in leading and delivering TYC, and gaining recognition for the programme through its brand

- Transpose boundaries to promote the feeling of shared purpose, both within TYC across delivery teams and staff, and out across the organisation leading the delivery of TYC and the communities which TYC will impact

Reiterating the message from the Regional Communications Strategy, it is very important that there is consistent branding developed which becomes synonymous with positive and powerful change of the TYC Programme.

Guidance on localising branding and support materials and templates will be provided to support the above, including, for example, briefing pack, documentation templates, pop up stands etc, as well as branding usage guidance. This is under development.

As we have move from the Review phase into Implementation, it was considered appropriate to change the strap-line from “Review of Health and Social Care in Northern Ireland” to something that better illustrated the following:

- All organisations involved in Health and Social Care are involved are bought into and have a role to play in delivering the TYC vision
- Future focussed and transformational in nature
- Covers all of Health and Social Care across Northern Ireland

7. Capability approach and plan

The purpose of the TYC Programme Capability Approach is to support those responsible for the delivery of the TYC Programme so that they have the opportunity to develop the transformation capability and leadership necessary for successful and sustainable implementation. It also aims to ensure that the capability and training needs arising from TYC projects and initiatives, and the workforce planning around the new service models are addressed in a managed way.

It sets out an approach for identifying, assessing and addressing development needs (both technical competencies as well as 'softer' skills such as core competencies and behaviours) for specific groups. The benefits of doing this are:

- Skills development increases the chances of programme being delivered on time and on budget
- Awareness of capability requirements at all levels and providing the most support to the areas where there are the biggest gaps, thereby making best use of our resources
- Motivating for staff, who are keen to develop their skills and opportunities
- We develop a clearer view of the skills development required in future which can feed into system-wide workforce plans

For all Capability Development interventions undertaken by the TYC Programme the following approach will be used to ensure it

- is focussed on the needs of the individual and organisation to whom it is directed;
- is designed to promote leadership and commitment to the values of TYC through empowerment and shared learning;
- is co-designed / produced with the team or organisation to whom it is directed; and
- employs an integrated approach with TYC engagement activities.

Any capability development undertaken by the TYC Programme will take cognisance of, and so far as possible will be designed to explicitly complement existing leadership and management development activities already underway and delivered by Trusts and other organisations, including programmes relating to Clinical Leadership. It will also be aligned to the NHS Leadership Framework.

It is intended that the HSC Leadership Centre will work alongside the Programme Team to design and deliver these interventions, as well as close involvement and collaborative design with their client organisations from across HSC to ensure it meets their needs.

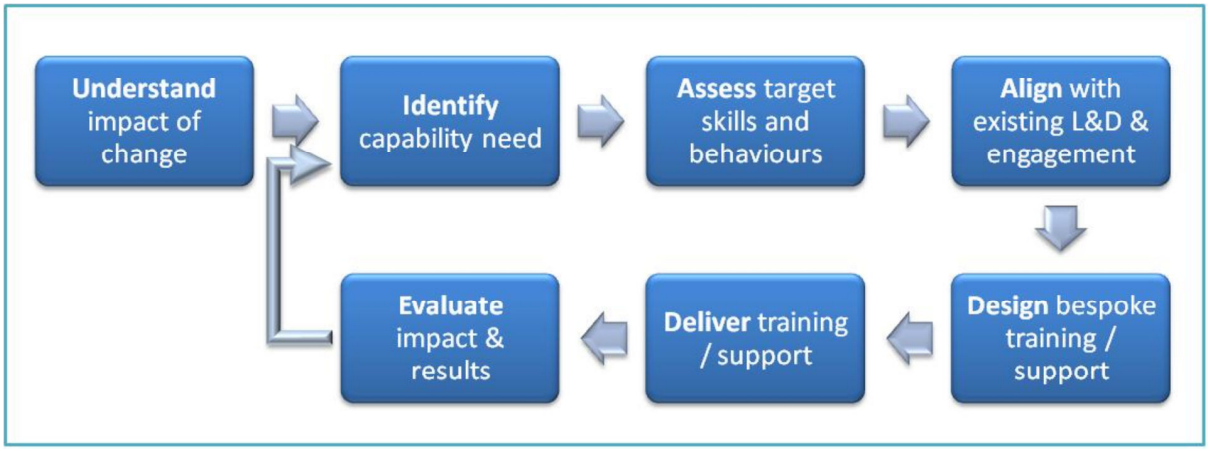


Figure 10: Capability Development Approach

7.1. Building capability to operate in the new model

As further work is undertaken on the detailed service modelling and through the Population Plans in later years, greater understanding will be developed on the workforce skills mix needed to deliver new models of care. This will support the identification of the training and capability needs for staff groups, and where any gaps and risks exist which could impact on the resilience of the service in later years.

Whilst the development of an appropriate HSC workforce to meet the requirements for service delivery is led by the DHSSPS, for the purposes of defining the impact of TYC, it will be supported by the TYC Finance and Workforce enabler workstream. Therefore the Capability and Engagement Plans need to be closely aligned with this work to ensure that short and medium term training and capability needs arising from the TYC initiatives set out in this document are addressed and monitored through the TYC Programme. It is critical that the capability to operate in the new model is developed throughout the TYC implementation period, but also that future skills and professional development needs are identified to enable a strong and resilient flow through from our educational institutions in future years.

In relation to specific changes, the process approach set out above, together with tools and templates to support its use, will be made available to each change initiative or project (whether at local or regional level). The Capability and Engagement Team will also provide support and guidance to project teams in how they go about assessing development or training needs arising from their project, and how they can build this into their plans from the outset. This will promote consistency to the approach taken to capability development across the TYC Programme, and help to ensure the smooth implementation and sustainability of the change.

7.2. Strategic programme level capability plan

Although there are many groups and individuals that are involved in the TYC programme, the focus for Programme Capability can be categorised into four key areas, as these capability needs and interventions are unique and specific to TYC (rather than a general development need which would be addressed through 'business as usual' Learning & Development activities, or a specific training needs arising from a single initiative or project).

Subject to further validation and collaborative design of change model, and detailed development needs analyses and plans, these four key areas of activity are:

a) Leading Transformation

b) Building capability to deliver

c) Learning from others: Skills Transfer Programme

d) Learning from others: Intelligence Hub

Figure 11 overleaf describes the Approach, target group and the **proposed** content for these interventions.

Health and Social Care Board

	Target Audience	Objective	Approach	Key Milestone Plan
Leading Transformation	Those responsible as a team for leading the TYC Programme throughout implementation. This is likely to include the Programme Board, LCG Leads, Directors of Planning, and ADs in TYC Programme Team	Recognising that delivering transformation of this scale and complexity across a whole system requires different skills and behaviours than those which may have been required in the past, this intervention is to support key leaders individually and collectively to develop common goals, translate transformation visions into applied changes 'on the ground', and manage challenges as a high performing Programme Board and senior team.	Blended approach including • Facilitated collective design workshops • Themed knowledge workshops • 'Organisational raids' from other areas undergoing large scale change • Board effectiveness.	***July / Dec 2012:*** Validation of proposals and model Scoping of needs and detailed OD plan ***Jan 2013 – Mar 2015:*** Programme Delivery with annual evaluation reports and updated plans to ensure alignment to objectives
Building capability to deliver	Anyone responsible for leading or managing a workstream, project or initiative as part of the TYC Programme Implementation. Participants would self-nominate or be put forward by their employing organisation. From both regional or local levels, this could include • Service Managers • Local PMO • Clinical staff • Core or non-core HSC orgs *[It is proposed delivery would be primarily through the HSC Leadership Centre with TYC specific products aligned with their existing portfolio of courses and resources. Organisations would be responsible for part funding their own participants]*	Evidence shows there are a number of skills and behaviours which are most likely to make change successful and sustainable. This programme is designed to provide a menu of products to allow flexible attainment of these skills and behaviours focussing on TYC requirements, and aligned to the TYC change model. These include: • Vision & Strategy • Engaging Others • Awareness & Comms • Innovation • Teamworking • Improving Performance • Project Management • Improvement Methodologies • Benefits Realisation	Blended approach as appropriate to the topics including: • Online Resources • Short Courses • Workplace support / consultancy • Coaching • Themed knowledge workshops	***July / Dec 2012:*** Validation of proposals and model of delivery Scoping of needs and detailed OD plan; rollout of existing available products and launch of online resource library Design of 'new' products. Promotion and marketing of products to book courses etc ***Jan 2013 – Mar 2015:*** Rollout of support and training products, with annual evaluation reports and updated plans to ensure alignment to objectives

	Target Audience	Objective	Approach	Key Milestone Plan
Learning from others: **Skills Transfer Programme**	It is hoped that members of project teams and clinical staff who undertake a change as part of TYC will be able to go and work with a project team in another Trust / LCG who are about to embark on a similar change to transfer their learning and skills. This would be structured and managed brokering of the transfer of skills to spread learning	The sharing of knowledge and spread of innovation across our HSC system is critical to the effective, efficient and sustainable delivery of the TYC Programme. We propose to support those involved in order to maximise the opportunities and learning for the following: • the individual • the substantive organisation • the receiving organisation	Blended approach including • Induction package for those embarking on the "Skills Transfer Programme" • Facilitated action learning sets • Regular evaluation of skills transfer application • CPD, Accreditation or qualification, as relevant • Coaching	***July / Dec 2012:*** • Validation of proposals and model of delivery • Scoping of needs and detailed OD plan • Design of materials and schedule of activities ***Jan 2013 – Mar 2015:*** Programme Delivery with annual evaluation reports and updated plans to ensure alignment to objectives
Learning from others: **Intelligence Hub**	Feedback from across the HSC organisation shows there is a need for having accessible and up to date knowledge and intelligence about recent developments. Such an 'Intelligence Hub' will provide access to knowledge and expertise to support those responsible for planning and designing major change initiative from across the HSC system. It would be open to those involved in planning and design TYC change projects from across HSC system.	To provide access to knowledge and expertise to plan and design of changes and improvement as part of TYC, with the purpose of • Maximising the spread of innovation from outside and within HSC • Providing the open space and encouragement to 'think differently' • Enabling teams to develop a clear and compelling vision and strategy for their change initiative • Supporting Population Planning for Years 2 & 3	An 'Intelligence Hub' to include: • Online resources with latest research • Brokering workshops with recognised experts • 'Hot Housing' events bringing together internal and external interests to learn and share	***July / Dec 2012:*** • Validation of proposals and model, identify priorities and develop 'quick wins' initial delivery plan • design of online 'site' and materials; agreement of event plan to Dec 2013; launch with rollout of initial delivery plan / events ***Jan 2013 – Mar 2015:*** Programme Delivery with annual evaluation reports and updated plans to ensure alignment to objectives

Figure 11: Proposed Programme Level Capability Interventions

8. Measurement and monitoring of capability and engagement activities

The overall effectiveness of activities will be monitored regularly during the implementation process to confirm that the capability and engagement activities are having the desired effect and that target stakeholder groups are achieving the planned levels of engagement and capability.

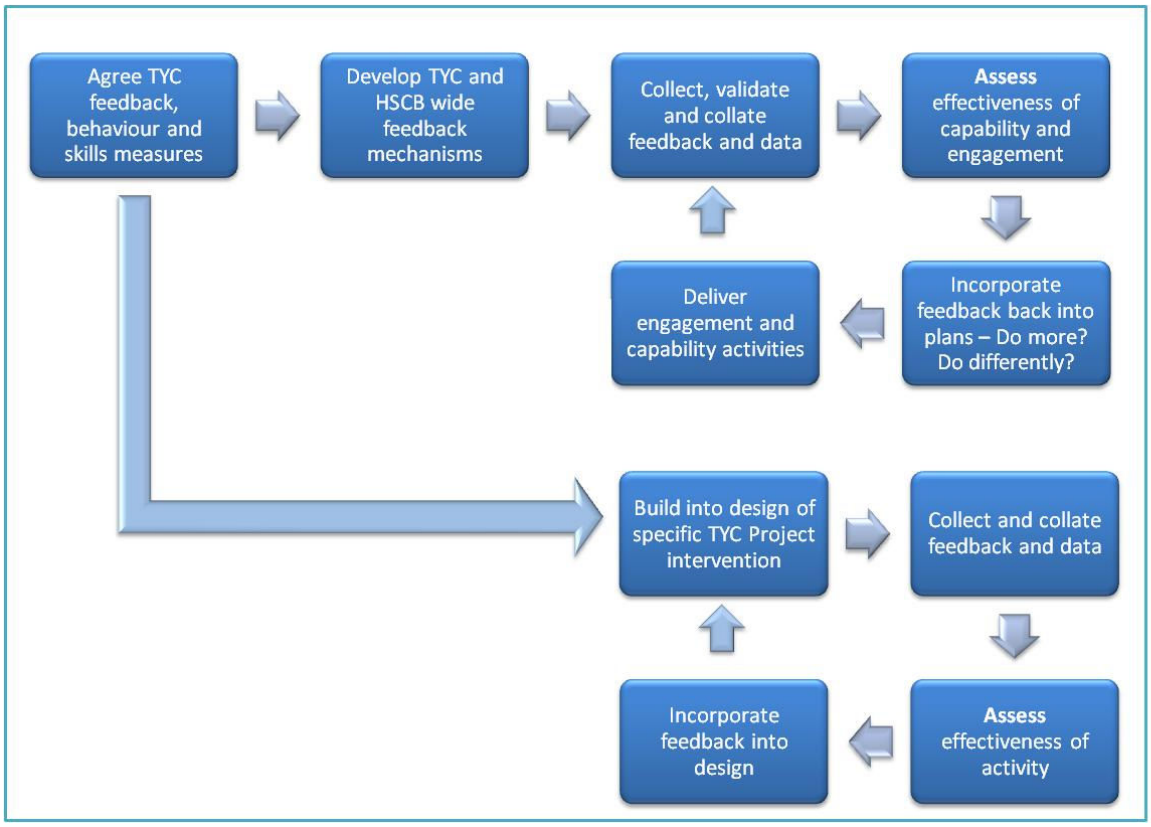


Figure 12: Evaluation Approach

We will apply proven techniques and models for measurements and evaluation of the effectiveness of the capability and engagement approaches, such as the Kirkpatrick model, which has four sequential levels which are increasingly more difficult to measure. These are:

1. **Reaction** – what participants thought and felt about the training (satisfaction; 'smile/happy sheets')
2. **Learning** – the resulting increase in knowledge and/or skills, and change in attitudes. This evaluation occurs during the training in the form of either a knowledge demonstration or test.
3. **Behaviour** – transfer of knowledge, skills, and/or attitudes from classroom to the job (change in job behaviour due to training programme). This evaluation occurs 3-6 months after the learning event.
4. **Results** – the final results that occurred as a result of the learning (can be performance based, financial, ROI, etc.)

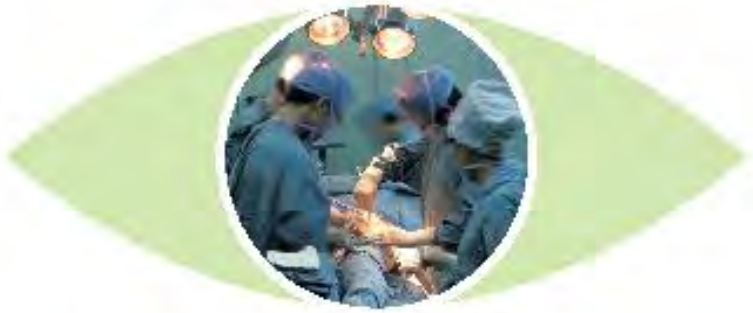
A number of simple feedback and monitoring mechanisms will be used to measure progress against the specific objectives that have been identified for each different group in relation to both engagement and capability, either at Programme level or for a specific project implementation. Feedback mechanisms will include feedback from staff and clinicians, patients and carers, Project Teams, Professional Bodies and other external stakeholders. It will also include quantitative measures such as social media hits, positive media coverage, website uptake and hits. We will seek to include feedback gathering on TYC into other regular opinion testing mechanisms (such as PPI, user surveys).

We will also use focus groups and interviews to investigate where specific issues have been identified during monitoring. This includes understanding the scale of the issue, the underlying causes and how engagement and capability activities can be focussed to address the issue.

In addition, the effectiveness of **each intervention** will be assessed at the point of delivery using feedback forms on communications and evaluation forms for every training session to ensure that the objectives for that activity are met. Simple and focussed annual evaluation exercises using consistent criteria each year will be undertaken for each element of the capability plan to inform planning for the year ahead.

The information from this monitoring process on the effectiveness of both specific interventions and the overall effectiveness will be fed back into the Programme Team, and used by the Capability and Engagement Team to modify the plan for the forthcoming year, feeding into individual Project / Workstream Plans, the Population Plans and the Strategic Implementation Plan as required.

Transforming Your Care



Vision to Action

A Post Consultation Report
March 2013

Chairman and Chief Executive's Foreword

Transforming Your Care is a challenging, yet vital, journey for the health and social care system in Northern Ireland. In October 2012 the Minister launched the *Vision to Action* consultation as a major step in the implementation of *Transforming Your Care*, and asked the Health and Social Care Board to lead the consultation process.

We are delighted that so many people became involved in the consultation, either through attendance at our NI wide events, through social media or by sending us their views. The HSCB received 2242 responses representing the views of many more organisations and individuals. We would like to say thank you to everyone who got involved in any way.

As a Board we are committed to the creation of a successful health and social care service which needs to be based on open and frank debate, and we see the emails, letters, reports, questionnaires and personal contributions as informing that ongoing debate. Whilst this report presents the formal outworkings of the consultation process, the HSCB will ensure that the information it has received will continue to be used to inform how we commission and deliver health and social care services in the future.

We have listened to the responses and a very strong message during the analysis is the clear recognition of the need for change. Transforming Your Care said 'no change is not an option'. Respondents to this consultation clearly agree. This consensus is reassuring and provides a strong foundation on which to plan change.

Most of what was said centred on how to implement *Vision to Action* and make it a reality. Many of the comments you made were focussed on critical themes in making change successful and sustainable. In this regard, there were some concerns over timing, resources, capacity and continued local engagement.

The HSCB considers this document demonstrates the consultation exercise was thorough and successful. This report will now be presented to the Minister. In due course he will indicate the specific steps to be taken on foot of the responses received.

John Compton
Chief Executive
HSCB

Dr Ian Clements
Chair
HSCB

Contents

Alternative formats
This document can be made available upon request in alternative formats including: braille, large print, computer disk, audio tape or in another language for anyone not fluent in English.

For an alternative format please telephone 028 9055 3790 (for text phone preface with 18001), or email tycconsultation@hscni.net

Health and Social Care Board

Executive Summary

June 2011	Minister for Health, Social Services and Public Safety, Edwin Poots MLA, asked for an independent **Review of Health and Social Care (HSC) in Northern Ireland**
Dec 2011	Report of the review was published – **Transforming Your Care** – with 99 proposals for change across a range of areas
July 2012	**Draft Population and Strategic Implementation Plans** published on how the Health and Social Care Board (HSCB) proposed to make service changes in response to the TYC Report
October 2012	The Minister launched **Transforming Your Care: Vision to Action** - setting out proposals for key service changes. The HSCB led the consultation process on behalf of the Minister including a household leaflet and range of public and stakeholder meetings.
January 2013	The **Transforming Your Care: Vision to Action** consultation period finished with 2242 responses received by the HSCB
March 2013	Analysis and consideration of the response to the consultation completed, and **Vision to Action Post Consultation Report** published

Transforming Your Care

Overwhelmingly the TYC Review was about making changes which would have the greatest beneficial impact for patients, users and carers, and about ensuring we have a safe, resilient, high quality and sustainable health and social care system for the future.

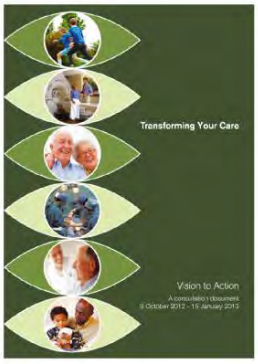
There is much to be proud of in our health and social care but there is a stark reality ahead mainly due to

population change and growth in demand. Change is inevitable. TYC presents a managed change.

Transforming Your Care proposes a reshaped model of care with the individual at the centre to improve the health and wellbeing of people by

- **promoting** good health decisions,
- **preventing** ill health in the first place,
- **achieving** better outcomes when ill health does occur &
- **enabling** people to live healthily and independently for as long as possible.

Vision to Action



The consultation document published in October 2012 set out the strategic way forward, focussing on the key service changes, to take forward the TYC proposals over the next 3 to 5 years. It was important to bring existing and new change initiatives into a managed programme of transformation – one that focussed on a single vision.

We set out to be as clear and transparent as we can at this early strategic stage, whilst understanding that further consultation on specific changes will be needed as we move forward.

As part of the consultation, a leaflet was sent to every home in Northern Ireland, public and special interest group meetings were held across the region, and social media was used to engage with the public. Respondents were encouraged to contact us and respond in a number of ways, and by 15 January 2013, 2242 people or organisations had done so.

	Free-form letter	Questionnaire	Standard letter responses	Totals
Organisation	148	66	-	**214**
Individual	96	188	1744	**2028**
Total	**244**	**254**	**1744**	**2242**

Health and Social Care Board

In the main, responses were extremely considered and we would like to **thank everyone** who came to one of our public meetings, or a special interest group meeting, and to everyone who sent us their views.

These are critical to informing decisions about the way forward and about how we implement Transforming Your Care.

Most of the responses specifically addressed the proposals we made and / or the questions we asked. However it is also very important to recognise that some respondents also made comments on wider Health and Social Care service issues, or areas for policy and legislative discussion.

Whilst these comments are very important, some are outside the scope of this consultation, as they relate to wider government policy which is beyond the remit of the Health and Social Care Board. None the less we are committed, to ensure that these are passed on to the appropriate agencies.

What people told us

'Doing nothing is simply not an option' 97% of people believe that our health and social care services need to change to promote health and wellbeing

Overall there was strong support for change, for the TYC model and for the proposals we made.

Against this backdrop of strong support for the vision within TYC, many of the respondents commented on those aspects which would, in their view be most critical in achieving the aims to which TYC aspired. Many of the responses referred to in this document talk about the translation of the Vision into Action and how this can best be done to the benefit of patients, users and carers. We believe there is a strong foundation upon which to plan changes.

"It seems clear that health and social care services must evolve in response to; demographic changes, disease prevalence, changing social models, new care options."
– Individual Response

Transforming Your Care

In considering the consultation responses, it became apparent that there were five key overarching messages which will be important in how we take TYC forward:

1. The need to ensure that investment is focussed on making change happen, and that alternatives are in place and working effectively before change occurs to current services
2. A focus on how we support carers as a key partner in care provision
3. Support for staff who are the key enabler to implementing TYC
4. Importance of engaging with the voluntary and community sector in designing services and in developing their capacity to be key partners in the delivery of TYC
5. Need for greater cross governmental / agency working to address health inequalities and be more 'joined up' in our plans for implementation

Critical overarching themes from what people said about the implementation of Transforming Your Care

Alternatives in place

Respondents often highlighted a need for assurances that investment will be focussed on making change happen, and that alternatives will be in place and working effectively before change occurs. There is already a commitment to having a structured and sensible implementation of the TYC proposals as set out in *Vision to Action*, and people wanted this to be delivered upon. This includes ensuring that new or different services must, and will, be developed and working well before we step down other parts of the service.

Voluntary & Community Sector

Many respondents mentioned the opportunities that could be gained from engaging with the Voluntary and Community sector in a different way. They have a unique contribution to make in terms of innovative ideas for service design and delivery, and have a role in engaging with service users. It was recognised that building capacity and capability in the sector is required.

Carers

Many respondents stressed the importance of carers in our health and social care system. They said we need to be better at identifying carers, assessing their needs and putting resources in place to support them, particularly in the context of 'care closer to home'. The provision of flexible, appropriate respite and involving carers when planning and designing services were seen as particularly vital.

Workforce

Many people mentioned the workforce as the key enabler to success. With the movement of services from hospitals to home and community settings, respondents highlighted the need for effective workforce planning so that sufficient skills and resources are where they are needed. Appropriate investment in training and skills is vital to support the workforce.

Inter-governmental working

A number of respondents believed that statutory bodies should work closer together when planning and delivering public services, including welfare, community services, transport and housing , in order to tackle health inequalities.

Health and Social Care Board

This document sets out the summary and analysis of the responses we received for each of the sections in the *Vision to Action* document. This includes statistics as well as comments that people made, either in their written response or at meetings with us.

We have been open about the questions or concerns people have raised, even when there is widespread support for a proposal. At the end of each section, we highlight specific actions we believe will be particularly important as a result of what we have heard, subject to the approval of the Minister. We also make an overarching commitment that the detail in the responses we received will be 'fed forward' into our implementation processes over the next 3 to 5 years.

Population Health and Wellbeing	Strong support for greater focus on early intervention and prevention of ill health. The need for a whole system approach to tackling health inequalities was highlighted, as in the "Fit and Well – Changing Lives" Public Health Strategic Framework recently out for consultation.
Delivering services at home and in the community: Integrated Care Partnerships	When asked whether ICPs could make a positive contribution to delivering care closer to home, 89% agreed. In general, there was a qualified welcome for the introduction of Integrated Care Partnerships, focusing on frail elderly and those with long term conditions. More information on how these will work in practice is needed, and ensuring that there is involvement and leadership from across health and social care professinals, voluntary and community sector, service users and their carers.
Older People	Providing care closer to home for older people was very well received and 73% of respondents agreed with the proposals. Respondents felt it important to help support older people to live as independently as possible for as long as possible where it is safe and appropriate to do so. There were some concerns highlighted about domiciliary care provision and proposed closure of statutory residential homes. We propose that investment in alternatives, which is enabled by closure of some statutory residential homes is the most appropriate way forward as we did not receive any compelling evidence to the contrary.
Long Term Conditions	There was a welcome for the proposals for those with long term conditions – 94% felt it would be helpful to have more information and education to encourage self-management, and 89% thought more use of technology could reduce avoidable visits to hospital. We recognise that self-management and increased technology, is not appropriate for everyone.
Palliative and End of Life Care	There was strong endorsement for implementation of the palliative care and end of life proposals – 95% agreed the proposals would support people to be cared for in a place of their choice. Some challenges were outlined by professional groups including the need for greater clarity on roles and accountabilities , and the need for awareness and education for staff across the different sectors (statutory, independent, and voluntary and community), and the public.
Mental Health	Overall 77% of respondents agreed with the proposals for mental health services. There was strong agreement for the continued implementation of Bamford proposals, with more services being provided in the community. The issue of the placement of the second metal health inpatient unit in the Western area was more emotive, and in this document it is suggested that further consideration is needed on this matter.

Transforming Your Care

Learning Disability	Again the consensus was in favour of the continued implementation of Bamford recommendations including resettlement of those currently living in long stay institutions, with 88% of respondents agreeing with proposals. People wished to see increased progress in this area. A particular focus was placed on a need for age-appropriate services for people with learning disabilities, including how people transition from child to adult to older people's services.
Physical Disability & Sensory Impairment	The majority of responses received demonstrated support to progress with the proposals outlined (92% agreed with the proposals) whilst making suggestions for how services could further be improved, notably the need for specific action plans. Respondents felt that it was crucial that people with physical disability and sensory impairment continue to be effectively engaged in the design and implementation of services.
Family & Child Care	There was strong agreement with the proposals with 92% agreeing. Respondents fully supported keeping children within their families and felt that an emphasis on early intervention and prevention would facilitate this, specifically with the introduction of Family Support Hubs. There was wide agreement for increasing the number of foster parents and an overwhelming support for improving child and adolescent mental health services (CAMHS).
Maternity & Child Health	There was positivity around the normalisation of birth from respondents and a welcome for the focus on improving antenatal and early parenting education. Overall 78% agreed with the proposals. Some respondents were concerned about the use of midwifery units, however most were positive when they were placed on site or in close proximity to consultant led obstetric care. There was a welcome for the Family Nurse Partnership Programme with respondents calling for them to be extended regionally.
Acute Care in Hospitals	As expected comments on this section were often in relation to specific proposals or localities. Overall 66% agreed with the proposals with recognition of the need to review acute hospital configuration and investment in specialties was warmly welcomed. It is important to emphasise that the proposals would not result in a closure of an acute hospital but that all of our current hospitals would work in a network with its neighbours to make best use of the resources we have across Northern Ireland. Clinical groups were supportive, as were patient and user groups so long as outcomes and quality of care can be assured. The use of clear and transparent evidence is important in this regard. The issue that attracted the largest number of responses (around 70% of the total response) was about Causeway hospital. These letters promoted the need for retention of full general hospital services at Causeway hospital and were supportive of the proposal to do an Options Appraisal about the future management arrangements for Causeway. Having considered all responses on this matter, we believe that the Options Appraisal should take place and should include community services in the Causeway locality.
Increasing links with Republic of Ireland & Great Britain	This proposal was very well received, 92% agreed with the proposals. Respondents felt that increasing links would ensure that patients can benefit from the most up to date treatment and knowledge, reduce waiting times for certain procedures with better outcomes for the patient. A small number of respondents raised concern around the pressures that travelling for treatment can place on patients and families.
Equality & Human Rights	Of those that answered these questions, 74% thought proposals would not have an adverse impact on equality groups, and 80% were unaware of any evidence of an adverse impact on opportunity or good relations. A small number of respondents, particularly from organisations sought a full Equality Impact Assessment (EQIA) on TYC as a whole. EQIAs will be undertaken as specific service changes are brought forward for implementation. Through our discussions with the Equality Commission and Human Rights Commission, we remain committed to a rights based approach to transformation and there was strong support for this in consultation responses.

Health and Social Care Board

Conclusion

The HSCB would like to repeat our thanks to all those who took part or provided their views during the consultation on *Vision to Action*.

We conclude that there is widespread recognition of the need for change in our health and social care system, strong support for the model that Transforming Your Care puts forward, and for the proposals for change which will turn that model into a reality. It is now critical that there is certainty about the way forward and about how TYC will be implemented. In doing so, we need to have an unrelenting focus on delivering high quality and compassionate care to deliver better outcomes for patients, service users and their carers.

What this consultation has demonstrated is that people want to be involved in the debate about how we develop health and social care services and how we can make the best use of the resources we have.

This report is the HSCB response to a request from the Minister to undertake consultation on the proposed service changes arising from the Transforming Your Care report published in December 2011. In our view it provides a strong foundation for the way forward and implementation of the *Vision to Action* proposals, having due regard to the feedback received during this consultation.

Subject to the Minister's approval to proceed, the HSCB, working closely with our colleagues in the Public Health Agency, Trusts and elsewhere, will put in place the detailed implementation plans to take forward the service changes set out. On-going consultation and engagement with the general public, and organisations involved in the health and social care sector will be critical to achieve TYC's objectives and deliver better outcomes for all. We look forward to continuing the debate and conversations opened during this consultation, over the coming years.

Part 1. Introduction and Background

1.1 The Review of Health and Social Care

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, asked for a Review of the Provision of Health and Social Care (HSC) Services in Northern Ireland. The Review was to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, service users, carers and communities are being met. Crucially it was to bring forward proposals for the future shape of services and provide an implementation plan.

The Review team was asked to ensure that available resources were used to best effect, and this continues to be a major driver for *Transforming Your Care* (TYC).

Overwhelmingly the Review was about making changes which would have the greatest beneficial impact for patients, service users and carers, and about ensuring we have a safe, resilient, high quality and sustainable health and social care system for the future.

There is much to be proud of in our Health and Social Care system but there is a stark reality ahead. We have a growing and ageing population and those with disabilities are living longer. While these are facts to celebrate, this, together with:

- the rising cost of technologies and drugs;
- lifestyle issues such as obesity and alcohol; and
- family structures and pressures leading to rising demand for children's services

means that we need to think differently to meet the demands that lie ahead. Without change there is a growing potential for instability in the Health and Social Care system and an increasing difficulty in meeting the future needs of our citizens.

We need to prepare our services for the future, and this will mean making choices about how we want our health and social care services to be delivered, based on the best evidence.

Health and Social Care Board

1.2 The Transforming Your Care: Vision to Action Consultation

In October 2012, the Minister launched *Transforming Your Care: Vision to Action* to provide information to help all citizens of Northern Ireland to contribute to the debate on the future of our Health and Social Care. It set out the proposed service changes, within and aligned to existing policy frameworks, in response to the TYC Report published in December 2011.

This document was based on the draft Population Plans which were developed by Local Commissioning Groups, with input from Health and Social Care Trusts, to reflect local needs, and a draft Strategic Implementation Plan which gave a wider Northern Ireland overview. All of these draft documents were originally published in July 2012 and were published again in October 2012 following a period of quality assurance.

The Minister for Health, Social Services and Public Safety, Edwin Poots MLA asked the HSCB to conduct a period of public consultation on the proposals for service changes set out in the *Vision to Action* document, and the draft plans. Further detail of the consultation process undertaken is set out in Part 2 of this report.

This Post Consultation Report is the HSCB's response to that request, and sets out a summary and analysis of the 2242 responses we received to our public consultation, and provides information on what we propose to do as a result of what we have heard, subject to ministerial consideration and decision.

In the main, responses were extremely considered and we would like to thank everyone who came to one of our public meetings, or a meeting held by an interest group, and everyone who sent us their views. These are critical to informing decisions about the way forward and about how we implement TYC.

Most of the responses related specifically to the TYC model, the proposals in *Vision to Action* and / or the questions posed. However it is also very important to recognise that some respondents also made comments on wider Health and Social Care service issues, or areas for policy and legislative discussion.

Whilst these comments are very important and some have relevance to the success of TYC, it is also acknowledged that some are outside the scope of this consultation as they may relate to wider government policy which is beyond the remit of the Health and Social Care Board. We are committed, however to ensure that these are captured and will ensure these comments are shared with the relevant body.

1.3 An overview of what Vision to Action proposed

The *Vision to Action* consultation document outlined how the new model of care is to be organised with the individual at the heart of the model, rather than the institution or the hospital.

The document broadly covered four key themes:

1. Individual - We looked at what we can do to keep individuals healthy and how we could help you improve your own health and wellbeing.

2. Delivering health and social care services as locally as possible - We proposed to make home or the community the hub of care, reducing the need for avoidable visits to the hospital.

3. Safety and Quality of acute care in hospital settings - We highlighted the need to ensure that emergency care and planned specialist care provided in hospitals is safe and sustainable and meet the best quality standards.

4. How we can collaborate better with our neighbouring jurisdictions - In some cases the very best care may not be in Northern Ireland, where there is low volume or the treatment is very specialised.

The document summarised the key proposals for change to be considered in the context of the challenges facing Health and Social Care (HSC) in Northern Ireland. It set out, across Programmes of Care, specifically how we propose to make service changes to the model of health and social care and what it will look like.

Health and Social Care Board

The sections in the *Vision to Action* document were:

1) Population Health and Wellbeing
2) Delivering services at home and in the community: Integrated Care Partnerships
3) Older People
4) Long Term Conditions
5) Palliative and End of Life Care
6) Mental Health
7) Learning Disability
8) Physical Disability and Sensory Impairment
9) Family and Child Care
10) Maternity and Child Health
11) Acute Care in Hospitals
12) Increasing our links with the Republic of Ireland and Great Britain

The key desired outcomes for TYC, as described in *Vision to Action*, are:

- People will get support to stay healthy, make good health decisions or manage their own conditions.
- More services will be provided locally with opportunities to access specialist hospitals where needed.
- More people will be cared for at home, where it's safe and appropriate to do so.
- People will have more choice and greater control over the types of services they are able to access.
- Investment in new technology will help people stay at home or receive care locally rather than in hospitals.
- Doctors, nurses, social workers and everyone providing care will work together in partnerships to help keep people healthy and prevent them going to hospital when that's not necessary.
- Any decisions about how we do things should be driven by evidence that it will be better for patients and users, and be better quality.
- Everyone working in health and social care services will be supported in helping to make the changes set out in TYC.

1.4 How is this document structured?

The *Vision to Action* document focused on the proposed service changes which we anticipated would have the greatest impact on shaping our health and social care services of the future, and be as clear and specific as possible about what this means for citizens. Similarly this document focusses on those aspects which have most impact on the implementation for TYC.

We found many responses provided significant and comprehensive views on both the proposals and on current health and social care services. Also some provided additional detail and evidence, often relating to their specific area of interest. It would be impractical to make individual responses available or to respond to each individually. We are committed to putting in place a process within the HSCB, working together with the Public Health Agency, to ensure that detailed responses are included in the commissioning and delivery of services going forward.

In this report, we draw out the themes from the responses, and in doing so wish to be as open and transparent as possible, whilst making this document as accessible, rather than overly long or complicated. We have therefore been open about the concerns people have raised as this is where we believe constructive debate can be had, even when there is widespread support for a proposal, or only a relatively small number of people have raised the concern. We make an overarching commitment to take account of all responses as we move forward. In this document, having considered all the consultation responses, we comment on the areas we think should be particularly highlighted as key for implementation on the proposed service changes. These HSCB comments are at the end of each section. All such comments and proposed response to what we have heard are subject to the Minister's decision to proceed.

We are also happy to discuss the outcome of this Post Consultation Report with any respondent or stakeholder during the course of the implementation.

In this Post Consultation Report we continue to use the structure around 'Programmes of Care' that was employed in the TYC Report, the draft Plans and in the *Vision to Action* consultation document. We also found there to be a series of overarching themes which impact on all Programmes of Care which would benefit from separate discussion.

Health and Social Care Board

The structure of this report is set out below:

In the next section, **Part 2**, we describe the consultation process and methods and the profile of respondents.

In **Part 3**, we address the need for change and the future model of care as proposed by TYC.

In **Part 4**, we draw out the key overarching themes identified from consultation responses, and provide our response to this in terms of actions we propose should be taken as a result of what we have heard.

In **Part 5**, we focus on each of the 12 sections in the *Vision to Action* document and questionnaire, plus Equality and Human Rights. Each of these sections will set out the quantitative results from the consultation questionnaire, provide a summary of the qualitative responses and comments made to us, and finally indicates how the HSCB proposes to respond in terms of the implementation of TYC.

In **Part 6**, we look at the responses and comments received about Part 5 of *Vision to Action* (Supporting these changes to happen). This looked at the possible implications for our workforce and organisation, for our finance, for technology advances, and for how we procure services from organisations outside the HSC family. Whilst specific questions were not asked on these aspects (and therefore we do not have quantitative results) many respondents have commented on these areas, and these will be summarised in this section.

The remainder of the document sets out what happens next.

Part 2. The Vision to Action Consultation Process

2.1 Overview

This section provides further information on the design and operation of each component of the consultation process, and information on the profile of responses.

The stated aim of the consultation was to be clear and transparent about what we are doing in a co-ordinated way rather than introducing piecemeal changes which people cannot see or fully understand. It was to focus on those areas which would see the most significant change and be as specific and explicit as possible, to enable everyone to contribute to the difficult choices ahead.

In achieving this aim, it was important to make the consultation as accessible as possible using all established methods of engagement, such as printed materials in a range of formats, up-to-date online information and face-to-face contact through a variety of meetings and events, as well as embarking on new channels of engagement through social media.

2.2 Promotion and Accessibility of the Consultation Exercise

There were a number of modes of contact open and promoted to those who wished to contact the Health and Social Care Board (HSCB) Transforming Your Care (TYC) Team or respond during the consultation exercise. This multi-channel approach included:

- Phone (including text phone)
- Post
- Email
- Fax
- Website (www.tycconsultation.hscni.net)
- Online questionnaire
- Downloadable forms and documentation
- Facebook (facebook.com/tycconsultation)
- Twitter (@tycconsultation)

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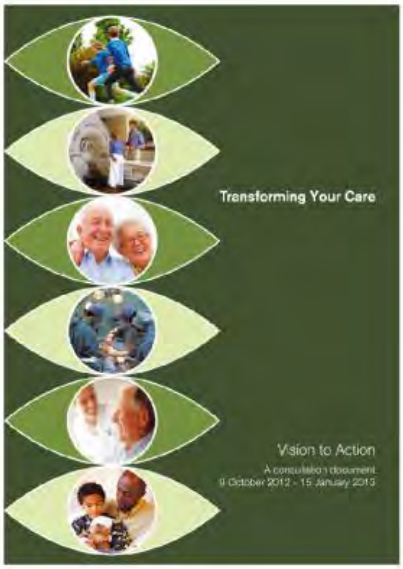


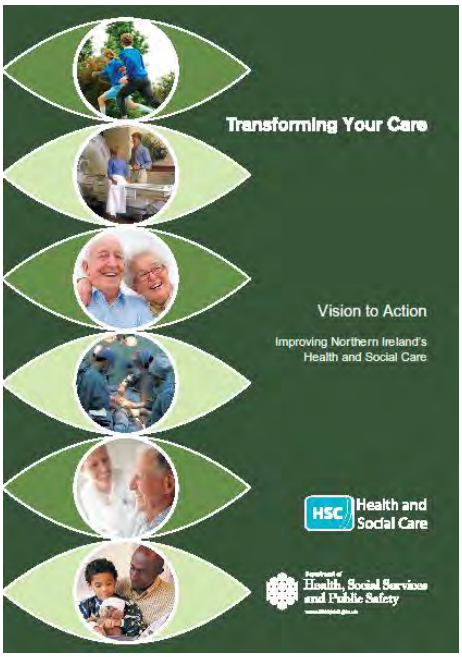
The *Vision to Action* document was made available in the following formats:

- Hard copy (circa 2000 were distributed)
- Downloadable
- Braille
- Audio
- Easy Read
- Large Print

A Questionnaire was also produced alongside the *Vision to Action* document, to support those who wished to respond to the questions posed in the document. This was available in the following formats:

- Online and downloadable (either pdf or MSWord)
- Hard copy with Freepost envelopes (A5 booklet versions were made available at all meetings and sent out to those who requested them – in total 610 of these were distributed)

To ensure that everyone in Northern Ireland had the opportunity to read some introductory detail on TYC, the consultation exercise, and the ways they could get involved, an information leaflet was delivered to every home in Northern Ireland in autumn 2012. This leaflet provided details on the consultation exercise and also gave contact numbers, website address, and links to Twitter and Facebook.



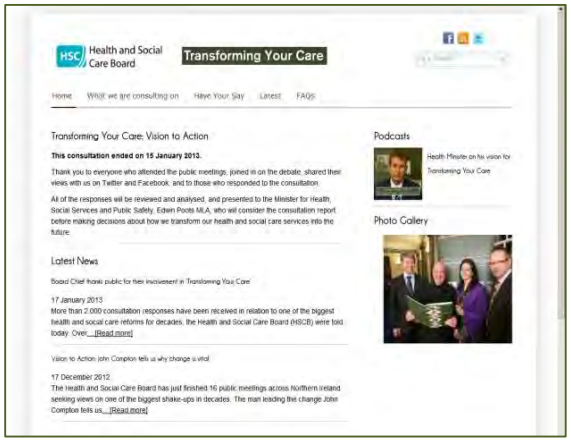
The leaflet was made available in various formats:

- Hard Copy and downloadable
- Audio (including 1800 sent to registered blind people on RNIB's database)

Transforming Your Care

The website developed for the consultation included the following:

- Information on TYC
- All documentation including draft Population Plans, draft Strategic Implementation Plan and Equality Screening
- Frequently Asked Questions.
- Four Podcasts on aspects of TYC
- Online Questionnaire and contact channels



The table below sets out usage information on these channels of engagement.

Communication and Contact Activity	**Number of contacts**
Household leaflet	758,780
Hard Copy documents distributed	2000 circa
Requests for alternative formats[1] of consultation document	8
Public Meetings	16
Numbers in attendance at public meetings	533
Stakeholder Meetings	26
Numbers in attendance at stakeholder meeting	280
Website Unique Visitors[2] Website Total Hits[3]	6,258 26,140
Facebook likes	40
Twitter Followers	145
Tweets/ Interactions	182 / 156

Finally, a number of activities were undertaken to raise awareness of the consultation exercise, including

- Media briefings, press releases and articles in local and regional press at the launch and during the period.

[1]Alternative formats include: Braille, Audio, Large Print, Easy Read
[2] Unique visitors is the number of unduplicated (counted only once) visitors to the website during the consultation
[3] Total number of times pages were viewed during the consultation period

- Adverts placed in local press providing details of the public meetings being held across Northern Ireland.
- John Compton, Chief Executive of the HSCB, wrote to over 500 individuals and organisations on our stakeholder list at the launch of the consultation and again to publicise the public meetings.
- A number of stakeholders were contacted directly to encourage response and offer focussed meetings or support to respond.

2.3 Public Meetings

As part of the public consultation, the HSCB led a series of public meetings across Northern Ireland, working closely with the Local Commissioning Groups and the Trusts for each area. There were 16 public meetings held in total and these are set out below, together with the registered attendance at each. At some meetings there were a number of attendees who declined to register at the meeting. Further details of where each was held and a summary of the format used are set out in Annex 1.

Pictured at the Lisburn TYC public consultation meeting.

Area	Locality	Attendance
Belfast	Belfast 1	31
	Belfast 2	18
	Belfast 3	18
South Eastern	Lisburn	24
	Down	27
	Newtownards	25
Northern	Coleraine	80
	Newtownabbey	35
	Magherafelt	36
	Ballycastle	23
Southern	Banbridge	55
	Armagh	22
	Newry	35
Western	Derry	26
	Omagh	45
	Enniskillen	33
	TOTAL	**533**

Each meeting ran to a similar format with a standard presentation, a series of TYC podcasts (short videos) and Q&A debate. An independent facilitator supported each of the public meetings, which was intended to ensure that all participants were enabled and supported to have their say and also that the public could be reassured that the process was open and transparent. More detail on the format of each meeting is in Annex 1.

The comments, views and queries raised at the Public Meetings have been included in the qualitative analysis undertaken to inform this document.

At many of the 16 public meetings local issues often took centre stage. At the Coleraine meeting, questions focussed on the future of the Causeway Hospital, and the proposed move of management to the Western Health and Social Care Trust. In the Tara Centre in Omagh mental health services in the area was emphasised in the public's questions. Often the future of the local hospital or local residential home was raised as a question by an attendee.

Pictured at the TYC public consultation meeting held in Armagh

Questions and comments raised in these meetings covered a wide range of issues across all of health and social care. However as the meetings progressed a number of themes emerged:

- The vital work of carers and their need for support was raised in all of the meetings, with access to respite seen as needing improvement.
- Representatives from the local workforce and trade unions were present at a number of public meetings. As a result staff concerns were raised, as were concerns around health and social care privatisation.
- A number of attendees were unsure about what an ICP would be and how it would operate, and requested clarification on their function and structure.

Members of the deaf community from the Newry and Mourne area chat to John Compton, HSCB Chief Executive, at the Newry public meeting.

Health and Social Care Board

2.4 Meetings with organisations, groups and agencies

In addition to public meetings which were open to the general public and interest groups, there were some specific engagements with organisations such as NI Council for Voluntary Action (NICVA), senior clinical staff in Trusts and Staff Side partners. Annex 2 provides a list of these meetings.

Pictured at a meeting with NIAMH (Northern Ireland Mental Health Association) during the consultation period.

Some organisations (such as British Medical Association, Royal College of Nursing, Age NI, Barnardos and Carers NI) held their own workshops and meetings to inform their collegiate response. We have not captured the numbers attending these meetings.

Across these meetings, the key message was one of support for the need for change and the vision and principles contained in TYC, as well as widespread support for the proposals. A significant proportion of debate centred on how implementation can ensure that the outcomes can be achieved, and those factors considered critical in doing so.

Due to the nature of these engagements, which were often focussed on specific interest areas, it would not be practical to summarise themes. These form part of the qualitative analysis within the remainder of this document.

2.5 Use of electronic communications & social media

A number of electronic communications and engagement channels were set up specifically for the purposes of *Vision to Action* consultation. We have evaluated the use of these channels and it is the view that social media and electonic communciations were an extremely useful and effective way to spread information and raise awareness about the consultation, and we found it started to host debates about the TYC proposals, but that more could be done in future to use these means as a way of capturing the views and opinions of groups and the general public and to promote debate.

There were over 160 comments/interactions from followers. Those commenting included politicians, voluntary and community sector, charities, campaigners, professional bodies and individuals. The majority of comments were positive from followers with many forwarding information about the TYC public meetings and key proposals to their own social media followers inviting them to respond to the consultation.

"Good debate on shifting balance of care from hospital to community setting" Attendee at TYC Public Consultation meeting in Belfast

"Every organisation I have spoken to says TYC is the correct way to go." MLA

"Don't forget to have your say on the future of health and social care in NI." Junior Doctor

Some comments received however, indicated concerns regarding TYC costs and administration, privatisation, support for carers and some personal comments on services in Mid Ulster and the Northern HSC Trust.

"Who is going to pay for this? What is the projected cost of administration alone?" Campaign group.

"Is the Mid Ulster area being by-passed again for public meetings surrounding TYC?" Campaign group.

"Carers need recognition and protection under the proposed health reforms." Charity

2.6 Compliance Assessment of Consultation process and data analysis

As part of the consultation process, the HSCB engaged the Consultation Institute to provide a compliance assessment to:

- Conduct an independent compliance assessment of data analysis methodology, both quantitative and qualitative
- Assess the quality control mechanisms in place and determine if they have been adhered to

- Assess whether the presentation and reporting of the material is in an acceptable manner, to comply with The Consultation Charter in respect of feedback to respondents and others, and 'feed-forward' to decision-makers.

They were able to provide assurance of our practice and commented that the data analysis methodology was "conscientiously planned and executed", and the quality control mechanisms were "these have been well considered and executed."

The Consultation Institute have awarded the HSCB a Certificate of Best Practice and endorsed our approach to these aspects of the consultation as a quality assurance measure.

2.7 Profile of Responses to the Consultation

A total of 2242 responses were received in written form, including letters, emails and completed questionnaires.

Respondents had a number of options for communication if they chose to make a written response. They were able to complete a questionnaire online via the website, could submit an email or hard copy of the questionnaire or write their response in a letter or an email (what we are calling 'free-form' responses).

Respondents included individual members of the public, voluntary and community or interest group organisations or groups, local Councils, public sector organisations such as Trusts and other public bodies, Trade Unions and Professional bodies, and political representatives and parties.

Both organisations and individuals chose to submit their views via the questionnaire and through free-form responses. A considerable number of individuals also chose to make their views known through the use of a generic letter format with consistent content provided to them – often this took the form of standard text with individuals' signature and contact details. We have called these 'standard letter responses'.

We were able to extract quantitative data from the questionnaire responses and this forms the basis of the graphs and statistics you see in this report. We were able to extract qualitative data from all three types of response: free-form, questionnaire and standard letters.

The breakdown of the type of response is shown in the table below.

	Free-form letter only	Questionnaire formed basis of response (may also have provided free-form views alongside)	Standard Letter Responses	**Totals**
Organisation	154	61	-	**215**
Individual	90	193	1744	**2027**
Total	**244**	**254**	**1744**	**2242**

2.7.1 Organisational Responses

Of the 2242 responses, 215 were from organisations, groups or political representatives, across questionnaire or free-form formats (or some organisations submitted both but this is counted as one submission). A breakdown of the organisational type is set out in the table below. A full list of the organisations who responded is in Annex 4.

Type of respondent	**Number of responses received**
Voluntary and Community (3rd) sector (including Interest Group)[4]	107
Public / Statutory Body (including Trusts and ALBs)	26
Professional Body	20
Council	19
Pharmaceutical	12
Political (Group)	9
Political (Individual)	8
Staff Side Organisation	7
Independent / Commercial Sector	3
Professional Body and Staff Side Organisation	3
Academic	1
Grand Total	**215**

[4] Please note that when referring to the Voluntary and Community or 3rd sector, we recognise that this is wide and varied sector of organisations, ranging from interest groups that come together to represent people's views about an issue through to large organisations who operate social enterprises, providing services or advice on a not-for-profit basis. There are also 'umbrella' groups who seek to represent the views of a range of members or user groups. It is also recognised that some organisations will span a number of roles. For the purposes of this document we use the acronym V&C sector to refer to this heterogeneous group or bodies, organisations, and interest groups.

Health and Social Care Board

2.7.2 Standard letter formats

The majority of respondents opted to write letters, many of which were in a standard format relating to a particular issue. The main issues that attracted this form of response were

- Proposals around Causeway Hospital, for which there were three standard letters, which combined made up 1538 letters.
- The Irish Congress of Trade Unions produced a standard letter for use by their members who wished to use this format and 141 such responses were received.
- Two organisations which expressed views about Residential Care facilities also produced standard letters: 33 standard letters were received from Friends of the Roddens (with signatures from 401 people), and 29 standard letters were received from Friends of Lisgarel.
- The Oyster Peer Support Group also sent 3 responses using a standard letter format.

The total responses received in some form of standard letter style were 1744 across the various areas of interest listed above. Copies of these can be found in Annex 5.

2.7.3 Questionnaire responses

In total, 254 completed questionnaires were submitted, either online, via email or on hard copies sent in by post. This included responses from individuals, public sector organisations, voluntary and community sector groups, the commercial sector and professional bodies. As the questionnaires requested a certain amount of demographic information from respondents, where this was completed it has been possible to provide some limited breakdown on the respondents. It should be stressed that not all questionnaire responses provided demographic information, but what was submitted is summarised overleaf.

Type of respondent	Number of responses received
Individual	188
Community and Voluntary (3rd Sector Including Interest Groups)	35
Public / Statutory Body (including Trusts ALBs)	11
Pharmaceutical	6
Council	4
Independent / Commercial Sector	2
Political (Group)	2
Political (Individual)	1
Professional Body	4
Academic	1
Total	**254**

In the questionnaire we asked a number of demographic questions. These were not mandatory. Where respondents have provided this information it is shown below:

Are you…	Number of respondents
Under 65	118
Over 65	46
A Carer	40
Disabled	20
A Parent	37
Other	57

Please note the total does not add up to 254 as respondents had the option of ticking multiple boxes

Health and Social Care Board

Part 3. The need for change and the Transforming Your Care model of care

3.1 What Vision to Action said

The *Vision to Action* document sets out compelling reasons why we need to change. This is not a criticism of what we have now, but recognises that with the challenges ahead, the way we do things now is not going to work well in the future.

The key factors driving why we need to change are:

1. **A growing and ageing population:** In Northern Ireland we have one of the fastest growing populations within the UK. The Northern Ireland Statistics and Research Agency (NISRA) has projected the NI population to rise by 8% by 2025 and project that over the same 15 year period, the numbers of people aged 65 and over will increase by 42%. Compared to 2010, it is projected that the over 85 population will have doubled by 2027.

2. **Increased prevalence of long term (chronic) conditions:** There are increasing numbers of people with chronic conditions such as diabetes, respiratory problems, stroke and obesity. Also, individuals often have multiple conditions and sometimes our system could be better co-ordinated in how we deal with this.

3. **Increased demand and over reliance on hospital beds:** it is estimated that the demand for services could grow by 4% per year until 2015. If services continue to be delivered as they are currently this could mean 23,000 extra hospital admissions, 48,000 extra outpatient appointments, 8,000 extra nursing home weeks, and 40,000 extra 999 responses. Simply providing more beds will not address these challenges and will not lead to improving the quality of our services.

4. It is getting more and more difficult to **ensure clinical workforce supply** which can put pressure on service resilience. We have a dedicated and highly skilled workforce but we need to ensure we have a health and social care system that is fit for purpose for them to work in.

5. We need to have **better productivity and value for money**: the TYC Review and Report was not about saving money, it was about making best use of what we have. We can always be more efficient and get more for less by doing things differently.

The 12 key principles underpinning the approach in TYC are set out below:

1.	Placing the individual at the centre of any model by promoting a better outcome for the user, carer and their family.
2.	Using outcomes and quality evidence to shape services.
3.	Providing the right care in the right place at the right time.
4.	Population-based planning of services.
5.	A focus on prevention and tackling inequalities.
6.	Integrated care – working together.
7.	Promoting independence and personalisation of care.
8.	Safeguarding the most vulnerable.
9.	Ensuring sustainability of service provision.
10.	Realising value for money.
11.	Maximising the use of technology.
12.	Incentivising innovation at a local level.

Health and Social Care Board

3.2 What people told us?

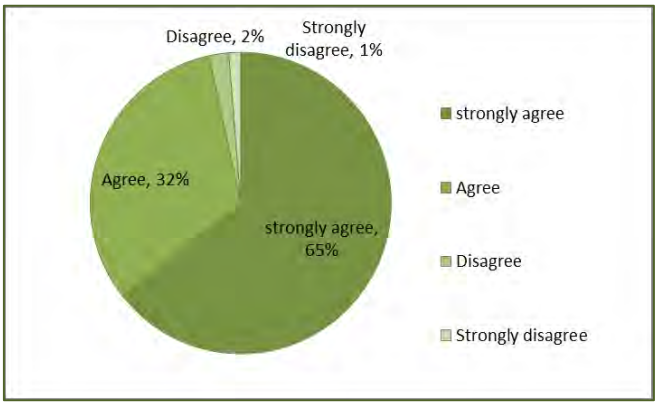
We asked five questions in this section of the consultation document:

Q1. Do you agree that our health and social care services need to change in order to meet the needs of the community and promote health and well-being through prevention and early intervention so that as much acute illness as possible is avoided?

Of the 254 questionnaire responses, 236 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that of those who expressed an opinion:

- ***97%** agreed or strongly agreed with the need for change*
- ***3%** disagreed or strongly disagreed*

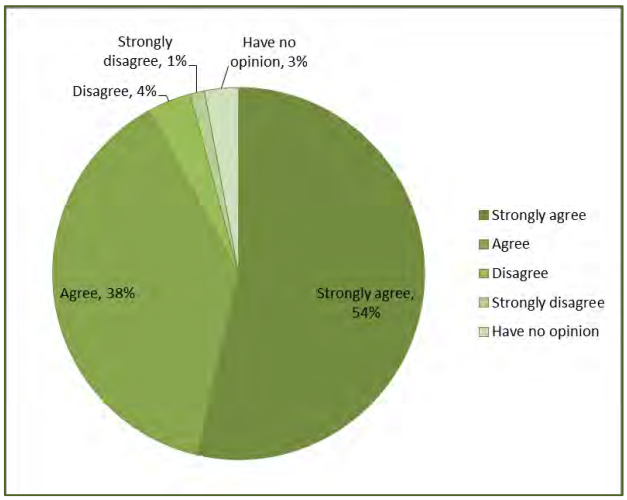


Q2. People should have control over how their assessed care and support needs should be met.

Of the 254 questionnaire responses, 237 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that of those who expressed an opinion:

- ***95%** agreed or strongly agreed that people should have control over how their assessed need should be met*
- ***5%** disagreed or strongly disagreed*

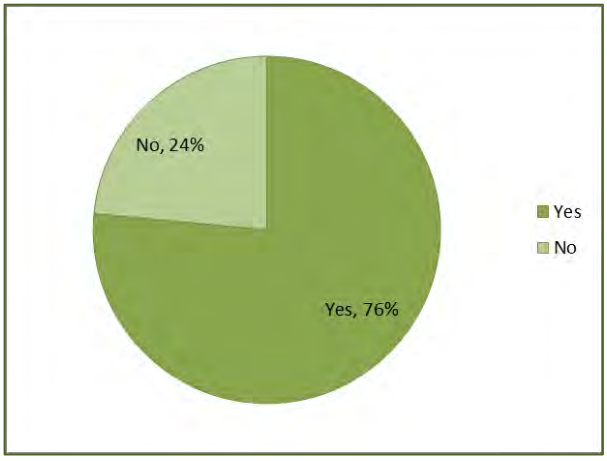


Q3. Do you feel that provision of individualised budgets and self-directed support should be more widely promoted?

Of the 254 questionnaire responses, 217 answered this question. The graph below sets out all the responses we received in percentage terms

The statistical analysis of the responses to this question show that:

- ***76%** thought that individualised budgets and self-directed support should be more widely promoted*
- ***24%** did not agree with this statement*

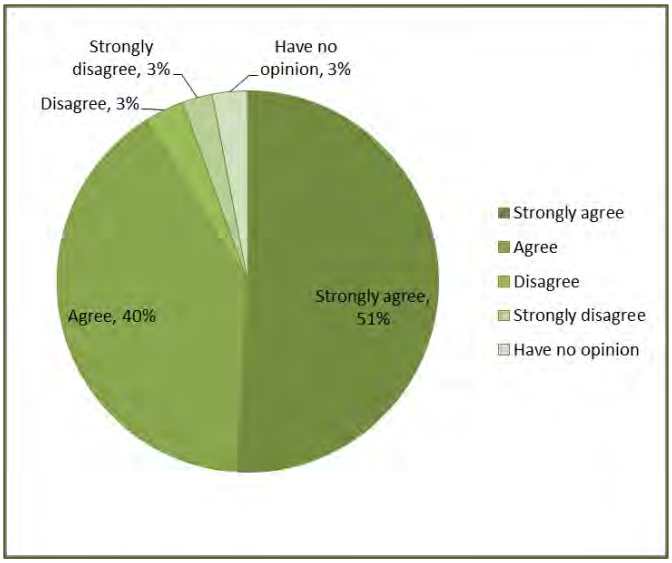


Q4. We should organise services to enable people to stay at home as long as possible or be cared for at home.

Of the 254 questionnaire responses, 234 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion:</u>

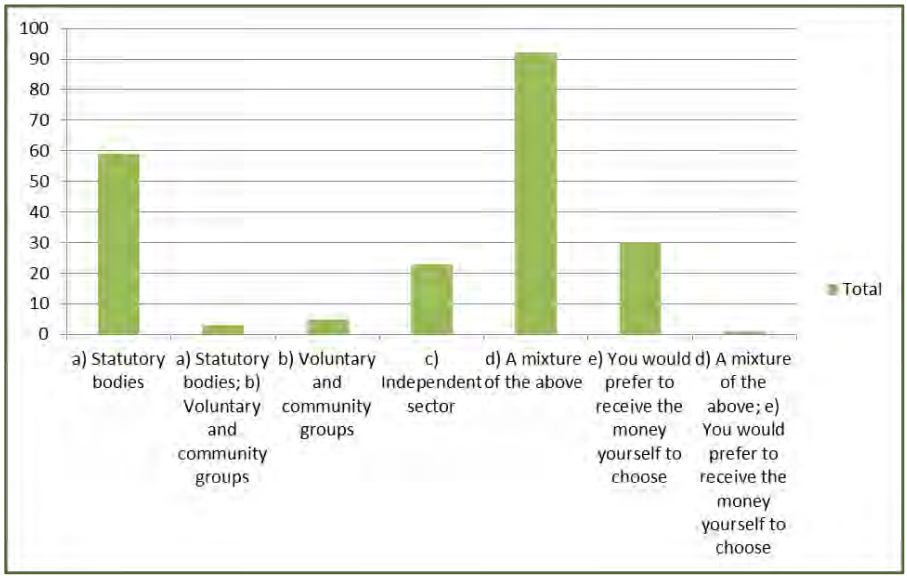
- ***93%** agreed or strongly agreed we should organise services to enable people to stay at home or be cared for at home*
- ***7%** disagreed or strongly disagreed*



Q5. Given the choice, who would you like to provide your care/support in your home?

1. *Statutory bodies*
2. *Voluntary and community groups*
3. *Independent sector*
4. *A mixture of the above*
5. *You would prefer to receive the money yourself to choose*

Of the 254 questionnaire responses, 213 answered this question as follows. Due to the range of responses to this question, this graph shows actual response figures, rather than percentages:



The statistical analysis of the responses to this question show that of those who answered this question (have no opinion was not an option for this question):

- The majority**, 92 respondents** felt they would like a mixture of providers. **59 respondents** felt they would like statutory bodies to provide their care/ support at home.
- **30 respondents** indicated that they would prefer to receive the money themselves to choose their own **care provider.**
- Smaller numbers of **respondents (23)** stated they would like their care to be provided by the independent sector.

In addition, a considerable number of respondents provided comments on this section of the document. These are summarised below.

The need for change

The responses from the questionnaire and the free-form comments show an overwhelming recognition of the need for change across our health and social care services in order to

- meet the needs of our community; and
- promote prevention and early intervention to avoid acute illness.

This underlines the view of the Review of Health and Social Care in Northern Ireland that “no change is not an option”.

It is noteworthy that of the respondents who answered this question on the questionnaire, everyone had a clear opinion on it, as none of the respondents chose the “do not have an opinion” option for this question. Similarly many of the free-form, non-questionnaire based responses also referred to the need for change. This was consistent across both responses from the general public and organisations.

Indeed, many of the responses mentioned the growing and ageing population and the current economic situation as key reasons why change is needed.

“The service was designed more than 60 years ago with a population that had a different age profile, life expectancy, much lower expectations of the service and vastly different access to communications and transport” – Individual Response

“We acknowledge that the current situation regarding the health service in Northern Ireland is untenable and believe there is a willingness within the medical profession to embrace the need to do things differently. Incremental changes to the existing models of care will not be sufficient in addressing the challenges which lie ahead. It is our view that a much bolder approach is needed” – British Medical Association

“The RCN endorses, in general terms, the commentary on the need for changes and the underlying vision, principles and objectives behind TYC” – Royal College of Nursing

It was also highlighted by a number of respondents that there is a need for increased productivity within health and social care and a need to demonstrate greater value for money.

There was a strong message that while there is support for change, that change must be properly managed, measured and resourced, and implemented with engagement from HSC staff and stakeholders:

"A compelling case for change has been made. The change process must empower and enable HSC staff to make definitive care decisions for patients and clients as soon as possible in the process of engaging with patients and clients." – Individual Response

Also, the importance of a parallel shift in resources in order to make change possible and sustainable was emphasised. This is discussed in more depth in Section 4.1 below.

There were a small number of respondents who disagreed with the need for change. Those respondents felt that the changes proposed under TYC were intended as cuts to health service funding and/ or indicated a move away from NHS core principles and a move towards privatisation of health care. Whilst acknowledging that some change is "inevitable", one Staff Side organisation disagreed with the assertion that TYC is about "making the best of what we have" and argue for greater investment in health and social care services. One political party commented that the financial framework of TYC is flawed due to their view it is advocating *"wholesale privatisation of services"* and will not address health inequalities. Other political parties did not share this view.

In commenting on the principles underpinning TYC, a small number of respondents suggested additional principles they would like to see included.

"We further recommend that an underpinning theme within TYC should be the promotion of age equality within health and social care."- Equality Commission for Northern Ireland.

Control over assessed care and support needs

The vast majority of respondents who used the questionnaire agreed or strongly agreed that people should have control over how their assessed care and support needs should be met. The qualitative comments and free-form responses concurred with this view. An illustrative comment was:

"Everyone is entitled to have a voice and only they know best what they need" – Individual Response

This key principle of TYC was highly supported by individuals and organisations alike, and respondents felt that this would help ensure that

people receive the care they need rather than just the care the system can currently offer. However, it was emphasised that not all patients will have the capacity or communication skills to effectively exercise choice over their care and there must be support in place and alternative arrangements for this patient group.

Support must be given to individuals and families to help them understand the choices available to them, as illustrated by the comment below:

"I feel people should have more of a choice when it comes to their care and have access to all necessary information to make informed choices." - Individual Response

There were a small number of responses which expressed concerns about the balance of choice and control and the need for professional input to patient decision making. In addition, it was also suggested by a very small number of respondents that this proposal could result in greater inequities in care across the province.

Individualised budgets and self-directed support

Again, many respondents agreed with this principle, saying that for some people it is appropriate that they have the choice. One respondent used a personal example to illustrate this:

"My mother has no say in where she goes for respite. She is forced into a home she doesn't like as opposed to the one she likes and goes to for day care. This in no way adheres to the principle of continuity of care or personal choice and dignity. The reason the Trust gives for this is budget." – Individual Response

It was suggested by some respondents that the availability of individualised budgets and self-directed support gives a strong signal that service users can become active participants in their own health and social care as opposed to passive participants in the process, and that this was a positive direction.

Some of the responses in this area implied that there could be a lack of understanding of the difference between individualised budgets, self-directed support and Direct Payments. Some of the comments made indicated that their past experience of Direct Payments would influence their views on this matter. We need to get better at explaining what these concepts would mean for people in practice.

Within this context, it was emphasised that before widely promoting the provision of individualised budgets and self-directed support there need to be structures in place to ensure end users can make informed decisions about complex choices, and that issues with bureaucracy experienced by some with Direct Payment are addressed.

Some of these views and comments are also illustrated within the sections on Older People, Mental Health, Learning Disability and Physical Disability and Sensory Impairment. Some general themes were:

- There was some caution expressed about the way in which individualised budgets will be implemented and it was highlighted that lessons must be learned from their implementation in England.
- A small number of respondents felt that this approach could be too difficult to manage for many people and could be open to abuse and mis-management.
- There were some suggestions that the promotion of self-directed support and individual budgets could introduce a two tier system of health and social care.

In addition, there were a small number of queries about the regulation of care providers under an individualised budget system and also about the alternatives for those who do not wish to take up the option of self-directed support and individualised budgets.

In taking forward the proposals on individualised budgets and self - directed support we believe there is need to have a strong focus on addressing the concerns and queries to ensure a safe and appropriate process. This will allow as many people as possible to benefit from this approach and will ensure that there is an equitable service in place for those who choose not to take up this option.

Enable people to stay at home as long as possible or be cared for at home

The quantitative response indicates overwhelming support for this key TYC principle. Individual and organisation qualitative comments back up this finding and also emphasised that in the application of this principle we must be mindful of what the individual feels will be best for them.

A strong message emerged that if this key principle is to be effectively applied community based services must be of a high quality and easily accessible. In this regard some concerns were raised about the current

quality of domiciliary care and it was emphasised that increased funding will be required to ensure quality care at home. In their submission, Age NI commented:

"Older people have been very clear in that they want to remain at home for as long as possible and to die at home. The provision of that "little bit of help" enables older people to remain at home for longer and potentially with a reduced package of care." – Age NI

The British Medical Association cautioned *"that care in the community is not cheap care"* and emphasised the need for highly trained staff to work in community settings.

The impact on families and carers must also be considered in the move towards more care at home:

"Please look after the carers without them this won't work" – Individual Response

The strength of feeling on carers was such that this has been drawn out as an overarching theme – see Part 4.

In enabling people to stay at home, it was recognised by respondents that there must be clear pathways to hospital care as and when required to support timely access to inpatient care when required.

Who would you like to provide your care/support in your home?

The analysis of responses to this question would seem to demonstrate support for a mixed economy of providers but there is a range of views.

"As the document states the challenge is to provide the right care at the right time in the right place, to achieve this we will need to shape health and social care services to promote the availability of a diverse range of high quality services for people. This will require a strong mixed economy of provision." – Individual Response

There was a strong feeling that decisions about who should provide services should be based on providers being able to supply an appropriately skilled workforce, who are fully regulated and well paid, valued and supported.

"As long as the care I receive is of a high standard and is client centred I believe anyone can deliver the care and support service if it meets my needs." – Individual Response

I really don't mind as long as I would be treated with dignity and respect and the person was 'trained for the job'. That might sound obvious but caring involves empathy, someone who can quickly identify changes in a person's condition and articulate concerns to the relevant person."
– Individual Response

This can be contrasted with the view of Staff Side organisations who felt very strongly that health and care services should remain within the statutory sector, and requested that this question be withdrawn. In response to this request, the HSCB replied that one of the principles underpinning TYC was greater diversity of service provision and giving people greater choice in how they access and receive services, we felt it was important to hear people's views on this so that we can make informed decisions about the way forward. We therefore declined to withdraw this question.

Queries and concerns were raised by a small number of respondents about the potential for variable standards of care if a mixed economy of providers was introduced. It was suggested that a mixture of provision may be hard to co-ordinate and may lead to many organisations duplicating services and working independently.

"NISCC would propose that failure to make the registration of the domiciliary care workforce mandatory is a risk to the success of implementing Transforming your Care" – Northern Ireland Social Care Council

The Regulation and Quality Improvement Authority (RQIA) underlined the importance of regulation saying:

"Regulation of the domiciliary care work force is imperative, if the aspiration of Transforming your Care to have the person's home as the hub of care is to be realised." - RQIA

The implications of further regulation in this regard would need further consideration.

Responses from the Voluntary and Community sector were very supportive of moves to introduce a more mixed economy of providers and highlighted the range of innovative health and social care services to which the sector can contribute. Thinking differently about the way we engage with the V&C sector in order to increase choice and diversity of service provision is also discussed in Part 4 of this report. Many of the comments in this regard also touched on the procurement and process of tendering, and this is discussed further in Part 6 of this report.

3.3 HSCB Response

The HSCB is pleased that there is an overwhelming recognition of the need for change and strong support for the principles which underpin TYC. In providing comments on these aspects of the Transforming Your Care and *Vision to Action* documents, respondents often provided further information on what they feel is important in how these principles translate into practice. These have been fed into the analysis of this report.

We believe this is a strong endorsement of the need to progress with the implementation of Transforming Your Care.

Health and Social Care Board

Part 4. Overarching themes that emerged during the Consultation Process

4.1 Introduction

Building on the analysis outlined in Part 3, which sets out the strong support for the need for change and the model proposed by Transforming Your Care (TYC) in terms of its vision and principles, a number of respondents (especially those who chose to respond in 'open' format rather than utilising the consultation questionnaire), focussed their commentary on the factors which in their view will be critical to achieving the outcomes to which TYC aspires. Some of these were in relation to the Programmes of Care, or specific proposals but many were more general in nature.

This section seeks to draw out some of these overarching themes as they are often consistent across Programmes of Care, to ensure that they are addressed on a more strategic and cross-cutting platform, rather than repeated in each Programme of Care, where some respondents commented that it was difficult to see the overall message or what was proposed in terms of service changes.

Whilst many of these were recognised in the original TYC report, and the *Vision to Action* document, it is clear that greater emphasis could be afforded to them in how changes are explained and implemented.

The five key overarching themes emerging from consultation responses are as follows:

1. The need to ensure that investment is focussed on making change happen, and therefore that alternatives are in place and working effectively before change occurs
2. A greater focus on how carers are supported as a key partner in care provision
3. Workforce as a key enabler to implementation
4. Importance of engaging with the Voluntary and Community sector
5. Need for greater cross governmental / agency working to address health inequalities and be more 'joined up'

4.2 Investment in services and ensuring alternatives in place

Respondents frequently stressed the need to ensure that new service models were adequately funded and established before any withdrawal of current services took place. This was expressed both in terms of the section which set out the need for change, and in relation to specific issues such as the shift of resources to primary care from secondary care and in relation to residential homes. Often groups and individuals sought greater levels of investment in health and social care overall and in specific Programmes of Care.

"More stimulation and activity required but don't shut down Day Care Centres and provide no alternatives - they do a tremendous job and provide great respite for carers." –Individual response.

"If care in the community is to be seen as a credible, viable alternative option to care in an acute hospital setting, this will require careful planning, investment, monitoring and review." - Banbridge District Council.

The standard letters which were focussed on the Causeway Hospital proposals also made reference to this point (1506 respondents):

"If the current system is dismantled before the proposed changes are in place, there will be an overall deterioration in health care." – Various Individual Responses

Those who commented on this wanted to be reassured that the necessary financial investment for new services, such as Health and Care Centres to support the proposed 'hub and spoke' model, would be made and cautioned that there needed to be a clear plan to release funds to follow activity transferring from hospital to community settings.

Others, notably from Staff Side organisations, asserted that TYC would represent a cut in funding for health and social care services.

HSCB Response

We refute the assertion that TYC is about cutting HSC services. It remains that the challenge facing our health and social care system includes rising demand exacerbated by a changing demographic and advances in treatments, and that our current model will become unaffordable in the medium to long term. Transforming Your Care does

not represent a cut in funding for services, but seeks to make decisions about how our model of care can be organised to make best use of the resources and funding available to meet this rising demand. However, it is a financial reality that increased investment will not always be readily available to meet the numerous calls for specific areas to be prioritised as received during this consultation.

Subject to the approval of the Minister to proceed, we reiterate the commitment to having a structured and sensible implementation of the TYC proposals as set out in *Vision to Action*. This includes ensuring that new or different services must, and will, be developed and working well before we step down other parts of the service. In support of this, we would develop measures to track the shift and re-investment of resources into primary and community care settings. The importance of Transitional Funding to enable this to happen has been underlined by the responses to this consultation, as this will enable alternatives to be in place, and support the health and social care system to make the changes in a managed way.

4.3 Carers

The issues that affect carers were highlighted more frequently than any other issue in the consultation responses, with the exception of local acute hospital comments. The general public, V&C sector groups and staff organisations all stressed the importance of being better at identifying carers, assessing their needs and putting resources in place to support them.

"The quality, planning and delivery of community care with carers at the core must be fully resources and supported." – Carers Trust

Respondents frequently referred to the planned shift of services from hospital to community settings, and stressed how this depended in some cases on the availability of carers, and how this could be a potential problem given changes in social structures in recent decades.

Promoting greater awareness of the role of carers, greater uptake of Carers' Assessments and a more robust response on the part of HSC to supporting carers was felt to be the core of a better approach to this issue. The provision of appropriate respite that is flexible to meet the different needs of different populations, was felt by most people to be a critical component of providing better support for carers. It was also

viewed as important that carers were engaged effectively when planning and delivering services.

"Carers need to be involved in any planning group that is working on respite/short break models" – Carers NI

HSCB Response

Whilst TYC and *Vision to Action* recognises the importance of carers, and there are specific proposals within some Programmes of Care, we are committed to further enhancing the plans we have drafted for the implementation of TYC as follows, subject to the Minister's approval to proceed:

- Review the draft Strategic Implementation Plan for TYC to ensure that supporting carers is given sufficient profile and priority in taking forward TYC. We will develop a specific overarching section or project to address carers' needs, recognising the challenges experienced in the past with developing a regional view of the approach to carers' needs and respite.
- Actively engage with carers in the design of new care pathways, where appropriate.
- Take every opportunity to promote Carers' Assessments and encourage service partners to do likewise. Ensure senior management review data on uptake rates for Carers' Assessments to track progress at promoting wider access to these.
- Ensure that the health and social care needs assessment process incorporates findings from Carers' Assessments where available so that there is a much better regional understanding of the range of services carers need most, including respite, that is then fed into the service redesign and commissioning processes.

4.4 Workforce as a key enabler to implementation

A significant number of responses mentioned the workforce as a key enabler to success, as recognised in both the original TYC report and *Vision to Action*. There were several strands to the responses in this area:

- the need for effective workforce planning to ensure sufficient skills are where they are needed;
- the need to ensure that appropriate investment in training and skills is in place to support the workforce impacted by changes;
- the need to make appropriate use of the current HSC workforce; and

- the need to understand the impact of any change in staffing numbers.

"On paper the proposals sound very positive and clearly the majority of people would prefer to be cared for in their home over a hospital setting. The success of this, however, will depend on adequate resources in terms of manpower, facilities, equipment, workforce expertise etc." - Action Cancer.

Some respondents referred to the proposed 'shift left' and the move of more care into community settings. Often their comments included a request to ensure that proper workforce planning took place so that the particular skills to provide more specialist clinical care in the community are in place for the time when they will be needed.

"These processes must be supported and underpinned by a coherent workforce strategy, incorporating a workforce development plan that ensures nurses are appropriately prepared to work in different practice settings" –The Royal College of Nursing

In addition, some respondents, particularly from Staff Side organisations, remarked that a lack of workforce planning had caused problems in the past. They felt that this was not an acceptable position and that every effort should be made to ensure that the skills available matched those that were required to provide safe levels of care.

A number of respondents, particularly professional bodies, sought to ensure that the skills of their members were put to appropriate use, whether that meant delivery of specialist care in the community, or participation in the design of care for delivery through ICPs. For example, the Pharmacy Forum highlighted the potential for Pharmacists to take on much more responsibility for care delivery such as vaccination services and minor ailments that would offer more access for patients than is currently available in primary care.

"There is a huge opportunity to make better use of the competencies and skills of pharmacists particularly when there will be a significant shift from provision of services in hospitals to provision of services closer to home; in the community and/or GP surgeries." – Pharmacy Forum

There were a small number of responses that made reference to the anticipated 3% reduction in HSC workforce over the next 3 to 5 years. Those who responded expressed concern that these would be service critical posts, the disappearance of which would put even greater strain

on those staff left behind. There was a perception on the part of some respondents, in particular Staff Side organisations, that the agenda was one of cost saving rather than any meaningful service redesign.

Comments on workforce were not restricted to those directly employed by the HSC, it was commented that skills and capacity must also be addressed in the V&C sector:

"It is important to note that the community and voluntary groups providing care and support would need to have the appropriate personnel with training/experience. The monitoring of quality and effectiveness would need to be managed well along with the improvement of coordination and communication between the different parties – individuals, statutory and voluntary and community." -North Belfast Partnership

HSCB Response

In response to the comments from respondents, we would reiterate the commitment made in TYC and in *Vision to Action* that one of the main reasons the way services are delivered needs to change is to ensure the best possible deployment of skills and staff and better networking between sites, to ensure support for the workforce in delivering services to patients and service users.

As with the original review, we did not receive any staff response which argued for the preservation of the existing model of service, and remain convinced that in order to enable this to happen we need to invest in workforce planning and development.

Therefore subject to the Minister's approval to proceed, we believe the following will be critical during implementation, having regard to the responses received during this consultation:

- Develop detailed planning and modelling around service models and workforce to map the impact of TYC, and ensure that the information is fed into short, medium and long term workforce planning.
- Continue to engage with Staff Side organisations through the establishment of a dedicated consultative forum to facilitate engagement with HSC Trade Union representatives about TYC.
- Continue to engage with professional groups to understand the training needs and implications for professional development as a result of TYC.

- Design how we set up HSCB TYC Programme projects and workstreams to ensure that workforce implications are considered as a core element of their action planning.

4.5 Importance of engaging with Voluntary and Community sector

A significant number of respondents mentioned the opportunities that could be gained from engaging with the Voluntary and Community sector in a different way. As one would expect this was expressed by a number of organisations and groups from this sector who responded but it was also mentioned by other individuals and groups.

In addition, a number of stakeholder meetings were held with members of this sector about TYC proposals in general, during which this overarching theme came across repeatedly. This included a cross-government discussion with leaders from the V&C sector, facilitated by the Northern Ireland Confederation for Health and Social Care (NICON).

Some respondents provided examples and evidence of where this has worked well in the past, and argued that a greater spread of innovation and consistent approach would be helpful.

"The use of voluntary and community organisations to support the work of the statutory bodies can ensure a full range of services can be available." - Action Cancer.

"..quality services can be provided to individuals through a mixed economy approach and AMH strongly advocates that the voluntary and community sector be given the opportunity to play a key role in the delivery of TYC." - Action Mental Health.

Against the backdrop of TYC proposals in relation to personalisation of care, and promoting diversity of service provision, there were a number of strands or emerging themes from the comments on this area:

- V&C sector often have a unique contribution to make in terms of innovative ideas for service delivery.
- Whilst they perform an important role as service providers in many cases, they also perform a critical role in terms of advocacy, engagement and community cohesion – all of which will be important for successfully transforming health and social care services.

"Having strong advocacy and lobbying groups within communities enables us to hear the needs of our communities and tailor services to meet these needs."- Community Development and Health Network

- The current procurement rules and practices can, at times, be restrictive to close collaborative working when it comes to service design; equally it is recognised that procurement rules and practices provide necessary protection and good practice.

"In order to retain the unique characteristics of the third sector and achieve greater involvement of the third sector in health and social care, government should undertake a review of its procurement practice which involves the third sector." – CO3

- The capacity of some V&C organisations to engage with tendering and stakeholder engagement processes (for example as part of ICPs) may be limited, and they recognise that how they organise themselves as a sector to respond will be critical.
- Understanding and building the capacity and capability of the Voluntary and Community sector will be important if more services are to be delivered in community care settings.
- The quality and safety of all services, regardless of who provides them need to be paramount.

HSCB Response

Subject to Minister's approval to proceed, and in response to the comments from respondents, and as part of the finalisation of the implementation plans to take forward the proposals set out in this document, we propose to address this overarching theme as follows:

- Undertake a specific piece of work to look at procurement of services from the voluntary and community sector across health and social care services, and anticipated needs in future.
- Continue to engage with key V&C umbrella groups, such as NICVA and CO3 to understand how TYC can support capability and capacity building in this sector.

In addition, the DHSSPS will be taking forward work on an inter-departmental basis on involvement of Voluntary and Community groups.

Health and Social Care Board

4.6 Inter-governmental /cross-agency working, and tackling inequalities

A number of respondents, most commonly those from local government bodies but also Voluntary and Community organisations and individuals, expressed concern that more could be done to ensure closer working with local government or other bodies such as transport services or the housing sector, to improve service access and delivery, and tackle health inequalities. This seemed especially at the fore for those from rural areas, and was mentioned at a number of public meetings.

TYC does not address the "importance of income, environment, employment and housing as key determinants of an individual's health and well-being." - COSTA

Staff Side organisations also raised their concern about inequalities in Northern Ireland and asked for effective inter-governmental and cross-agency working to ensure that each played its role effectively. Local councils stressed their willingness to work alongside HSC, making reference to their new remit for community planning. With their control of facilities such as leisure, environmental health and similar services, they felt that they had a critical role to play in improving the health of their populations.

"Belfast City Council view the integration and sharing of assets (current and future) across the public, community and voluntary and private sectors as critical to meeting local health needs and gaining potential efficiencies for the public purse. It is essential for local government to be directly involved at both a strategic and local level to ensure the desired synergies and efficiencies are achieved". - Belfast City Council

Recognition of "the need for effective cross-departmental working to ensure that the roads infrastructure is there to help ensure effective transport for patients/clients." - Antrim Borough Council

Whilst many of the comments were made at a strategic level, others related to specific Programmes of Care, such as Family and Child Care (including the importance of close working with the education sector), access to Acute Hospital Services (in particular the impact of public transport and road networks), and supporting people to live independently at home (in particular Housing Strategy and Reform). One consistent theme from many of these comments was a desire to see greater levels of joined up thinking across government agencies.

Welfare Reform

Particular reference was made to Welfare Reform by a number of respondents. This related to the need to understand the implications of the Government's Welfare Reform proposals as these will have an impact on the lives of some groups of service users, and therefore could impact on what they need from health and social care services. Some respondents who mentioned this expressed disappointment that the TYC proposals didn't make explicit commitment about how it would link with the Welfare Reform programme and felt this was a weakness in the document.

"LTCANI have concerns regarding the impending impact of welfare reform for many people living with long term conditions and their carers." – Long Term Conditions Alliance NI

HSCB Response

The need for inter-governmental working was recognised in the original TYC Report, with two proposals focussing on the wider role of the NI Executive in decision making which can impact on health outcomes, and joint working projects in areas such as rural isolation and transport. It is appropriate that these matters are policy-led, requiring joined up working at the highest levels.

In terms of the *Vision to Action* proposals and the HSCB implementation of those aspects of TYC for which it has responsibility (subject to Minister's approval to proceed), we believe there will be a need for:

- On-going engagement with the Department for Social Development and other agencies to understand and share plans for Welfare Reform and Housing; and
- Close working with local service providers to continue to engage with local councils during the rollout of local implementation plans.

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Part 5. Consultation Responses to the Proposals in TYC: Vision to Action

5.1 Population Health and Wellbeing

5.1.1 What TYC: Vision to Action said

The *Vision to Action* document outlined that there was an overwhelming need to focus on the health and wellbeing of the population and highlighted why strategic and bold action is required.

An increase in obesity and smoking related illnesses, misuse of alcohol and drugs, and the large number of deaths to preventable illnesses each year were the key driving factors for increasing the investment in health and wellbeing. Throughout the document reference is made to the fact that greater investment in preventative care is highly cost effective in the long run.

Across the Programmes of Care outlined in *Vision to Action* examples were given of proposed or existing prevention and early intervention programmes for example *Family Nurse Partnership Programmes* and a number of other strategies were mentioned as these provide the policy framework and direction for work in this area, including *"Fit and Well- Changing lives - a Ten Year Public Health Strategic Framework for Northern Ireland"* and *"Healthy Child- Healthy Future".*

However there was a recognition that more needs to be done to improve the health and wellbeing of the population especially for those most vulnerable in the system and that we need to make better use of the resources we have.

5.1.2 What people told us

An overwhelming support for a greater focus on prevention and early intervention was evident in the responses received. Many respondents agreed it is crucial that Transforming Your Care (TYC) takes account of and supports investment in and implementation of "Fit and Well", the public health strategic framework which has recently undergone public consultation. Some commented that TYC could have made a more explicit commitment to addressing health inequalities through its implementation plans.

As *"Fit and Well"* was out for consultation at the same time, no specific questions were asked about population health and wellbeing within TYC, and therefore there is no quantitative data.

A number of themes emerged from the comments on this section:

- The HSC can only make a difference through collaborative community development based approaches working with the whole range of stakeholders, including the Voluntary and Community sector and local councils. It was emphasised that a greater investment in this area of care would be of benefit.
- It was recognised that there are many social determinants of health and many of the comments were in the context of seeking significantly more 'joined up thinking' in the design and implementation of public services and health and social care services to address health inequalities.

"If we take action on the social determinants of health we can change patterns of disease while simultaneously reducing health inequalities" - Community Development and Health Network

- Health improvement services need to be more patient centred and easily accessible out of hours and based in local communities.
- It was suggested that there is a need to focus on measuring the outcomes of health improvement initiatives rather than solely meeting targets.
- There was strong support for ensuring all healthcare professionals have access to training in health improvement interventions and expanding roles so that all professional groups can contribute to health and wellbeing. For example, Community Pharmacy NI commented:

"Through community pharmacies key interventions could be delivered to 10% of the Northern Ireland Population every day"- Community Pharmacy NI

- A small number of responses advocated for legislation of the food, drinks and tobacco industries in order to really make an impact on health and wellbeing. There was a strong call for Transforming Your Care to take greater regard of the impact of Welfare Reform and Housing Reform in promoting health and wellbeing.
- A number of respondents emphasised the need to ensure that proposals related to health and wellbeing take account of the rural profile of Northern Ireland and do not disadvantage those populations in rural areas.

- The importance of early intervention and education through schools was emphasised as most health behaviours are established at an early age.

"The Public Health Agency needs to build on key messages that have come from young people. This includes focus on health education in schools and further and higher education establishments in conjunction with the relevant Departments and education providers. Health promotion should also include a range of agencies and not just those directly involved in health and social care provision" - Young People's Priorities in Health and Social Care (Patient Client Council 2012: 34)

- Many local councils highlighted their role in providing health and wellbeing services and called for greater collaboration with councils and with communities through community planning approaches in addressing health inequalities.

5.1.3 HSCB Response

The consultation on *"Fit and Well-Changing lives - a Ten Year Public Health Strategic Framework for Northern Ireland"* has recently been completed and is due to report soon, and we will support the implementation of this through alignment in our plans and as we move forward with any service changes following this consultation and Ministerial decision.

The need for a strong focus on the prevention of ill health, and promotion of health and wellbeing is one which is recognised by the original TYC report and this is a principle which underpins many of the proposals set out in *Vision to Action* and the draft plans for service changes over the next 3 to 5 years. We agree that this is vital in reducing health inequalities for the citizens of Northern Ireland.

It is also recognised that there are wider social determinants of health inequalities, and health and social care needs to play its part in addressing these, together with other government agencies. In particular the impact of Welfare Reform and housing reform has been raised in this regard and we will seek to engage with the Social Security Agency and Department for Social Development.

5.2 Delivering services at home and in the community – Integrated Care Partnerships

5.2.1 TYC: Vision to Action Key Proposals

1. There would be initially 17 Integrated Care Partnerships (ICPs) across NI, including all GP surgeries and therefore providing services for all of the population.
2. It is anticipated that much of the **initial focus** of ICPs would be on improving some key aspects of the way services are organised for frail older people, and of services for people with specific long term conditions such as Chronic Obstructive Pulmonary Disease and diabetes. Building on this experience there would be scope for ICPs to evolve and develop into other areas in future. An objective would be to reduce measurably hospital admissions.
3. ICPs would proactively develop and put in place strategies to **identify patients at most risk** of having to go into hospital unexpectedly and put in place plans and actions to prevent this, drawing on the whole range of health and social care disciplines.
4. ICPs would include **strong collaboration** with independent health care providers, and the voluntary and community sectors.
5. **Patient and client representatives** would have a role to play in the oversight of the ICP.
6. ICPs should be clinically led and be based on **multi-disciplinary working**. It is envisaged that GPs would have a key leadership role to play: however, clinical leadership should not be seen as exclusive to General Practitioners and opportunities for leadership development will be inclusive and available to other health and social care professionals. ICPs would be **judged and measured** by how well they improve patient experience and outcomes.

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5.2.2 What people told us

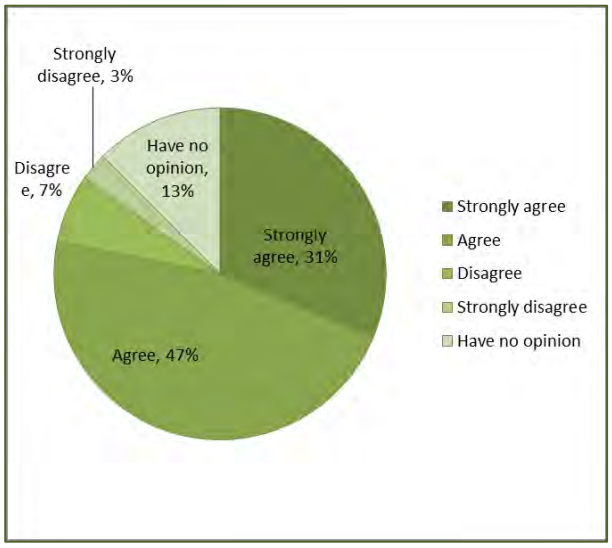
We asked:

Do you agree that Integrated Care Partnerships could make a positive contribution to the delivery of care closer to home rather than in hospitals? If your response is 'disagree' or 'strongly disagree', do you think there are any alternative ways to deliver care closer to home?

Of the 254 questionnaire responses, 224 answered this question. The graph below sets out all the responses we received in percentage terms

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion</u>:

- ***89%** agreed or strongly agreed that Integrated Care Partnerships could make a positive contribution to the delivery of care closer to home rather than in hospitals*
- ***11%** disagreed or strongly disagreed*



In addition, a number of themes can be drawn out from the comments we received about these proposals:

The *Vision to Action* document set out several key areas for ICPs, and some respondents mentioned those specifically. Other respondents made more general remarks or raised issues that were not specifically mentioned in the consultation document.

Clinical and Patient group responses

The Royal College of General Practitioners (RCGP) were broadly supportive of the proposals around ICPs and stressed the importance of ensuring appropriate funding to support the work of these groups. They mentioned their Patients in Partnership Initiative and recommended this model of engagement. The British Medical Association (BMA) was also strongly supportive of the concept, and in addition held the view that GP Out of Hours services should sit within ICPs. In meetings held with

senior medical staff in the hospital sector in Northern Ireland, there was clear support for the proposals around ICPs with attendees expressing a willingness to work collaboratively to develop and deliver care pathways for the targeted patient groups. Some observed that there was a much greater role for primary and community care services in helping patients leave hospital in a more timely fashion and thereby alleviate pressures on the acute system.

"People wanted to see services organised so there was a sense of continuity of relationship with health and social care services; whether in primary, community or hospital care." The Peoples Priorities for Transforming Your Care 2012 (Patient Client Council).

Some Pharmaceutical bodies (and also Voluntary and Community sector representatives) were keen to work in partnership with ICPs to progress initiatives targeted at the frail elderly and those with long term conditions.

One professional group, the Royal College of Psychiatrists, were less supportive of ICPs, although they strongly endorsed the principle of integrated working across primary, secondary and community care settings, they felt that ICPs had the potential for increased bureaucracy.

The Royal College of Nursing (RCN) expressed concern about the leadership of ICPs and felt that leadership roles should be available to those with the requisite leadership skills rather than being dominated by GPs.

The RCN also highlighted the need for clarity around how the ICP model will fit with existing local commissioning arrangements and, in particular, with the work of the Local Commissioning Groups.

Many respondents felt that whilst the concept of ICPs appeared reasonable, they were unable to give their complete endorsement to the proposals because there was not yet sufficient detail on how the partnerships would work in practice.

Initial focus on frail elderly and those with long term conditions

The majority of respondents who expressed an opinion were supportive of the planned focus of ICPs on frail older people and those with long term conditions. The British Geriatrics Society said the proposals for ICPs were *"a very promising development, and we welcome the focus on frail, older people." - The British Geriatrics Society*

Health and Social Care Board

Focus on patients at risk of emergency admission

Some respondents specifically mentioned the importance of identifying patients at risk and encouraged much closer working between hospital and community teams, including social care professionals to help avoid emergencies.

Collaboration with independent healthcare providers and V&C sector

V&C sector representatives were keen to build strong collaborative working relationships with ICPs. Some respondents, most notably those from Staff Side organisations were critical of the language used in the Consultation document which referred to 'strong collaboration with independent health care providers', arguing that this appeared to open the door to privatisation of HSC services.

Macmillan Cancer Support did suggest that some V&C sector bodies would not have the capacity to engage with 17 separate ICPs. This was echoed at the meeting held with the Long Term Conditions Alliance.

Pharmacy and V&C sector representatives highlighted their unique position to support patients, particularly those with long term conditions, but also the frail elderly where they face social isolation and transport issues. Pharmacy providers commented that they routinely pick up and deliver prescriptions for patients who are unable to do so themselves.

Patient and Client representatives and multi-disciplinary working

Many respondents who expressed an opinion were supportive of the concept of ICPs being multi-disciplinary groups that were clinically led. Some non-medical clinical bodies recognised the need for multi-disciplinary work and questioned the role of GPs. For example, the Royal College of Nursing asked that it be made clear that GPs were not the only profession that could fulfil a leadership role in ICPs. Similarly the NI Association of Social Workers questioned the assumption that the new model would be led by a medic. This is already recognised in the proposals in the *Vision to Action* document which says that "opportunities for leadership development will be inclusive and available to other health and social care professionals."

Other respondents, such as those representing Allied Health Professionals were keen to stress that they had much to contribute to the goals of the proposed partnerships to better support the frail elderly

and those with long term conditions, and highlighted their willingness to do so.

The College of Occupational Therapists stressed the vital role of Occupational Therapy in promoting independent living and asked that ICPs ensured that their profession was able to play a full and active part in their work to target support at the frail elderly and those with long term conditions.

Some organisations, such as Carers NI and the Patient Client Council, emphasised the need for a specific place for service users and carers within the membership of ICPs. In particular it has been suggested that over time service users and carers would take a leadership role in the ICPs.

Other remarks

A number of those who expressed an opinion wished to see greater clarity on the governance arrangements and accountability frameworks that would exist for ICPs, as well as clarity on their role, often remarking that this would be critical in helping them to understand the contribution they will make to delivering care closer to home and better outcomes. In a minority of cases, there appeared to be some confusion over whether the ICPs would be providers or commissioners of services.

Health and Care Centres

Respondents generally wished to see more services provided in the community for the targeted user groups and urged that the infrastructure to support delivery of care in the community was properly developed and resourced. Professional bodies were generally supportive of the proposals to provide more care in the community, with appropriate safeguards to ensure high standards of care.

There were expressions of support for some proposed sites for these facilities. There were occasional expressions of concern that the capital to build new facilities such as health and care centres would need to be protected to ensure that these were built in good time.

Access to Primary Care

Many responses recorded dissatisfaction with the level of access to GP services both in normal hours and out of hours, and looked to ICPs to address this. Some respondents felt that ICPs could add to the

workload of GPs and therefore further undermine access to and delivery of services, and that backfill to protect services was important; others were sceptical about GP willingness to engage with the proposals.

The multiple letters received in regard to services in the Causeway area also made reference to the view that "*GPs are already overworked*".

Workforce development

A number of respondents, particularly those from professional bodies, remarked on the need to ensure the development of the workforce to support the provision of more services in the community. The need to provide training and support, but also to undertake sufficient advance workforce planning would be very important to ensure that appropriate levels of skills to provide effective community-based care were in place to support a 'shift left'.

In their response, the British Medical Association (BMA) reflected that there could be an impact on the training of junior doctors by moving services from a hospital to a community setting.

5.2.3 HSCB Response

We have heard strongly that further clarity and understanding of the practicalities involved in the establishment and operation of ICPs is required. That there is support for the proposals and agreement that they will be critical in delivering services closer to home and in the community, which is one of the key objectives set out in the original TYC report.

Subject to approval to proceed by the Minister, in taking forward the proposals, the HSCB will use the detailed comments and responses to inform the plans, and in doing so we will be particularly mindful of:

- The need to clarify areas such as the role of ICPs, their role as a provider, their funding and governance arrangements.
- Provide detail about the establishment of ICPs, the management support they will have and how clinical/social care time will be backfilled to protect service provision.
- How a range of organisations and groups can be better supported to maximise engagement and involvement in the ICP.
- Importance of engaging with stakeholders to understand the skills and resources needed to deliver more community-based services

5.3 Older Peoples' Services

5.3.1 TYC: Vision to Action Key Proposals

1. **Integrated Care Partnerships** would focus on how care is provided to frail older people, particularly by the GP, community nurse and care manager, with much closer working one with the other.
2. A **Falls Prevention Programme** to raise awareness of risk factors and identify those at risk of falls and fractures with the objective of reducing those needing hospital services.
3. Improvements in access times to **cataract surgery and audiology services** to support living at home.
4. **Reablement programmes** in order to promote rehabilitation and independence rather than unnecessary or premature reliance on services, often after an unexpected incident or illness. The HSCB is working closely with HSC Trusts and voluntary and community sector partners to promote and rollout this new service model. As a result evidence suggests it is possible to reduce the number of newly referred older people who need long term domiciliary care service by up to 45%.
5. Promote the **wider use of technology** in the form of telehealth and telecare for remote health monitoring and support with activities of daily living. Providing individuals and families with security and communication options to support people in their own homes. This will help to identify potential problems or the deterioration of a condition much more effectively and allow action to be taken sooner.
6. Further develop and review **intermediate care provision** (including sub-acute and non-acute hospitals), for example when support with rehabilitation is required after an operation or illness. There is a range of such facilities in Northern Ireland. As the new care model develops and alternatives are in place, some of these will expand whilst others will close. It will be for local commissioners to determine the specific changes in individual units to ensure that remaining sites are large enough to provide safe, high-quality care and maintain a safe and efficient level of staffing. Some services will be provided by the statutory sector with some by the independent sector.
7. Increase the opportunity for people to have **self-directed support and individual budgets**; this means that individuals or their carers would be able to have more choice and control about the services they receive.

Health and Social Care Board

8. The role played by **carers** is central to supporting the care and wellbeing of older people in the community; consequently, there will be a commitment to improve the quality of life and support for carers through **increased provision of respite and short breaks.**
9. **Implementation of the *NI Dementia Strategy***, using in particular the Integrated Care Partnerships to support this process.
10. Enabling individuals to live at home requires a **mixed economy** of service providers to include community and voluntary, private and statutory sectors. Services would be procured to deliver this outcome. This signals a larger role for both the voluntary and private sectors in future. Looking towards this, we will undertake a review to accurately cost such services to ensure value for money and high quality services.
11. Due to improved availability of community-based alternatives, it is expected that demand for our statutory residential homes will further decline. We are proposing therefore **to close at least 50% of our current statutory residential homes over the next 3 to 5 years.** As part of the transitional process towards this, we will consider whether to restrict future admissions in some instances.

5.3.2 What people told us

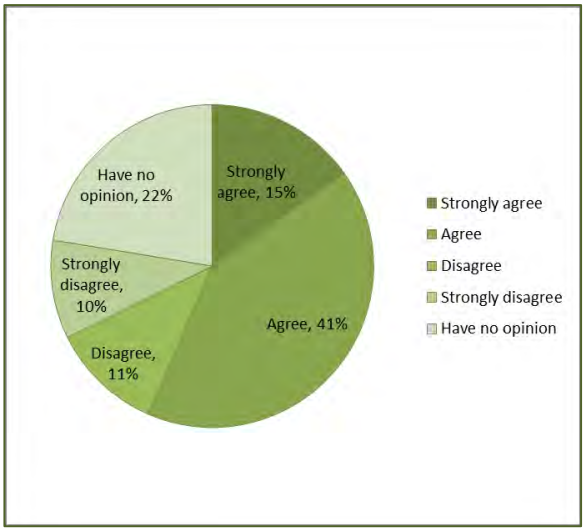
We asked:

Do you agree with the proposals set out in respect of older people's services? Do you believe there are better alternatives?

Of the 254 questionnaire responses, 223 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion:</u>

- ***73%** agreed or strongly agreed with the proposals*
- ***27%** disagreed or strongly disagreed*



In addition, a number of themes can be drawn out from the comments we received about these proposals:

The majority of individuals and groups gave their endorsement to the proposals for older people and welcomed the aspiration to provide care for older people closer to home where possible and appropriate. Respondents did stress there must be choice in the models of care available because people's needs are different. For some older people, care closer to home may not be suitable to meet their needs, considering their health and social circumstances.

"We support the proposals for older people's services underpinned by the concept of home as the hub of care. We support the increased emphasis on promoting independence through the provision of services at or close to home and more support for carers. A great deal of our work is with older people at home and they have confirmed for us their desire to stay at home for as long as possible and to have services fitted around their needs." – Extra Care

Respondents often highlighted the critical role played by carers in supporting older people, and asked that this be borne in mind when designing more community-based models of care. They commented that it will be essential to invest in services such as flexible respite, rapid access to health and social care support and domiciliary packages if we are to help more older people to live independently.

"I agree that older people should be supported in their own home for as long as possible, receiving the care they need and have family around them. However, services in this area must be improved for this service to be successful" – Individual Response

Integrated Care Partnerships

As referenced in the section detailing the responses to ICP proposals, there was broad support for a strong focus on the needs of frail elderly people. There was scepticism among some groups who felt that ICPs will not achieve what they set out to, based on personal experience of services in the past.

Falls prevention, cataract surgery and audiology

Few respondents mentioned these specifically but there were some expressions of support for a focus on improved falls prevention services.

Health and Social Care Board

There were no responses that disagreed with these as suitable areas for attention.

Local Government organisations referred to their remit for community planning and in particular their provision of leisure and recreation services. They expressed a keen interest in working in partnership with health and social care services to tailor services for older people to improve mobility, reduce the risk of falls, and offer more opportunities for social interaction.

Reablement / Care at home

A number of responses referred to the proposals around Reablement. Furthermore, the vast majority of those who responded with comments relating to Older People's services remarked on the importance of supporting people to live as independently as possible as long as it is their choice and where it is safe for them to do so. Reablement was not always cited specifically but frequent reference was made to domiciliary support.

Yes- my mother is 94+ and after repair of her broken femur is at home- much more preferable." – Individual Response

A small number of respondents remarked that further evidence is required for the Reablement model.

A significant number of responses highlighted concerns about domiciliary care provision, whether the level of it or the nature of what was provided. Some respondents felt that packages of care were often inflexible and tailored more to providing what was available , rather than meeting the needs of the client. There were some remarks about the short duration of domiciliary care worker visits and how a fifteen minute call was often not sufficient.

In addition, a small number of respondents felt that the Reablement model was important in developing a different way of working with the V&C sector. One respondent commented:

"The reablement proposal is another example for the potential of HSC to stimulate economic growth in the social economy sector while at the same time providing effective care to older people in their homes and community." – Western Investing for Health partnership

Technology

There were few references to technology with regard to older people but of those who did mention it, respondents expressed conditional support for the use of technology to support older people to live more independently, as long as it was remembered that it would not be suitable for all. Some respondents remarked that not all older people would be comfortable using it and therefore would not respond well to it. Some respondents stressed the need to ensure that older people did not end up more isolated socially as a result of the application of technology.

"Older frail people need human contact and interaction as much as a sound building and technology." – Individual Response

Intermediate Care

There were few references to Intermediate care in the responses received to the proposals for older people other than to note its important role in delivering services.

Self-directed support, individual budgets and enabling a 'mixed economy' of providers

There was some qualified support for increasing the opportunity for self-directed support and individual budgets for older people with respondents stressing the need to remember that such initiatives will not suit all situations, whether because of capacity issues or concerns some older people or their carers may have about taking on the role of employer. This indicates that perceptions or past experience with Direct Payments will influence views in this area.

Respondents stressed that there will be a clear need to protect vulnerable people from abuse.

There were very few specific references to the proposal of promoting a mixed economy approach to care provision for older people particularly. V&C sector representatives expressed a keen interest in continuing to provide services for older people and professional groups were complimentary of the input provided by such groups. As mentioned elsewhere, some respondents expressed opposition to increasing private sector provision of services, although their opposition tended to be specific to organisations who would do so for profit.

"We agree with the use of the mixed economy of care, but again the best value/quality ratio must be the driving force here. No group whether statutory, voluntary or independent has a 'right' to deliver care. Commissioners must ensure that the best value/quality teams are used. The evidence for telemedicine and telecare remains scant and large investment in this sort of technology should be avoided until the evidential base for their use is fully developed with this patient group." - North Down Primary Care Partnership

"In the 'shift left' of services towards care in the home or community for the elderly or those with multiple chronicity or specialist needs, a more sophisticated mixed economy of care will be required." - NI Rare Disease Partnership

At some public meetings, representatives of the V&C sector asserted that as alternative providers, not part of the statutory sector, they were working to the same standards of care as statutory providers and that profit was not their motivation.

Carers

The significant proportion of respondents who made comments on the proposals for Older Peoples' services specifically mentioned and strongly supported the need to understand the needs of carers, and to adequately respond to them. This was felt to be so important by so many respondents that this area has been reported separately as an overarching theme in that section of this report.

Implementation of the NI Dementia Strategy

Of respondents who mentioned this subject, all were supportive of the intention to support this strategy. Some expressed disappointment that no funds had previously been made available for it, and their hope that TYC would remedy this.

Closure of 50% of current statutory residential facilities

This proposal generated much discussion and comment from respondents both at public meetings and via written responses. Whilst some respondents recognised that remaining independent at home is often preferable, or that good alternatives exist (including non-statutory residential care or supported living accommodation), they were also keen to maximise choice. The majority of comments from those who

disagreed with the proposals for older people were related to Statutory Residential Homes.

Some respondents on this proposal were anxious that if some statutory residential facilities closed, there would be a gap in provision of service for people for whom support was currently provided in such settings. It was clear that the public wished to have detail on what alternative support services would exist in each locality to address the needs that are currently being met by statutory residential care, and to be reassured that these would be as good if not better than the current arrangements.

"There is concern over closure of some residential homes but an understanding that places of care could be run differently with more innovativeness. The need to acknowledge the specific social needs of older people and their family unit." - South Belfast Partnership Board

"If residential homes are closed, they should be closed because they are no longer needed as alternatives are in place, rather than by a Trust making a decision without that adequate community support." - Dr Brian Dunn, GP, NI Conservatives Health Spokesman

Also some asked for consideration of issues of social isolation and the role that statutory residential homes currently play in providing social interaction for people by virtue of sharing accommodation. Respondents wanted to be reassured that this issue would be given priority status in any planning to reduce residential provision so that people who received an alternative form of care to statutory residential care in future would still have the opportunity to spend time with other people.

Some concerns were noted around the process of moving current residents to different settings if their current home closed, and how this process would be managed to minimise distress to residents and families. Reminders were provided that for residents, this is their home.

"Many older people cannot manage at home but do not require intensive nursing support therefore there is a need for Residential care until Trusts or housing associations can provide supported living alternatives." – Individual Response.

Some attendees at public meetings referred to previous home closures and wanted to be assured that any changes would be carried out in a way that was sensitive to the needs and wishes of residents and carers.

"Important to manage the re-provision of Rathmoyle Residential Home in a manner that meets the needs of and enjoys the confidence of the service users, carers and the wider community."- SDLP, Moyle District Council

The Commissioner for Older People asked that a framework be put in place to ensure a sensitive and pragmatic approach to any changes. Age NI, whilst not opposed to the proposals, did ask that any changes are done in consultation with older people and carers and that any funding released goes into community and primary care services, and also proposed an agreed framework is put in place for doing so.

Some V&C responses also cited the need to carefully consider relocation of residents, as moves can be difficult for older people, particularly those with memory impairment. The Alzheimer's Society stressed, that any reduction in the numbers of care homes must be contingent on a significant investment in the quality and availability of home care.

A small number of responses expressed concern about the impact on staff currently working in statutory residential facilities that could face closure. Staff Side organisations stated their opposition to the proposals to close statutory facilities, asserting their perception that the proposals were a privatisation and cost-cutting exercise.

They raised concerns that staff in these settings would suffer a detriment to their terms and conditions of employment if they worked in the independent sector and that staff are anxious about the impact of the proposals to close some residential facilities.

Some respondents questioned why it was only the statutory sector that was to be reduced and no mention was made of similar reductions in the independent sector. This highlights the need to clarify exactly what is intended in the proposals – that it relates only to statutory residential facilities for older people, not EMI (Elderly Mentally Infirm) facilities, or those for people with Mental Health or Learning Disability-specific placements. It would also be helpful to clarify that some of the current facilities may continue to provide respite care.

Reference to current examples of innovative new developments, such as Cedar Court in Kilkeel were made and it was suggested that it may help to provide examples of what is now possible, and thereby reassure the public that a different model of care to the traditional statutory residential care service can work very well for some people.

We received some letters from a small number of support organisations for residential facilities such as Friends of Lisgarel, Friends of the Roddens and the Portballintrae Residents Association which stressed that there would always be people for whom independent living was not an option, and there was no alternative to residential care. It was said that it would be important for the HSC to demonstrate that for people who really need residential care support, this will still be available, albeit this may be in a different facility in some instances. It is also important to reflect the fact that the needs of older people change as they get older, and that some of the people currently in residential care would eventually have had to move to an alternative setting because the time would come when they would need more intensive nursing care.

Other remarks

"Older people are not a heterogeneous group" - AGE North Down and Ards, stressing that the needs of the older population need to be properly identified and understood.

Some respondents mentioned issues around fuel poverty and the need to ensure that people living independently were not put at risk by living in a cold environment.

A small number of respondents stressed the need to ensure rapid access to and provision of equipment and adaptations to help people remain in their own homes, or return to them after a period of ill health.

5.3.3 HSCB Response

There is broad support for the proposals made in *Vision to Action* for Older People's services, in particular making the home the hub of care for older people which means promoting independent living at home, and care closer to home, where it is safe and appropriate to do so. This includes addressing people's social needs to avoid isolation within their communities, and the continued development of intermediate care and respite services to support rehabilitation.

With regard to the proposals for statutory residential homes, we recognise and acknowledge the anxiety and concern expressed by some respondents. We reiterate the commitment to providing greater choice for older people, and that it is extremely important that any transition ensures alternatives are in place and working well, and that

Health and Social Care Board

implementation would be in a planned and managed manner with residents, families and local communities involved in local consultation processes. We also believe that statutory residential care is not always able to provide the best facilities for older people, and better alternatives currently exist and will continue to be developed, such as supported living accommodation. Through this consultation we have not received any compelling evidence that investment in these alternatives, which can be enabled through the closure of some statutory residential homes for older people, is not the most appropriate way forward.

Therefore, subject to the approval of the Minister to proceed, we will move to provide details about what changes to residential care provision would mean, and how the public and stakeholders can be involved in any changes that affect them. All such changes would be subject to local consultation.

In moving forward with the plans for Older People's services, we are committed to the following, which came through particularly strongly in the responses:

- The need to provide more information on the alternative models of care that will be available, with assurances for the public that the timescales will be carefully planned to ensure that there will not be a gap in provision of essential services.
- Seek to develop a framework for transition for those currently in residential care which may be impacted.
- Changes should also set out what the impact for staff working in any facilities that close will be and provide the necessary details about employment protection.
- Consider issues such as social isolation when developing implementation plans.
- When planning services for older people, maximise effective engagement with and input from other agencies with responsibilities for; housing, recreation and leisure, transport, V&C sector, local enterprise organisations, where appropriate.
- Any future plans would need to be developed with openness and transparency, in consultation with Staff Side organisations, demonstrating that the employer discharges their full duty of care to staff under the law.

5.4 Long Term Conditions

5.4.1 TYC: Vision to Action Key Proposals

1. To develop **new LTC 'Care Pathways'** – this means that all those responsible for or involved in providing you with health care services at the moment would develop simpler ways for you to access services, often through your GP or specialist nurse at home. At times this may mean that you may be admitted directly to hospital if you need to be, rather than having to go through A&E.
2. Using the latest clinical evidence we would develop '**risk profiling'** which would help those providing care to target specific support for those most at risk of an acute episode who may need a hospital admission to help to prevent them needing to go to hospital at all.
3. You would be supported and receive education on how to **manage your condition yourself** so that you would more easily identify when you are getting worse or your medication may need to change.
4. **Appropriate follow-up and regular review** of your condition by your GP or practice nurse. This would mean a change in the way hospital specialists work and mean that you get more follow up care.
5. Your pharmacist would play a key role in helping you understand your condition and how to **manage your medication** effectively.
6. Investment in new technology called '**telemonitoring'** where this is appropriate to your situation. This means that you may have new technology in your own home to monitor and test your condition, enabling your clinicians to receive information about your condition in a realtime or regular basis. This can mean that issues are quickly identified and dealt with.
7. Putting the range of initiatives set out in the plans in place would mean there are **fewer emergency visits to hospital** and a reduction in the amount of time you need to spend in hospital when you have an acute episode.

Health and Social Care Board

5.4.2 What people told us

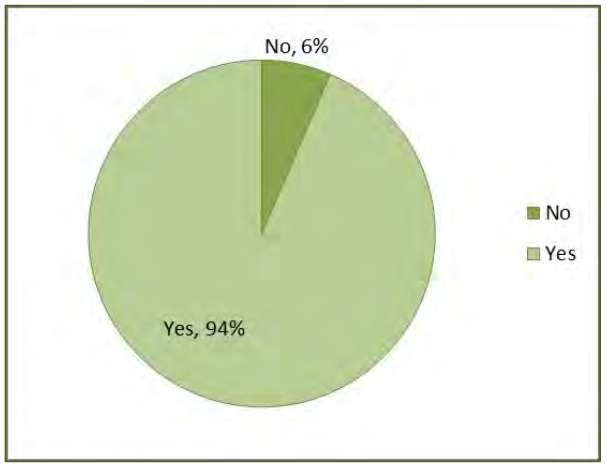
We asked two questions in relation to the proposals for Long Terms Conditions

1. *Would it be helpful to make more information and education available to help those with LTCs monitor and manage their condition?*

Of the 254 questionnaire responses, 232 answered this question. The graph below sets out all the responses we received in percentage terms

\The statistical analysis of the responses to this question show that

- **94%** felt it would be helpful to make more information and education available to those with LTC's
- **6%** felt it would not be helpful

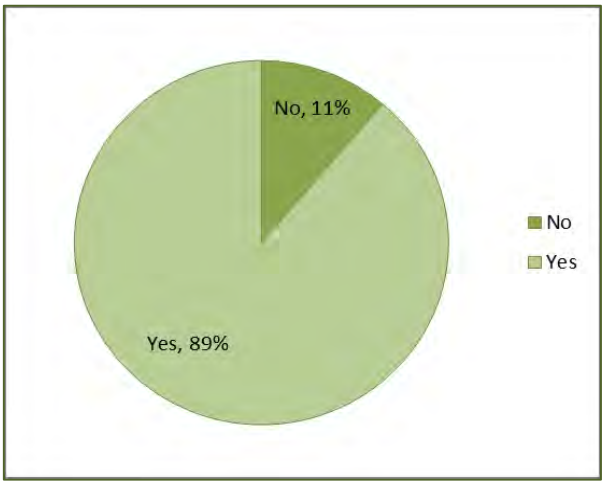


2. *Would it be helpful to enable those with LTCs to make more use of technology in their home to identify problems earlier and reduce need for avoidable visits to hospital or the doctor?*

Of the 254 questionnaire responses, 223 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that

- **89%** felt it would be helpful to make more use of technology in their home
- **11%** felt it would not be helpful



In addition, a number of themes can be drawn out from the comments we received about these proposals:

The majority of those who responded expressed support for the proposals to provide more information and education to improve self-management, and to make greater use of technology in the home to identify problems earlier and reduce the need for hospital visits.

Professional groups such as hospital doctors, General Practitioners and V&C sector groups that represent particular long term conditions all welcomed the increasing focus on improving self-management, home-based care and changing the pattern of care to a more community-based one.

There were a number of specific areas featured in the Consultation Document as part of the proposals around Long Term Conditions. Where responses were made to those the key messages are summarised below.

Pathways, risk profiling, self-management and appropriate follow up and reviews

Some respondents referenced Service Frameworks as a useful tool in setting out appropriate pathways, and in the case of Diabetes, a specific service framework was requested, with Diabetes UK arguing that this would improve the health and wellbeing of this patient group.

There were few references to risk profiling although a small number mentioned this directly, including Diabetes UK, encouraging health care services to develop a better understanding of the 'at risk' population in Northern Ireland.

Of respondents who expressed an opinion, the majority were very supportive of the proposal to provide more information to patients to help them manage their conditions more effectively, including when to make use of each type of care service.

Many respondents felt that patients would prefer to have their care delivered closer to home although it was often stressed that for some, hospital care would be the most appropriate and that it was important that any pathways guaranteed swift access to specialist opinion and treatment where required.

Responses from Pharmacy and Pharmaceutical bodies all stressed the significant contribution they had to make to improve the health and wellbeing of patients with long term conditions. Professional bodies highlighted the potential for pharmacists to provide support and information to patients and carers to ensure that medicines were used more effectively, and with appropriate protocols, to play a part in supporting patients to manage their conditions in the community. Responses from this group welcomed proposals to focus on pathway design, self-management and appropriate follow up and reviews.

The British Geriatrics Society remarked that it is important to bear in mind that very few older people have only one long term condition; the majority have two or more, and that this means pathway design has to take account of such complex co-morbidities.

Technology

A number of respondents, including those who spoke at public meetings, highlighted the problems of internet access and broadband coverage for more rural areas. They felt that this could compromise proposals to have more remote monitoring of patients with long term conditions; however they accepted that where this was possible, it could be of benefit.

Some respondents mentioned the need to consider the whole circumstances of the person when trying to decide whether remote monitoring was an option. There could be issues of capacity, where lack of face to face contact with a health care professional could lead to increased levels of anxiety. For other patients, the contact with a health care professional calling at their home could be one of very few social interactions they had, and taking that away could lead to the person feeling more isolated.

The implementation of the proposals in relation to long term conditions will need to carefully consider how these will impact on the relationships between the various stakeholders, particularly the patient. Whilst the word ’remote’ could raise concerns that patients will have much less contact with health care professionals than is currently the case, it would be important to stress what the style of that contact is intended to be in future, and that it would be a much more pro-active relationship with key clinical staff to avoid stressful emergencies and build a partnership between clinicians and the patient. The faster access to specialist investigations, opinion and advice brought by the use of technology

should be considered an important element of building this new style relationship.

Other comments

The V&C sector responses generally expressed a keen interest in being involved in the planning, design and delivery of specialist interventions in their area of expertise. They noted that they have long experience of partnership working with HSC at local level and that there was considerable expertise there to be drawn upon. They wished to provide more specialist input but as referenced elsewhere, they sought help and support in dealing with the rigours of procurement, which were particularly difficult for small organisations with little management infrastructure.

Some responses were received from V&C sector representatives of specialist interest groups which highlighted that there are rarer conditions such as Muscular Dystrophy, Multiple Sclerosis, etc. that are long term conditions which are not specifically mentioned in the proposals and requests that these conditions should be included in the planning of services.

Some respondents asserted that cancer should increasingly be seen as a long term condition as survival rates continue to improve and people are living with cancer for much longer than in the past.

5.4.3 HSCB Response

Overall there was strong support for the need to focus on the care pathways for long term conditions, and support patients to be more self-managing, where this is appropriate to do so. This includes the increased use of technology, where it is appropriate.

Having considered the responses to the consultation in this area and subject to approval of the Minister to proceed, as we develop plans for the implementation of proposals it is recognised that we need to be particularly mindful of:

- The need to provide information based on practical examples for the public, particularly those affected by long term conditions, on how the care they receive could be different under the proposals, how this would impact on their quality of life and the type of contact they have with clinical staff and health services.
- Develop an accurate understanding of levels of internet access/ broadband coverage to allow an assessment of where remote

monitoring is an option, as a key enabler to the investment in 'telemonitoring'.

- Ensure that roll out of remote monitoring or other technology-based supports also takes account of factors such as social isolation.

5.5 Palliative and End of Life Care

5.5.1 TYC: Vision to Action Key Proposals

1. To greatly increase the number of people who are **supported to die in their preferred location,** where they have expressed a preference.
2. **More 24 hour community support** for people in the last year of life, in accordance with their assessed needs.
3. Implementation of the **End of Life Care Operational System** (EOLCOS). This is a system to identify people who may be in the last year of life .It allows for the beginning of a discussion which will support people to express their needs and preferences of how and where they would wish to die.
4. Increased access to **specialist palliative support** out of hours, including specialist 'in-reach' into nursing homes and people's homes when they need it.
5. Working more closely with the **voluntary and community** sector in the provision of palliative care.
6. Better links and **integrated working** between specialist and generalist services, especially through the Integrated Care Partnerships.
7. Increase the **education and training** (and therefore the number) of staff confident and competent in the core principles of palliative and end of life care in all sectors.

5.5.2 What people told us

We asked:

Do you agree that the proposals set out in respect of palliative and end of life care would support you to be cared for in a place of your choice? Do you believe there are better alternatives?

Of the 254 questionnaire responses, 222 answered this question. The graph overleaf sets out all the responses we received in percentage terms.

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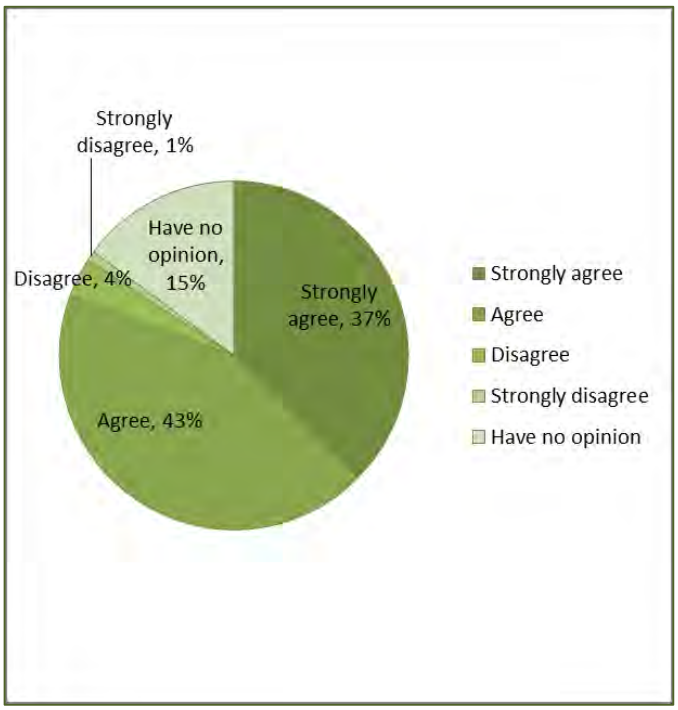
The statistical analysis of the responses to this question show that <u>of those who expressed an opinion:</u>

- **95%** agreed or strongly agreed that the proposals would support them to be cared for in a place of their choice
- **5%** disagreed or strongly disagreed



In addition, a number of themes can be drawn out from the comments we received about these proposals:

There was strong endorsement for implementation of the palliative care and end of life proposals laid out in the consultation document. It was also recognised that implementation needs to be planned for and thought through to address challenges ahead.

"We greatly welcome proposals set out in relation to palliative and end of life care. We agree that better links and integrated working between specialist & general services, especially utilising the structure of the ICP's are required" North Belfast Partnership

A collaborative response from Marie Curie Cancer Care, Northern Ireland Hospice, Macmillan Cancer Support, Southern Area Hospice Services and Foyle Hospice commented:

"Whilst we fully support the policy direction of Transforming Your Care, there is much work to be done to translate those elements which are still at an aspirational level into practical results." – Collaborative response from Marie Curie Cancer Care, Northern Ireland Hospice, Macmillan Cancer Support, Southern Area Hospice Services and Foyle Hospice

There is a recognition by respondents of the need for close working with, and further investment in the implementation of *"Living Matters, Dying*

Matters", the Palliative and End of Life Care Strategy for Adults in Northern Ireland.

Some challenges were outlined by professional groups in supporting people to die in their preferred location, including;

- the need for greater clarity on roles and accountabilities;
- queries about how progress will be monitored; and
- the need for training and awareness raising amongst staff and the public.

Respondents identified implementation of the End of Life Care Operational System (ELCOS) as key to improving palliative care and advocated for an awareness programme to support its use. One comment was:

"We strongly support this model and the potential it holds to bring clarity to key questions around EOL care provision, when it begins, roles and responsibilities etc. not only for care providers but for patients their families, carers etc." – Collaborative response from Marie Curie Cancer Care, Northern Ireland Hospice, Macmillan Cancer Support, Southern Area Hospice Services and Foyle Hospice

Some respondents suggested that the most effective model is one where specialist palliative care teams are centred around and support GP practices to allow support from specialists to local teams who know the family best.

Respondents from the V&C sector highlighted a need for funding of bereavement care and support services for young people, which in turn will improve mental health for future generations.

Advanced care planning and conversations around death and dying have particular implications where capacity to make decisions or to express wishes diminishes and this must be taken account of. In this context, there were some concerns raised that there is a lack of reference to how people will have choice and control over planning of services for end of life care. It was emphasised that families must be involved in decision making.

Palliative and end of life care for children and young people was highlighted as an area in particular need of focus, and children and young people must be involved in their own end of life care planning.

The Voluntary and Community sector has a big role to play but some caution was expressed to ensure that staff from this sector are effectively supported and trained.

Some responses highlighted that there will always be occasions when inpatient end of life care is required and we must ensure there is enough inpatient and hospice capacity.

5.5.3 HSCB Response

Of those that expressed an opinion about Palliative and End of Life care, there was strong agreement with the proposals put forward. Many of the qualitative comments underlined the need for supporting people to die in their preferred location, with increased access to specialist care. It was recognised that this needs to be enabled by appropriate training and skills, more close working with the V&C sector, and a clear focus on practical results. It is recognised that an Implementation Board is already in place for *Living Matters: Dying Matters*, and their sub-groups and workstreams will take the lead in this area.

The responses received in this area will be used to inform this and in developing the implementation plan, subject to Ministerial approval to proceed, we will be particularly mindful to the following:

- The need to prioritise development of a cross sector programme of development and education for palliative care, underpinned by an assessment of current skills and capacity. This will support delivery of proposals 2, 4, 6 and 7.
- Specifically in support of proposal 5, progress the development of an explicit procurement process to ensure capacity and capability building, and effective engagement with the voluntary and community sector in provision of palliative care services.
- The need to engage with forthcoming reviews of palliative care for children, and ensure that the outworkings of the review are built into TYC plans in a timely manner.

5.6 Mental Health

5.6.1 TYC: Vision to Action Key Proposals

1. Be **more joined up** in how we provide services, in particular, how mental health services work with GPs (and other primary care providers) and hospitals – this is critical to getting better at earlier intervention.
2. In line with the Bamford Review recommendations**, reduce the number of people in institutional care and inpatient beds** by existing residents moving to live in the community through intensive home support, alternative supported living arrangements based in the community, and individual budgets. This will take full account of the complex family dynamics in this area.
   It is our intention to continue with the Northern Ireland Executive's resettlement programme. At the point of writing, this means that the remaining 116 people from the original targeted group identified in 2007 would move to alternative community based living arrangements, by March 2015. We would also work towards resettling those people who have become long stay residents since 2007, due to delay in their discharge for longer than a year.
3. **Develop 6 in-patient acute mental health units** for those aged 18+. There would be one site in the Northern, Southern, South Eastern and Belfast areas, with two in the Western area. In order to reduce stigma and ensure there is good access to acute care, it is necessary to locate mental health hospitals close to acute hospital provision, recognising that this may not be possible in all circumstances. These principles would imply that the second location in the Western LCG area would be in the proximity of the new South West Acute Hospital rather than Omagh as previously planned and this consultation seeks views on that issue of principle.
4. **Enhancing the support for carers,** to ensure they have access to services in their community which enhance their quality of life.
5. **Promote the uptake of self-directed support and other programmes** which would mean that people have more choice and control over the type of care they receive.

Health and Social Care Board

5.6.2 What people told us

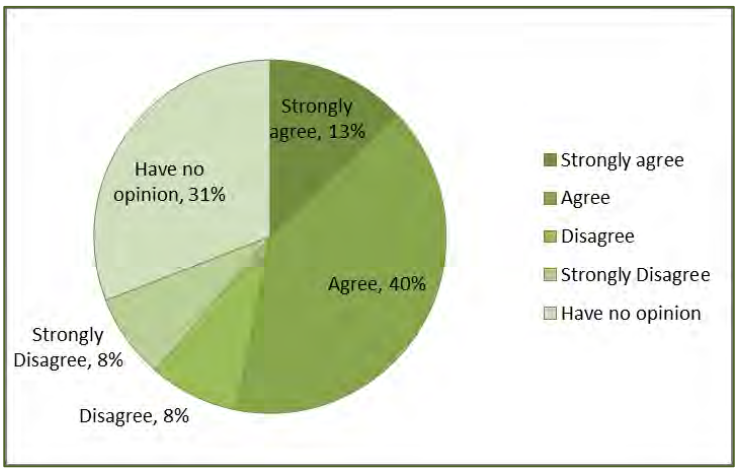
We asked:

Do you agree with the proposals set out in respect of mental health services? Do you believe there are better alternatives?

Of the 254 questionnaire responses, 217 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion</u>:

- ***77%** agreed or strongly agreed with the proposals*
- ***23%** disagreed or strongly disagreed*



In addition, a number of themes can be drawn out from the comments we received about these proposals:

There was general support amongst respondents for the continued implementation of Bamford recommendations. Some respondents expressed a sense of disappointment and frustration that putting this into action has been a slow process but were hopeful that Transforming Your Care would add new drive and impetus to the process.

"We welcome the continued emphasis on the reorientation of provision towards community mental health provision."- NIAMH

"needs to build on and pace up the implementation of Bamford recommendations, work really closely with carers, service users and the third sector and demonstrate leadership which genuinely embraces the ethos of social innovation."- CAUSE

Acute Mental Health

An area of debate during the consultation process and in the responses received has been in relation to the placement of a second mental health inpatient unit in the Western LCG Area. Support for placing this unit in Omagh on the site of the new Omagh Enhanced Local Hospital was expressed by the Western Health and Social Care Trust, Omagh District Council and some members of the local community. A very small number of those disagreeing with the proposal via the questionnaire referred to this matter. Support for retention of inpatient mental health services at the Tyrone and Fermanagh Hospital were also expressed at the public meeting held in Omagh.

Reasons given included:

- The retention of expertise and experienced staff working in Omagh.
- The historical role of mental health provision in the area.
- The potential negative economic impact to the local community if the mental health unit was relocated.
- The infrastructure of the new enhanced hospital has commenced.
- The Western Health and Social Care Trust also suggests that the placement of the acute mental health inpatient unit in Enniskillen may impact on the provision of old age mental health care.

Conversely medical opinion has been strongly in favour of co-locating the new mental health inpatient unit with the South West Acute Hospital in Enniskillen. The Royal College of Physiatrists firmly endorsed the co-location of acute mental health units alongside an acute hospital. Building on their stance expressed in the 1998 document "*Not Just Bricks and Mortar*" stating that:

"15 years on, the case for being on an acute site is even more compelling. Those admitted are significantly more disturbed than in the past and access to a cardiac resuscitation team is seen as important….[A] closer working relationship between psychiatrists and other doctors is clearly a good thing, and is further argument for the acute treatment of the most severely mentally ill to be on the same modern sites, as that for the most severely physically ill." – The Royal College of Psychiatrists

The British Medical Association state that they

"concur with the view that mental health hospitals should be located close to acute hospital provision."- The British Medical Association

Others concurred with the need to ensure access to general hospital services but further suggested that in agreeing the location of units, further criteria should also be used, including travel distance and time for both patients and family.

The transition of Mental Health services out of hospitals and into the community was greeted with approval from respondents, however there were a small number of respondents concerned that there would not be enough inpatient beds in the planned 6 mental health units.

The importance of access to a psychiatry liaison service for all general hospital patients was highlighted. There is significant correlation between physical and mental problems and it is important they are treated in an integrated way.

It was expressed by some (most notably by the NI Association for Mental Health) that Emergency Departments are often unsuitable environments for mentally ill individuals and as a result should be avoided where possible. Direct admission to wards, improved working across primary and secondary care and better access to care in the community were put forward as ways to accomplish this goal.

Resettlement

The resettlement of mental health patients and allowing those with mental health issues to remain at home for as long as possible was supported by consultation respondents, with The Law Centre stating that it:

"welcomes the proposal to reduce the number of people in long term institutional care in line with the Bamford recommendations."- The Law Centre.

Appropriate capacity and capability in the community to care for those with serious mental health concerns, including alternative accommodation must be in place for this to happen. It is recognised that resettlement for those with complex and challenging behaviours will need to take account of their particular needs. The focus must be on enhancing the service user experience rather than just replication in a different setting.

Support for carers in the form of respite was mentioned as vital to enable the resettlement of long stay mental health patients into the community. For example, CAUSE stated that:

"No-one wants to be in hospital where this can be prevented. This would also be the view of carers who actively support loved ones who have experienced serious mental illness."- CAUSE

Primary Mental Health

While the issue of the placement of the Western LCG Area's second mental health inpatient unit was the most emotive issue it was noted in a number of responses that the vast majority of mental health is now already based in the community and the home. Greater access to Cognitive Behavioural Therapy (CBT) and other primary and preventative care was expressed as a priority.

Some respondents felt that health and social care staff would benefit from greater awareness of mental health issues. This was emphasised in relation to primary care with special focus placed on GPs as gatekeepers to further care. Questions were raised asking for clarity on the role for ICPs in relation to mental health. The possibility of an expanded role for Community Psychiatric Nurses was suggested and for pharmacists in relation to medications management.

Stigma was highlighted as remaining a key issue attached to mental health. Co-location of inpatient mental health services with acute hospital services was seen by most as a means of reducing stigma but more would be needed. Raising public awareness of mental health concerns was advanced as a means to achieve this goal. Inter-departmental and joint agency work tasked at reducing stigma at an early age in schools was highlighted as important for achieving this aim, and educating the public on mental health.

There was support from a number of respondents for the role of the V&C sector in delivering services. There was also support for greater involvement from service users and the V&C sector in the shaping of Mental Health services. The role of service users shaping services in Belfast Health and Social Care Trust was proposed as a case of best practice that should be extended.

The central goal of *Transforming Your Care* for people with mental health problems to live at home will rely on the commitment and hard work of carers. Support for carers has already been highlighted as a central theme that has emerged from the consultation process across the whole spectrum of health and social care, and this was further endorsed by respondents in this area.

Health and Social Care Board

Pathways across Primary and Secondary Mental Health

Respondents noted the opportunity presented by TYC to improve pathways in health for people living with mental illness. Simplicity and clarity in managing the health and care system was highlighted as an area for improvement. This was true in moving from primary to secondary care, but also a need for more rehabilitation and intermediate facilities to aid the transition from secondary to primary care.

5.6.3 HSCB Response

Of those that expressed an opinion in regard to the proposals for Mental Health services, there was broad support for the direction of travel and the proposals as a way of achieving the aims set out. In particular the need to progress with Bamford was supported, and in alignment with the discussion and proposals in the original TYC report, the need to accelerate and invest in doing so. A small number of responses contained specific suggestions on the way forward, and, subject to the Minister's approval to proceed, we will be mindful of these in developing implementation plans, in particular the need to ensure that joined up community services are in place to support this aim.

With regards to the location of acute mental health inpatient units, the response to the consultation, in particular from clinical opinion, would indicate that the principle of being close to an acute hospital is appropriate in order to reduce stigma and be close to other acute services. In relation to the location of the second acute mental health inpatient unit in the Western area the application of this principle in light of this consultation would benefit from further consideration. Therefore we would propose that a further options appraisal is undertaken in relation to this matter.

5.7 Learning Disability

5.7.1 TYC: Vision to Action Key Proposals

1. In line with the Bamford Review recommendations**, reduce the number of people in long stay institutional care** by existing residents moving to community based options and reducing new admissions through the continued development of self-directed support, supported living arrangements and individual budgets. This will take full account of the complex family dynamics in this area. It is our intention to continue with the Northern Ireland Executive's resettlement programme. At the point of writing, this means that the remaining 175 people from the original targeted group identified in 2007 would move to alternative community based living arrangements, by March 2015. We would also work towards resettling those people who have become long stay residents since 2007, due to delay in their discharge for longer than a year.
2. **Improve access to respite** and provide a wider range of non-facility based respite for both service users and carers. This will reduce the number of people being admitted to acute beds.
3. Increase the number of people with **self-directed support and individual budgets**; this means that people have more choice about what services they receive.
4. Continue to develop creative and **age-appropriate day opportunities** to promote independence and choice, such as access to employment, leisure and educational activities. This will include more opportunities being provided in partnership with other sectors (including voluntary & community, education and employers). Our statutory facilities may be re-configured as a result.
5. Enhance the **involvement of carers** in care planning and service planning to bring their experience to bear on these functions.
6. Be **more joined up** in how we provide services for people with learning disability so that they have a seamless service when accessing specialist services and health screening.

Health and Social Care Board

5.7.2 What people told us

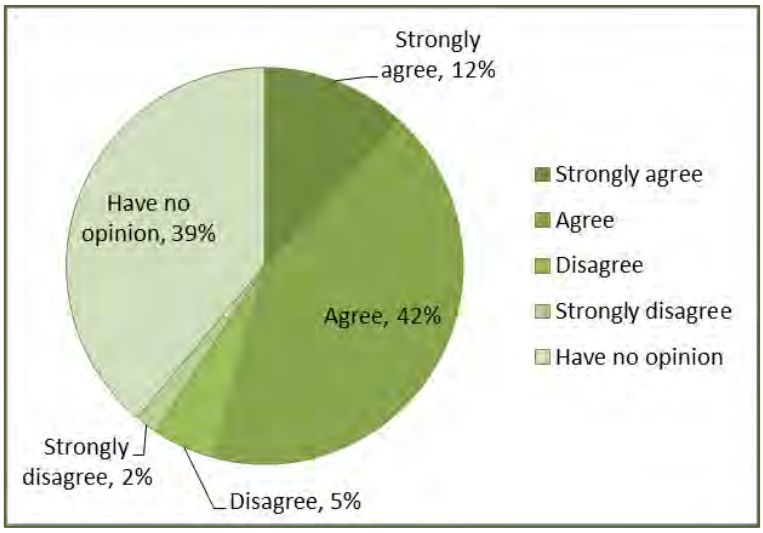
We asked:

Do you agree with the proposals set out in respect of learning disability services? Do you believe there are better alternatives?

Of the 254 questionnaire responses, 212 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that of those who expressed an opinion:

- ***88%** agreed or strongly agreed with the proposals*
- ***12%** disagreed or strongly disagreed*



In addition, a number of themes can be drawn out from the comments we received about these proposals:

There was general support amongst respondents for the continued implementation of Bamford recommendations. Respondents expressed a sense of disappointment and frustration that putting Bamford proposals into action has been a slow process but were hopeful that Transforming Your Care would bring added impetus. The values of the Bamford report are reaffirmed as the blueprint for the transformation of health and social care for those with learning disabilities, but the process moving forward must not be limited to Bamford.

In addition to agreeing with the proposals, some respondents sought further investment in Learning Disability services, and suggested further areas they would like to see addressed through the implementation plans for TYC.

Resettlement

An issue that has been seen as controversial has been that of the resettlement of long stay learning disability patients into the community, as outlined in Bamford. The majority of responses have been supportive of the proposal. Alongside this agreement some pleas were raised around the timescale of resettling patients and whether there is adequate capacity in the community to care for these patients. Frustration amongst respondents is noted concerning the slow pace of the resettlement process thus far. Also highlighted by some respondents is that those patients still remaining in long stay institutions will be the most difficult to resettle and will require a higher level of support to live in their own homes.

Older People with Learning Disability

There is a need for greater recognition on the growing numbers of people with learning disabilities reaching old age, according to some respondents. This was expressed by the NI Local Government Association as follows:

"This group have very individual needs and with greater life expectancy, there is a requirement to agree - with them, their families and / or carers - arrangements for their lifelong care." –NILGA

This has been thanks to advances in health care and is to be celebrated however as a result there were clear suggestions that the particular needs of older people with learning disabilities need to be recognised. Age appropriate services for older age people with learning disability will need to be developed to reflect this growing demographic. The carers for these older people with learning disabilities are in most cases elderly themselves. The need for these older carers to have confidence that those they care for will be safeguarded and cared for into the future was expressed. Supported living schemes have a role in addressing this growing need, and more work needs to be done to provide this service.

Age Appropriate Services

The need for flexible and "age appropriate" services was addressed by individuals and by the Patient Client Council. The period where people with learning disabilities move from childhood into adult services was indicated as an area that needed particular attention. The role of day services for adults with learning disabilities was indicated as particularly important.

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Access to HSC Services

Some respondents expressed that there was currently a difficulty for people with learning disabilities to access other services. Access to mental health services for people with learning disabilities was indicated by the Royal College of Psychiatrists as a particular area where more work could be done; while some people with learning disabilities access mainstream mental health services, many still do not. Greater joint working between learning disability services and other areas should be promoted. The need for greater access to Dentistry was also highlighted.

Staff

There were calls for staff training relating to learning disabilities for practitioners to better facilitate communication and help involve people with learning disability in decisions being made about their lives. Having a specialist learning disability nurse in each hospital was proposed in the response of Barnardo's Disabled Children and Young People's Participation Project.

Carers Needs

The central goal of Transforming Your Care for people with learning disabilities to live at home will rely on the commitment and hard work of carers. Support for carers has already been highlighted as a central theme that has emerged from the consultation process across the whole spectrum of health and social care. Specifically for carers of people with learning disabilities a lack of access to information is a difficultly, as noted by the Patient Client Council and Positive Futures.

Community

Greater independence for those with learning disabilities was praised:

NICVA is encouraged that fundamental to TYC there is a commitment to delivering the best outcomes for people with learning disabilities by increasing their independence and choice" - NICVA

Respondents proposed this will require inter-agency and inter-departmental co-operation. Support for opportunities in the community for education and employment for people with learning disabilities was voiced with particular support for the social firm model to provide employment opportunities for the learning disabled. This will require

support not just from government but also industry and the V&C sector, as Action Mental Health notes:

"The voluntary and community sector have vast expertise to offer in respect of services for this service user group particularly in the areas of day opportunities, training and employment." – Action Mental Health

Self-directed support

Approval for self-directed support and individual budgets stood at 76% from those who answered question 3 of the *Vision to Action* consultation questionnaire, with Positive Futures stating that:

"We agree that this should be a priority for future development and recognise the complexities that this development will mean for individuals with a learning disability and their families wanting to pursue this option." – Positive Futures

While there was support for the policy, respondents expressed a number of doubts that must be addressed; self-directed support is not appropriate for everyone with learning disabilities, there are concerns around the capacity of some carers to manage the budget, and worries that this may become an added burden to administer. The Patient Client Council noted that at present there is a clear difficulty accessing individual budgets, and a need for more information and support to uptake the scheme:

"Some people said they either has difficulty accessing them or had never heard the term before" – The Peoples Priorities for Transforming Your Care 2012 (Patient Client Council).

5.7.3 HSCB Response

There was broad agreement with the proposals contained within *Vision to Action*, and in developing detailed plans (subject to Minister's approval to proceed), we believe particular consideration is required for the following:

- In order to facilitate the independence of people with learning disabilities and carers a special focus needs to be made to simplify services and care pathways.
- Continued and enhanced engagement with service users in the design of services, particularly where these are cross-Programmes of Care, such as Learning Disability services for older people and children.

Health and Social Care Board

- Creating age appropriate day opportunities for people with learning disabilities was a key proposal set out in *Vision to Action*. The issue was a recurring theme from respondents. We will consider how greater emphasis needs to be placed on this beyond day opportunities when commissioning services.
- Specific work needs to be done around the issues of the transition from children to adult services, and the growing need for services for older people with learning disability.

5.8 Physical Disability and Sensory Impairment

5.8.1 TYC: Vision to Action Key Proposals

1. Undertake reviews of the current provision of day-care services with the aim of developing **alternative ways to provide day activities**.
2. Put in place more, and a **wider range of, respite** options for carers.
3. Increase the number of people with **self-directed support and individual budgets** to allow them to have more choice about what services they receive.
4. Examine the potential for the development of **specialist supported living options**, for example for those people with acquired brain injury.
5. Enabling individuals to live at home requires a **mixed economy** of service providers to include community and voluntary, private and statutory sectors. Services will be procured to deliver this outcome. This signals a larger role for both the voluntary and private sectors in future. Looking towards this, we will undertake a review to accurately cost such services to ensure value for money and high quality services.

5.8.2 What people told us

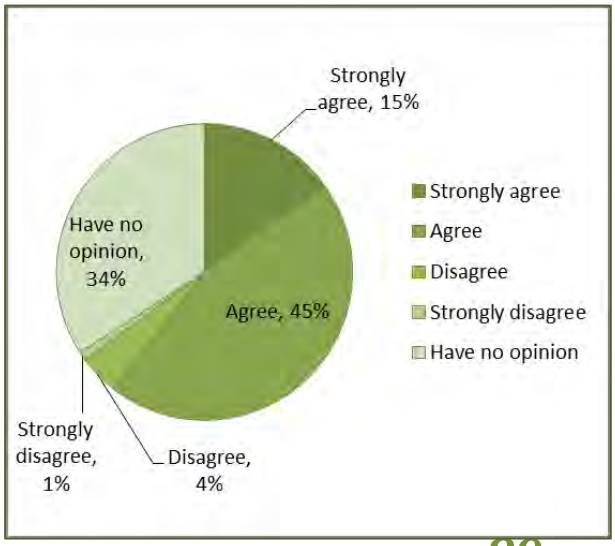
We asked:

Do you agree with the proposals set out in respect of physical disability and sensory impairment services? Do you believe there are better alternatives?

Of the 254 questionnaire responses, 211 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion</u>:

- ***92%** agreed or strongly agreed with the proposals*
- ***8%** disagreed or strongly disagreed*



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In addition, a number of themes can be drawn out from the comments we received about these proposals:

The majority of responses received demonstrated considerable support to progress with the proposals outlined in the consultation document, including those from groups representing service users with physical disability and sensory impairment. For example, the Royal National Institute of Blind People (Northern Ireland) commented:

"RNIB supports the proposals for people with physical and sensory disability contained in TYC. RNIB is actively engaged with the health and social care sector and other community and voluntary sector stakeholders in implementation of the Physical and Sensory Disability Strategy. We would hope that over the next 3 years, many of the issues which frustrate disabled people will be satisfactorily addressed and that in particular the joint planning of services by a wide range of stakeholders including the community and voluntary sector will lead to better co-ordination of services, and a wider range of services which will support greater choice and control for disabled people." - RNIB

Action on Hearing Loss commented:

"Action on Hearing Loss warmly welcomes the Transforming Your Care document and the recommendations made in it. We support the move towards better home- and community-based care." – Action on Hearing Loss

Many of the comments received with regards to these proposals set out suggestions for how it would be further improved, most notably the need for specific action plans. In this regard, there was consensus that TYC should work in tandem with the implementation of the Physical and Sensory Disability Strategy and it was suggested that an associated action plan should be published along with details of the dedicated investment into these services.

It was emphasised that it is crucial that people with physical disability and sensory impairments are effectively engaged in the design and implementation of services, as well as greater levels of joint planning across the sector. Although one respondent questioned the greater involvement of the Voluntary and Community sector in terms of the regulation and quality of services.

Illustrative comments include:

"This is the opportunity to transform our care not reinstate old and bad practices of excluding disabled people from decision making processes" - North West Forum for People with Disabilities

"Joint planning for people with physical disability across government departments and Voluntary and Community organisations will be necessary in order to achieve the key elements of personalisation, independence and control identified in TYC" - The Peoples Priorities for Transforming Your Care 2012 (Patient Client Council).

It was suggested that there is a need for engagement with the deaf and visually impaired community with regard to public health messages where standard formats may not be appropriate.

Some respondents highlighted the need for dedicated mental health support for people with sensory impairment and physical disability. It was suggested that there is a need for more vocational support for people with physical and sensory disabilities and a greater focus on supporting people to access leisure activities.

The impact of Welfare Reform will be considerable for this service user group and must be taken account of in the implementation process. There was also a request to have regard to access to public transport in more rural areas for this service user group.

There was support for greater use of assistive technology to allow people with physical disability and sensory impairment to live independently but some caution was expressed around ensuring this does not lead to greater social isolation.

The Patient Client Council in their report on the People's Priorities for Transforming Your Care assert that improvement is needed to reduce long waiting times for equipment and home adaptations to support people with disabilities to live independently.

5.8.3 HSCB Response

Of those who expressed an opinion and commented on the proposals in relation to Physical Disability and Sensory Impairment, there was strong support for the proposals. Therefore, subject to the approval of the Minister, in taking forward the implementation of these proposals, having

Health and Social Care Board

regard to what we have heard, we will be particularly mindful of the following:

- Continued and enhanced engagement with service users in the design of services, particularly where these are across Programmes of Care.
- In undertaking reviews of current provision of day-care services (proposal 1), include a focus on the provision of more vocational support and rehabilitation to those with physical disability and sensory impairment.
- The need to consider how better collaborative planning of services can be achieved across government departments.

5.9 Family and Child Care

5.9.1 TYC: Vision to Action Key Proposals

1. Promotion of a **multi-agency / partnership approach** to prevent children having to be separated from their families and enable some children to remain safely with their families. Where children cannot remain with their family, alternative arrangements to bring permanency in the best interests of the child will be made.
2. Embed **Family Support Hubs** across Northern Ireland to focus on early intervention. An emphasis should be placed on two key areas: the promotion of positive parenting and positive speech and language communication skills for all our children.
3. **Increase the number of foster carers,** and in particular specialist foster carers for those children and young people who are deemed hardest to place, and present significant challenges.
4. Engage with **Strategic Regional Review of Residential Care Services for Children and Young People** to take forward recommendations of local review in line with regional recommendations. Reduce the reliance on **residential care homes**.
5. Continue to improve the **Child and Adolescent Mental Health Services (CAMHS)**, to reduce the number of children waiting for service and a reduction in waiting times.
6. Increase availability of **emergency CAMHS** cover to avoid acute admissions.

5.9.2 What people told us

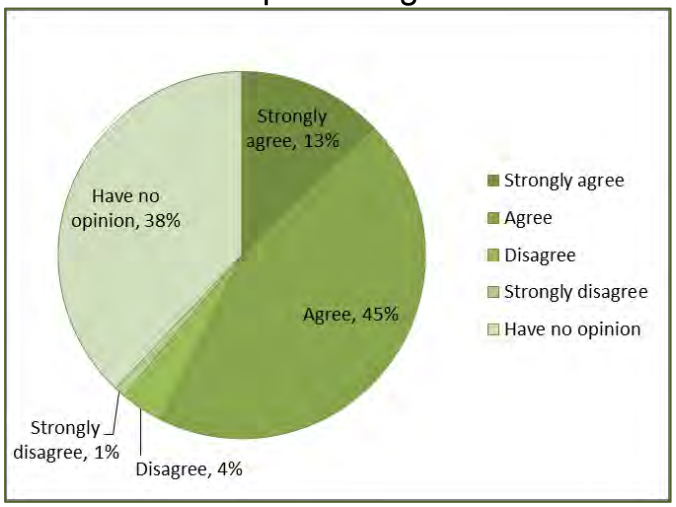
We asked:

Do you agree with the proposals set out in respect of Family and Child Care? Do you believe there are better alternatives?

Of the 254 questionnaire responses, 211 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion:</u>

- ***92%** agreed or strongly agreed with the proposals*
- ***8%** disagreed or strongly disagreed*



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In addition, a number of themes can be drawn out from the comments we received about these proposals:

Multi-agency/partnership approach

There was a strong view expressed from respondents that the proposal to promote a multi-agency / partnership approach to help prevent children being separated from their parents was the correct way forward.

"The promotion of a multi-agency /partnership approach to provide services which support a more stable and secure situation for children is vital." - Northern Ireland Music Therapy Trust

It was widely agreed that, where appropriate, families are the best environment to bring up children. To fully support the proposal it was felt that the focus should be on early intervention and prevention. Respondents felt that if the emphasis is placed on early intervention and prevention this could help families / children avoid entering into the care system in the first instance. References were made to the fact that the terms "intervention" and "prevention" should not solely refer to acute services but also to social care. However, the Northern Ireland Association of Social Workers did highlight the fact that social workers often do not get to spend as much time as they would like doing proactive preventative work due to the large volumes of paperwork they navigate on a daily basis.

In addition, some respondents talked about the multi-agency approach with regards to the need for greater levels of joined up government.

"An integrated approach will be crucial to the success of an integrated early intervention agenda" - Save the Children

One respondent emphasised the role of the school:

"Schools can be at the centre of a 'multi-agency' approach with possibly the appointment of a senior family support worker as part of the senior management team of each school... That person can then support families locally with positive parenting strategies and signpost to services within other agencies." – Individual Response

Others mentioned the need to address the needs of children across departments:

"HSCB [should] identify as a priority how it will work meaningfully with those agencies and Departments, such as the Departments of Education, Social Development and the First and Deputy First Minister, to progress the proposals in Vision to Action. Such an integrated approach will be

crucial to the success of an integrated early intervention agenda" - Save the Children

Family Support Hubs

There was a welcome by many organisations and individuals for the development of Family Support Hubs to support early intervention. Respondents felt that they would have a positive impact on parenting skills and the development of speech and language in young people.

"We agree that promoting and supporting positive, engaged parenting for all families is key towards improved communication and bonding" – Early Years

It was suggested that investment in this type of early intervention could help save money in the future and also relieve the burden on adult services as it,

"predicts better outcomes in adult life thus relieving the burden on adult services" - NI Social Care Council

It was suggested that Family Support Hubs could improve access for parents to specific resources for parenting a child with a particular need. Northern Ireland Social Care Council (NISCC) was one of the many organisations that welcomed Family Support Hubs suggesting that this type of early intervention is a positive development.

Foster Carers

There was wide agreement for increasing the number of foster parents. It was highlighted how the life outcomes for children cared for by foster families are significantly better than for those who are raised in residential care. Therefore it was felt that impetus should be given to continuing to engage with the Strategic Regional Review of Residential Care Services for Children and Young People and reduce the reliance on residential care homes.

Voice of Young People in Care (VOYPIC) highlighted that the increase in foster parents would be beneficial especially for those children who are hard to place. Such as:

- young parents in care;
- bail placements; and
- short term and emergency placements.

A few respondents felt that the fostering process was unnecessarily complicated and suggested this discourages people from taking up this role.

Health and Social Care Board

Child and Adolescent Mental Health Services (CAMHS)

There was overwhelming support for continuing to improve Child and Adolescent Mental Health Services (CAMHS). Respondents felt that CAMHS at present are underfunded and there needs to be a greater investment in these services. Many respondents felt that investment in early intervention and prevention in CAMHS would enable better outcomes, and reduce demand in the future for adult Mental Health services.

"Contemporary evidence suggests that investment in prevention and early intervention approach saves significant money in the long term and benefits society as a whole" - National Children's Bureau NI

Respondents agreed with the proposal that there is a need to increase emergency CAMHS in particular. It was also suggested that by increasing the investment in early intervention and prevention this could help reduce the level of crisis intervention needed in the future.

It was noted there is a need for more effective joined up and consistent working between CAMHS and GP primary care providers. It was recognised that there are examples of good joined up government in this area and it should be built upon, particularly in 'upskilling' the education sector and parents.

5.9.3 HSCB Response

Of those who expressed an opinion about the proposals for Family and Child Care, there was strong agreement with the proposed way forward. As with many of the other Programmes of Care, many of the comments related to what respondents see as priorities to ensure that these are successfully implemented, and areas where attention should be given in doing so. In particular the need for investment in early intervention and early years services, better joined up government and further development of CAMHS came across strongly in this section.

Subject to approval of the Minister to proceed, in developing the implementation plans, detailed responses and comments will be taken into account, for example we will be particularly mindful to the emphasis on early intervention and prevention, and seeking ways in which Family Support Hubs can take a role in signposting families with particular needs to the correct pathways of care.

5.10 Maternity and Child Health

5.10.1 TYC: Vision to Action Key Proposals

In respect of maternity services, key proposals were:

1. Promote **normalisation of birth** - bringing ante-natal and post-natal visits into line with best practice and NICE guidance, and improving access to midwives as initial point of access.
2. Reduce the length of time mothers **stay in hospital**, where appropriate.
3. **Increase the number of women** having their ante-natal care in the community, rather than attending hospitals.
4. Improve **ante-natal education** and **early parenting** to promote good parent/child relationships in the early years.

In terms of the configuration of maternity units, **the following was proposed**:

1. In the **Belfast** area, a freestanding midwife-led unit would be developed in the Mater Hospital, with one consultant-led obstetric unit in the Royal Jubilee Maternity Hospital. We also plan to provide an 'alongside' midwife-led unit in the new regional maternity hospital.
2. In the **Northern** area, initially the current services will remain at both Causeway and Antrim Hospitals. The volume of activity in the consultant obstetric unit in the Causeway Hospital will be reviewed to ensure it meets the required standard. Given the likely number of births at the Causeway Hospital it is probable that there would be change in obstetric services at the Causeway Hospital over the next 3 to 5 years as it is not likely to be possible to maintain a safe and sustainable consultant-led service there.
3. In the **South Eastern** area, there would continue to be a consultant-led obstetric unit and an 'alongside' midwife-led unit at the Ulster Hospital, with freestanding midwife led units in Downe and Lagan Valley Hospitals. These units are to be reviewed over the next 3 to 5 years to ensure their continuance is demonstrably supported by mothers choosing to use them.
4. In the **Southern** area, there would continue to be a consultant-led obstetric unit and an 'alongside' midwife unit at Craigavon Hospital, and a consultant-led obstetric unit in Daisy Hill hospital. The level of medical cover for the consultant-led obstetric unit in Daisy Hill Hospital would continue to be reviewed to ensure it meets the required standard. An 'alongside' midwife-led unit would also be developed at Daisy Hill Hospital.

5. In the **Western** area, there would continue to be consultant-led and midwife-led units in both Altnagelvin Hospital and the South West Acute Hospital. The level of medical cover for the consultant-led obstetric unit in the South West Acute Hospital would be reviewed to ensure it meets the required standard. It is likely there will be additional activity from the Republic of Ireland.

In respect of Child Health, the key proposals were:

1. Establish **Family Nurse Partnership Programme** pilots; in the first instance these will be in 3 specified areas (Western, Southern and Belfast), to improve the health and wellbeing of our most disadvantaged children and families, thus preventing social exclusion.
2. When children require **hospital care** they need prompt access to skilled staff. It is not possible to provide a full range of paediatric sub specialities for a population the size of Northern Ireland and therefore we will continue to ensure there are arrangements in place when families have to access services in other parts of the UK or when services are not available locally.
3. There is a need to move towards admitting all children under the age of 16 to age appropriate paediatric settings. The DHSSPS will be starting a **review of acute paediatric services.** A review of paediatric palliative and end of life care services will follow. This will facilitate a regional approach to how services should be organised in future, including agreement on the age of transfer from paediatric to adult services.

5.10.2 What people told us

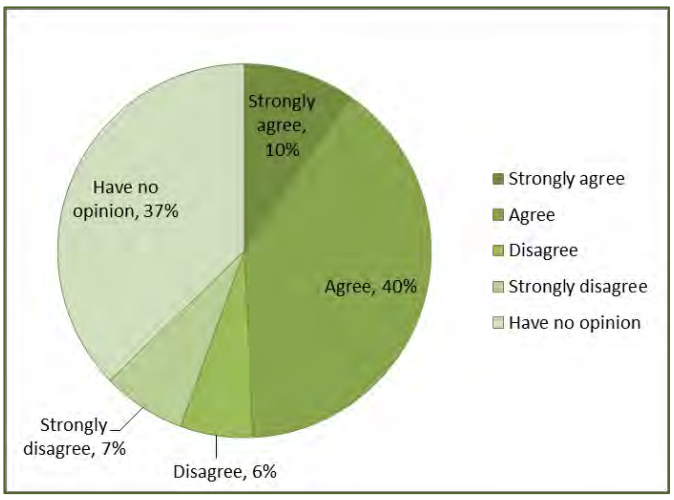
We asked:

Do you agree with the proposals we have set out in respect of maternity and child health services? Do you believe there are better alternatives?

Of the 254 questionnaire responses, 207 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion</u>:

- ***78%** agreed or strongly agreed with the proposals*
- ***22%** disagreed or strongly disagreed*



A number of themes can be drawn out from the comments we received about the proposals in relation to Maternity Services:

Normalisation of Birth

Overall, respondents welcomed the proposals for the normalisation of births.

The proposal for moving antenatal care to the community was received very positively as long as the care is adequately planned and resourced. Respondents felt that antenatal care provided in the community would create better outcomes for mothers and babies as more mothers would attend routine appointments.

Some respondents felt that more consideration was needed to be given to the proposal of reducing the length of stay particularly for first time mothers and those with specific maternal vulnerabilities. The Northern Ireland Practice and Education Council for Nursing and Midwifery stated that

"timely discharge from hospital is appropriate for mother and baby…however should be managed on an individual basis."-NIPEC

Antenatal Education and early parenting

Respondents liked the idea of improving antenatal education and early parenting care. It was felt that good health begins before birth and there was a high importance for good easily available pre-conception care, advice, information and support. Some respondents felt that by placing an even greater focus on pre-conception care for example promoting physical activity, healthy diet, stopping smoking, reducing alcohol intake this will reduce the burden on paediatric services in the long term. There was a welcome to the commitment to promote and support positive, engaged parenting particularly in those families where parenting skills are limited.

Configuration of Maternity Units

Royal College of Midwives agreed with proposals regarding the regional configuration of maternity units, and endorsed the view that any future changes should be planned and managed with full engagement:

"we support the proposals…however we seek assurance that any future change in service configuration will be managed in a timely fashion." - Royal College of Midwives

However, there were some concerns about the proposed freestanding midwifery led units from some respondents. The British Medical Association disagree with the implementation of freestanding maternity units saying

" evidence of safety of midwifery led units is lacking" - BMA

However respondents were generally positive about midwifery led units when on the same site or in close proximity to a consultant led obstetric unit.

There was strong support from a small number of respondents for retaining full obstetric led services at Causeway Hospital.

It was also noted that the on-going reviews of paediatrics services by the DHSSPS may impact on maternity services.

" any changes in paediatric care provisions across regional, district and general hospitals such as in neonatal care will directly impact on maternity services" – NI Commission for Children and Young People

In addition to the proposals set out in *Vision to Action*, it was suggested by a number of respondents that Northern Ireland would need a full inpatient perinatal mental health unit for mothers and babies. The Royal College of Psychiatrists stated that Northern Ireland currently "lags behind" in perinatal psychiatry and The Royal College of Midwives argue that

" further and urgent consideration should be given to the development of an inpatient perinatal mental health facility from women in Northern Ireland" – Royal College of Midwives

In addition to the quantitative data shown above which covered maternity and child health proposals, a number of themes can be drawn out from the comments we received about the proposals in relation to Child Health:

Family Nurse Partnerships

There was a welcome from many for Family Nurse Partnerships (FNPs) with respondents stating that they would like to see them extended further as they promote positive parent/ child interactions especially for families where parenting skills are limited. It was also recognised that these are currently in development phase.

"…we look forward to the wider roll out of this programme to support vulnerable young mothers…" – National Children's Bureau NI

Review of acute paediatric services

There was a general agreement on the need to move towards admitting children under the age of 16 to age appropriate paediatric settings. Concern was expressed around the lack of inpatient facilities for children who have to go to adult wards. The Northern Ireland Children's Hospice highlighted the fact that, due to advances in treatment, many children with life limiting conditions are living longer and may now survive into adulthood, therefore there needs to be a smooth and managed transfer of their health and other care needs to adult services and this is challenging. They also showed support for the review of acute paediatric and end of life services and

"support the aspiration to develop a regional approach to the future organisation of services" - Northern Ireland Children's Hospice

Health and Social Care Board

Paediatric Sub specialities

There was a small number of responses commenting on the on-going Paediatric Cardiac Congenital Services consultation expressing the wish for full cardiac services to remain in Northern Ireland.

Other Comments

The Northern Ireland Commissioner for Children and Young People raised the fact that health professionals often fail to; actively engage children in decisions about their health, provide information to children, or to understand children's capacity to make decisions and give consent. They call for health professionals to be mindful of the rights of the child and encourage children and young people to be actively involved in decision making in accordance with age and maturity.

5.10.3 HSCB Response

Of those that expressed an opinion in regard to the proposals for Maternity and Child Health services, there was broad support for the direction of travel and the proposals as a way of achieving the aims set out. Subject to approval of the Minister to proceed, as we develop detailed implementation plans, we will be particularly mindful of the need to;

- Continue to promote the normalisation of birth and community services for ante-natal care, supported by seeking to ensure that the number of community midwives are commensurate to demand (this will be part of the workforce planning work described in Part 4.4).
- Conduct further consultation and engagement on future changes to hospital maternity services – this will be particularly relevant with regard to freestanding midwife led units.
- Subject to the evidence from the pilots in the West, South and Belfast areas, seek the rollout of Family Nurse Partnership Programme regionally.
- Ensure the outcomes of the forthcoming Review of Acute Paediatric Services, and further reviews to be undertaken, are reflected in future plans.

In addition, the HSCB has already embarked on a scoping exercise for a regional perinatal mother and baby unit, and as part of this we will review the views on this matter expressed during this consultation.

5.11 Acute Care in Hospitals

5.11.1 TYC: Vision to Action Key Proposals

With regards to regional services the key proposals were:

1. Making sure everyone has 24-hour access to safe, sustainable cardiac **catheterisation laboratory services** – including the introduction of an (emergency) primary Percutaneous Coronary Intervention service, which is a milestone of the Northern Ireland Executive's Programme for Government – with an associated investment of up to £8m over the next three years. Two sites would be developed: one in Altnagelvin Hospital and the other in Royal Victoria Hospital.
2. Expansion of **orthopaedic** services in Southern, Western and Belfast Trusts with an investment of up to £7m revenue over the next 3 years, to significantly reduce waiting times for fracture and other orthopaedic services for patients.
3. To ensure safe, sustainable arrangements are in place for the provision of **Paediatric Congenital Cardiac Surgery** and **Paediatric Interventional Cardiology** for the population of Northern Ireland.
4. The DHSSPS will be carrying out a **review of paediatric services**, with a view to beginning consultation within 6 months. A review of palliative and end of life paediatric services will follow.
5. Our **Ambulance** services will continue to develop new protocols which support "right care, right place, right time, right outcome". Protocols will be outcome-driven and reflect best practice. They will provide alternatives to going to hospital, support people to safely manage their health at home (where appropriate), and take patients without delay to the most clinically appropriate destination.

   This means that sometimes a patient may not be taken to the closest Emergency Department but be taken directly to a facility they have been to before, or be taken to a hospital which is not the one closest one but specialises in treating their condition.

   Key initiatives include looking at the feasibility of:
   - A "111" urgent care service sitting alongside "999" – simplified access to urgent care 24/7 with real-time clinical advice and direction/support in accessing healthcare.
   - Hospital-at-home protocols with suitably trained and equipped ambulance, hospital and community based clinicians organising and providing clinical assessment and treatment in settings other than hospital.

Health and Social Care Board

6. Enhance the dedicated paediatric and neonatal transport services throughout Northern Ireland.

In relation to each area, the key proposals were:

1. In **Belfast** the hospitals, comprising Royal Victoria Hospital, Belfast City Hospital, the Mater Hospital and Musgrave Park Hospital, would operate as one network with clinical services dispersed across the sites in the best configuration available. Specifically recent consultation recommends one emergency surgery centre at the Royal Victoria Hospital. Emergency department configuration across the network will be consulted on in 2012.

2. The principal hospital in the current **Northern** network is Antrim. It would continue to deliver all core general hospital services – surgery, medical, emergency department, maternity, renal etc. – responding to its natural population area. A large number of people using Antrim Area Hospital live in the greater Belfast area. Network arrangements need to reflect this and ensure appropriate links with Belfast Hospitals.
   The need to ensure that acute hospitals are providing safe and high quality services and the natural population flows in the area means that change will occur on the Causeway site in terms of its core in-patient services. There would be access to 24/7 emergency/urgent care on both Antrim and Causeway sites, which would be doctor led. We need to responsibly manage this change over the next 3-5 years.

   In that context, any decisions about the networking and future services in Causeway Hospital reflect a strong commitment to the continuing local role for the hospital, but also enable it to benefit fully from being networked with other hospitals.

   There will always be some degree of networking between Causeway and both Antrim Area and Altnagelvin Hospitals across the wide range of services, as there is at the moment. However, in planning the organisation of our services, we should consider which formal networking arrangement would have greatest benefit to the population served by the Causeway Hospital and to ensure effective delivery of safe, sustainable and resilient services for patients and clients.

One option is to focus on developing existing networking arrangements with Antrim Area Hospital. However, given the future changes which are likely to occur in services at Altnagelvin, such as increased radiotherapy, cardiology and orthopaedics, and consequently the likely natural flow towards Altnagelvin, it may be better to develop a more formal network between Causeway and Altnagelvin.

There would in effect be three options:

(a) An enhanced network with more formalised integrated working between Causeway and Antrim Area Hospitals, with the Causeway Hospital remaining the responsibility of the Northern Trust.

(b) An enhanced network with more formalised integrated working between Causeway and Altnagelvin Hospitals with the Causeway Hospital remaining the responsibility of the Northern Trust.

(c) An enhanced network with more formalised integrated working, between Causeway and Altnagelvin hospitals with the Causeway Hospital becoming the responsibility of the Western Trust. Consideration could also be given to the transfer of community services for the population served by Causeway Hospital to the Western Trust.

Looking to the future an appraisal of the implications of each of the above options should be undertaken. It is envisaged that a final decision would be made within 6 months of the close of consultation.

3. In the **Southern** area, there is already strong evidence to suggest that changes have occurred across Craigavon Area Hospital and Daisy Hill Hospital which demonstrate robust networking. This includes a network of medical staff which supports the provision of safe, quality care for more acutely ill patients in the High Dependency Unit in Daisy Hill Hospital, through 'virtual wards rounds' with specialist medical staff based in the Intensive Care Unit in Craigavon Area Hospital. They use new technology which means that the specialist is involved in clinical decision making and can talk to patients and families, as if they were physically present. There is also a networked approach to Emergency Departments to ensure that service is safe and sustainable on both sites at all times through shared protocols

Health and Social Care Board

and management. This model is to be supported and encouraged, and it is expected that further sensible changes will occur to maximise the effectiveness of this network in line with the criteria for acute care.

4. In the **South Eastern area** there is a principal hospital network encompassing the three hospitals – Ulster Hospital, Downe Hospital and Lagan Valley Hospital with clinical activity dispersed across the 3 sites. The Ulster Hospital will have 24/7 Emergency department and the full range of normal acute hospital services. The urgent care model operating at Downe Hospital covered by GP out of hours would continue and it is proposed that this would be extended to Lagan Valley Hospital.

   Of equal importance is the network between the South East and Belfast. This is most obvious in a flow from Lisburn to Belfast and from east Belfast to the Ulster Hospital. This networking is to be supported and encouraged. Looking to the future the evolving network will continue to use the criteria to shape service provision.

5. The **Western area** has two acute hospitals – the new South West Acute Hospital in Enniskillen and Altnagelvin in Londonderry. The South West Acute Hospital will reflect the needs of its population areas including the dispersed rural population and provide all general hospital services. Altnagelvin Hospital will in future provide a wider range of specialist regional services, including future investment in orthopaedics and cardiology, and cancer services from 2016. Altnagelvin will continue to network with Causeway Hospital and Antrim Area Hospital as appropriate.

   The South West Acute Hospital would network strongly with both Altnagelvin and with Craigavon Area Hospital in the Southern area. This reflects natural population flows and takes account of planned specialist service developments.

5.11.2 What people told us

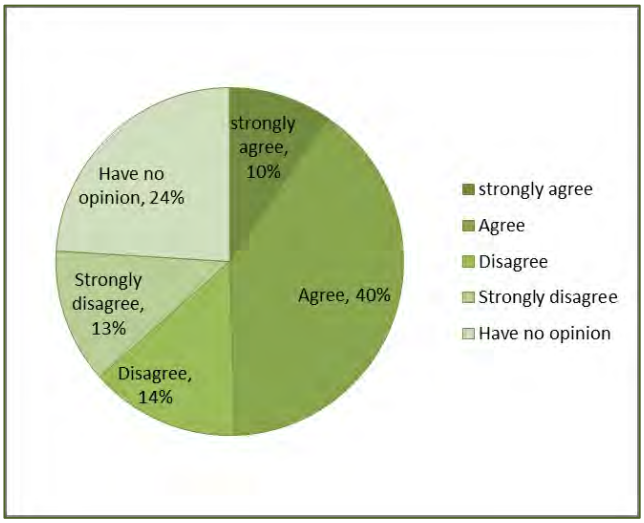
We asked two questions in relation to Acute Hospital Services:

1. *Do you agree with the proposals set out in respect of acute hospital services? Do you believe there are better alternatives?*

Of the 254 questionnaire responses, 208 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion:</u>

- ***66%** agreed or strongly agreed with the proposals.*
- ***34%** disagreed or strongly disagreed.*



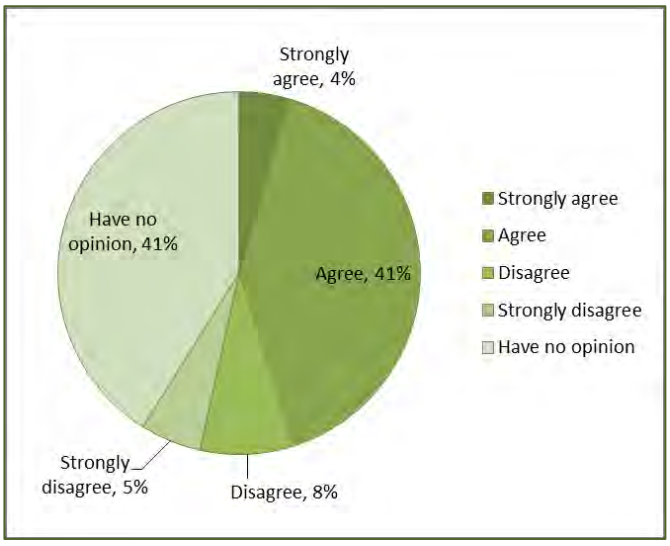
2. *Do you agree that the criteria set out in Appendix 1 against which acute services have been assessed remain the most appropriate criteria?*
If you disagree or strongly disagree, please provide specific details on what you see are more appropriate criteria. Please give reasons for your comments.

Of the 254 questionnaire responses, 202 answered this question. The graph below sets out all the responses we received in percentage terms

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion</u>:

- ***77%** agreed or strongly agreed with the criteria.*
- ***23%** disagreed or strongly disagreed*

In addition, a number of themes can be drawn out from the comments we received about these proposals:



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There was general support for the need to review acute hospital configuration and investment in specialties was warmly welcomed and recognised. Of those who expressed an opinion via the questionnaire, 66% agreed with the proposals, with some saying that we are over-reliant on too many acute hospitals, and others saying that these are necessary changes which should be done in a managed way rather than through response to crisis, which could mean that community and other services will not be adequately equipped.

A number of respondents felt that there was a need for more clarity on what hospital networks mean and how they will operate. It was also evident in some responses that there may be some confusion that the proposal for 5-7 hospital networks was interpreted as 5-7 acute hospitals – it is not the case that *Vision to Action* proposed to close acute hospitals. Although some respondents did promote the need to reduce the number of acute hospitals.

"Agree. NI has too many acute hospitals. The service should be designed to provide the best sustainable clinical solution that is as accessible, within geographic constraints." - Individual Response

Overall, safety and quality of services, was paramount for many respondents.

The Patient Client Council commented:

"People are concerned about the future of hospital care and treatment. They want to be assured that their families have access to hospital services within a reasonable timescale and be assured of the quality of care they can expect" - The Peoples Priorities for Transforming Your Care 2012 (Patient Client Council).

There is clear evidence of a need to engage with the public in the implementation of any changes to acute hospitals and community based services if real change in the pattern of acute services is to be achieved.

"There needs to be a clear communication to the public about the profile of services available for each hospital and how they access them" - Western Health and Social Care Trust

Whilst some expressed an anxiety that they may need to travel further for some specialities, others recognised that increasing specialisation meant hospitals needed to work in networks, and not all services would be available everywhere:

"Agree, young people are willing to travel further as long as the treatment is better" - Barnardos

A strong emphasis emerged of the need to take account of access to acute hospitals for rural communities and emphasised that a critical enabler would be improvement of public transport access and the road network. This issue was raised at the public meetings and was also reflected in written responses received.

There was a significant welcome for development of more local and community based services especially among those in rural areas.

In general respondents called for changes to acute hospitals to be planned and managed effectively and for alternatives in the community to be in place and working effectively before changes are made.

"Investment in local services and community alternatives and ICPs will make the transition to fewer acute hospitals possible" - Individual Response

There were some perceptions that the proposals would result in a reduction in accessing acute care at a time when A&E services are already under pressure and that there should instead be an investment in front line staff and a reduction in management costs.

Also in relation to staff and resources, it was proposed that a robust medical workforce strategy should be developed to keep acute facilities operational into the future. There was support for implementing seven day a week services in acute hospitals as well as networking with other sites in the locality. The Royal College of Nursing felt it was important to clarify the patient flow and staffing within networks (particularly Causeway Hospital).

It was suggested that there should be a greater focus on the impact changes in the acute hospital configuration will have on the NI Ambulance Service. Many respondents highlighted that the success of reconfiguring hospital services will be dependent on a fully resourced and responsive ambulance service. This was especially important to those living in rural areas where some respondents felt that the ambulance service is currently under pressure to meet targets and worried that response times could suffer if proposed changes to acute services are implemented.

Health and Social Care Board

It was proposed by some clinical respondents that acute diagnostic accuracy is a major clinical and financial problem and more emphasis on diagnostic accuracy would improve all aspects of the health service.

There were very few responses which addressed the proposals for introduction of the Urgent Care "111" service but there was some concern expressed by one of the professional groups that this would have significant impacts on primary care as evidenced in England.

Local Proposals

Often local issues dominated responses and discussion at public and stakeholder meetings, and were raised with regard to maintaining or re-instating full acute services at Causeway Area Hospital, Mid Ulster Hospital and the lack of acute facility in Tyrone, specifically Omagh. These issues were very strongly highlighted in those localities and those present emphasised how important a fully functioning Emergency Department and acute hospital was to them.

The single issue which prompted the most responses was in relation to Causeway Hospital, in the Northern Area, which formed the basis of nearly 70% of overall responses. These were single issue responses, focussing mainly on the Causeway area, in one of three standard letter formats signed and submitted by individuals. This highlighted the strength of local feeling. A copy of the text of these letters can be found in Annex 4.

All of these letters wished to emphasise the need for full acute services at Causeway Hospital. The majority of these (1,506) supported the option to transfer management of the Causeway Area Hospital to the Western Health & Social Care Trust to allow better networking with Altnagelvin hospital. Coleraine Borough Council was in support of further appraisal of the options for the future. The Causeway Hospital Medical Staff Committee commented:

"Causeway Hospital Medical Staff see the TYC proposals as an opportunity to create improved care networks for the local population and create safe, sustainable and resilient service for the future… In the opinion of Medical Staff, enhanced networking with Altnagelvin with Causeway becoming the responsibility of the Western Trust is an option that must be fully explored" – Causeway Hospital Medical Staff Committee

This can be contrasted with the views of the Northern Trust which set out its view for maintaining the current arrangements for both acute and community services.

It was also emphasised by many that if management of the Causeway hospital transfers to the Western Trust it is vital that the community services for that locality also transfer. In relation to other local proposals the following was noted:

- In relation to proposed investment in cardiac catheterisation, the South Eastern Trust comments that TYC does not make reference to the regional review which has been deferred for 18-24 months; also they argued for the inclusion of acute cathetarisation lab services for Ulster Hospital. In addition they wished to see reference to development of orthopaedic services at the Ulster Hospital.
- There were a number of respondents who referred specifically to the Northern Trust in terms of performance and current services. This includes some of the Councils in that area, and other interest groups (for example 'Save the Mid'). Some of these responses highlighted current service issues, and did not feel that the proposals address these sufficiently.
- In the Southern Area, there was welcome for greater networking and the security that this gives to Daisy Hill Hospital. Given the rural nature of the area and poor roads infrastructure it is essential that services are retained and enhanced at Daisy Hill, supported by Ambulance services.
- In the Western Area, the main concerns expressed were the lack of profile given in the proposals and plans to the new enhanced local hospital in Omagh and its role in future.
- There was general support for the networking of Belfast hospitals although the response from the Mater Hospital Trustees did emphasise their position that in order to meet the needs of the North Belfast population, general medical and support services must be maintained on the Mater hospital site including a twenty-four hour A&E unit.

Acute criteria

Very few respondents commented specifically on the criteria set out in the document against which acute services have been assessed. One respondent wished to see more rationale behind the criteria.

Many of those who did comment on the acute criteria generally agreed with those proposed and supported their use in assessing acute services. There was a view that 'Local Access' and 'Stakeholder Support' should have more weight within the criteria.

It was proposed that patient outcomes should also be a critical indicator as well as safety and quality, and that retention of a skilled workforce should also feature as a key criterion (this is already contained under 'Deliverability and Sustainability').

5.11.3 HSCB Response

Following consideration of the responses to the proposals for acute hospital services, this would indicate that a more detailed Options Appraisal on the future of management arrangements for Causeway Hospital should go forward with a view to completing this appraisal within 6 months. The responses also indicated this should include consideration of community services.

Subject to approval of the Minister to proceed, in moving forward with developing detailed plans for acute hospital services, we also recognise that the following will be particularly important in response to what we have heard:

- Workforce development plans which are to be developed to underpin TYC should take account of the call for more '7 day a week' services to be commissioned.
- Ensure that there is clear and widespread communication to clarify what is meant by a hospital network, emphasising that TYC does not propose 5-7 hospitals but rather 5-7 hospital networks, and what this will mean for the public, both regionally and locally.
- Ensure that communication plans make clear the investment and progress in local services and community alternatives via ICPs and intermediate care.

In addition, the need to consider how better collaborative planning of public services relevant to the access to acute services for rural communities and the improvement of public transport links, can be achieved across government departments, as set out in proposals in the original TYC report.

5.12 Increasing links with Republic of Ireland and Great Britain

5.12.1 TYC: Vision to Action Key Proposals

1. Create more formal contractual arrangements with the Republic of Ireland to reflect this pattern of care.
2. Establish closer planning links to enable the achievement of best outcomes for citizens

5.12.2 What people told us

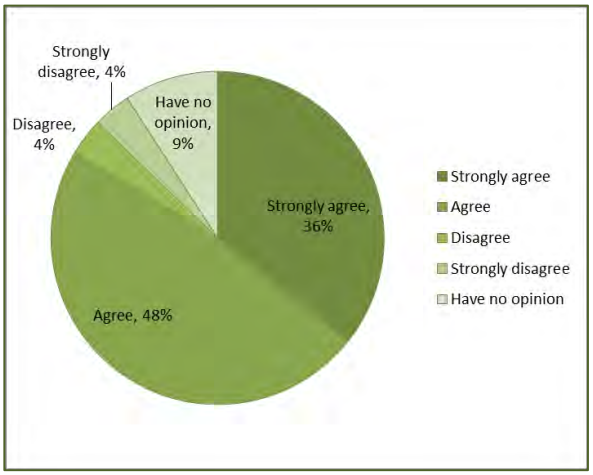
We asked:

To what extent do you agree we should develop closer working relationships with the Republic of Ireland and Great Britain?

Of the 254 questionnaire responses, 219 answered this question. The graph below sets out all the responses we received in percentage terms.

The statistical analysis of the responses to this question show that <u>of those who expressed an opinion</u>:

- ***92%** agreed or strongly agreed*
- ***8%** disagreed or strongly disagreed*



In addition, a number of themes can be drawn out from the comments we received about these proposals:

The majority of respondents agreed with *Vision to Action*, and the feedback given was very positive with the overall feeling being that the proposals were logical and sensible. In particular, respondents felt that:

- The sharing of learning between clinicians will ensure that patients can get the best care and expertise and will benefit from the most up to date treatment and knowledge.

"…links are vital for sharing best practice and innovation…."- Ulster Chemist Association

- Respondents welcomed the fact that increasing links can mean a reduction in waiting times for certain procedures and it was generally felt that for very specialist care they did not mind where that care was being received as long as it meant a better outcome and better results for them.

"Break down all barriers and work with whoever is necessary to provide the patient with the service they require to keep them well or to get them well" – Individual Response

- In respect of forging more formal arrangements with other jurisdictions, support was given by a large number of respondents and the new radiotherapy centre in Altnagelvin was mentioned by some as a good example of how this is already happening.

Whilst there was broad agreement there were a number of respondents (8%) who disagreed with the proposals. Various reasons were given, including:

- The impact of travelling to another country for treatment would have on families and the need to be mindful of the huge stress and strain this could place families under. The British Psychological Society stated that

" ..the stress caused would complicate an already emotionally challenging situation"- British Psychological Society.

- Concern that we do not have enough resources to support the Northern Irish population therefore we should not have formal arrangements with other jurisdictions.

"NI health service can't support people in Northern Ireland never mind another drain on resources" – Individual Response

Additional Comments

Some respondents felt that although forging links with Great Britain and the Republic of Ireland was good it was important not to overlook Northern Ireland as a centre of excellence and that it is important for Northern Ireland to be able to carry out research and become a pioneer in medical research.

A number of respondents also mentioned the Paediatric Congenital Cardiac Services review being carried out by Health and Social Care Board, and expressed concern that these services would be impacted.

5.12.3 HSCB Response

Given the broad agreement, and subject to approval from the Minister, we propose to move forward with plans for establishing links with the Republic of Ireland and Great Britain as set out in *Vision to Action*, ensuring patient care and outcomes are the priority in doing so.

Health and Social Care Board

5.13 Equality and Human Rights

5.13.1 What Vision to Action said

The HSCB undertook an Equality and Human Rights Screening on the proposals set out in *Vision to Action*, and published this as part of the consultation.

One of the stated objectives of TYC and the draft plans is the reduction in health inequalities and the promotion of equality of opportunity. The proposals are not about pausing or stopping changes that are already underway and delivering better outcomes and experiences for patients, staff, service users and carers, but rather TYC seeks to draw these together into a clear and coherent picture.

This means that some of the proposals had already been subject to robust screening and impact assessment as appropriate. Other service changes which are new or represent a significantly different way to provide health and social care services will be subject to all appropriate equality screening and impact assessment.

Also due to the strategic nature of the draft plans, the detail of the approach to implementation has yet to be worked out. As these become known, and further evidence on the nature of the impact on each group becomes clearer Equality Impact Assessments (EQIA) will be undertaken as required and in accordance with our obligations in this regard, and our commitment to promoting equality and human rights.

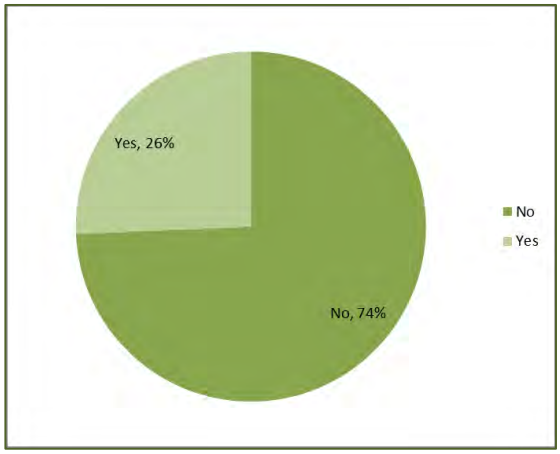
This document also emphasised that the equality issues identified in response to this consultation exercise will inform future screening and impact assessment exercises.

5.13.2 What people told us

We asked the following four questions:

1. *Are the proposals set out in this consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals.*

Of the 254 questionnaire responses, less than half answered this questions (113 responses), although it was also featured in some free-form responses.

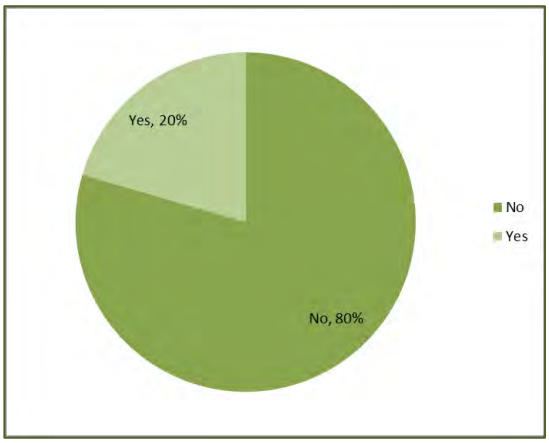


The statistical analysis of the responses to this question show that:

- ***74%** felt that the proposals were not likely to have an adverse impact on any of the nine equality groups*
- ***26%** thought it could have an adverse impact*

2. *Are you aware of any indication or evidence – qualitative or quantitative – that the proposals set out in this consultation document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.*

Of the 254 questionnaire responses, again response rate was low with only 122 answering this question.



The statistical analysis of the responses to this question show that:

- ***80%** responded that they were not aware of any evidence that the proposals would have an adverse impact on equality of opportunity or on good relations*
- ***20%** responded that they were aware of evidence that the proposals would have any adverse impact*

3. *Is there an opportunity to better promote equality of opportunity or good relations? Please give details as to how.*

4. *Are there any aspects of the proposals where potential human rights breaches may occur?*

Health and Social Care Board

With regards to questions 3 and 4, these were freeform responses with no quantitative data. Comments received have been included in the analysis below.

In addition to the above data, we received comments from some respondents. The themes emerging from these are set out below.

The majority generally indicated, as both graphs above illustrate there would be no obvious breach of human rights or equality obligations as a result of the proposals in *Vision to Action.*

There was agreement with the movement towards a greater emphasis on a human rights approach within Health and Social Care being promoted by the Transforming Your Care agenda. Particularly welcomed were the continued discussions between the HSCB and a number of organisations such as The Northern Ireland Human Rights Commission and Equality Commission, with Northern Ireland Hospice stating the

"Commitment to on-going dialogue with Northern Ireland Human Rights Commission will assist a Human Rights Based approach"
– NI Hospice

Of those that made comments in this area, the majority of which were from organisations, there were calls for a full Equality Impact Assessment (EQIA) to be undertaken for the entire TYC programme at the earliest opportunity. Northern Ireland Council for Ethnic Minorities believes that, a full EQIA is required as:

"TYC represents a new strategic direction with particular vision, aims and priorities and thereby represents a fundamental shift in the delivery of all existing health and social care provision." – NI Council for Ethnic Minorities

Disability Action noted the difficulty responding to this section without an EQIA stating:

"As no evidence is provided in relation to the EQIA the consultee has no research on which to base our comments." – Disability Action

The Equality Commission welcomed the key principles and intended outcomes in TYC and also welcomed the increasing equality approach and that the plans *"provide an opportunity for the Department (sic) to actively contribute to the progressive realisation of the right to health and social care",* and also requested that consideration is given to an EQIA *"at this stage or when firmer proposals have been developed at a later stage".* The HSCB would welcome further discussions with key

stakeholders on how we can best ensure that equality and human rights can continue to be integrated into our plans.

Also the Equality Commission expressed concern that the relevant Departmental templates had not been used. Just to provide clarity on this point, the HSCB used their own screening template, as the *Vision to Action* document covered the service changes proposed by HSCB. We would welcome discussion on this point in future to ensure that we can develop an appropriate framework for the continued screening and assessment of equality issues.

The equality screening was completed using the most up to date data available at the time. However a few respondents have recognised that this data is subject to change with the on-going release of 2011 census data. With the Equality Commission stating:

"We would stress the importance of using the new census data as it is released in order to ensure that equality impacts are accurate." – Equality Commission

A small number of organisations also made comments with regards to human rights, referencing the international conventions and frameworks that would have relevance to health and social care. Whilst comments do not provide any compelling evidence of human rights breaches, it does give helpful indication of issues we must be mindful of, and the need to explore ways we could potentially further promote human rights. For example, particular comment was made around the rights of children and young people in health and social care by the NI Commissioner for Children and Young People. They said that due regard should be paid to human rights obligations under international law specifically in this case The Convention on the Rights of the Child:

"It is of particular importance that TYC is underpinned by a rights based approach to health and wellbeing; promotes a holistic and life course understanding of health; engages directly with children and young people in relation to both their individual care and broader development and review of services. This should include the participation of vulnerable groups of children and those with particular or complex health and social care needs."-NICCY

The HSCB continues to engage with the Human Rights Commission to explore how we can take an increasingly human rights based approach.

A small number of individuals raised concerns around privacy. Arising from the use of new technology such as Electronic Care Records and

telemonitoring in health and social care, there will be a requirement for robust data management and security.

Specific comments in relation to s75 equality groups include:

- Women's Support Network and Women's Resource and Development Agency noted that women are more likely than men to have caring responsibilities. The Northern Ireland Society of Social Workers (NISAW) agreed adding that the proposals could *"increase the burden on this section of the community."* Carers NI drew attention particularly to women bringing up their own children while simultaneously caring for a parent.
- The movement of resources from secondary care to primary and community care was noted as having a potentially negative impact on a number of groups who are more likely to access care through the Emergency Department and not through a GP or other primary care. This was mentioned specifically in relation to the traveller community.
- Age discrimination was referred to by a number of respondents, with the Equality Commission making reference, in a stakeholder meeting, to the possible introduction of new age discrimination legislation, and for account to be given to the possible effect of this. Care for the elderly was commonly presented as an area of concern, with a small number of respondents interpreting the reduction of statutory residential care as age discrimination. The disparity between children's and adult services in learning disability has been mentioned by a number of respondents.
- The proposed shift of services into the community led some respondents to highlight worries about the availability of foreign language interpreters and signers for deaf patients.

5.13.3 HSCB Response

As a result of the responses received to this consultation, the HSCB is committed to updating the screening document that developed alongside the draft Strategic Implementation Plan and *Vision to Action* covering those service changes arising from TYC for which HSCB has responsibility. This will take account of the evidence and views expressed to us during this consultation.

Whilst we acknowledge the calls for an EQIA at this point, we remain of the view that it would not be meaningful to conduct an assessment on an overarching strategic vision, rather it would be more meaningful for specific service changes to be subject to full impact assessment as the

specific impact on s75 groups can be fully assessed once detailed plans are known. This view also recognises that some of the proposals have already been subject to screening and EQIA when they were developed as policy. We are therefore not proposing to conduct a full EQIA at this point, but will continue to keep this under review.

The HSCB is committed to both fulfilling our obligations with regards to equality and human rights, and also to integrate an equality and human rights based approach into the design of services in future. Through the TYC implementation therefore we will continue to have on-going dialogue with both the Equality Commission and the Human Rights Commission on how this can be best achieved.

In doing so, we recognise that more could be done to engage people in the debate and concepts of equality and human rights, and we should be seeking to take the lead in engaging the general public on these matters. The low response rate to these questions (which are standard equality and human rights questions commonly used in public consultations) and the finding that many organisations did not comment on this section perhaps indicates that more could be done to build understanding amongst those we are engaging with and consulting. This will be taken into account as we continue to engage and consult during the implementation of TYC.

Health and Social Care Board

Part 6. Supporting the Changes to happen: Consultee Response

6.1 Workforce

Due to the responses received in relation to workforce, this has drawn out as an overarching theme, and a discussion of what people told us is set out in Part 4.

6.2 Procurement

The response to Question 5 showed there was broad support for having a mixed economy of service providers for care in the home, although it is also recognised that a significant minority of those responding to this question would prefer this to be provided by statutory bodies.

Many comments received around the subject of procurement highlighted the view that the process should be more accessible to smaller organisations to ensure that their unique contribution could be secured and there is adequate and fair competition. The complexity of the process, the considerable time involved and level of specialist knowledge required means that some smaller groups, particularly within the Voluntary and Community sector, find this restricts their participation or even excludes them altogether from the tendering process because they cannot provide enough people to prepare the necessary details for submission. Some respondents from this field also recognise that the sector needs to do more to build collaborative networks within and across the sector to support their own capacity in this regard.

"It is envisioned, the voluntary and community and independent sectors are to play an increased role, including in service provision, serious consideration needs to be given to capacity building work which may be required to enable organisations with required skills and experience to participate in the procurement process." - NICVA

A further comment was that it is difficult to conduct medium to long term business planning, and recruit and retain staff where contracts for services are only awarded on a short term basis.

The very small number of respondents from the private / independent sector recognised the need for wider cultural changes, and wished to see greater involvement between the independent sector and the HSC

to *"assist with assessment of the capacity of the sector and the level of service offering both now and into the future" – Home Care.*

There were also calls for a price regulator for the sector.

Some respondents commented that the personalisation of care agenda raises the debate of procurement for individuals where initiatives such as Direct Payments are taken up, this could mean the service user buying their own services.

Some respondents were very supportive of Direct Payments where they are appropriate. Others highlighted risks around this, not least the potential for people to receive sub-standard care that is unchallenged because of the difficulties regulating care delivered to a person in their own home by a non-statutory provider, purchased by the individual. RQIA in particular highlighted this point:

"Whilst this model enables people to arrange more convenient and person centred care, there is no robust mechanism in place for assurance about the training, skills and suitability of people who may be procured to provide care by those using Direct Payments." - RQIA

There were some comments about standards of community care packages that were in place at present which will need to be borne in mind in future procurement exercises for this type of care. The comments centred on the lack of flexibility in domiciliary care services; the lack of continuity of care staff; and the variable costs to the individual of some nursing and residential placements. These are all matters that are of concern to service users and carers and consideration should be given to this in terms of the quality standards that apply to future procurement exercises. Some respondents from the independent sector said that the true cost of providing domiciliary care needs to be assessed, to ensure that the services are of high-quality.

In response to the comments made in respect of procurement and subject to the Minister's approval to proceed, the HSCB will move forward to standardise domiciliary services and nursing home places across Northern Ireland. In addition to support the overall implementation of TYC, we shall:

- Seek further guidance regarding Social Enterprise and how to facilitate this whilst ensuring correct procurement practice.
- Seek further guidance on further regulation of social care and domiciliary care workers.

- Operating within appropriate procurement guidance, consider ways to support the V&C sector to build the necessary capability and capacity to participate effectively in service design and in procurement processes. This could include, where possible, to promote longer term contracts and social objectives/ clauses.

6.3 Technology

There were many references to making more effective use of technology, whether it is by using systems to share information between hospital, primary and community care services more effectively or some of the practical considerations around telemonitoring and telehealth. There is specific mention of responses on technology in the sections on Long Term Conditions and Older People.

There was broad support for the Electronic Care Record where an opinion was expressed, and those respondents saw significant advantages for patients and staff in this approach.

"We believe that the use of electronic care records to assist better communication between the various settings in which cancer patients receive care, together with tele-health have a valuable contribution to make in delivering care closer to home." Macmillan Cancer Support

"We believe it would be better to invest in technology that will better connect primary and secondary care to facilitate shared records, information transfer, treatment and advice plans, and enable easier communication between doctors in general practice and hospital. The success of TYC itself will depend on clear lines of communication between primary and secondary care."- BMA

Greater use of technology to provide healthcare remotely was generally welcomed although people tended to associate it more with delivering care in community settings than facilitating hospital networking approaches. With regard to delivering care in community settings, people generally welcomed the facility for their clinical carers to have remote access to results and records to help manage their condition and many saw this as a very important part of the hub and spoke model of care, which must be appropriately resourced.

Technology to support remote monitoring of people in their own homes was generally welcomed although there were some caveats around ensuring that the person being monitored had the capacity to benefit

from the technology and would not find it counter-productive by, for example, making them more anxious rather than providing reassurance that their condition was under control.

"Assistive technology should not be seen as a "quick fix" for people with dementia, or used as a replacement for human interaction in care for people with dementia. Rather, assistive technology should be seen in the context of complementing an individual's care and support to enhance their quality of life." – Alzheimer's Society

In addition, some respondents were sceptical about the evidence that remote monitoring would make much impact on overall outcomes and on emergency hospital attendances in particular, as there would always be people for whom the safest and only option was admission because their circumstances were such that they could not be safely cared for at home.

For some patients, it was noted that technology would not be appropriate because they had little or no broadband coverage.

"We recommend that the HSCB model the provision of broadband connectivity across NI in advance of rolling out any programmes of telemonitoring in rural communities." – Rural Community Network

Key professional groups were supportive of the need for investment in ICT and Technology, but wished to highlight:

- There is a need to invest in the basic ICT infrastructure as well as applying new and innovative solutions.
- Technology should augment and support the clinical relationship.

In accordance with the response set out in the Long Term Conditions section, HSCB is committed to the investment in technology to support the wider implementation of TYC. As a result of what we have heard during this consultation and subject to the approval of the Minister to proceed, particular focus will be:

- Development of an accurate understanding of levels of internet access /broadband coverage to allow an assessment of where remote monitoring is an option, as a key enabler to investment in 'telemonitoring'.
- Ensure that the assessment process for patients considering remote monitoring includes social factors such as isolation, the needs of the patient's carer and capacity.
- Bring forward outcome based evidence for proposed investment in telehealth, including patient views.

Health and Social Care Board

6.4 *Finance*

Respondents generally did not comment on the particular financial aspects of *Vision to Action*, but some commented on the overall investment available for health and social care services in general and/ or for particular user groups or Programmes of Care.

The range of negative responses with regard to finance included a view that TYC was a cost-saving exercise and a concern that the funding to develop the necessary service models and infrastructure to achieve the shift towards care closer to home would not be forthcoming given financial pressures. An illustrative comment from a Staff Side organisation:

"We would have concerns that the allocation of funding to allow for the transfer of Acute Care, to Community is insufficient and when given the administration costs involved there is little left to resource front line services undergoing the transition." - GMB Union

Where respondents did refer to planned changes and transfer of funds from the acute to community care, some of these sought more detailed information on how and when funds would be transferred. There was little real opposition to proposals to increase investment in community and primary care, but some respondents did feel that secondary care services were struggling and that these would still require investment.

As discussed in Part 4, the need for adequate investment and alternatives to be in place to support the transformation was emphasised by many.

In response to the comments made in this regard, the HSCB reiterates the *Vision to Action* statement that the Health and Social Care budget over the remaining budgetary period are not being cut. Indeed there are projected to be modest increases during this budgetary period. However, we also know that demand is increasing at a faster rate and that sometimes difficult choices will be required. We are embarking on a period of transformation to enable the system to put in place changes in a managed and co-ordinated manner, which will help to prepare for this rising demand, and make better use of the resources we have. The alternative to this is haphazard change in response to crises which limits the opportunity for effective and meaningful engagement.

As part of the implementation and as part of our role as commissioners, we are committed to developing a financial plan linked to the TYC

proposals demonstrating the shift in resources from secondary to primary/ community care. There remains a strong recognition that we will need to be supported by Transitional Funding over a three year period to make the changes happen.

6.5 Organisational implications

Other than remarks that focused specifically on proposals such as the configuration of acute services, the options for Causeway Hospital, and the role and remit of ICPs, there were no significant remarks about organisational implications. A very small number of respondents commented that the focus needs to be on transforming services rather than on organisational structural changes, as the Review of Public Administration was only relatively recently completed.

Health and Social Care Board

Part 7. Conclusion and next steps

The HSCB would like to repeat our thanks to all those who took part or provided their views during the consultation on *Vision to Action*.

We conclude that there is widespread recognition of the need for change in our health and social care system, strong support for the model that Transforming Your Care puts forward, and for the proposals for change which will turn that model into a reality. It is now critical that there is certainty about the way forward and about how TYC will be implemented. In doing so, we need to have an unrelenting focus on delivering high quality and compassionate care to ensure better outcomes for patients, service users and carers.

There will always be calls for more money and more investment in vital services, such as those the HSC provides. However we all know that our current financial reality set against the rising demand means that this will not always be possible. Therefore we need to think and act differently to ensure we meet the needs of everyone in future, and deliver the very best outcomes.

What this consultation has demonstrated is that people want to be involved in the debate about how we can make the best use of the resources we have. Many of the responses expressed their view on what's important to them or the people they represent. We have captured the themes of these responses in this document, including being open and transparent about where people have expressed concerns about the future.

We also recognise and acknowledge the detailed information that sits within these responses, and commit to feeding this forward into how we commission and deliver services.

This report is the HSCB response to a request from the Minister to undertake consultation on the proposed service changes arising from the Transforming Your Care report published in December 2011. In our view it provides a strong foundation for the way forward and implementation of the *Vision to Action* proposals, having due regard to the feedback received during this consultation. Subject to the Minister's approval to proceed, the HSCB, working closely with our colleagues in the Public Health Agency, Trusts and elsewhere, will put in place the

detailed implementation plans to take forward the service changes set out. On-going engagement and consultation with the general public, and organisations involved in the health and social care sector will be critical to achieve TYC's objectives and deliver better outcomes for all, and we welcome continuing the debate and conversations opened during this consultation, over the coming years.

Health and Social Care Board

Part 8. Annexes

Annex 1. Public Meetings held as part of the Consultation Process

Area	Venue	Date	Time
Belfast	NICVA 61 Duncairn Gardens, Belfast BT15 2GB	19/11/12	5.30pm-7.30pm
Banbridge	Banbridge Enterprise Centre, Scarva Road Industrial Estate, Banbridge, Co Down BT32 3QD	20/11/12	6.00pm-8.00pm
Armagh	Health & Social Care Board, Tower Hill, Armagh BT61 9DR	21/11/12	6.00pm-8.00pm
Derry/ Londonderry	St Columbs Park House, 4 Limavady Rd, Derry /Londonderry BT47 6JY	21/11/12	7.30pm-9.30pm
Belfast	The Mount Conference Centre 2 Woodstock Link, Belfast BT6 8DD	22/11/12	3.00pm-5.00pm
Coleraine	The Sandel Centre, 6 Knocklynn Road, Coleraine BT52 1WT	27/11/12	7.00pm-9.00pm
Enniskillen	CAFRE Main Hall, Enniskillen Campus, 2 Mullaghmeen Rd, Levaghy, Enniskillen, Co Fermanagh BT74 4GF.	28/11/12	7.30pm-9.30pm
Lisburn	Trinity Methodist Church, Knockmore Rd, Lisburn, Co Antrim, BT28 2EA	03/12/12	2.00pm-4.00pm
Omagh	Tara Centre, 11 Holmview Terrace, Omagh, Co Tyrone, BT79 0AH.	03/12/12	7.30pm-9.30pm
Belfast	Farset International, 466 Springfield Rd, Belfast BT12 7DW	04/12/12	7.00pm-9.00pm
Down	Great Hall Downshire Hospital, Ardglass Rd, Downpatrick, Co Down BT30 6RA.	04/12/12	7.00pm-9.00pm
Newtownards	Ards Art Centre, Town Hall, Conway Square, Newtownards, BT23 4DB	05/12/12	7.00pm-9.00pm
Newtownabbey	Linen Suite Mossley Mill, Carnmoney Road North, Newtownabbey BT36 5QA	06/12/12	2.30pm-4.30pm
Magherafelt	Civic Room Magherafelt District Council, 50 Balyronan Rd, Magherafelt, BT45 6EN	06/12/12	7.00pm-9.00pm
Newry	WIN Business Park, Mourne Enterprise Agency, Newry BT36 6PH	06/12/12	6.00pm-8.00pm
Ballycastle	Ballycastle High School, 33 Rathlin Road Ballycastle, County Antrim BT54 6LD	11/12/12	7.00pm-9.00pm

The format was as follows:

- Facilitator opened the meeting, provided some introductions to the panel and some background on the process and running order of the meeting.
- A presentation on the main features of the TYC recommendations was delivered by a senior officer of the HSCB, usually a Director.
- The audience were invited to submit questions in writing if they wished, using pre-printed papers provided in the pack of information provided to each audience member. Where a member of the audience wished to ask their question themselves, this was permitted. It was stressed that asking for written submissions was to ensure that all people felt able to submit a question, not just those who felt comfortable to ask personally, and also to help ensure a written record of public questions and concerns.
- Questions were collected, where provided in writing, during a short coffee break. Where there was a volunteer member of the public willing to assist one of the TYC support team to theme the questions, this took place during the coffee break to allow the facilitator to then put those questions to the panel under the relevant headings. Asking a member of the public to assist theming the questions was intended to provide reassurance to the public that there was no attempt to avoid answering certain questions or interfere with the debate in any way.
- The second hour of the meeting was devoted to the questions and comments raised by the audience, which were put to the panel either by the facilitator, or if the audience member wished, they would ask the question directly.
- The meetings typically lasted for 2 hours, after which they were brought to a close.
- Sign language communicators were on hand where requested and TYC documentation was available in audio, easy read and Braille format at each meeting.
- Each meeting was scribed by a member of the TYC team and in addition, audience members were encouraged to provide comments by post-it note by attaching these to a large response poster. They were also provided with contact details to submit a more detailed response to TYC via the various options, as detailed in the information leaflets sent out to every home.

Health and Social Care Board

Annex 2. Consultation meetings held with organisations, groups and agencies

Ballymena Borough Council

Belfast Health and Social Care Trust

British Medical Association (BMA) (Conference Speech)

Chief Officers 3rd Sector (CO3) where a number of Community and Voluntary organisations were engaged

Cookstown District Council

Democratic Unionist Party (DUP)

Equality Commission

Institute of Healthcare Management (IHM) (Conference Speech)

Joint Consultative Forum (JCF – forum for a number of trade union groups)

Mosside Women's Institute

NICON event with a range of attendees

NICVA event (Northern Ireland Council for Voluntary Action) where a number of Community and Voluntary organisations were engaged

Northern Health and Social Care Trust

Northern Ireland Ambulance Service

Northern Ireland Association for Mental Health (NIAMH): 2 workshop events

Northern Ireland Human Rights Commission

Northern Ireland Practice and Education Council (NIPEC)

Omagh District Council

Patient Client Council (Road shows)

Regulation and Quality Improvement Authority (RQIA)

Social Democratic and Labour Party (SDLP)

Social Security Agency

South Eastern Health and Social Care Trust

Volunteer NOW, where a number of Community and Voluntary organisations were engaged

Western Health and Social Care Trust

In addition, a meeting with Community Development and Health Network had been arranged but was subsequently cancelled by CDHN.

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Annex 3. Organisations who responded to the consultation

The following is a list of organisations who responded to the consultation.

55 Alive
ABPI NI
Action Cancer
Action Mental Health
Action on Disability
Action on Hearing Loss
Age Concern Causeway
Age NI
AGE North Down and Ards
All Party Group for Ethnic Minority Communities
Alliance Party Northern Ireland
Allied Health Professions Federation NI (AHPFNI)
Alzheimer's Society
Antrim Borough Council
Ards Borough Council
Armagh City and District Council
Armagh, Banbridge and Craigavon Senior Network
Arthritis Care
Association for Clinical Biochemistry
Association of British Pharmacy Industry
Autism Initiatives
Aware Defeat Depression
Ballymena Borough Council
Ballymoney Borough Council
Ballynahinch Support Group
Bamford Monitoring Group
Banbridge District Council
Bannside Pharmacy
Barnardos Disabled Children and Young Peoples Participation Project
Belfast City Council
Belfast Health and Social Care Trust
Belfast Healthy City
Boots
British Association of Dermatologists
British Dietetic Association NI Board
British Geriatrics Society

Transforming Your Care

British Heart Foundation
British Medical Association
British Psychological Society
British Red Cross
Cancer Focus
Cancer Lifeline
Cancer Research UK
Carers Northern Ireland
Carers Trust
Carrickfergus Borough Council
CAUSE
Causeway Hospital Campaign Group
Causeway Hospital Medical Staff Committee
Causeway Older Active Strategic Team (COAST)
Causeway Trade Union Council
Centre for Behaviour Analysis (QUB)
Centre for Independent Living NI (CILNI)
Chartered Society of Physiotherapy
Chief Officers of 3rd Sector (CO3)
Coleraine Borough Council
College of Occupational Therapists
Commissioner for Older People
Community Development and Health Network (CDHN)
Community Organisations of South Tyrone and Areas (COSTA)
Community Pharmacy NI
Contact a Family NI
Cookstown District Council
Coperation and Working Together (CAWT)
Craigavon Borough Council
Cruse Bereavement Care
Diabetes UK
Disability Action
Disability Social Care Forum
Domestic Care Group
Down Community Health Network
Dungannon and South Tyrone District Council
Early Years
East Belfast Partnership
Environment Link
Equality Coalition
Equality Commission
Extra Care
Family Group Conference Forum (NI)

Federation of Clinical Scientists
Federation of the Royal College of Physicians of the UK
Fermanagh District Council
Fermanagh Sinn Fein Health Group
Fold Housing Association
Friends of the Cancer Centre
Fuel Poverty Coalition
Glens Sinn Fein
GMB Trade Union
Guild of Healthcare Pharmacists Northern Ireland Group (GHPNI)
Headway Newry
Home Care Independent Living
HSC Clinical Education Centre
Institute of Public Health
Irish Congress of Trade Unions
Julie McCarthy Society of Family and Friends
Larne Borough Council
Law Centre
Lisburn City Council
Long Term Conditions Alliance NI
MacMillan Cancer Support
MacMillan, Southern Area Hospice, Marie Curie Cancer Care, NI Hospice and Foyle Hospice ((Palliative stakeholders)
Mater Hospital Trustees
Mederva Ltd
Mid & East Antrim Agewell Partnership
Mindwise
Moyle District Council
Moyle District Council, SDLP
Multiple Sclerosis Society
Multiple Sclerosis Trust
Muscular Dystrophy
National Aids Trust
National Childrens Bureau
National Deaf Childrens Society
National Energy Action (NEA)
National Pharmacy Association
Newry and Mourne District Council
NEXUS
NI Association for Mental Health (NIAMH)
NI Association of Social Workers
NI Commissioner for Children and Young people
NI Council for Ethnic Minorities

NI Council for Voluntary Action (NICVA)
NI Local government Association (NILGA)
NI Practice and Education for Nursing and Midwifery; Incl Educational Steering Group
NIPSA
North Belfast Partnership
North Down Primary Care Partnership
North West Ageing Well Together
Northern Health and Social Care Trust
Northern Health and Social Care Trust Dietetic Service
Northern Ireland Ambulance Service (NIAS)
Northern Ireland Association for the Care and Resettlement of Offenders(NIACRO)
Northern Ireland Children's Hospice
Northern Ireland Conservatives
Northern Ireland Hospice
Northern Ireland Musical Therapy Trust
Northern Ireland Pain Society
Northern Ireland Regional Training and Advisory Group for Cardiac Physiologists
Northern Ireland Social Care Council
Northwest Forum of People with Disabilities
NOVO NORDISK
Omagh Chamber of Commerce and Industry
Omagh District Council
Omagh Forum for Rural Associations
Omagh Womens Area Network
Ophthalmic Committee of HSC Business Services Organisation for Northern Ireland
Opportunity Youth
Optometry Northern Ireland
Pain Alliance NI
Palliative Transport Service
Parkinson's UK
Participation, Engagement, Skills project
Participation and Practice of Rights
Patient Client Council
Pfizer Ltd
Pharmaceutical Society of NI
Pharmacy Forum
Portballintrae Residents Association
Positive Futures
Positive Life

Health and Social Care Board

Praxis
Rare Disease Partnership
Regional Health and Social Care, Personal and Public Forum
Regulation and Quality Improvement Authority
Robinson Memorial Hospital
Royal College of GPs
Royal College of Midwives
Royal College of Nursing
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Speech and Language Therapists
Royal National Institute of Blind
Rural Community Network
Save the Children
Save the Mid
Oyster Peer Support Group
Signature
Sinn Fein
Sinn Fein North Antrim
Skeagh House Action Committee
Skills for life Learning Centre CIC
Society of Chiropodists and Podiatrists
Society of Radiographers
South Belfast Partnership Board
South Eastern Trust Staff Comments
South West Age Partnership
Southern Health and Social Care Trust
Strabane District Council
Stroke Association
Strule Medical Practice
Threshold
Trade Union Office
Training for Women Network
Ulster Chemists Association
Ulster Unionist Party
UNISON
UNITE
United Kingdom Homecare Association
Upper Springfield and Whiterock Integrated Partnership
Volunteer Now
VOYPIC
West Belfast Health Plan
Western Health and Social Care Trust

Western Investing for Health Partnership
Women's Aid
Women's Resource and Development agency
Women's Support Network

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Annex 4. Examples of Standard Letters received

The following pages contain the text of six letters that we received multiple times, often in relation to single proposals:

- 3 in relation to the Causeway Hospital
- 2 in relation to residential homes
- 1 from members of Staff Side organisation
- 1 in relation transgender issues (from Oyster Peer Support Group)

Transforming Your Care

Letters relating to Causeway Hospital (re-typed as scanned image quality was poor)

TYC has many good points and the principle of improving overall standard of health care by better access and increasing provision in the community should be supported.

The delivery plans, however, are flawed because of shortage of trained staff in the community and the high expense. If the current system is dismantled before the proposed changes are in place, there will be an overall deterioration in health care.

Causeway requires a full major Acute Hospital to provide safe and effective care to the resident population and the large numbers on holiday and attending special events. Because of the geographic isolation, this cannot be provided by hospitals in Antrim, Belfast or Derry/Londonderry. Causeway Hospital must be kept open to continue to provide these services.

Improved networking with other acute hospitals and GP/community services would improve efficiency and effectiveness and guarantee sustainability. This would be best achieved by formal links with the Western HSC Trust as there is already effective cooperation in place in orthopaedics, urology and eyes with Altnagelvin Hospital.

This is an expression of great concern among local people about the potential diminution and eventual removal of the Accident and Emergency Service at the Causeway Hospital and the consequent impact on other services in the hospital.

Without the existing provision patients would need to travel an average distance of 27 miles from Coleraine to either Antrim, or Londonderry. The average travel distance by road to an A&E unit in N.Ireland is 8.4 miles, in the Causeway it is 10 miles and now the prospect is a further 27 miles – unlikely to be achieved in under an hour. Even to operate the A&E unit by day only is dangerous and could put lives at risk.

The road network must also be taken into consideration when making such decisions as on one side we have the Frocess road, one of the most dangerous roads in the Province, and on the other side we have the Limavady mountain road which is subject to closure in bad weather. There is no guarantee that in an emergency an ambulance would have a safe and fast route to an A&E department.

The population growth in this area is substantial and is augmented considerably at holiday times. Annual events, such as NW200, the Portrush Air Show and the Raft Race would indicate the need for an adjacent A&E unit.

It is understood that Antrim Hospital is already in difficulty meeting the demands of its catchment population.

The people in the Causeway area are anxious and concerned. We hope that you will consider the above issues and the wellbeing of the local communities when making your decisions.

Health and Social Care Board

Causeway hospital provides acute services for a geographically isolated catchment area with an increasing elderly population. 80% of acute admissions to hospital are older than 65. Over the next 15 years the over 85 group will almost double. As this group has the highest demand for acute services it is essential that they are locally based in keeping with the philosophy of TYC.

Our catchment area grows year on year. Patients from outside our boundaries, particularly since closure of the mid ulster hospital use Causeway as their local hospital. Almost 40% of A&E attendances in the Northern Trust are at Causeway. The population increases to almost 150,000 residents during the summer months and this doesn't include large numbers of day visitors at events such as the NW 200.

Time dependent conditions such as acute stroke requiring a clot busting drug or a child with meningitis where every minute counts require treatment in a centre less than one hour from the onset of illness, not travel time. The current road infrastructure and traffic congestion do not allow acceptable travel times.

TYC has many good points and the principle of improving overall standard of health care by better access and increasing care in the community must be supported. The delivery plans, however, are flawed because GPs are already overworked and are unlikely to be able to take on the extra work. Large number of other health workers will be required if domiciliary care is to be safe and effective, resulting in serious financial and logistical difficulties. If the current system is dismantled before the proposals are shown to work, then there will be an overall deterioration in health care.

Acute care locally in Causeway demands a full Major Acute Hospital. There is no logical rationale for the suggested 5-7 hospitals. The number should be determined by what is required to provide a safe, effective and sustainable service, and the geographic isolation of Causeway supports the need to retain acute services. Improved networking with other acute hospitals and GP/community services would improve efficiency and effectiveness and guarantee sustainability.

The benefits of retaining full acute services in Causeway include the essential support for Regional events such as the NW 200, Raft Race and major golf events and eliminate the deleterious emotional, financial and environmental effects of longer travel distances for patients and relatives. There is already good cooperation with the UUC and there is the potential for further effective research projects. Causeway is a major local employer and closing acute services would have serious economic consequences.

Transfer of formal links to the Western HSC Trust is logical geographically, organisationally and professionally. There are already effective networks in place in orthopaedics, urology and eyes. Services in cardiology and cancer will be further developed in Altnagelvin Hospital giving the opportunity for increasing effective bi-directional co-operation and networking between the two hospitals.

Transforming Your Care

Letters / emails from TUS members:

10 January 2013

Dear Sirs

Public delivery of our Health and Social Care System in N Ireland is part of the NHS which must be valued and maintained as the best and fairest way of meeting Health and Social Care needs.

The Transforming Your Care (TYC) programme while suggesting it will strengthen and make our Health Services more effective, invites and creates opportunities for private (for profit) sector interests to deliver services. This is not a reliable way of ensuring good services. TYC looks like the NI version of the Lansley Act. Complete withdrawal of statutory provision of residential homes for the elderly and an increased focus on direct payment are worrying developments.

Closure of hospital beds and a 3% reduction in jobs signal to me that TYC is about managing cuts with Health and Social Care workers doing more for less.

There is a lack of clarity as how new arrangements for social care in the community will be impacted by the Welfare reforms and Housing needs.

I am concerned that there will be a double impact on those most reliant on the State for support.

I am not comfortable with the fact that the role of local Commissioning Groups is greatly enhanced altering the governance and diminishing democratic accountability within the system.

Our Health Service must remain free at the point of delivery and based on clinical need. TYC does not give me confidence that the strategies it advocates will maintain or protect the NHS in N Ireland.

Name:

E-mail address:

Health and Social Care Board

Letter from Friends of Lisgarel

Response to proposals in 'Transforming Your Care' from Friends of Lisgarel
Friends of Lisgarel is a group of people in the Larne area who are concerned about the proposal to close the services currently provided within Lisgarel Residential Home, Larne.

Lisgarel has played a vital role for the community in the Larne area for many years. It comprises a group of services including a day-centre, residential beds, step-down beds and supported chalets. In many ways it is a good example of the range of services for older people in a genuine community setting that is being set out in the TYC vision. There are currently 22 residents in the Lisgarel residential unit and we are aware that new referrals for permanent beds were stopped by the Northern Trust some time ago. There is a total of 41 residential places which could also be used for respite care.

The provision of service in Lisgarel is absolutely outstanding. The quality of care provided by all staff is excellent. All Lisgarel residents have their own single rooms. There are excellent bathroom and toilet facilities, and many of the residents require support to use these, provided by the dedicated staff. It is notable that the private sector residential care alternative in Larne does not offer residents their own single rooms, but expects residents to share rooms, which we believe is undignified.

The Larne area does not have a large number of health and care facilities These have been reduced in the last 10 years with the closure of half the beds in Inver House. The capacity for private sector provision of residential care in the Larne area is lower than it would need to be to re-provide single room accommodation for Lisgarel residents.

"Friends of Lisgarel" believes that Lisgarel still has a vital role to play in the provision of health and care in the Larne area. In line with the TYC vision, Lisgarel can play a part in reducing the pressure on hospital beds by providing respite and "step-down" beds in a community setting. We are aware that the bed occupancy rate in Antrim hospital is currently over 90%. Making greater use of existing facilities in Lisgarel to relieve this problem would be a positive contribution to the wider picture for older people"s care, and save money on hospital beds, while also moving people closer to their own home setting.

As TYC points out, we have an ageing population, some of whom will need greater care and support to remain in their own homes. Sadly, as people age, there will also be a need for support for those people who are no longer able to live in their own homes due to the level of daily support they need to remain safe and well.

As part of a stepped care model, we believe it is important that people get the level of intervention and support they need. We are concerned that costly nursing home provision will be over-used to try and minimise the need for residential care at this time of change. There is still a need for quality residential care provision for the current residents of Lisgarel and the older Larne residents of the future.

We believe the Lisgarel complex is an important and badly needed facility in the Larne area to allow people who need daily support, step-down care or respite care. To close Lisgarel would be a great loss to the people of the Larne area who value and use this excellent complex.

“Friends of Lisgarel‟ would like to talk with the Northern Trust about the future of Lisgarel under Transforming Your Care and points out the very positive experience and user-feedback that the residents have on a daily basis.

Health and Social Care Board

Letter from Friends of the Roddens

Dear Sirs,

As members of the Committee of Friends of the Roddens we have been alarmed by sections of the Minister for Health's Policy statement made in Stormont on 9th October 2012.

Since the Roddens, Queen Street, Ballymoney is a state-run residential home, we are very concerned that this long-established facility, which is an invaluable element of the very fabric of our community, will be axed under the Minister's proposed overhaul of the Health Service.

In his statement, Mr Poots referred to how the treatment and care of our growing and ageing population is being improved through technology-driven improvements in the design and delivery of care and that change in provision is inevitable.

Technological improvements in design, in themselves, are of enormous benefit to all of us, and, undoubtedly, complement, but cannot replace, the excellent and humane standards of care given to each and every elderly citizen who has been fortunate enough to have become a resident of the Roddens.

It is ominous that in recent months, the number of full -time residential beds has been reduced by approximately 34%, and that no other permanent beds are to be allocated, which gives the impression that the Roddens is now quietly becoming a respite, rather than a residential home, and that the provision of care, as we know it, is indeed undergoing change without the knowledge of the local community and prior to the results of any formal consultation, which the Minister promised would take place before change is delivered.

We found it extremely disturbing to learn from a conversation with Mr Sean Donaghy, directly after a public meeting held in the Sandel Centre, Coleraine, that he was totally unaware of the fact that the management of the Roddens were directed, approximately eighteen months ago, as were the management of other state-run homes, not to admit any further permanent residents, even though Mr Donaghy is at the top of the chain of command from which that directive came.

Cont'd/

Mr Donaghy told us it was his opinion that the residents of residential homes are not ill, in the true sense of the word, and that residential care provided by the state is surplus to requirements, and, no doubt, although he did not say so, a "soft" target from which to gain considerable financial savings for the Health Service at the expense of so many who are without a voice.

Mr Donaghy has, obviously, little or no first- hand experience of residents in residential homes who require twenty four hour care for a variety of reasons and have not been granted such care on the whim of a disgruntled relative but by careful and fair assessment by trained and experienced professionals who are aware of the very limited provision made by the state.

However, Mr Donaghy assured us that there are beds available in the private sector which has led us to believe there are parts of the Transforming Your Care package which will lead directly to total privatisation of some areas of the NHS and, with the information we have to hand, it is well on its way and no amount of supposed consultation or public meetings will halt the inevitable.

We strongly oppose all proposals and endeavours to redefine the status of the Roddens Residential Home and ask for reassurance from Mr Sean Donaghy, Chief Executive of Northern Health and Social Care Trust and Mr Edwin Poots, Minister for Health, that our fears and suspicions are unfounded and that they will, as a matter of urgency, allay those fears at the earliest possible opportunity by communicating, clearly, their intentions for the future of the Roddens to remain in its present and dedicated role, as a residential home primarily for the benefit of the long-term care of the elderly citizens of the town and borough of Ballymoney.

We look forward with much hope to a favourable response at your earliest possible convenience.

Health and Social Care Board

Responses from Oysters Peer Support Group

Response to the Consultation Document "Transforming Your Care- Vision to ACTION."

Dear Minister,
I am responding to your consultation on the document "Transforming Your Care – Vision to Action" your response to the Compton report on future organisation and delivery of health and social care services in Northern Ireland.

I welcome your commitment to implement your vision to drive up the quality of care for patients, clients, and service users, improve outcomes and enhance the patient experience so that people are treated in the right place, at the right time and by the right people.

I, too, share your vision that people have the right to expect quality services appropriately delivered by professionals fully trained in their chosen area of expertise as near as possible to their place of residence.

I commend you and your HSCB colleagues on your emphasis in placing the individual at the centre of the care delivery model, the need for integrated care and working together in a partnership of the service user and the provider. I particularly welcome the emphasis on sustainability of service provision and your willingness to collaborate better with neighbouring jurisdictions in the provision of the right care in the right place at the right time. It is against this backdrop that I offer the following submission to the consultation process.

I attend a group called Oysters – a Trans Peer support group. Our group is attached to the Regional Gender Identity Clinic in Belfast. Presently our condition falls within the ICD definition of mental health disorders, so it is perhaps appropriate to examine the future provision of Mental Health Services. Our group welcomes the intent to plough more resources into Mental Health Services in general. For too long Mental Health Service has lagged far behind other service areas.

When we examine the mental health services provided for people like me we must remember not to overlook the fact that gender dysphoria is a "whole of life" condition which affects us at every stage of our lives from birth (when we are assigned the wrong sex), through childhood and adolescence into adulthood and even into old age (which could present unique challenges for care and residential workers should we go on to develop dementia). The condition presents many challenges for us as individuals but also has implication for the health of our parents, siblings and relatives. Thus it has implications for the whole range of health and social care services.

There is one Gender Identity Clinic in Northern Ireland which deals with adults presenting with Gender Identity Disorder. I believe that given the size of Northern Ireland that expertise should reside in one central place but given the exponentially increasing number of patients presenting for treatment the current staffing levels are woefully inadequate and need to be increased urgently to avoid burnout in the existing staff and ensure continuity of care for those presenting. We recognise that at a time of austerity it will be difficult to achieve an increase in staffing for this essential service but would urge the minister to explore at least, the possibility of making at least parts of the service an "all island" service in concert with your colleagues in the Republic. For example consultation with consultants and surgery. This would not only increase the provision for Northern Ireland patients but would also improve the provision of services for my Irish transgendered brothers and sisters who have no consistency of approach towards treatment and access to appropriate services is a lottery with no clearly defined treatment pathway.

Access to the Regional Gender Identity Clinic continues to be a bit of a hit and miss affair. The "gatekeepers" to access, the GPs are not universally aware of the service's existence or how to refer to it, despite the sterling efforts of clinic staff to disseminate information to them. The Gender Identity Clinic, as a regional service, relies heavily on the co-operation of the Primary Care Teams to oversee and monitor the implementation of its individual patient regimes. All too often we have to report this doesn't happen and co-operation is patchy to say the least. We feel strongly that this needs to be addressed.

Whilst recognising the importance of a regional service with appropriate expertise and to ensure a quality service with consistency of approach and delivery we would recommend that clinic staff should start to offer satellite clinics in the main centres of population to ensure ease of access to their expert services.

At present there is no co-ordinated treatment or support services for children or adolescents presenting with gender identity disorder. This needs to change. We need a Gender Identity Clinic for children and adolescents, a "one stop shop" where children and adolescents will have access to quality services not just for themselves but also for their parents, siblings and other family members (remember that Gender Identity Disorder affects not only the individual but also their whole family system as well).

Again we recognise the reality of economy of scale and would recommend that in order to create a quality sustainable service you should again examine the provision of such a service on an "all island" basis.

As regards confirmation surgery services we recognise that due to the small size of our population we would not merit a dedicated surgical team in Northern Ireland who would not get enough practise to sustain their skills. Even on an "all island" basis it is doubtful we could sustain a safe dedicated surgical team. However, again we would recommend that consideration be given to an "all island" approach to surgical interventions, perhaps on the same basis that the specialty of orthopaedics addressed the waiting list initiative by experts coming to Northern Ireland and performing operations in our facilities, close to the patient's home. A similar approach to confirmation surgery could lead to benefits for transgendered people, not least in the area of surgical aftercare. Such an approach would inevitably lead to the development of appropriate aftercare expertise. At present post –op patients have to rely on district nurses or Accident and Emergency staff who are often "nervous" to say the least to intervene lest they undo or damage the surgeon's work.

This leads me on to Generic Health and Social Care service provision to transgendered people. As I said at the beginning of this submission Gender Identity Disorder is a "whole of life "disorder and people experiencing it access generic health services on a daily basis. The quality of that interaction is very important and can influence how we experience and enjoy our lives.

I will now examine some specific areas of current Health and Social Care provision. The list is by no means comprehensive but represents a snapshot of how the very complicated monolith of Health and Social Care interacts with and responds to our needs as transgendered people.

(A) General Practitioner Services

There is a need for on-going training of GPs in regard to Gender Identity Disorder and also for them to recognise their important role in the delivery of regional specialist services and the importance of collaborating with the Gender Identity Clinic in the on-going monitoring of

individual patient treatment regimes, not the least of which is to take care of the psychological and mental health needs of patients involved in the very complex on-going medical process of transition.

GPs and all of their staff from receptionists, treatment room nurses to PAMs staff need to be aware that their interactions with transgendered people can have very serious implications for their successful treatment if they are not treated with dignity and respect.

(B) Child Care Services

Here I am referring to everything from day care provision such as nurseries, family support services, child and adolescent psychology, family and childcare social work teams and even residential services. It is now recognised that children develop their sense of "self " from age 18-24 months. It is no longer appropriate to force children into stereotypical gender roles. It is important to allow the child to be him/herself without feelings of guilt or having to conform to predetermined gender stereotypes. This guilt can and does influence the people we become, the fear we experience of being rejected or not fitting in. In short these initial experiences of our true gender expression can lead to mental health problems and exacerbate underlying physical tendencies towards chronic medical conditions which could be an additional drain on our already overstretched Health and Social Care budgets. This issue can be addressed by appropriate training for all staff involved so they can support individual children, their siblings, parents and wider family.

(C) Health Promotion

(1) Suicide Prevention.
It is estimated that 40% of transgendered people who seek treatment attempt suicide at least once. We have no information on completed suicides in the transgendered community. The needs of transgendered people need to be recognised and addressed in the Regional Suicide Prevention Strategy and reflected in the local Suicide Prevention action plans within each Trust area.

(2) Health Screening.
It is totally appropriate that transgendered people are invited for screening appropriate to their acquired gender during and after the gender confirmation process. However it is equally important that transgendered people be invited for screening for conditions where they continue to be at risk from genetic influences . Proper systems need to be developed that allow us to be notified of appropriate screening and to access screening in an environment suitable to our individual circumstances whilst protecting our right to confidentiality and be compliant with Data Protection Legislation. Dr. A. Mairs is presently consulting with us regarding appropriate and acceptable systems. His approach is to be commended and should be replicated by other service providers.

(D)Training Implications.

As our condition becomes better known and understood there is a clear need to inform and influence the training offered to professionals in all areas of Health and Social Care so that their individual practice can be informed by appropriate knowledge and best practice techniques. We would urge you to negotiate with the universities, Royal Colleges and the professional bodies to incorporate appropriate training modules on Gender Identity Disorder in all of their professional training.

There is additionally a need for training of all health and social care professionals on developments in the field of Gender Identity Disorder but for GPs in particular who act as gatekeepers for access and partners in the delivery and monitoring of individual treatment regimes. We would recommend that it be made mandatory for all GPs as part of their ongoing professional development to attend specific training on Gender Identity Disorder

For the wider Health and Social Care family of staff we would commend the recent HPA's development of an e-learning package for its staff on LGBand T issues. As far as I understand it is now mandatory for all HPA staff to complete this package. We would ask the minister that this package be rolled out to all Health and Social Care staff whether working in the statutory sector or in voluntary or community organisations in contract with the Trusts to provide Health and Social Care services on their behalf. We request the minister to make completion of the package mandatory for all such staff and that he monitors the implementation of this suggestion so that our experience of Health and Social Care over all improves

(E)Research.

There is an urgent need for NISRA to undertake focussed research into the incidence of Gender Identity Disorder, its causes and the efficacy of and satisfaction with treatment services provided for Gender Identity Disorder.
There also needs to empirical research into the long term effects of HRT for Trans men and Trans women so that we will be able to make fully informed consent when we embark on our journey to confirm our true gender identity.

Finally I want to assure the Minister that we as the transgendered community are ready, willing and able to be involved in the planning, implementation and delivery of appropriate Health and Social Care Services so that care for all the transgendered people yet to be born can be collectively transformed.

Health and Social Care Board

Annex 5. Glossary

Term	Meaning
A & E	Accident and Emergency.
Bamford Review	Review of Mental Health and Learning Disability, making recommendations for the improvement of Mental Health and Learning Disability services.
CAMHS	Child and Adolescent Mental Health Services.
Care Pathways	Tool based on evidence based practice for groups of patients with predictable clinical course to promote organised, safe and efficient care through standardised models of care.
CATH Lab	Catheterisation Laboratory for diagnostic and interventional procedures for patients with Coronary Heart Disease.
DHSSPS	Department of Health Social Services and Public Safety.
Direct Payments	Cash payments by HSC Trusts to the value of services they would otherwise provide, that allow individuals to arrange for themselves the social care services required to meet their needs as assessed.
ED	Emergency Department.
EOLCOS	End of Life Care Operational System
EMI	Elderly Mentally Infirm
Family Nurse Partnership Programme (FNP)	Intensive home visiting from early pregnancy until the child is 2, designed to support young mothers.
Home as Hub	A model identifying home as the central focus for the care of each individual rather than an acute setting.
HSC	Health and Social Care.
HSCB	Health and Social Care Board (Commissioner for health and social services in Northern Ireland).
Hub and Spoke model	Primary Care model, whereby hubs are centres which provide services for the local population and a range of spokes, these are surrounding GP surgeries.
Integrated Care Partnerships (ICP)	Collaborative network for local health and social care professionals, working as part of a multi-disciplinary team to come together and work in a more integrated way to provide care and support on a more complete range of services.
ICT	Information Communication Technology.
Intermediate Care	The primary function of intermediate care is to build up people's confidence to cope once more with day to day activities. It services as an extension to specialist clinical care and rehabilitation, but not as a substitute for it.
Local Commissioning Group (LCG)	Responsible for the commissioning of health and social care by addressing the care needs of their local population.
Long Term Condition (LTC)	Chronic ailment from which there is no cure but will require long term treatment or monitoring.
MLA	Member of the Legislative Assembly
NIAMH	Northern Ireland Association for Mental Health

NICE	National Institute for Health and Clinical Excellence. NICE guidance supports healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for money.
Nursing home	A Nursing home is a home registered for nursing that will provide personal care and will also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse.
PCC	Patient Client Council
Personalisation	Care is tailored for each individual shaping support to meet individual needs. Individuals are empowered to shape their own lives and services they receive. They have the preferences to choose how, when, and what treatments or other services they receive, organised around their lifestyles.
PHA	Public Health Agency.
Population Plans	Document outlining key proposals for how TYC would be implemented developed by each LCG in conjunction with respective providers.
Reablement	Programme of support to assist people in getting back to independent living.
Resettlement	Shift from long term institutional care to living in the community.
Residential Care	Refers to the provision of residential accommodation with both board and personal care, usually long-term, for people who need help with personal care due to old age, illness and/or infirmity, disablement, dependence on drugs or mental illness. This service is means tested.
RQIA	Regulation and Quality Improvement Authority.
Self-directed support	Individuals will have as much on-going control as they want over the individual budget spent on their support.
Shift Left	Change in service delivery from an acute setting to community-based delivery; also a shift to greater emphasis on prevention of illness rather than response to exacerbations.
Strategic Implementation Plan (SIP)	Describes a planned approach for the delivery of the TYC proposals over the next 3-5 years reflecting the shared ambitions and commitments of the TYC programme.
Telehealth, Telecare, Telemedicine Telemonitoring	Use of telecommunications to facilitate an independent lifestyle, includes alarm systems and monitoring systems, particularly in Long Term Conditions.
Transforming Your Care (TYC)	Report on the Review of Health and Social Care in Northern Ireland 2011.
Trust	Provider of Health and Social Care Services to a particular population.
V&C Sector	Voluntary and Community sector

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Northern Ireland Audit Office

Management of the Transforming Your Care Reform Programme

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
11 April 2017

N I A O

Northern Ireland Audit Office

Management of the Transforming Your Care Reform Programme

Published 11 April 2017

This report has been prepared under Section 29 of the Police (Northern Ireland) Act 2000 for presentation to the Northern Ireland Assembly in accordance with Section 30 of the Act.

K J Donnelly
Comptroller and Auditor General

Northern Ireland Audit Office
11 April 2017

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Contents

Contents

Abbreviations

AHP	Allied Health Professionals
CAMHS	Child and Adolescent Mental Health Services
CHIC	Connected Health Innovation Centre
CPN	Community Psychiatric Nursing
DCP	Delivering Choice Project
DEP	Developing Eyecare Partnerships
DHSSPS	Department of Health, Social Services and Public Safety
FTC	Financial Transactions Capital
GP	General Practitioner
HSC	Health and Social Care
HSCB	Health and Social Care Board
HIB	Health Infrastructure Board
ICP	Integrated Care Partnership
LCG	Local Commissioning Group
LTC	Long Term Condition
NI	Northern Ireland
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service
OECD	Organisation for Economic Co-operation and Development
pPCI	Primary Percutaneous Coronary Intervention
PCID	Primary Care Infrastructure Development programme
PHA	Public Health Agency
ROI	Republic of Ireland
RQIA	Regulation and Quality Improvement Authority
3PD	Third Party Developer
SBC	Strategic Business Case
SIP	Strategic Implementation Plan
SPEARS	Southern Primary Eyecare Assessment and Referral Service
TYC	Transforming Your Care
UK	United Kingdom
VR/VER	Voluntary Redundancy/Voluntary Early Retirement

Executive Summary

Key Facts

TYC proposed a programme of **99** proposals for change to health social care

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Estimated Gross Cost of TYC reforms of **£148 million**

£40 million actually spent on TYC reforms

£130 million expected benefits to be realised by reforms

£28 million benefits actually realised by TYC reforms

£83 million intended reallocation of resources from secondary care to primary/community by March 2016

£65.4 million reallocated at March 2016 – expected to reach **£80 million** by March 2018

£126 million of Departmental Capital Funding for new Health & Care Centres in Banbridge, Ballymena and Omagh

£80 million Third Party Development cost of new Health & Care Centres in Lisburn and Newry - Ministerial Directions were given for this expenditure

Executive Summary

Management of the Transforming Your Care Reform Programme

1. In common with countries across the developed world, the Department of Health (Department) has been striving to transform how it delivers and manages health and social care in Northern Ireland to meet population needs. The context within which it does so includes: increasing demands placed on these services by an ageing population (often living with a number of chronic conditions); constrained resources; technological advances; and rising patient expectations.

2. In 2011, a review of health and social care delivery[1] set out an ambitious vision for health and social care services under *Transforming Your Care* (TYC) which aimed to respond to the many challenges these services faced. As initially envisaged, a reform programme to deliver the model of care set out in TYC was to take place over a five year period. TYC was to act as a beacon, setting out a shared view on how services would need to change and what models of care would be required to meet the vision of everyone living longer, healthier lives, where home would become the "hub" of the health and social care services they receive.

3. Given the time taken to identify and consult on the range of service changes required, full implementation of the transformation programme did not commence until March 2013. Indeed, the scale and complexity of the task TYC set itself is not to be underestimated. As far back as 1993[2], Peter Drucker, often described as the founder of modern management, concluded that healthcare organisations are the most complex form of human organisation ever to be managed. According to Drucker, this complexity derives from, among other things, the confluence of professions (e.g. general practitioners, nurses, hospital consultants, pharmacists and administrators) and other stakeholders (e.g. patients and government) who may often have seemingly incompatible interests, perspectives and time horizons.

4. In addition to funding constraints and the need to satisfy a growing demand for health and social care, the challenges these relationships present to health and social care leaders have also been exacerbated by other initiatives in the sector: for example, the constant and immediate pressure Health and Social Care (HSC) Trusts face to meet waiting time targets and to manage their finances in the face of potential deficits - both of which can be barriers to the reallocation of resources across sectors or allocating resources in areas which are perceived to have major care deficits.

Key Messages

5. The evidence brought together in this report identifies a range of ways in which health and social care bodies have sought to improve outcomes and deliver better value services for patients under TYC. Making better use of available data on local health and

1 *Transforming Your Care: A Review of Health and Social Care in Northern Ireland,* Department of Health, Social Services and Public Safety, December 2011

2 The New Realities, Peter Drucker, 1993

Executive Summary

social care needs, these initiatives have involved changes in clinical practice so that care is provided more appropriately and in more co-ordinated ways: for example, the use of reablement services[3] has allowed £7 million to be redirected to support the management of demand for domiciliary care services; fewer hospital beds have been required as a result of changes in the rehabilitation of those suffering from strokes; and further inroads have been made in developing community based mental health services.

6. Despite the progress made in developing locally based services and revising how core elements of health and social care services are delivered, the impact of TYC overall has been more limited and the pace of change not as swift as originally envisaged. In January 2016, commenting on our *General Report on the Health and Social Care Sector 2012-13 and 2013-14*[4], the Public Accounts Committee (PAC) said: *"Transforming Your Care is heralded as the great transformational saviour for health and social care, but the pace of change has been at best mediocre."* This reflects the fact that, while each individual example of change may be impressive on its own (see **Appendix 2**), scaling up the new models of care has proved challenging in the face of rising demand. In addition, as referred to at paragraph 3, there was a delay in the full implementation of the TYC programme due to the work required to identify and consult on the service changes involved.

7. TYC's most substantial financial proposal – the reallocation of £83 million of resources from secondary care to the primary and community care sectors - was originally planned to take place between 2012-13 and 2015-16. However, as implementation of the transformation programme did not begin until March 2013 due to the work involved in defining and consulting on the specific service changes required, only £65 million had been reallocated between the sectors by 2015-16. The Department's current forecast is that this will rise to £80 million by March 2018.

8. Realisation of the benefits which TYC was designed to deliver and when they would be delivered has also posed a difficult challenge for the Department. While we found that the Department and its partners have demonstrated a clear commitment to managing the realisation of the benefits of TYC in terms of improved patient outcomes, a precise action plan had not been established at the outset of the programme setting out clear measurable aims and objectives together with an appropriate set of performance indicators for assessing its performance. The Department told us that the complexity of the relationships between the various health and social care stakeholders involved had impeded the development of a profile for the delivery of improved patient outcomes.

3 Reablement encourages independence, with the aim of helping to avoid unnecessary admissions of older people into hospital. It also provides a range of support services required to help older people return to their own homes following a stay in hospital, an accident or other care crisis.

4 Northern Ireland Assembly, Public Accounts Committee, General Report on Health and Social Care Sector 2012-13 and 2013-14, published 20th January 2016

9. The lack of progress towards meeting the aims of TYC was also highlighted in the Donaldson Report, set up by the Department in 2014 to take a fresh look at governance arrangements across the health and social care sector. In terms of TYC, the review called for a new, costed, timetabled implementation plan and a greater involvement of Community Pharmacists and NI Ambulance Service staff in the new service models.

Conclusion

10. In our view, the Department's focus on transformation is welcome and we recognise that TYC has provided a shared vision for the reform of health and social care services which patients, carers and health professionals can unite behind. Although not as large-scale as intended, many TYC initiatives have been successfully implemented. Given the scale of the challenge that the health and social care sector faced, this is not an inconsiderable achievement. Reforms could not have been accomplished without the commitment and effort of many health and social care staff, supported by the Department and the Health and Social Care (HSC) Board.

11. However, while progress towards better service provision has been made under TYC, in our view there is huge opportunity for further improvement. Following the lead given by the Donaldson Report, we consider there is a clear and compelling case for the Department to build on the foundations established by TYC by developing a clear strategy to guide the implementation of change. In this regard, the Department has recently established a series of initiatives which offer good grounds for optimism that more progress can be made and that the pace of implementing the vision set out in TYC can be accelerated.

12. Significantly, in January 2016, the Department appointed a clinically focused expert panel[5] to lead the debate on the best configuration of health and social care services for Northern Ireland. The panel's report[6] was published alongside the Department's vision[7] for future health and social care delivery in October 2016. The panel expressed its confidence that the capability exists within the integrated workforce to deliver on reform but has pointed out that it considers the health and social care system here faces a further eight-to-10-year period in which to build on and realise the aspirations originally set out in TYC. In our view, moreover, this optimism must be weighed against daunting objectives, set out in successive HSC Board annual Commissioning Plans, that Trusts will achieve financial balance, secure considerable efficiency savings and recover performance against key targets.

13. Transformational change of the kind set out in TYC will almost invariably require adaptability and flexibility as it is implemented. Leadership of the

5 The Panel was chaired by Professor Rafael Bengoa who has practiced as a doctor for seven years in both hospital and primary care. From 2009 to 2012, he was Minister for Health and Consumer Affairs in the Basque Government in Spain and during that time implemented a transformation of the region's health service during a period of even harsher austerity than we now face in Northern Ireland.

6 *Systems, Not Structures: Changing Health and Social Care*, Expert Panel Report, Department of Health, October 2016

7 *Health and Wellbeing 2026 – Delivering Together,* Department of Health, October 2016

Executive Summary

highest order is, therefore, needed to ensure that, as transformation moves into the post-expert panel phase, it avoids the pitfalls that have hampered progress under TYC in terms of creating and sustaining the implementation capabilities required to take forward the new strategy. In doing so, there are a number of key challenges to be faced.

Key challenges

14. ***Developing a clear action plan for transformation:*** Leaders within the health and social care services need to match resources to the vision established by TYC and to find more effective ways of turning the vision into practice. Designing a coherent short and longer-term strategy for implementing transformation, focussing on the objective of accelerating change through supporting front-line staff, is a daunting one for any industry, especially the health and social care system which is among the largest and most complex industries there is. However, this task has to be faced now, as the implications of not facing it are already well sign-posted.

15. ***Models of care which centre on patients will have implications for workforce planning:*** Self-care has the potential to reduce the burden on health and social care professionals and make the most appropriate use of their skills, as well as improving patient outcomes. With much of the health and social care budget spent on staff, exploring ways of using the workforce differently is likely to assume growing importance. From our review of transformation to date, it seems clear that the health and social care system of the future will require staff who are team players and who are able to adapt their skills to changing patient needs. This will enable care to be provided by staff who have the most appropriate skills, allowing the most senior and qualified staff to perform only those functions that cannot be better undertaken by others.

16. ***There is a clear need to build on experience and evidence:*** Even for the high-level analysis undertaken in this report, we found it difficult to find early evidence on the progress and impact of many of the recent initiatives under TYC. This is not surprising as the field of evaluating such interventions is beset by methodological issues, such as the attribution of impact to discrete interventions when there is almost always a range of policy and practice-oriented activities taking place simultaneously. We recognise that it is a massive undertaking to gather, sort and analyse the admittedly uneven evidence base, however, we consider that the sensitive use of available evidence can guide providers towards those interventions which show the greatest potential for success and help increase the pace of change.

17. ***Funding needs to be focused on new community-based models:*** TYC has faced considerable difficulty in releasing funding from the acute sector to increase

investment in primary and community care as a result of the growing demand on existing services. While there is considerable potential to release finance already in the health and social care system, some short-term, pump priming funding has also been seen as necessary, from the outset of TYC, to help achieve the scale of service reconfiguration required. To date, TYC has not received dedicated funding to support the change agenda and this has undoubtedly hampered the reform process. However, in March 2016, the Department announced the creation of a ring-fenced £30 million Transformation Fund to be invested in health and social care projects/initiatives focused on innovation, prevention and collaboration. It is hoped that this one-off investment will add further stimulus to the implementation of the vision set out in TYC.

Part One:
Health and Social Care reform is underway

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Health and Social Care reform is underway

Introduction

1.1 Across the developed world, governments are striving to transform how they deliver and manage health and social care in a way which is fit for a modern context. That context includes the increasing demands placed on these services by ageing populations (often living with a number of chronic conditions), constrained resources, technological advances and rising patient expectations. Northern Ireland has not been immune to these increased demands and to the realisation of the need for real strategic change.

1.2 In June 2011, the Minister for Health, Social Services and Public Safety announced that a review of the provision of Health and Social Care (HSC) services would be undertaken. The purpose of the review was to improve the quality of care, improve outcomes and enhance the patient experience. The key objectives were to:

- undertake a strategic assessment across all aspects of health and social care services;
- consult and engage on the way ahead;
- make recommendations on the future configuration and delivery of services; and
- provide an implementation plan for the required changes.

Transforming Your Care (TYC) outlined a blueprint for reform

1.3 Having engaged with stakeholders and carried out an assessment of local and international evidence, the review findings, "Transforming Your Care" (TYC), published in December 2011, identified 12 principles for change to underpin a new model of care (see **Figure 1**).

1.4 Using these principles, TYC proposed a programme of 99 proposals (**Appendix 1**) for change to health and social care, incorporating, a number of programmes which were already in existence across the sector. Of the overall 99 proposals, 39 related to the implementation of 14 existing regional programmes. As the Health and Social Care (HSC) Board implementation plan notes, it: *"… provides a coherent, controlled and managed framework (bringing) existing programmes together and (adding) new ones, in a well-integrated way…..".*

Figure 1: Twelve Principles of Transforming Your Care

1. **Placing the individual at the centre of any model by promoting a better outcome for the user, carer, and their family**
2. **Using outcomes and quality evidence to shape services**
3. **Providing the right care in the right place at the right time**
4. **Population-based planning of services**
5. **A focus on prevention and tackling inequalities**
6. **Integrated care – working together**
7. **Promoting independence and personalisation of care**
8. **Safeguarding the most vulnerable**
9. **Ensuring sustainability of service provision**
10. **Realising value for money**
11. **Maximising the use of technology**
12. **Incentivising innovation at a local level**

1.5 The central tenet of the TYC proposals was to bring about a radical shift from a model of care based predominantly on acute hospitals towards a more preventative approach that promotes self-care and is much more personalised and co-ordinated around the needs of the individual. In practical terms, TYC called for the reallocation of services and associated resources, estimated at £83 million, from the acute sector to the primary and community sector.

1.6 While TYC represented a watershed in its analysis of how health and social care services should be organised, it reflected other policy directions issued at various points over the last decade and before. The Hayes report of 2001[8], for example, highlighted that health and social services should be more closely integrated to provide a seamless system, while a 20-year strategic framework for primary care in 2005,[9] noted the need for much wider development of community-based alternatives to hospital admission. More recently, a review[10] commissioned by the Department in 2010 had similarly highlighted that the supply of resources had become skewed towards secondary care and the acute sector, and pointed to the need for enhanced community and primary care services and stronger public engagement.

The Health and Social Care Board has been assigned the task of managing the TYC reform agenda

1.7 Given the scale of the proposed reforms and the number of inter-dependencies between different parts of the health and social care system, the Department faced a major challenge in trying to ensure coherence over the course of the transformation process. To ensure good governance and management of whole system transformation, the Department established a Strategic Planning Group, and allocated the lead responsibility for the implementation of the 99 proposals in TYC to the Department, the Public Health Agency (PHA) or the HSC Board.

8 *Acute Hospitals Review Group Report,* 2001, Belfast: TSO

9 *Caring for People Beyond Tomorrow, DHSSPS,* 2005

10 *Reshaping the System: Implications for Northern Ireland's Health and Social Care Services of the 2010 Spending Review,* McKinsey, 2010

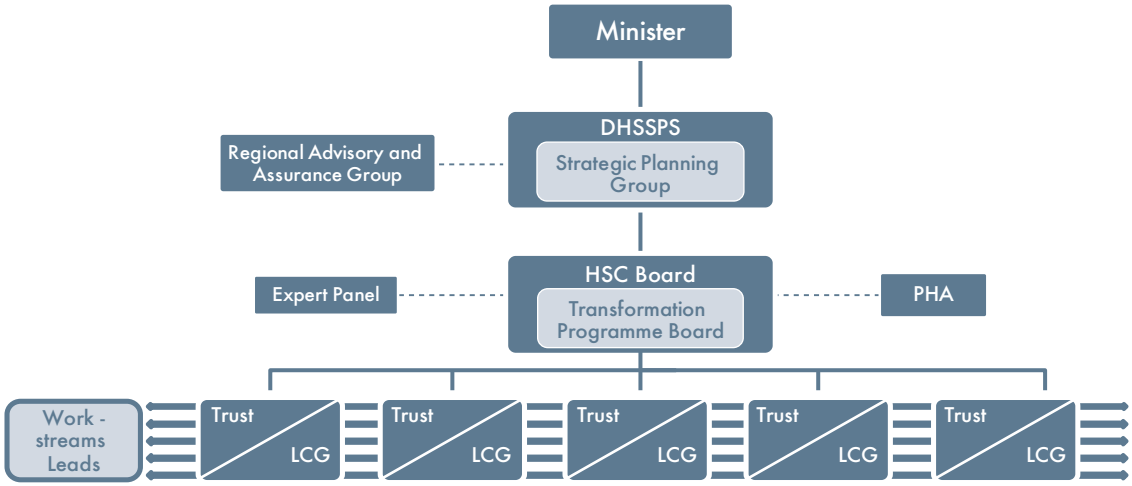
Part One:
Health and Social Care reform is underway

Around 70 of the 99 proposals flowing from the TYC review fell within the remit of the HSC Board (see **Appendix 1**). The HSC Board set up a Transformation Programme Board chaired by its Chief Executive, with representatives from its own ranks, Local Commissioning Groups and others from the HSC Trusts (**Figure 2**). The Transformation Programme Board managed and tracked the progress of reforms against the 70 proposals for which it had responsibility, along with the plans set out in the Strategic Implementation Plan and the TYC Vision to Action document[11].

1.8 The HSC Board's TYC Programme Management Team supported and monitored the progress of the transformation programme against approved plans for the Programme Board. In addition, this team worked with the Public Health Agency, the Trusts and other service providers involved in change projects and reported monthly to the Programme Board. The tools used to monitor progress included: a detailed project plan; project highlight reports; benefit realisation reports; finance reports; lessons learned registers; and risk registers.

1.9 The actual implementation of the numerous projects under the TYC banner were taken forward jointly by the five Local Commissioning Groups (LCGs)[12] working in conjunction with their respective HSC Trust, and colleagues in the primary care and voluntary and community sectors. HSC Board and

Figure 2: Governance Arrangements for HSC Board led TYC Transformation Programme



Source: The Department

11 *Transforming Your Care: Vision to Action – A Post Consultation Report,* HSC Board, March 2013

12 The Health and Social Care (Reform) Act (Northern Ireland) 2009 established five Local Commissioning Groups (LCGs) which function as committees of the Health and Social Care Board. Each LCG is co-terminus with its respective HSC Trust area and is responsible for assessing needs and commissioning health and social care for its local population.

HSC Trust officials provided regular updates to the Programme Board on the progress of implementation.

1.10 On the basis of population plans drawn up by LCGs, the Project Team drew up an overall Strategic Implementation Plan (SIP) to provide stakeholders with a clear understanding of the TYC proposals and how they would be delivered. The SIP listed the planned and existing programmes and enabling activities, at regional and local level, which were considered essential to maximise delivery of the TYC proposals. The projects could be aligned with one or multiple proposals.

Scope of NIAO review

1.11 This review provides an opportunity to describe the scale and urgency of the challenge set by TYC and the extent to which progress to date remains faithful to its original vision. The report draws together key insights from our examination of the implementation of TYC initiatives and also provides some commentary on the next steps in the transformation process. **Part 2** describes the resourcing arrangements put in place to support transformative change under TYC; **Part 3** draws together an update on the outcomes of the changes made under TYC up to 31 March 2016; and **Part 4** describes how transformation is to be taken forward from this juncture and provides some suggestions on what might be intelligent next steps in this process.

Part Two:
Funding the TYC reforms

Part Two:
Funding the TYC reforms

TYC funding helps to pump-prime reconfigured services

2.1 The Strategic Business Case (SBC) estimated that the gross cost of the reforms included in the TYC review between 2012-13 and 2015-16 would be £148 million. Transitional funding required to support the transformation was anticipated to be £70 million: £25 million in the first year (2012-13); £25 million in the second year (2013-14) and £20 million in the third year (2014-15). From 2015-16, it was anticipated that further transitional funding would not be required, with the release of cash savings from this and subsequent years re-invested to fund any future recurrent costs arising from the reform programme.

2.2 Much of the funding required for the initial implementation of TYC, therefore, was short-term -"pump priming"- rather than recurrent in nature. Once deployed, the argument was that enough resource should already exist within the system to bring about the improvement envisaged by the changes. Pump-priming funding would be needed, for example, to enable the transfer of care services from the acute sector and into a primary care/community setting to take place.

2.3 The SBC apportioned the estimated costs of implementation across four areas of spending:

- **Service Change** (£68 million): At the heart of TYC was the drive to shift resources and service provision away from hospitals and to increase care being provided in the community as close to home as possible. The new model of care placed the patient at the centre, with home as the "hub" of care as far as possible. The reforms under TYC also sought to build on the already integrated health and social care systems, with enhanced integration on the ground via the transition to local population-based service planning and a central role for GPs in the development of population-based primary care teams;

- **Integrated Care Partnerships (ICPs)** (£36 million): These were one of the key mechanisms through which service change was to take place for the clinical priority areas they were asked to address. ICPs are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals and the voluntary and community sectors, as well as service users and carers, to design and coordinate local health and social care services. ICPs are discussed in greater detail in Part 3;

- **Implementation Funding** (£8 million): For example, Trust backfill costs to free up staff to work on implementing TYC; and

- **Voluntary Redundancy/Voluntary Early Retirement Schemes** initiated under the Transforming Your Care programme and distinct from other

cost saving programmes (£35 million).[13]

These estimates, however, were subject to a significant degree of uncertainty as the Department had little reliable information on which to base its estimates and had to make broad assumptions.

Potential limitations of current funding arrangements for TYC reforms

2.4 Just under £40 million has been spent implementing the service changes required by the model of care set out in TYC, against a gross projected cost of £148 million: a shortfall between planned and actual spend of just over £108 million. In our view, a successful transition to the health and social care delivery systems envisaged in TYC requires an adequate and stable source of funding. By contrast, funding for TYC has been a discretionary choice for the Department and has depended on its ability to secure investment through In-year Monitoring[14] bids. As **Figure 3** demonstrates, however, many of the Department's bids have been unsuccessful: against bids of over £86 million, the Department received £28 million, with a further £11.6 million added from the HSC Board's own funds. The absence of a clear commitment to dedicated funding, therefore, has made the effective delivery and embedding of changes in patient care that TYC aspires to much more challenging.

Figure 3: Departmental bids for TYC revenue funding

Monitoring Round/ Invest To Save	Bid £m	Received £m
June 12-13	10.6	10.6
June 13-14	28.0	9.4
October 13-14	18.7	0.0
January 13-14	5.0	0.0
June 14-15	21.3	0.0
October 14-15	2.6	8.0
June 15-16	0.0	0.0
Bid Sub Total	86.2	28.0
HSC Board own funds (2014-15 & 2015-16)		11.6
TOTAL	**86.2**	**39.6**

Source: Department of Health

The financial benefits proposed in the TYC review have not been realised to date

2.5 The Strategic Business Case for the TYC reform programme anticipated that the reforms would realise financial benefits of £130 million by March 2016. At that date, however, as **Figure 4** shows, only £28 million had been realised – just over 20 per cent of that expected. Given the financial constraint surrounding the funding for TYC as outlined above, it is not surprising that opportunities for achieving improved efficiencies have not been fully realised.

13 Transforming Your Care, Strategic Business Case

14 In-year Monitoring allows the NI Executive to: adjust the allocation of resources set out in the multi-annual budget in relation to emerging expenditure pressures; and/or reprioritise the use of resources which are no longer required for the purpose originally allocated.

Part Two:
Funding the TYC reforms

Figure 4: Estimated and Actual Financial Benefits realised by TYC at 31 March 2016

Monetary Benefits	Estimated Total 2012-13 to 2015-16 £'000	Actual 2015-16 £'000
Integrated Care Partnerships	16,361	
Service Change – Stroke	4,085	16,800
Service Change – PCI/Cardiac Catherisation	12,814	
Service Change – Reablement	33,206	
TYC VR/VER	21,313	
TYC Implementation Benefits*	37,835	11,300
Telecare	1,333	
NIAS `See, Treat, Leave or Refer'	3,376	
TOTAL BENEFITS REALISED	**130,323**	**28,100**

* Incidental benefits occurring as a result of increased level of earlier diagnostic and preventative measures having been established.

Source: Department of Health

Primary Care Infrastructure Development programme (PCID)

2.6 The TYC programme also recognised the important need for capital investment in health and social care infrastructure, given that much of the primary care infrastructure was considered no longer fit for purpose and lacked the capacity to deal with the impact of service reforms TYC envisaged. This led to the establishment of the Health Infrastructure Board (HIB) comprising senior representatives from the Department, the HSC Board and the Strategic Investment Board. The remit of the HIB is to oversee the development and implementation of investment to reconfigure the primary care infrastructure under the Primary Care Infrastructure Development programme (PCID).

2.7 The PCID is based on a "hub and spoke" model, with hubs providing core services for their range of spokes. Each spoke would have a defined level of services, depending on economies of scale, and would draw on the services of the hub as required. The hubs would essentially encompass those services which do not require a hospital bed but which are too complex or specialised

to be provided in a local GP surgery (a spoke). In the main, hubs would include the capacity to deliver GP and Trust-led primary care services and those services which will "shift-left" from secondary care under TYC. The spokes will be local GP surgeries and health centres which include practitioners such as GPs, practice nurses and Trust services where there is localised demand.

2.8 This direction of travel pre-dates TYC as the 2005 strategic framework for primary care had already described such 'hubs'. The Portadown Health and Care Centre, for example, which opened in March 2010 includes eight GP practices along with diagnostic and treatment facilities. Belfast has seven similar centres: Arches Centre (East Belfast - completed 2005), Beech Hall Centre (West Belfast), Bradbury Centre (South Belfast), Carlisle Centre (North Belfast), Grove Wellbeing Centre (North Belfast – completed 2008), Knockbreda Centre (Castlereagh) and Shankill Centre (West Belfast). These are described by the Belfast Trust as 'Health and Wellbeing Centres' – 'one stop shops' for treatment, care and information which had previously been provided from a number of sites.

2.9 In launching a programme of new Health and Care Centres, however, the TYC Strategic Implementation Plan (paragraph 1.10) indicated that there would be a significant projected shortfall in available capital funding to enable their development. Conventional capital funding was used to complete Health and Care Centres in Banbridge (£16 million)[15], Ballymena (£25 million)[16] and Omagh[17] (£85 million). However, an alternative funding stream – Third Party Development (3PD)[18] – was established in order to enable the delivery of new Health and Care Centres in Lisburn (£40 million) and Newry (£40 million).

2.10 Ministerial Directions were required to commission procurement for these two sites[19]. While the business cases for these centres demonstrated that the lowest cost option was to build them through the Department's own capital programme, in the Department's view the capital costs associated with conventional procurement options were not affordable within the capital programme if the centres were to be progressed in the short to medium term. The Ministerial view was that delaying the projects would impact on the reform of the health and social care system.

15 Banbridge Health and Care Centre opened in January 2016. It employs around 220 staff delivering a range of community services including physiotherapy, occupational therapy and speech and language therapy, specialist nursing, a rehabilitation suite and two dental surgeries. There is also bookable space available for other visiting services.

16 Ballymena Health and Care Centre opened in February 2016. It includes six GP Practices as well as a mix of locally accessible acute, primary and community care services. In addition to a mental health consultation wing there is also a separate children's wing for all child associated assessments and clinics. Dental Services are also provided from the centre.

17 A new Health and Care Centre is also integral to the new hospital in Omagh, due to open early 2017.

18 The procuring authorities are the South-Eastern HSC Trust in the case of Lisburn and the Southern HSC Trust in the case of Newry. Under 3PD, the Trusts partner with private developers and take the head lease on the buildings. Broadly, a 3PD agreement provides for the developer to build new premises to a certain standard and design and, on practical completion of the development, the nominated HSC Trust partner will sign a lease. GPs then take a sub-lease from the HSC Trusts. While the GPs pay rent and rates to their respective HSC Trust, this is a "pass through" cost and is paid for by the HSC Board. The HSC Trusts, in turn, pay the developers an Annual Service Payment for the use of the building.

19 When a Minister wishes to proceed with a course of expenditure against the advice of his or her Accounting Officer, a Ministerial Direction is notified to the Public Accounts Committee, leaving the accountability line for this expenditure with the Minister rather than the Accounting Officer.

Part Two:
Funding the TYC reforms

2.11 The Strategic Implementation Plan for Primary Care Infrastructure Development was completed in 2014 and identified the next tranches of the roll out of the programme. Local Commissioning Groups are examining the current and future health needs for their local populations to ensure that the right care can be delivered in the right place. Once identified, these schemes will require business cases to be developed for further consideration.

2.12 GPs have had access to ring-fenced funding made available by the Department of Finance, known as Financial Transactions Capital (FTC)[20]. Under this scheme, GPs are given a loan to invest in the modernisation of their owned premises (spokes). During 2015-16, £1 million of funding was taken up by GPs. The FTC scheme remains open for GPs to invest in their own premises but the Department told us that funding is likely to decrease over the coming years.

2.13 3PD funding and Financial Transactions Capital can be viewed as helping to enable the delivery of the health and social care reforms set out in TYC. In particular, facilitating investment in premises is aimed at increasing the number and quality of facilities used to provide primary care and to create opportunities for greater integration between GPs and Trust services. Such investment will also help to create a modern environment where facilities are fit-for-purpose and allow GPs to provide a higher standard of care to their patients.

2.14 In our view, the process of implementing a new model of primary care through 3PD and FTC is an important addition to the long-running Departmental strategy of diverting patients away from inappropriate and more expensive secondary care and, also, to ensure the long-term sustainability of health and social care services. While the impact of the more recently opened health and care centres has yet to be evaluated, the experience of the Portadown Health and Care Centre demonstrates that the changes this approach seeks to make can be realised through the integration of health and care, and by reconfiguring services away from hospitals (see **Figure 5**).

2.15 While we acknowledge that the use of capital funding streams like 3PD and FTC can have significant benefits such as those described in the Portadown example, in our view they also need to dovetail closely with more concerted efforts to move resources away from secondary care in line with the aspirations of TYC. In particular, the change in capacity associated with an initiative like PCID will have specific workforce implications. The integrated care provided in these centres

20 FTC funds may only be deployed as a loan to, or equity investment in, a private sector entity. The investment must be consistent with, and supportive of, the Northern Ireland Executive's overall strategic aims and objectives. HM Treasury require FT capital to be repaid although they do not require full repayment. Different scheme allocations may have different repayment levels. Departments retain half the difference in the funding allocation and the repayment to HM Treasury. For example, when the private sector repays the department, if the repayment rate to Treasury is 60 per cent, the department will retain half the remainder i.e. 20 per cent of the original funding. Projects in receipt of FT capital are required to comply with European Union (EU) rules on "State Aid". FT capital that is not used for loan or equity investment must be surrendered back to HM Treasury.

Figure 5: Case Example - Portadown Health and Care Centre

Opened: March 2010 Cost: £16.5 million

Patients attending the Portadown hub are benefiting from the ability to access a wide range of primary and community care services all under one roof. Such services include: GP services; physiotherapy; orthopaedics; x-ray and ultrasound investigations; podiatry; and social care, as well as a wide range of specialist GP and consultant-led clinics.

The experience of the hub has been that this has taken significant pressure off outpatient referrals to the local acute hospital because people have been getting the service closer to home. By way of example, the x-ray facility in the hub has accommodated 80 per cent of referrals from GPs based within the hub and 20 per cent from GPs based in spoke practices surrounding the hub. A total of 6,553 x-ray attendances were undertaken in 2012-13 which would otherwise have required referral to an acute hospital.

Source: Martin Kelly, PCID Programme Director

requires professionals to work in new ways, for example, in multi-disciplinary settings where trusting colleagues and being able to work collaboratively is essential. In this regard, Proposal 97 of the TYC Review called for a "*more formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation, with regard to workforce planning*". Viewed in the context of a PCID programme which has funnelled resources into primary care infrastructure, it is essential that adequate attention is given to building capability in the operational and change management skills needed to make sustained improvements in patient care.

2.16 The Department is aware of the need to develop the required capability and meet the recurrent costs of the new facilities in the face of the many other pressures on resources including, but not limited to, funding new service developments, the perceived lack of growth in the general practice workforce to keep pace with the demand for services, and a reported decline in the community nursing workforce over recent years.

The importance of dedicated funding in the transformation of services

2.17 Providing ring-fenced financial support for the transformation of health and social care services is currently exceptionally challenging. However, funding transformation represents a significant investment in the future of health and social care services and the alternative is to risk a decline in the quality and safety of that care and a reduction in access to, or the breadth of, services that HSC Trusts provide. Without resources specifically dedicated to transformation, there is a risk that health and social care services will be unable to deliver the changes considered

Part Two:
Funding the TYC reforms

essential by TYC and that the costs of continuing to provide services along traditional lines will only get larger.

2.18 Towards this end, we acknowledge the creation of a ring-fenced £30 million Health and Social Care Transformation Fund for 2016-17. Its specific purpose was to fund innovative projects aimed at improving outcomes for patients and also saving money that could be redirected to other frontline services. Funding such as this can be a catalyst for change, however, we are aware too of the risk that the Fund may become subject to pressure to fix immediate crises, support pet projects or, potentially, be an easy target for expropriation when extra funding is needed elsewhere. It will be essential that some level of guarantee can be given to prevent funding being diverted away from the purposes intended.

2.19 We acknowledge that funding cannot do all of the work of the TYC programme, or solve all of the problems of the health and social care system, and some transformation tasks will require little additional funding. It will be important, therefore, that the focus on funding does not distract attention from the wider issues involved in a change programme of the magnitude of TYC, for example, leadership and overcoming embedded organisational silos. Alongside the intelligent distribution of funding for transformation, Parts 3 and 4 of the report outline a range of other factors which are also important in supporting and sustaining the successful implementation of a transformation programme.

Part Three:
What have been the outcomes of the TYC reform initiative to date?

Part Three:
What have been the outcomes of the TYC reform initiative to date?

The significant shift of resources from secondary to primary and community care planned under TYC has yet to be completed

3.1 Providing care closer to home has been a perennial feature of health and social care policy for many years and the TYC review reaffirmed and consolidated this direction of policy: a reallocation of at least £83 million from existing expenditure levels on secondary care and its reinvestment into primary, community and social care services. According to the TYC review, this level of resource re-allocation reflected the anticipated level of resource shifting required to meet the level of intended transformation of services. The redistribution of the £83 million was to be divided across the following service areas:

- increase spend in the Personal and Social Services by £21 million (a two per cent increase);
- increase spend in Family Health Services and Primary Care Services by £21 million (a three per cent increase); and
- increase spend in Community Services by £41 million (a nine per cent increase).

3.2 Shifting resources from the acute sector to the home or community, however, continues to present challenges in the face of rising demand and the Department has not made the progress towards achieving the proposal within the timeframe envisaged in the initial TYC vision. As noted at paragraph 3, the delay in the reallocation of resources reflects the fact that, as a result of the time taken to identify and consult on the range of service changes required, implementation of TYC did not commence until March 2013. **Figure 6** shows that against the original target to reallocate £83 million by 2015-16 just over £65 million was reallocated at that date. The current forecast is that £80 million will be 'shifted' by March 2018 – three per cent below what was expected to be in place by March 2016.

Despite the slow progress of transformation overall, TYC has led to some notable achievements in the development of locally based services

3.3 While the pace of change in terms of realising efficiencies and the shifting of resources from the acute sector has not been within the timeframe originally envisaged due to a number of external influences, TYC has brought about some notable changes that have the potential to make a difference to patients' services and outcomes. In particular, as **Figure 6** shows, the reallocation of resources due to service changes amounted to £25 million. The main service changes that have contributed have been:

- reablement (£4.8 million);

Figure 6: Actual reallocation of resources

	Actual 2012-13 £m	Actual 2013-14 £m	Actual 2014-15 £m	Actual 2015-16 £m	Actual Total £m
Integrated Care Partnerships	–	–	–	0.9	0.9
Service Change	6.0	8.3	2.4	8.3	25.0
Resettlement of Mental Health & Learning Disability Patients	11.4	13.7	2.4	12.0	39.5
Implementation	–	–	–	–	–
TOTAL	**17.4**	**22.0**	**4.8**	**21.2**	**65.4**

Source: Department of Health

- telecare and telemedicine (£2.9 million);
- elderly care (£1.7 million); and
- dementia strategy and memory services (£1.3 million).

Appendix 2 provides further detail on a range of case examples within these categories which demonstrate how services have been successfully re-designed to meet the objectives of TYC in a more efficient, effective and patient-centred manner.

3.4 The Department has undertaken regular monitoring of actions within the health and social care sectors to deliver the model of care set out in TYC. In November 2015, an update showed that around half of the 99 proposals had been completed, with good progress made on nearly all the rest.

3.5 The Benefits Management Framework of the TYC Programme was the subject of a review commissioned by the Health Committee in December 2014. That review highlighted deficiencies in the Benefits Realisation Plan, at that time. In particular, while performance metrics had been developed for tracking some of the reforms (see **Appendix 3)**, it was not clear how progress was to be measured in other areas. We acknowledge that the ambitious nature of the changes TYC proposes has raised complex issues, particularly where improvements in patient care are often to be achieved at some point in the future. However, given the scale of transformation underway, defining performance metrics for more complex care objectives will be crucial in the face of increasing demands for accountability.

3.6 The annual Commissioning Plan Direction issued by the Department to

Part Three:
What have been the outcomes of the TYC reform initiative to date?

the HSC Board is a key document in the commissioning of health and social care services with a view to delivering the patient-centred service model set out in TYC. The Direction sets out the Department's priorities for the health and social care services and the areas where it expects to see improvements. In response, the HSC Board then prepares a Commissioning Plan aimed at delivering the planned transformation of services. The Department identified three strategic themes, consistent with TYC, in its Direction for 2015-16:

- to improve and protect population health and wellbeing and reduce inequalities;
- to provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction; and
- to ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

3.7 The priorities and targets detailed in the Commissioning Plan Direction are complemented by a core set of indicators which can be used by the HSC Board, the Public Health Agency and the Trusts to monitor trends and take early and appropriate action to address any variations / deterioration in unit costs or performance against Ministerial targets (see **Appendix 4**).

3.8 In terms of performance against these indicators, demographic changes, an increase in the number of people with long-term complex conditions and the challenging budgetary climate, as noted previously, continue to highlight capacity gaps in the system, which in turn have led to increased waiting times across a number of specialties and services in 2015-16. These pressures have been identified within the 2016-17 HSC Financial Plan and will require careful financial management in order to deliver efficiencies.

Integrated Care Partnerships (ICPs) are key components in the successful implementation of TYC

3.9 At the heart of TYC was the establishment of 17 Integrated Care Partnerships (ICPs), each covering a population of around 100,000 people. ICPs are collaborative networks of care providers[21] whose priority is to make sure each person gets the care they need, in the right place, at the right time. To achieve this, the work of ICPs involves: identifying patients in 'at risk' groups and focusing on prevention or managing existing conditions to stop a problem becoming an emergency; sharing information and thinking ahead to plan care around the individual; helping people to stay out of hospital unless absolutely necessary; and coordinating care in the community.

21 By March 2016 all 17 ICPs had been fully populated, each comprising 13 members: one medical specialist; one nurse; one allied health professional; one social worker; one member of the ambulance service; one member from the voluntary sector; one from the community sector; two service users/carer representatives; two GPs; a council officer concerned with community planning and two community pharmacists.

3.10 ICPs obtain agreement for the revision of care pathways and (where required) obtain funding through Local Commissioning Groups. The commissioning relationship between LCGs and ICPs, therefore, is central to the delivery of integrated health and social care services under TYC. At the same time, this presents a formidable challenge for ICPs as they need to be rigorous in their determination of priorities, assessing competing needs and demands in order to reach agreement on the key priorities.

3.11 To date, ICPs have reviewed and improved local care pathways for diabetes, respiratory, stroke and services for the frail elderly. This crucially also involved full engagement with service users and carers, offering opportunities for integration and improvements to be identified, leading to a more joined up service for the user across sectors and professional groupings.

3.12 The principal currency of ICPs lies in their capacity to influence and lead across organisational and professional boundaries. Achieving change in this way requires exceptionally strong and skilful leadership, and places a high premium on these 'soft' skills – for example, taking account of the different cultures and ways of working within the health and social care sector. Effective leadership and management qualities, therefore, will be essential if ICPs are to grow into mature partnerships with the ability to engender willingness among the various interests to work together and agree local priorities.

3.13 The development of ICPs under TYC signals a more distributed approach to leadership within the health and social care sector by helping to ensure that all partners actively participate in the reform process and in facilitating cultural change. It is simply not always possible to push change through in a directive way. As such, devolved leadership, which relies on inspiring and facilitating people, is often more appropriate for bringing about change. **Figures 7 and 8** outline two cases which demonstrate how a more distributed form of leadership can underpin successful transformation initiatives in contrast to leadership which depends solely on a small number of key individuals in a hierarchy. The two cases show how effort and expertise has been pooled across a system or health community and describe a process of change which emphasises the building of relationships and connections with other leaders and the wider system.

Part Three:
What have been the outcomes of the TYC reform initiative to date?

Figure 7: Transforming Your Palliative and End of Life Care Programme

An alliance between Marie Curie, the Public Health Agency (PHA) and the HSC Board has developed a programme which aims to design and support the delivery of coordinated services to enable people with palliative and end of life care needs to have choice in their place of care, greater access to services and improved outcomes at the end of their lives.

The initial two-year Programme to August 2015 is based on the Delivering Choice methodology developed by Marie Curie which uses a whole systems approach to improve care and outcomes. The Delivering Choice methodology has been previously delivered in 19 sites across the UK. It includes:

- comprehensive needs assessment to understand local changes;
- a patient-centred approach;
- collaboration between all the relevant resources and stakeholders;
- a mechanism to deliver change and leverage expertise for new models of care; and
- reconfiguring or designing new sustainable services.

The Delivering Choice methodology has been shown to improve patient outcomes in palliative and end of life care, involving increased use of community and voluntary resources and a shift of resources from acute to community services. The evaluation of the Delivering Choice project (DCP) in Somerset evidenced reduced emergency admissions and A&E attendances in the last month of life for DCP users than for non-users. *(The University of Bristol, 2012)*

The Regulation and Quality Improvement Authority (RQIA) has reviewed the progress made in taking forward the Programme and concluded that very significant progress was made during the period 2010 to 2015 towards implementing the recommendations of the strategy. Many initiatives have been developed to raise awareness of palliative and end of life care. But there remains a significant lack of understanding about these services amongst service users and staff. There is a continuing need for a coordinated approach to raising public awareness about palliative and end of life care.

Figure 8: Dementia Care and Appropriate Medication

Another example where collective leadership will be important is around the use of anti-psychotic drugs for people with dementia. The Dementia Strategy, launched in 2011, emphasises the need to promote the use of appropriate medication and to avoid the inappropriate use of anti-psychotic drugs for the management of behavioural and psychological symptoms of dementia. The Strategy sets an ambitious goal that:

"The HSC Board and PHA will ensure that medication for the management of dementia is prescribed appropriately, that medication review is an integral part of the care management process and that a range of therapeutic interventions are available to people with dementia and their carers appropriate to their assessed needs."

This is a significant undertaking: a recent study which reviewed prescribing data for over 250,000 people, aged 65 years and over and living here from 2008 to 2010; found that 8.2 per cent were prescribed such drugs before entry to care homes, rising to 18.6 per cent after entering care. Many groups of people and many individuals will be needed to play a part in helping to achieve the goal set for the HSC Board and the PHA, including people with dementia and their carers, and the voluntary and advocacy groups that support them, leaders of care homes, the clinicians and clinical teams who prescribe, dispense and review the medications, as well as commissioners of health and social care.

Part Four:
Where now for transformation?

Part Four:
Where now for transformation?

Governance and commissioning

4.1 In April 2014, the Department commissioned a review of governance arrangements across the health and social care sector. The ten recommendations which flowed from the Donaldson Review[22], although focused on governance, included specific reference to TYC: in particular, there was a clear recognition that, while TYC contained many good ideas for developing alternatives to hospital care, belief among those within the health and social care services that it could be implemented or that necessary funding would be made available to assist with the reform process was at a low ebb.

4.2 The Review also commented on the apparent lack of a measurable action plan to guide the implementation of TYC. In responding to the Assembly's Health Committee[23] in 2016, the Department characterised TYC as a set of guiding principles and proposals for the development of patient-centred health and social care services whose role was to inform commissioning decisions, rather than a "plan" which was to be completed within a specific timeframe. As a result of these differing interpretations, the Committee took the view that the absence of a plan against which the achievement of TYC's aims could be measured raised concerns about the governance and funding of the programme.

4.3 The link between commissioning and the reshaping of services is picked up in more recent research carried out by the OECD[24]. This takes the view that the absence of a longer-term strategy which clearly establishes what the commissioning process is trying to achieve has led to decision-making being focussed more on immediate performance targets rather than longer-term impacts. As a result, this research considers that the strategic ambitions of several reform initiatives, including TYC, have had limited traction.

Expert Panel

4.4 In January 2016, the Department appointed an expert, clinically-led panel (based to some extent on a recommendation in the Donaldson Review) to consider, and lead the debate on, the best configuration of local health and social care services. Within a month of its formation, the panel held a cross-party health summit and developed a set of 13 working principles. These bear a striking resemblance to those guiding TYC, as summarised below (**Figure 9**).

22 *The Right Time, the Right Place: an expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland*, The Donaldson Report, December 2014

23 *Review of Workforce Planning in the context of TYC*, Committee for Health, Social Services and Public Safety, NIA 268/11-16

24 Organisation for Economic Co-operation and Development

Figure 9: Expert Panel Working Principles Summary

Ethos

1. **The system should be collaborative, not competitive** – (i) organisations must work together to provide high quality care, (ii) unwarranted variance in care across the system should be minimised, (iii) the HSC should continue to work in partnership across government, with industry, academia, the community and voluntary sector, staff and patients to deliver new models of care.
2. **The system should adopt a population health and well-being model with a focus on prediction and prevention rather than reaction** – this principle acknowledges that HSC resources and service developments are often *"locked into reactive disease care"* and there should be an increased emphasis on prevention and health promotion, particularly for those experiencing inequalities.
3. **Patients should be active participants in their own care, not passive recipients** – patients should be supported to take greater ownership of their own health outcomes.

Delivery Model

4. **Health and Social Care is already integrated in Northern Ireland. Remodelling must build on this strength and take a whole system perspective** – building on the integration that already exists to allow patients to be able to transition smoothly between social care, community care and hospital care.
5. **Only people who are acutely unwell need to be in a hospital** – the principle is backed by research showing that hospital use is affected by deprivation, with people in poorer areas more reliant on emergency services, and making insufficient use of planned elective services, and studies showing positive feedback from patients who were treated in community settings.
6. **Very specialist services can be based anywhere in Northern Ireland** – it is proposed that any acute hospital in NI has the potential to become a regional centre and that the HSC should: *"continue to explore and realise the mutual benefits of collaboration with other jurisdictions in ensuring patients have access to high quality, sustainable services"*.
7. **The location and composition of resources should be based on meeting patients' needs and achieving the best outcomes** – co-ordinated workforce and service planning should be carried out on the basis of the population's need rather than to maintain services which are not sustainable in the long term.
8. **The real value of Health and Social Care is in its people, not its buildings** - local initiatives should be encouraged and best practice should be shared across the region, with HSC staff given the freedom to innovate and deliver services in a way that best meets people's needs.

Part Four:
Where now for transformation?

Implementation

9. **Whole system remodelling is a medium to long term process:** *"Reform and remodelling on this scale will take time and must be supported by an evidenced, costed and resourced implementation plan. This will need policy and political commitment in the long term".*
10. **The system must be supported to implement change with pace and scale:** *"Service developments and investment from this point should be geared towards supporting and complementing a long term strategy for sustainable and quality care".*
11. **Technology should be developed and adopted where it can support and enable transformation** - it was acknowledged that NI has one of the most advanced electronic care record systems in Europe: *"Innovation and new technologies should be embraced in collaboration with industry where they offer the potential to deliver better or more efficient services".*

Leadership and Culture

12. **The panel will engage constructively with elected representatives when designing and communicating a remodelled HSC. The Panel will also engage openly with HSC staff and the public:** *"Without change, the Northern Ireland Health and Social Care system is not sustainable in the medium to long term. Elected officials will play a key role in analysing proposals and enabling the public to understand the need for change".*
13. **Northern Ireland can be a world leader in transforming health and social care** – this principle highlights that NI can be a pioneer in *"designing and delivering health and social care services fit for the 21st Century".*

4.5 The panel's report[25] was published alongside the Department's vision[26] for future health and social care delivery in October 2016. In its vision, the Department clearly demonstrates that the panel's report will be used to guide the development of plans for health and social care over the next eight-to-10 years. The changes to be introduced will involve shifting more health and social care from hospitals to settings closer to people's homes, enhancing support received in primary care, and reforming and reconfiguring hospital services. In turn, this may involve making difficult decisions about changing, reducing or cutting some services. Moreover, such moves would also require a significant shift in the behaviour of the local public about how they access, use and receive health and social care services.

4.6 Given the context outlined above, we have identified a series of factors which need to be addressed in order to increase the pace of transformation and the implementation of more effective models of care. The issues surrounding these are discussed below.

Developing a clear action plan for transformation

4.7 The key objective of shifting care from the acute hospital sector to community-based services requires a clear action plan and a compelling narrative that can drive and sustain the transformation process. As we have pointed out, the TYC programme of reforms was strategic in nature and stakeholders lacked a clear framework of how such a shift in resources was to be achieved in practice. In addition, there was a lack of clarity around measures of success, such as milestones and indicators for measuring progress.

Transforming models of care will have implications for workforce planning

4.8 In aiming to move care closer to home and tailor it to meet the needs of individual patients, TYC has increased the significance attached to the community-based workforce. If the vision for future services, set out in TYC, is to be realised, it will be important that equal weighting is afforded to both health and social care which will, in turn, require a workforce development plan to underpin it. Recruiting and retaining staff on permanent contracts remains a significant problem within the health and social care services – for example, among hospital consultants and GPs.

4.9 Another significant issue is that the social care workforce will require better access to relevant training and development opportunities, to ensure that individuals can be deployed in a range of roles. The registration, training and development needs of the social care workforce are issues previously addressed by PAC in 2011 following

25 *Systems, not Structures: Changing Health and Social Care,* Expert Panel Report, Department of Health, October 2016

26 *Health and Wellbeing 2026 – Delivering Together,* Department of Health, October 2016

Part Four:
Where now for transformation?

our report on the quality of care in homes for older people.[27] Recently, a review of domiciliary care[28] has identified the challenges faced by the social care sector in terms of recruiting and retaining care workers and the terms and conditions under which they are employed. The report points out, too, that these issues impact more severely on social care workers employed in the independent sector.

4.10 As the transformation programme develops, the health and social care services will face the ongoing challenge of trying to ensure that staff with the right skills are available to provide new community-based models of care. The Regional Workforce Planning Group, chaired by the Department, was established in August 2012 to consider the implications of TYC for the workforce and to ensure that this was reflected in the workforce planning programme. While it took the Group until April 2015 to finalise a Regional Workforce Planning Framework, the Department highlighted to the Health Committee that other streams of work had been progressed in parallel, including a programme of medical specialty reviews, additional uni-professional reviews, and a pilot workforce review for domiciliary care for older people - in the context of a programme of care rather than a particular profession.

4.11 The specific workforce planning elements within TYC include key proposals 79, 95 and 97A:

- 79: make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements;
- 95: development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is co-ordinated at home or close to home; and
- 97A: more formal integration of workforce planning into the commissioning process to drive the financial transformation.

4.12 The Commissioning Plan for 2015-16 (see paragraph 3.6) set out a number of workforce initiatives and services as follows:

- Integrated service - the regional workforce planning framework will drive the practical implementation and improvement of workforce planning across the HSC;
- Profession specific - there will continue to be workforce planning and development through profession specific activities, including: a workforce planning review for Nursing and Midwifery services in Northern Ireland - *Delivering Care: Nurse Staffing in Northern Ireland;* Trusts to increase working practices which support seven day services; a range of workforce plans across different specialties have been developed or are underway; the

27 *Arrangements for ensuring the quality of care in homes for older people,* NIAO, 8 December 2010; *Arrangements for ensuring the quality of care in homes for older people, Public Accounts Committee, NIA 39/10/11R, 3 February 2011*

28 *A Managed Change: Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland,* HSC Board, November 2015

implementation of the Social Work Strategy, which includes workstreams such as workload, job rotation, extended hours and flexible working;

- Capability Development Initiatives to support the reform agenda – these include: change management and core skills programme for those involved in TYC or transformation projects; effective partnership working and skills programmes for those on ICP Committees or supporting their operation; development of an HSC Knowledge Exchange open to all those involved in the design, commissioning or provision of health and social care services across Northern Ireland; and investment in 'Organisation Workforce Development and Service Improvement' skills to support staff in their roles;

- The *Delivering Care: Nurse Staffing in NI* Project - a framework to determine staffing ranges for the nursing and midwifery workforce in a range of specialties: phase one set out the nursing workforce required for all general and specialist medical and surgical hospital services – the HSC Board has agreed an implementation plan; three further phases were at development stage: phase two focuses on nurse staffing within Emergency Departments; phase three focuses on District Nursing; and phase four focuses on Health Visiting.

Evidence-based planning and innovation will be key elements in moving transformation forward

4.13 TYC initiatives such as those we describe in **Appendix 2** will generate much needed evidence about what works and the best ways to spread successful interventions. It will be important that this evidence base is appropriately recorded, collated, synthesised and shared. Ongoing evaluation of "what works" and "how it works" should be a core activity of the Department's approach to transformation. If the evaluation of interventions is not undertaken, this could have negative impacts both locally, where it has been tried, but also regionally, through a failure to share learning.

4.14 The case examples we have used in the report demonstrate clearly that a core part of transformation and the allocation of funding has been an established evidence base. This is most notable in the case of the Bamford Review which examined the evidence for improvement across a number of key areas in order to develop a transformation plan. ICPs are responsible for drawing up proposals to implement an intervention and in doing so they must demonstrate the use of existing evidence on implementation and the extent to which it can be replicated; the proposals are evaluated by a Local Commissioning Group according to the evidence base, which includes projected activity, costs and outcomes.

Part Four:
Where now for transformation?

4.15 During our fieldwork we identified a number of ways in which HSC bodies have been attempting to encourage and develop innovative approaches to services by harnessing the creativity and skills of the people who provide the services. Radically different models of care are likely to depend on emulating the approaches taken by peers and by finding ways of learning from experience and adapting innovations that emerge from other health and social care communities. In this regard, we acknowledge a number of different ways in which innovative ideas can be encouraged to develop and flourish, for example:

- The Health and Social Care Knowledge Exchange, hosted by the HSC Leadership Centre on behalf of the health and social care sector, provides links to existing projects and activities being undertaken to ensure health and social care is delivered as effectively and efficiently as possible.

- The Quality Improvement Innovation Centre, based in the South Eastern Trust, aims to bring together innovative and creative thinking, forming a hub for staff.

- The Connected Health Innovation Centre (CHIC) focuses on business-led research in the area of connected health. CHIC seeks to lead transformational research which aligns care needs with technology providers, researchers and clinical experience. This alignment builds on partnerships with the local integrated Health and Social Care Trusts, universities, investment organisations and Government. CHIC targets research in areas such as e-Health, digital health, tele-health, tele-monitoring, disease management, and home-based care.

4.16 Our review of TYC initiatives demonstrated to us that, even where local reforms have been successfully implemented, it does not automatically follow that such projects can be replicated in other settings. However, we did conclude that the sensitive use of the available evidence can guide the Department and providers of health and social care services towards those interventions which are most likely to have more meaningful and widespread impacts and those which would allow resources to be employed more prudently.

Encouraging a distributed leadership approach

4.17 While a transformation programme like TYC may have a compelling narrative, interesting new models of care and a battery of aligned interventions, unless it is supported by an adequate leadership culture, progress is likely to be hampered. In view of the complexity of the reform process, our review of the work of ICPs indicates that the participation of health care

professionals and staff engagement has been crucial in facilitating reform through a more distributed type of leadership which promotes doctors' commitment to improvement initiatives. Paradoxically, therefore, gaining more control over transformation can mean giving up some control. Leading successful large-scale change will require the building of strong cultures based on common purpose and shared values. This will mean encouraging the development of a distributed leadership system which focuses less on the behaviours and actions of individual leaders and more on relationships, interventions and leadership practice across the whole health and social care system.

Dedicated funding to support transformation

4.18 One of the issues we identified which challenged the successful implementation of TYC was the fragmentation of the funding required during the transition period. The Department, therefore, needs to identify adequate and timely longer-term funding to support transformational change. It has provided a series of short-term funding through in-year monitoring to help local bodies implement change but this does not provide the level of funding or certainty to make large-scale sustainable changes. Towards this end, we welcome the Department's announcement in March 2016 of a £30 million Transformation Fund to support innovative change.

Appendices:

Appendix 1: (paragraphs 1.4 and 1.7)

Ownership of the 99 TYC proposals at July 2012

Proposal No.	Proposal	Lead Responsible Body
1	**Population health** – Renewed focus on health promotion and prevention to materially reduce demand for acute health services.	DHSSPS & PHA
2	**Population health** – Production by PHA of an annual report communicating progress on population health and wellbeing to the public.	PHA
3	**Population health** – Maintenance of existing, and implementation of new, screening and immunisation programmes where supported by clinical evidence.	PHA
4	**Population health** – Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: (i) in relation to pricing of alcohol; (ii) 'junk' food; and (iii) further controls on tobacco usage.	DHSSPS
5	**Population health** – Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.	DHSSPS
6	**Population health** – Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.	DHSSPS
7	**Population health** – An expanded role for community pharmacy in the arena of health promotion, both in pharmacies in the community.	DHSSPS & HSCB
8	**Population health** – Support for the health promotion and preventation role played by Allied Health Professionals, particularly with older people.	PHA
9	**Older People** – Home as the hub of care for older people, with more services provided at home and in the community.	DHSSPS
10	**Older People** – A major reduction in residential accommodation for older people, over the next five years.	HSCB
11	**Older People** – Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.	HSCB
12	**Older People** – A greater role for nursing home care in avoiding hospital admissions.	HSCB
13	**Older People** – More community-based step-up/step-down and respite care, provided largely by the independent sector.	HSCB
14	**Older People** – A focus on promoting healthy ageing, individual resilience and independence.	HSCB

Appendix 1 (continued)

Proposal No.	Proposal	Lead Responsible Body
15	**Older People** – More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.	DHSSPS & HSCB
16	**Older People** – a holistic and consistent approach to assessment of older people's needs across NI and an equitable range of services.	HSCB
17	**Older People** – A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.	HSCB
18	**Older People** – Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.	DHSSPS & HSCB
19	**Older People** – A policy review of carers' assessments and more practical support for carers, including improved access to respite provision.	HSCB
20	**Older People** – An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.	DHSSPS
21	**Long Term Condition (LTC)** – Partnership working with patients to enable greater self-care and prevention.	HSCB
22	**LTC** – Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.	HSCB
23	**LTC** – Patients to have named contacts for the multi-disciplinary team in each GP surgery, to enable more straightforward communication.	HSCB
24	**LTC** – Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.	DHSSPS & HSCB
25	**LTC**– A stronger role for community pharmacy in medication management for LTCs.	DHSSPS & HSCB
26	**LTC** – Development of admission protocols between Secondary Care specialist staff and those in community.	HSCB
27	**LTC** – Maximising the opportunities provided by telehealth in regard to LTC patients.	PHA

Appendix 1: (paragraphs 1.4 and 1.7)

Ownership of the 99 TYC proposals at July 2012

Proposal No.	Proposal	Lead Responsible Body
28	**Physical Disability** – Promoting independence and control for people with a disability, enabling balanced risk-taking.	HSCB & PHA
29	**Physical Disability** – A shift in the role of the health and social care organisations towards being an enabler and information provider.	HSCB & PHA
30	**Physical Disability** – Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.	HSCB & PHA
31	**Physical Disability** – Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.	HSCB & PHA
32	**Physical Disability** – More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.	DHSSPS
33	**Physical Disability** – More respite and short breaks provision.	HSCB
34	**Maternity** – Written and oral information for women to enable an informed choice about place of birth.	HSCB
35	**Maternity** – Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.	PHA
36	**Maternity** – Services in consultant-led obstetric and midwife-led units available, dependent on need.	HSCB
37	**Maternity** – Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions	HSCB
38	**Maternity** – Continuity of care for women throughout the maternity pathway.	HSCB
39	**Maternity** – A regional plan for supporting mothers with serious psychiatric conditions.	PHA & HSCB jointly
40	**Child Health** – Further development of childhood screening programmes as referenced in the Health and Wellbeing section.	PHA
41	**Child Health** – Child health included as a component of the Headstart programme, referenced in the Family and Childcare section.	HSCB & PHA
42	**Child Health** – Promotion of partnership working on children's health and wellbeing matters with other government sectors.	DHSSPS
43	**Child Health** – Close working between hospital and community paediatricians through Integrated Care Partnerships.	HSCB

Appendix 1 (continued)

Proposal No.	Proposal	Lead Responsible Body
44	**Child Health** – Completion of a review of inpatient paediatric care to include palliative and end of life care.	DHSSPS
45	**Child Health** – Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.	DHSSPS
46	**Family and Child Care** – Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.	DHSSPS
47	**Family and Child Care** – Exploration through pilot arrangements of budgetary integration for services to this group across departments, under the auspices of the Child and Young People's Strategic partnership.	DHSSPS & HSCB
48	**Family and Child Care** – Completion of a review of residential care to minimise its necessity.	HSCB
49	**Family and Child Care** – Promotion of foster care both within and outwith families.	HSCB
50	**Family and Child Care** – Development of a professional foster scheme for those hardest to place.	HSCB
51	**Family and Child Care** – Implementation of the RQIA recommendations in relation to Child and Adolescent Mental Health Services (CAMHS).	DHSSPS & HSCB
52	**Family and Child Care** – Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS.	HSCB
53	**Mental Health** – Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.	DHSSPS
54	**Mental Health** – Establishment of a programme of early intervention to promote mental health wellbeing.	DHSSPS
55	**Mental Health** – Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.	DHSSPS
56	**Mental Health** – A consistent, evidence-based pathway through the four step model provided across the region.	HSCB & PHA
57	**Mental Health** – A consistent pathway for urgent mental health care, including how people in crisis contact services, triage and facilities in emergency departments.	HSCB
58	**Mental Health** – Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.	HSCB

Appendix 1: (paragraphs 1.4 and 1.7)

Ownership of the 99 TYC proposals at July 2012

Proposal No.	Proposal	Lead Responsible Body
59	**Mental Health** – Further shift of the balance of spend between hospital and community, with re-investment of any hospital savings into community services.	DHSSPS & HSCB
60	**Mental Health** – Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.	HSCB
61	**Mental Health** – Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.	DHSSPS & HSCB
62	**Mental Health** – Close long stay institutions and complete resettlement by 2015.	HSCB
63	**Learning Disability** – Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds, as referenced in the Family and Childcare section (Section 12).	HSCB & PHA
64	**Learning Disability** – Further development of the current enhanced health services on a NI basis.	HSCB & PHA
65	**Learning Disability** – Support from integrated care partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.	DHSSPS
66	**Learning Disability** – Better planning for dental services should be undertaken.	HSCB
67	**Learning Disability** – Further development of a more diverse range of age-appropriate day support and respite and short-break services.	HSCB
68	**Learning Disability** – Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.	DHSSPS
69	**Learning Disability** – Development of information resources for people with a learning disability to support access to required services.	HSCB
70	**Learning Disability** – Advocacy and support for people with a learning disability, including peer and independent advocacy.	HSCB
71	**Learning Disability** – Commitment to closing long stay institutions and to completing the resettlement process by 2015.	HSCB

Appendix 1 (continued)

Proposal No.	Proposal	Lead Responsible Body
72	**Acute care** – Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document	DHSSPS (with HSCB/PHA to implement)
73	**Acute care** – Over time move to a likely position of five to seven major acute hospital networks in NI. [*The text of the Report recommends that LCGs develop proposals for acute hospital service configuration on the basis of an assessment that the service is sustainable and resilient in clinical terms, along with the potential to provide services to the ROI*].	HSCB
74	**Acute care** – Ensure urgent care provision is locally available to each population.	HSCB
75	**Acute care** – Set targets for the reduction of hospital admissions for long-term admissions and end of life care.	DHSSPS
76	**Acute care** – Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.	DHSSPS
77	**Acute care** – Ensure the transition takes full account of Service Frameworks and clinical pathways.	HSCB
78	**Acute care** – Expeditious implementation of a managed clinical network for pathology.	DHSSPS
79	**Acute care** – Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.	DHSSPS
80	**Palliative & End of Life Care** – Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.	HSCB
81	**Palliative & End of Life Care** – Enhanced support to the Nursing Home Sector for end of life care.	HSCB
82	**Palliative & End of Life Care** - Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.	HSCB
83	**Palliative & End of Life Care** – Electronic patient records in place for the patient, their family and staff.	HSCB
84	**Palliative & End of Life Care** – Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.	DHSSPS
85	**Palliative & End of Life Care** – Palliative and end of life care for children considered as part of the proposed review of paediatric services as referenced in the Maternity and Child Health section.	DHSSPS

Appendix 1: (paragraphs 1.4 and 1.7)

Ownership of the 99 TYC proposals at July 2012

Proposal No.	Proposal	Lead Responsible Body
86	**Service Implications** – Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.	DHSSPS to lead on policy; HSCB & PHA on implementation
87	**Service Implications** – Development of population plans for each of the five LCG populations by June 2012.	HSCB
88	**Service Implications** – Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/allied health professions, and social care.	HSCB
89	**Service Implications** – Development of clear pathways for networked and regional services.	HSCB
90	**Service Implications** – Establishment of a forum to take forward how technology will support the new model of care linking the services to industry and academia.	DHSSPS
91	**Service Implications** – Full rollout of the Electronic Care Record Programme.	HSCB
92	**Service Implications** – Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.	HSCB
93	**Service Implications** – Introduction of a single telephone number for urgent care.	HSCB
94	**Service Implications** – Introduction of a single robust community information system.	HSCB
95	**Service Implications** – Development of new workforce skills and roles to support the shift towards prevention, self care and integrated care that is well co-ordinated, integrated and at home or close to home.	DHSSPS
96	**Service Implications** - Development of GPs to assume a critical leadership role in the new integrated care teams.	DHSSPS & HSCB
97	**Service Implications** – More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.	DHSSPS
98	**Service Implications** – Re-allocation of resources estimated to equate to a 4 per cent shift of funds from hospitals into the community.	DHSSPS
99	**Service Implications** – Initiation of a sensible debate about growing income within the spirit of NHS principles.	DHSSPS

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

Case Example 1: Service Change: Reablement

TYC Proposal 11

Objectives: Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.

Deliverables: To provide people with the support required to return to their own homes following a stay in hospital, an accident or other care crisis.

Achievements to date: Between April 2013 and March 2014, 5,517 people started reablement. Of these 77 per cent were discharged within three weeks of admission to hospital and 43 per cent required no on-going statutory services.

An audit of the reablement service confirmed that c. £7m (gross) in the calendar year 2013 was associated with cost avoidance/cash releasing for domiciliary care as a result of reablement.

Based on actual Trust performance in the period April 2014 - October 2014, the potential for further savings was estimated to be in the region of £5m for 2014-15 (subject to Trusts taking forward specific audit recommendations). The opportunities for further savings/cost avoidance are greatest in Southern and Western Trusts (representing 78 per cent of the opportunity) through full roll-out of the service. This is an objective to which both Trusts are committed; however, it should be acknowledged the phasing/pace of roll-out will be influenced by other competing service demands.

Of 248 successfully reabled service users, 40 per cent were 85+ years of age and of these 38 per cent had two or more ill-health conditions. Of these, 83 per cent were discharged without any on-going care package and 77 per cent have remained out of the service, leading to net savings of £1.3 million.

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

Case Example 2: Service Change: Telecare and Telemedicine

TYC Proposal 27

Objectives: Investment aimed at avoiding hospital care through the provision of health monitoring technology for a range of long term chronic conditions, which allows early intervention in the management of care for these patients before their conditions exacerbate to the stage where a hospital admission is necessary.

Deliverables: To deliver a major procurement of remote monitoring of chronic disease, in line with policy directions, to develop early intervention strategies; promoting and securing community alternatives to hospital referrals and admission; and the better use of ICT combined with reform of the care delivery system.

Achievements to date: Telemonitoring NI service has been made available to over 5,500 users by end March 2016 with 3,000 clients receiving telecare under the terms of the contract at the end of March 2016. Improved access to patient education/self management programmes and remote telemonitoring has allowed increasing numbers of people to effectively and more confidently manage their condition at home, reducing the risk of exacerbation of their condition which could lead to unnecessary admission to hospital.

Case Example 3: Service Change: Hospital at Home Service for Older People

TYC Proposals 13 & 16

Objectives: A service designed to enable health and social care providers to work more closely together to keep people well in local communities and to better share information to plan safe, high quality care around each individual's needs.

Deliverables: Patients referred to the service have, within their own home environment, the same access to specialist tests as hospital inpatients and will receive assessment and treatment from a team of specialist professionals, including a hospital consultant.

Between 2014-15 and 2015-16, £961,000 of funding was provided by the Belfast Local Commissioning Group and the initiative has been established by the Belfast Integrated Care Partnership which brought together the healthcare professionals, voluntary and community representatives and service users and carers who have been involved in designing the new service.

Appendix 2: (continued)

Case Example 4: Service Change: Dementia/Memory Services

TYC Proposal 58

Objectives: In November 2011, the Department released the Northern Ireland Dementia Strategy. It made recommendations aimed at improving the current services and support arrangements for people living with dementia, their families and their carers.

Deliverables/Achievements to date:

- **Belfast Trust - *Dementia Inpatient and Outreach Service*:** The inpatient service provides specialist assessment, treatment and care of people with dementia to enable them to return to the community. The outreach service then provides assistance to enable better care in the community and to prevent unnecessary admission or readmission to hospital.

- **Northern Trust - *Dementia Home Support Team and Inver Model of Care*:** The team is made up of social workers, behavioural science nurses and support workers, with sessional input from a consultant clinical psychologist. Its aims are to provide comprehensive assessment, providing a better understanding of a person's needs, and then to determine how best these needs can be met. The Inver Model of Care was used to guide the refurbishment of the ward so that it is more dementia friendly.

- **South Eastern Trust - *Liaison Psychiatry, Mental Health Services for Older People*:** The community psychiatric nursing (CPN) service came up with the simple solution of aligning itself with each of our care homes in order to provide the first response to the home in cases of delirium, rather than the GP. The service developed a systematic checklist that standardised the approach of the CPN on examination of the patient.

  There has been a marked reduction in waiting times for patients with dementia who exhibit challenging behaviour, from a four-month wait for an acute psychiatric referral or appointment to one week; and a marked reduction in the number of straight referrals to the department of acute psychiatry by 26 per cent. Care home staff have reported that they now feel more confident and supported in dealing with delirium and challenging behaviours, the CPNs have consolidated their knowledge and there is less chance of the symptoms of delirium being missed in the treatment of our patients. CPNs now organise post-diagnostic support clinics where they are involved in anxiety management groups and participate in a new and innovative well-being hub in the Dunmurry and Stewartstown area.

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

- **Southern Trust - *Knowledge is Power, Memory Clinic Information Packs*:** Best practice guidance was consulted to identify information requirements and gaps in the provision of information on dementia. Packs produced containing information on types of dementia, what happens after diagnosis, practitioners within the dementia care services, and health matters specific to dementia. All people living with dementia and their carers are provided with a pack, the intention being that people living with dementia and their carers are better informed and empowered to make decisions about their care.

- **Western Trust - *The Memory Assessment Clinic*:** The clinic is staffed by a nurse, social worker, psychiatrist, geriatrician and psychologists, who meet weekly to discuss and assess patients referred to the service. This facilitates a more focused and streamlined approach, with less overlap between professional roles. There is joint decision making in relation to diagnosis, which delivers prompt decisions, which are unified and more accurate. The result of this teamwork is that people living with dementia have to attend fewer appointments. The team won the 'Team of the Year' in the 2012 Northern Ireland Dementia Excellence Awards, and ranked the Western Trust fifth in the UK, in an Alzheimer's study mapping dementia prevalence and diagnosis rates.

Case Example 5: Service Change: Primary Percutaneous Coronary Intervention

Objectives: Primary Percutaneous Coronary Intervention (pPCI) is a state-of-the-art medical technology that clears blockages in the arteries which can stop blood from flowing to the heart. The objective was to roll out 24/7 coverage across all Trust areas.

Deliverables: A 24/7 primary PCI service at Altnagelvin started on 15 September 2014 and is available to all patients in the Western Trust and a proportion of patients within the Northern Trust. The launch completed full roll-out of the pPCI service across Northern Ireland. £10.6 million was spent on the initiative against a TYC estimate of £9.3 million.

Achievements: State of the art cardiac catheterisation facilities have been of enormous benefit to patients having a heart attack, allowing them to bypass the emergency department and go straight to the laboratory for treatment. Primary PCI is a good example of a modern, responsive, 24-hour, seven day a week service that provides the right care in the right place at the right time.

Appendix 2: (continued)

Case Example 6: Resettlement of Mental Health & Learning Disability Patients

Objectives: Closing long stay institutions and completing the resettlement of adults with mental health and learning difficulties by 2015.

Deliverables: Establishment of a range of community based services.

Achievements: An initial target was to resettle all learning disability patients from long-stay hospitals by 2002. However, this target was not met and by 2002 only half of the patients had been resettled. The Bamford Review of Mental Health and Learning Disability recommended that "by June 2011, all people living in a learning disability hospital should be relocated to the community". TYC's objective was to complete the process by 2015 but as outlined below, this was not fully achieved.

At 31 March 2015, 35 long stay patients remained in learning disability hospitals. Twenty of these patients were planned to commence resettlement during summer 2015 with the longest four planned to be resettled into a new build which will not be completed until the 2016-17 financial year.

At 31 March 2015, 23 long stay patients remained in psychiatric hospitals. Resettlement plans are in place for 16 patients which had not commenced by 31 March 2015. This is due to some schemes being delayed due to procurement, planning permission issues and being new builds. Five of these patients are planned to be resettled into new builds which will not be completed until the 2016-17 financial year.

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

Case Example 7: Western HSC Trust - Respiratory care service

Objectives: Service was changed to encourage a consultant-led focus on the community.

Deliverables: The multidisciplinary model comprised a consultant, an oxygen specialist nurse, a respiratory pharmacist and a respiratory physiotherapist. The change in approach involved the introduction of outreach clinics; the use of phone or virtual clinics; phone and email consultations; home oxygen assessment; drugs reviews; and physiotherapy being available at home.

Achievements: The outcome in one year has been a 38 per cent reduction in the length of stay in the South West Acute Hospital for respiratory inpatients; there were 152 new referrals contacted, and 48 of those patients were discharged; using phone and email consultations, 33 admissions and 89 review clinic appointments were averted; the waiting time for oxygen assessment reduced by 10 months.

Five of the top six drugs prescribed in the Western Trust are respiratory drugs. In four months, there was a saving of approximately £70,000, and almost 100 admissions were prevented through physiotherapy interventions. Patients have reduced side effects from drugs, have interventions to avoid admission, are supported in a more timely fashion and, if admitted, have shorter hospital stays. The Haematology Service in the Western Trust has also transformed outpatient services using similar approaches.

The transformation in services achieved in respiratory care can be replicated in other service areas: work is underway in diabetes, cardiology, ENT and renal services.

Appendix 2: (continued)

Case Example 8: Developing Eye Care

Objectives: In 2012, the Department of Health Social Services and Public Safety (now the Department of Health) launched a five year strategy for eyecare services *(Developing Eyecare Partnerships (DEPs): Improving the Commissioning and Provision of Eyecare Services in Northern Ireland)*. DEP aims to facilitate an integrated approach to the development of eyecare services in Northern Ireland.

Deliverables: DEP adopts a pathway approach to this integration across all sub-specialties where appropriate, from primary care through to specialised secondary care utilising the expertise of a varied skill mix. Supporting these pathways will be the use of new and emerging technologies with seamless communication between those providing the care. The result will be a patient-centred service with emphasis on clinical leadership, training and development giving improved patient experience and outcomes. Information technology is a major enabler for the delivery of DEP

Achievements: There have been several developments over the last 12 months: for example, a local enhanced service for suspect Ocular Hypertension (OHT) referrals has been launched and is working well. Initial data shows that cases which would have been originally referred to secondary care for suspect OHT in line with NICE CG85: Glaucoma: Diagnosis and Management are being successfully deflected by the repeat measurement of Intra Ocular Pressures, reducing false positive referrals and associated patient anxiety. In addition the Health and Social Care Board has registered a number of Independent Prescribing (IP) Optometrists and who have now been issued with NHS prescription pads.

In September 2014, a pilot project was launched in 13 community optometry practices in one locality of the Southern Local Commissioning Group area. The Southern Primary Eyecare Assessment and Referral Service (SPEARS) will enable accredited optometrists to investigate and manage, or triage for onward referral, patients presenting with acute, sudden onset, mainly anterior, non-sight threatening eye problems who would otherwise visit their GP, the Emergency Hospital Eye Service or, an Ophthalmology out-patient clinic.

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

Case Example 9: Service Change: Stroke Services

There are 2,700 new stroke cases each year, and 35,000 stroke survivors currently living in the community. The TYC strategic business case envisaged stroke service change costs of £10.6m for a range of areas, including provision of stroke service improvement leads in each Trust, a regional stroke co-ordinator, enhanced community infrastructure teams and funding to enable early supported discharge of stroke patients from hospital.

The development of the actual service changes have been impacted by the need to formally request, consider and approve specific provider initiatives as well as the process delays brought about by the need to bid annually to the Department of Health (Department) for TYC in-year funding and the timing, and value, of the funds received from the Department.

All Trusts have in place a stroke service improvement lead (although this has not always required transitional funding as outlined in the business case). The regional stroke co-ordinator was recruited later than expected.

A number of Trusts/ICPs have initially been slow to develop and implement proposals for reforming secondary care stroke services: however that is now changing with the appointment of the regional stroke co-ordinator.

The actual spend of £0.96m by 2015-16 includes TYC funding made available to the Northern Trust who have reformed their secondary care stroke services. This has complemented reform the Trust has taken forward in relation to intermediate stroke rehabilitation, which overall has resulted in 1,714 fewer beds being required in 2014-15 compared to 2013-14. This has been achieved whilst the number of emergency admissions relating to stroke has remained constant.

It is estimated that stroke costs the health and social care services almost £240 million every year. Currently, around a third of stroke patients suffer a decline in health and wellbeing post-stroke and it is recognised that many require additional support to achieve their optimum level of recovery.

In January 2016, the Department announced a Northern Ireland-led international consortium had been awarded €3.6 million (£2.7 million) from the EU's Horizon programme to improve care for stroke patients.

The new research aims through a co-creation process to re-engineer the current approach to stroke patient rehabilitation and discover novel, highly effective rehabilitation technologies and techniques which will have a tangible impact on patient health.

Appendix 3: (paragraph 3.5)

List of all TYC Programme Benefit Measures as at March 2016

Ref	Benefit Measure Description
1a	Increase number of **specialist foster carers** registered
1b	Maintain the number of 'Blueprints' best practice **family early intervention programmes** that are operating in NI
1c	By March 2017 reduce the number of New Emergency Department Attendances, with a Primary Diagnosis of Acute Paediatric Asthma, by 2% compared to 2015-16 volumes (Care Pathways)
1d	By March 2017, maintain at 2015-16 volumes the number of non-elective patient admissions with a primary diagnosis of heart failure (Care Pathways)
1e	90% of complex discharges from acute hospitals to take place within 48 hours for Unplanned Admissions for those with a specified Long Term Condition (LTC) and Frail Elderly patients **(ICP Measure)**
1f	Increase the number of community pharmacies accredited in the **Health Plus Pharmacy Scheme**
1g	Increase the number of adults who have completed a Long Term Condition (physical or mental health related) **patient education** or self-management course
2a	Increase the number of Frail Elderly people treated via an ICP Acute/Enhanced Care at Home Service **(ICP Measure)**
2b	Measure relating to Outpatient Reform to be identified
2c	Increase the number of adults in **supported living accommodation**
2d	Increase the number of adults availing of **Day Opportunity** Placements
2e	Increase the % of the NI population aged 65+ who do not need any **care package** in a given year
2f	Reduce the % of the over 85 population who are treated in acute General Hospitals, who subsequently die in hospital **(ICP Measure)**
2g	Increase the number of clients in receipt of **Direct Payments** for Self Directed Support
2h	Monitor the rate of **normal births**
3a	Reduce the Average Length of Stay resulting from unplanned admissions for all patients with specified long term conditions or defined as Frail Elderly **(ICP Measure)**
3b	Reduce the number of new and unplanned review attendances for the Frail Elderly at Emergency Departments **(ICP Measure)**
3c	Maintain the overall number of **Emergency Department Attendances** at 2014-15 year end volumes
3d	Increase the number of adults in receipt of **short breaks**
3e	The proportion of adults receiving **short breaks** via residential home and nursing home breaks to be 22.6 % or less

Appendix 3: (paragraph 3.5)

List of all TYC Programme Benefit Measures as at March 2016

Ref	Benefit Measure Description
3f	**Shift Left** £83m from hospital/institutional based care into primary, community and social care services
3g	Measure relating to Outpatient Reform to be identified
4a	Increase the number of indicative patients who receive **Telehealth** monitoring
4b	Increased use of **Telecare** services (Monitored Patient Days)
4c	Reduce the rate of emergency readmissions within 30 days of the original discharge date for those with specified LTCs or the Frail Elderly **(ICP Measure)**
4d	Increase the % of people Discharged from **Reablement** who require no further care package
4e	Nursing measure to be identified
4f	Increase the number of active users of **Electronic Care Records**
Qual	**Service User Feedback** on their experience receiving targeted care, treatment and support, perception of joined-up nature of treatment/support

Appendix 4: (paragraph 3.7)

2015-16 Commissioning Plan Direction - Ministerial Priorities and Targets

Ministerial Theme 1: *To improve and protect population health and wellbeing and reduce health inequalities*

Standards and Targets

1	**Bowel cancer screening**	By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited.
2.	**Tackling obesity**	From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.
3.	**Substance misuse**	During 2015-16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes
4.	**Family Nurse Partnership**	By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme

Ministerial Theme 2: *To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.*

Standards and Targets

5.	**Unplanned admissions**	By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas
6.		During 2015-16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting do not exceed 2013-14 levels.
7.	**Carers' assessments**	By March 2016, secure a 10% increase in the number of carers' assessments offered.
8.	**Direct payments**	By March 2016, secure a 10% increase in the number of direct payments across all programmes of care.

Appendix 4: (paragraph 3.7)

2015-16 Commissioning Plan Direction - Ministerial Priorities and Targets

9.	**Allied Health Professionals (AHP)**	From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment
10.	**Hip fractures**	From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.
11.	**Cancer services**	From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.
12.	**Unscheduled care**	From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.
13.		By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.
14.	**Emergency readmissions**	By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.
15.	**Elective care – outpatients / diagnostics/ inpatients**	From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks.
16.		From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken
17.		From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.
18.	**Organ transplants**	By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD (donation after circulatory death) and DBD (donation after brain death) donors.
19.	**Stroke patients**	From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.
20.	**Healthcare acquired infections**	By March 2016 secure a reduction of 20% in MRSA and *Clostridium difficile* infections compared to 2014-15.

Appendix 4: (continued)

21.	**Patient discharge**	From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.
22.	**Mental health services**	From April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).
23.	**Children in care**	From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.
24.		By March 2016, ensure a three year time frame for 90% of children who are adopted from care.
25.	**Patient safety**	From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.
26.	**Normative staffing**	By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.

Ministerial Theme 3: *To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.*

Standards and Targets

27.	**Excess bed days**	By March 2016, reduce the number of excess bed days for the acute programme of care by 10%.
28.	**Cancelled appointments**	By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment.

Appendix 4: (paragraph 3.7)

2015-16 Commissioning Plan Direction - Ministerial Priorities and Targets

29.	**Delivering transformation**	By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model.
30.	**Pharmaceutical Clinical Effectiveness Programme**	By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

NIAO Reports 2016 and 2017

Title	Date Published
2016	
Governance of Land and Property in the NI Housing Executive	07 January 2016
Continuous Improvement Arrangements in Policing	08 March 2016
Local Government Code of Audit Practice	31 March 2016
Managing Legal Aid	21 June 2016
Contracted Training Programmes	28 June 2016
Renewable Heat Incentive Scheme	05 July 2016
The National Fraud Initiative: Northern Ireland	07 July 2016
Department for the Economy - Access to finance for small and medium sized enterprises	19 July 2016
The Rivers Agency: Flood Prevention and Management	13 September 2016
Local Government Auditor's Report 2016	20 September 2016
Northern Ireland Public Sector Voluntary Exit Schemes	11 October 2016
Managing Emergency Hospital Admissions	08 November 2016
Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland – 2016	06 December 2016
Special Educational Needs	12 December 2016
2017	
Continuous improvement arrangements in policing	04 April 2017

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Regional Workforce Planning Group

(Interim Terms of reference) **RWPG2/14**

Terms of Reference

1. The aim of this Regional Workforce Planning Group is to establish a framework for workforce planning, agree the functions/ roles/ responsibilities of the various organisations involved to enable the framework to deliver and allow sufficient flexibility to meet the dynamic nature of the HSC workforce requirements and assess the level of skill/resource/ tools required to deliver workforce plans on an ongoing basis.

2 The Regional Workforce Planning Group, chaired by the HR Director (HSC) and will draw its membership from:

- Trust HR Directors
- HR Director BSO/HSCB
- Chair Medical Workforce Planning Subgroup
- Departmental statistician
- Deputy Chief Medical Officer
- Department Nursing Workforce Planning Lead
- Department HRD Workforce Planning Lead

The Group will review its membership when the Strategic Workforce Planning Framework has been developed. Other Individuals will be invited to attend meetings in line with agenda specific items.

Professional Leads within the Department will serve as "critical friends" to quality assure and agree the framework and implementation plan. As the need arises a meeting of the group will be convened, in addition to virtual correspondence.

3 In line with the overarching aims of supporting the wider agenda of service maintenance, development and transformation this group's work will have a focus on the following TYC recommendations outlined below:

Recommendation 79: Make necessary arrangements to ensure critic al clinical staff are able to work in a manner which supports the new arrangements.

Recommendation 95: Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

3 In order to achieve this in the short term this group will produce

(i) an agreed Workforce Planning Framework, supporting policy, procedures and protocols, and

(ii) an implementation plan, which will include an assessment of the resource requirement.

(It is anticipated that these will be completed by July 2014)

5 A Comprehensive Framework will ensure

- There is clarity of roles and responsibilities in respective organisations
- There is a prioritised action plan for the development of workforce plans for the service with associated resource requirements
- There are integrated governance arrangements to support implementation
- There is a structured process designed to ensure the Department and the service share quantitative and qualitative workforce planning information to provide an evidence base for the education commissioning agenda through the development of workforce plans
- There is clarity in the education commissioning process encompassing government and departmental Policy
- There is integration of workforce planning with the commissioning process;
- There is an identification of the development needs (training/education and skills) to deliver the TYC aim to provide greater care in the community as well the wider strategic direction
- There are appropriate workforce planning mechanisms in place to support service transformation and service delivery in the short, medium and longterm.

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Regional HSC Workforce Planning Framework

March 2015

Skills for Health

better skills better jobs better health

Contents

Section 1

Introduction

- Effective workforce planning is complex and challenging but is essential in order to contribute to ensuring services across Northern Ireland are both sustainable and delivered to the appropriate standard. The range of challenges faced by the health and social care system has reinforced the need to ensure that the workforce is balanced correctly in terms of numbers and skills.

- There are many **drivers** for workforce planning, such as:

    a. The recognition of the changing nature of health and social care needs and the link to demographic changes in local populations; (greater emphasis on preventative approach and supporting people)

    b. The need for revised service delivery models to meet the needs of patients and clients and health and social care staff and in meeting the career needs of the health and social care workforce in the wide ranging geography of Northern Ireland;
    c. Patient safety and quality of care;
    d. Affordability of services given the challenging financial context for all organisations; and
    e. The need to connect workforce issues with the overall strategic direction as set out in documents e.g. Programme for Government Transforming Your Care, , Making Life Better, HSC Quality Strategy 2020 and the annual Commissioning Plan Direction.

- This Framework aims to support the following **outcomes** for the workforce planning process:

    a. An adaptive Health and Social Care workforce of the right size with the right skills deployed in the right way.

b. Developing a shared understanding of the core elements of effective workforce planning;
c. Providing greater clarity of roles and responsibilities, process, structures and governance;
d. Providing an understanding of how organisations and individuals can contribute effectively in a mixed economy; and
e. Encouraging partnership working both within and between organisations;
f. Better informed education commissioning decisions.

Section 2

Workforce Planning: A Working Definition

- At its simplest, effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, delivering services to provide the best possible care for patients and clients within available resources

- The approach to workforce planning as set out in this Framework Document is designed to:
    a. *Be centred around the needs of patients and clients;*
    b. *Embrace complexity;*
    c. *Recognise uncertainty;*
    d. *Be open and transparent;*
    e. *Be flexible and responsive to change;*
    f. *Whole system approach to workforce planning taking into account impact on changes to one part of the system on another (taking a Programme of Care approach where possible);*
    g. *Recognise that workforce planning is not just about the numbers but also the competence and deployment of the workforce;*
    h. *Enable the HSC to anticipate where possible, and respond to, Departmental and Ministerial directions and policies;*
    i. *Set out the NHS Six Step Model and its underlying principles as the primary model for workforce planning (Annex A), which can be complemented by other regionally agreed methodologies where appropriate;*
    j. *Make a clear linkage between workforce data, intelligence and projections with decisions on the commissioning of education and training;*
    k. *Engage with key stakeholders including employers and staff;*
    l. *Ensure timely, robust and accurate workforce information and analysis is available.*

Section 3

Organisational Roles and Responsibilities

- Effective workforce planning demands a collaborative, consistent, integrated and proactive approach across multiple stakeholders. No individual, group or organisation can undertake the process unilaterally and as a result, there is a range of responsibilities that lie within and between organisations that contribute to effective workforce planning.

- This section sets out the core roles and responsibilities involved in the HSC workforce planning process. Not every organisation with a role in workforce planning is included in this overview however key stakeholders will be included in the process as appropriate.

- The Framework focuses on the core elements deemed necessary to support effective workforce planning.

Department of Health, Social Services and Public Safety (DHSSPS)

- The DHSSPS has a range of statutory responsibilities regarding the effective functioning of health and social care service provision across Northern Ireland. As part of these responsibilities, the DHSSPS should ensure that key core responsibilities regarding workforce planning are delivered both in terms of leadership and ensuring effective functioning of the process. It is responsible for:

    a. setting the strategic vision;
    b. securing commitment to a high level workforce strategy which will underpin the Department's wider policy objectives;
    c. providing regional workforce information and trends;
    d. ensuring a regional approach is taken to workforce planning;
    e. facilitating of capacity building within the HSC Trusts; and

f. making decisions on the commissioning of pre- and post-registration education and training across the HSC.

Health and Social Care Board/Public Health Agency

- The commissioning of health and social care services is a crucial function within the wider health and social care economy. The Health and Social Care Board, through Local Commissioning Groups, and the Public Health Agency have a duty to ensure, through the commissioning process, that they are able to:
    - meet the current and future health and social care needs of the population of Northern Ireland;
    - secure value for money and ensure the appropriate quality of service provision; and
    - utilise appropriate processes to develop and reform services.

- In relation to workforce, the commissioners' role is to:

a. agree the models of service delivery;
b. be assured that HSC Trusts and independent practitioners have considered and identified the workforce needed for service delivery, through for example demand/capacity analysis;
c. exercise a challenge function where appropriate;
d. identify to the Department areas where intervention is required; and
e. lead or contribute to workforce reviews as required.

The Public Health Agency has an additional specific role in providing professional advice across the HSC and to the Department

Health and Social Care Trusts

- HSC Trusts are responsible for:

    a. ensuring that they have an appropriate and skilled workforce to deliver the services commissioned from them;
    b. utilising both qualitative and quantitative information to inform operational Workforce Plans (to include information projection and risk) which are reviewed annually;
    c. regularly liaise with other stakeholders (including local commissioners) to determine priorities and overcome challenges; and
    d. agree courses of action and implementation of workforce change.

Regional Workforce Planning Group

- The Regional Workforce Planning Group, chaired by the Director of Human Resources, DHSSPS, will:

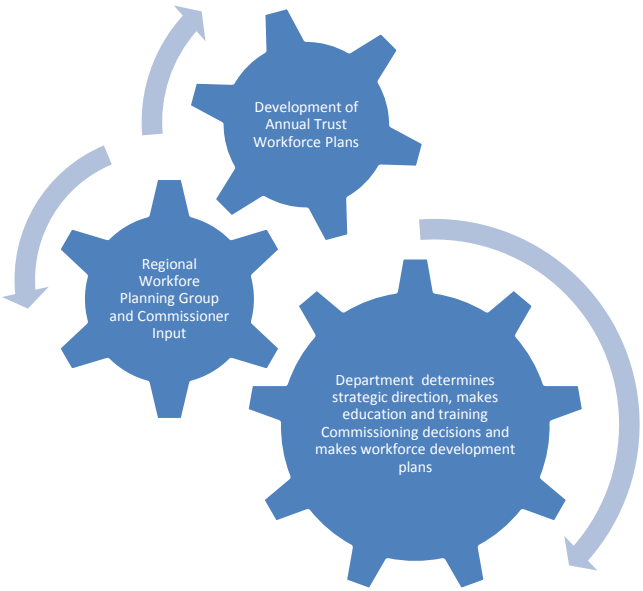
    a. act as the hub for all workforce planning activity within Health and Social Care;
    b. provide expert advice to the Department regarding workforce planning matters;
    c. inform the overall strategic direction for workforce planning;
    d. agree a programme of workforce reviews; and
    e. receive, comment on and endorse commissioned Workforce Reviews.

- The Table below describes the key roles and responsibilities in relation to regional workforce planning:

DHSSPS	HSCB/ PHA	Trusts	Regional Workforce Planning Group
Set the strategic vision	Agree models of service delivery	Ensure Trusts have an appropriate and skilled workforce to deliver the services commissioned from them	Act as hub for HSC workforce planning activity
Secure commitment to a high level workforce strategy which will underpin the Department's wider policy objectives	Be assured that HSC Trusts have considered and identified the workforce needed for service delivery, through demand/capacity analysis	Utilise both qualitative and quantitative information to inform operational Workforce Plans, which are reviewed annually	Inform overall strategic direction
Ensure a regional approach is taken to workforce planning	Exercise a challenge function where appropriate	Regularly liaise with other stakeholders to determine priorities and overcome challenges	Agree a programme of workforce reviews
Facilitate capacity-building within HSC Trusts	Identify to the Department areas where intervention is required	Agree courses of action and implementation of workforce change	Receive comment on and endorse commissioned workforce reviews

Take decisions on the commissioning of pre- and post-registration education and training across the HSC	Lead and contribute to workforce reviews as required

Diagram to Illustrate Workforce Planning process



Governance Arrangements

- This Framework Document has been developed under the aegis of the Regional Workforce Planning Group (RWPG). This Group will be re-purposed to oversee the next phase of workforce planning within Health and Social Care. It will have a revised Terms of Reference (including membership), which will be formally submitted by the Chair of the RWPG for approval by DHSSPS.

- Membership of the RWPG will include core representation from the DHSSPS, HSCB, PHA and HSC Trusts, at Senior Executive level as well as other key stakeholders. A list of the members is attached at the Annex B.

- Additional members will be co-opted on an agenda-specific basis or as the work programme dictates.

- Processes will be put in place to ensure that wider stakeholder engagement is facilitated.

Section 5

Next Steps

- This version of the Framework articulates the regional roles and responsibilities envisaged for HSC workforce planning; however it is recognised that this is an evolving process. In view of this, the Framework will be subject to ongoing review and refinement as appropriate.

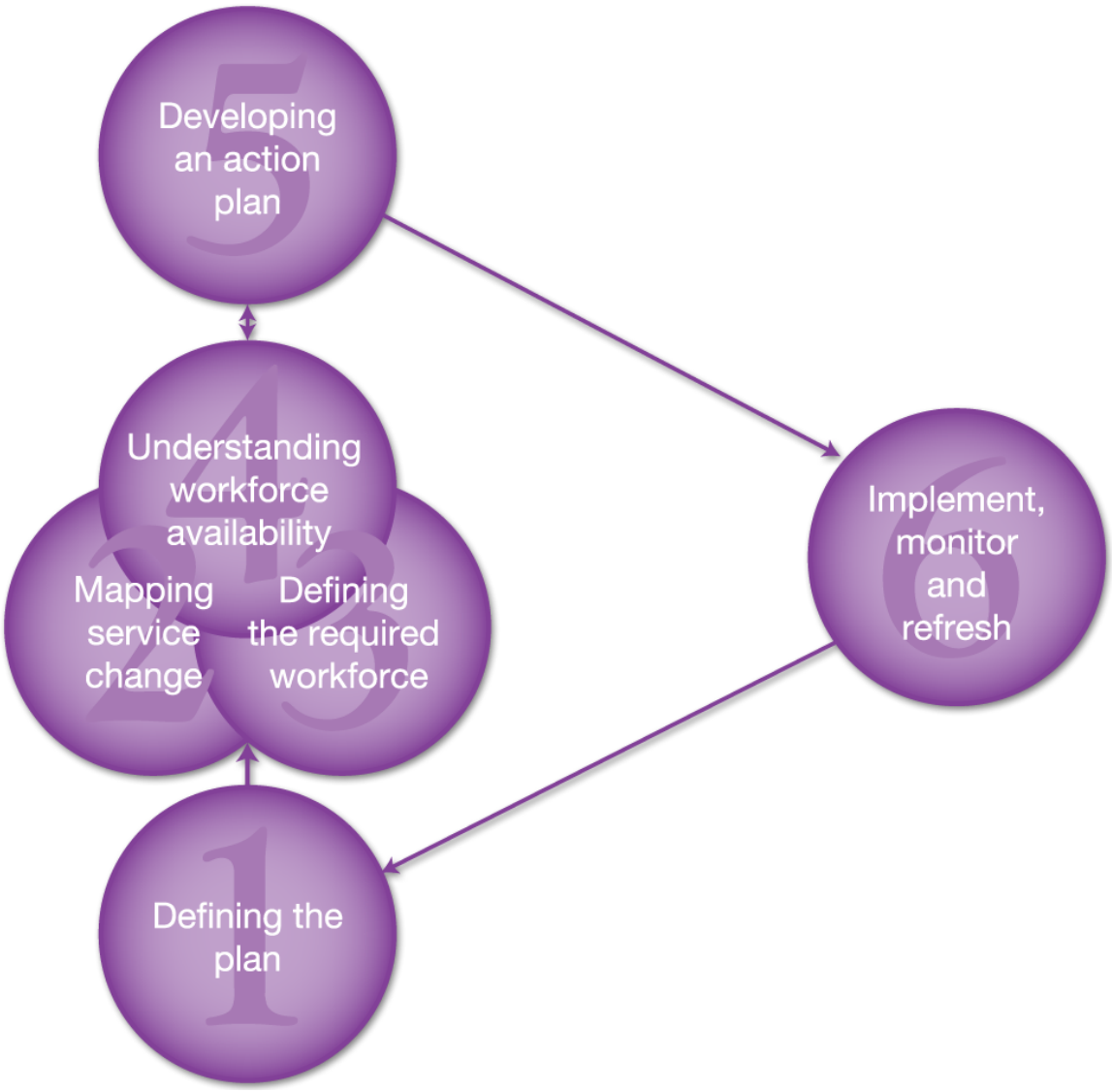
- Implementation of the framework will be led by the DHSSPS, and primarily taken forward through the RWPG. The primary implementation steps shall be:

    a. Development of revised Terms of Reference for the RWPG for approval by DHSSPS;
    b. Reconstitution of the membership of RWPG to fulfill the Terms of Reference;
    c. To pilot a service area review within a Programme of Care (POC) approach;
    d. Further development of workforce planning capability and capacity across the region.

For further information regarding this Framework please contact wpu@dhsspsni.gov.uk.

Annex A

Adapted from the Six Step Model to Integrated Workforce Planning



Step 1 – Defining the Plan

Identify why a workforce plan is needed and for whom it is intended:

- Purpose;
- Scope;
- Ownership.

This is the critical first step in the planning process. It is important to be clear why a workforce plan is required and what it will be used for. The scope of the plan should be determined, for example, whether it will cover a single service area, a particular patient pathway or a whole health economy; responsibility for ensuring the plan is delivered and other parties who will need to be involved in the planning process should be clearly stated.

Step 2 – Mapping Service Change

Identify the purpose and shape of any proposed service change that will impact upon future workforce requirements:

- Goals / benefits of change;
- Current baseline;
- Drivers/constraints;
- Option appraisal;
- Working models.

This is the first of three interrelated steps. It is the process of service redesign in response to service user choice, changes in modes of delivery, advances in care or financial constraints. It is important to be very clear about current costs and outcomes and to identify the intended benefits from service change. Those factors that support the change or may hamper it, should be identified. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

Step 3 - Defining the Required Workforce

Identify the skills required and the type / number of staff to deliver the new service model (workforce demand):

• Activity analysis;
• Types / numbers;
• Productivity / New ways of working.

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff could best carry out particular activities in order to reduce costs and improve the service user experience even where this leads to new roles and new ways of working.

Step 4 - Understanding Workforce Availability

Identify current and future staff availability based on current profile and deployment (workforce supply):

• Understanding the current workforce;
• Workforce forecasting;
• Demographics;
• Supply options.

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any particularly challenging areas arising from its age profile or turnover. It may be the case that the availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.

Step 5 - Developing an Action Plan

Plan to deliver the required workforce (new skills in new locations) and manage the change:

• Gap analysis;
• Priority planning;
• Action planning;
• Managing change.

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. An assessment of any anticipated challenges and how the momentum for change will be created, including staff engagement should be included in the plan.

Step 6 - Implement, Monitor and Refresh

Implement the plan, monitor progress and refresh the plan as required.

• Implementation;
• Measuring progress;
• Revisiting Six Steps.

As the plan is being implemented, it should undergo periodic review and adjustment as appropriate. This should be done by monitoring the agreed indicators of success and by identifying any unintended consequences of the changes.

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

DOMICILIARY CARE WORKFORCE REVIEW

Northern Ireland

2016 - 2021

31 August 2018

CONTENTS

FOREWORD

Domiciliary care is a vital service provided to around 24,000 service users [1] each week throughout Northern Ireland. The publication by the Expert Panel *Systems not Structures: Changing Health and Social Care* and the response *Health and Wellbeing 2026 – Delivering Together* highlighted the demographic changes and the requirement to respond to the needs of our ageing population. It also acknowledged that for many individuals, being able to stay in their own home, supported by the health and social care system, is their preferred option.

Health and Social Care spends approximately £204 million per year on domiciliary care services. Approximately 24,000 people receive domiciliary care each week and close to 270,000 hours of domiciliary care are delivered every week[1].

Our population is ageing with the number of people aged 65 and over projected to increase by 14% by 2021 (to 332,900) and 45% by 2030 (to 423,000)[2].

In total, it is estimated that the workforce providing HSC Trust commissioned domiciliary care is around 12,000 (both employed by HSC and independent sector). Collectively, this workforce provides vital services to our service users, supporting them to remain at home for as long as possible by assisting them to lead dignified and independent lives.

It is vital that the domiciliary care workforce feels valued, skilled and trained with the ability to be flexible and adaptive to future changes in service delivery models if it is to ensure that the changing needs of service users continue to be met appropriately.

It is well recognised that this workforce is paramount to delivering high quality, safe care to our older population and others with social care needs. To ensure this is achieved, it is necessary to develop this workforce plan providing the right number of people with the right skills in the right place at the right time!

A challenging goal.

[1] Domiciliary Care Services for Adults in NI (2016).
[2] 2014-Based Population Projections for NI (2015) NISRA.

EXECUTIVE SUMMARY

The Department's Workforce Policy Directorate has carried out a workforce review for the domiciliary care workforce following on from the Health and Social Care Board's (HSCB) *Review of Domiciliary Care – A Managed Change*.

Domiciliary care within Northern Ireland is a complex service provided by both the statutory and independent sectors with over 100 registered care providers including the five HSC Trusts. Each week over 268,000 hours of support is provided to over 23,000 service users in their own homes at an annual cost of approximately £204 million.

Domiciliary care is provided to individuals with an assessed need and to three main service user groups:

- Persons aged 65+;
- Adults with a range of complex care needs; and
- Children with a range of complex care needs.

Our population is ageing with the number of people aged 65 and over projected to increase by 14% by 2021 (to 332,900) and 45% by 2030 (to 423,000). Many will have long-term complex care needs thus increasing the demand on this service.

In March 2015, the Department of Health accepted the Six Step Methodology (developed by Skills for Health) as the preferred model for all future HSC workforce planning.

The domiciliary care workforce review therefore follows this process.

A Steering Group to oversee the review and a Project Group to carry out the review were established with Terms of Reference agreed.

This review has been undertaken during a period of change, with the Minister's *Health and Wellbeing 2026 Delivering Together* at the fore of all future service delivery. However, as much of the transformation work is at an early formative stage, this report is based on knowledge of existing systems and structures at the present time. The findings of the review are therefore framed in the context of a number of assumptions and constraints about the future delivery of domiciliary care over the next five years.

Assumptions	**Constraints**
Mixed economy – it is acknowledge that care will continue to be provided by both the statutory and independent sectors.	***Tendering process*** – current tenders in place for next five years.
Self directed support – HSCB's policy of self directed support will continue with a	***Workforce data*** – lack of data available, especially in the

target of 33% uptake by 2019.	independent sector, and lack of consistent reporting across the statutory sector.
Eligibility criteria – current criteria remains the same.	***Service delivery models*** – absence of clarity about current and future service delivery models.
Funding – it is acknowledged that sufficient funding will be required to meet future demand.	

The Steering and Project Groups were representative of the key stakeholders in the delivery of domiciliary care comprising Department of Health, Department for the Economy, Health and Social Care Trusts, Health and Social Care Board, Northern Ireland Social Care Council, Public Health Agency, independent sector, with staff side, from a user perspective, being provided by the PHA representative.

In order to engage with a wider group of stakeholders, a stakeholder engagement event was held in Ulster University in June 2016. Over 100 delegates registered to attend the event from across the statutory sector, independent sector, staff side, carers and service users. The event was an interactive e-participation engagement session.

This event focused on three key areas:

- Growing and retaining the domiciliary workforce;
- Stabilising the market; and
- Skills mix and career development.

The review was undertaken using a co-design approach.

Whilst it has not been possible to provide bespoke financial implications, the review has demonstrated that, at present, services are already stretched, with a gap in the supply and demand chain due to unmet need.

Even should we continue to deliver the same level of service to the same percentage of the population, given the projected increase in our ageing population, it is estimated that by 2021 **2,700** service users are going to require support which would result in the need for a further **1,400** domiciliary care staff. This will require investment of approximately **£27 million**.

Training demands are also going to play a role in ensuring that staff have the appropriate skills to deliver the right service to the right people at the right time. For example, the introduction of new technology will have a significant impact on the role of the domiciliary care worker and service users, and up-skilling of this workforce will be critical to ensure optimum benefits are realised from the technology. In addition, with many people living with more complex needs e.g. diabetes, stroke and Alzheimer's etc., staff may also require specialist training.

The Minister's vision for *Health and Wellbeing 2026 – Delivering Together* highlights the need to work in partnership between patients, service users, families, staff and politicians. This is of significant importance in the delivery of domiciliary care as family members and friends, who may currently provide care needs, make an enormous contribution to the economy and society as a whole.

The review outlines a number of recommendations under headings of key themes going forward, e.g. commissioning, recruitment and retention, education and training, career development, workforce planning and partnership and community working.

An Action/Implementation Plan, to be rolled out over the five-year life span of the review, has been developed. Due to the nature of the service being delivered, many of the actions will be led by the employers. However, a high level of Departmental support will be required to ensure that issues such as commissioning, training and partnership working are developed to maximise capacity within the sector.

ABBREVATIONS

AHP	Allied Health Professional
BMI	Body Mass Index
CIB	Community Information Branch
CIS	Community Information System
DfE	Department for the Economy
DHSSPSNI	Department of Health, Social Services and Personal Safety Northern Ireland
DoH	Department of Health
HRPTS	Human Resources Payroll Travel and Subsistence System
HSC	Health and Social Care
HSC Trusts	Belfast, Northern, Southern, South Eastern, Western and Northern Ireland Ambulance Service Trust
HSCB	Health and Social Care Board
IPC	Institute of Public Care
NISCC	Northern Ireland Social Care Council
NISRA	Northern Ireland Statistical & Research Agency
PHA	Public Health Agency
PRTL	Post Registration Training and Learning
QCF	Qualifications and Credit Framework
RQIA	Regulation and Quality Improvement Authority
RWPG	Regional Workforce Planning Group
SDS	Self Directed Support
TYC	Transforming Your Care

1.0 INTRODUCTION AND BACKGROUND

1.1 Strategic Context

Domiciliary care within Northern Ireland is a complex service provided by both the statutory and independent sectors, offering a variety of terms and conditions to staff employed to deliver a range of health and social care to service users. Currently there are over 100 registered domiciliary care providers, including the five Health and Social Care Trusts.[3]

Domiciliary care is provided to individuals with an assessed need and to three main service user groups:

- Persons aged 65+;
- Adults with a range of complex care needs; and
- Children with a range of complex care needs.

Each week close to 270,000 hours of support are provided to around 24,000 service users in their own home.

The range and type of domiciliary care and personal support provided in people's own homes varies, but usually includes support with activities of daily living, which may include help with personal care, support the administration of medicines, meeting the needs of service users with specific issues including memory issues and those requiring nutritional support and essential domestic tasks. Domiciliary care also plays a key role in underpinning a more efficient healthcare system through supporting timely discharges from secondary care settings.

The population in NI is ageing; it is predicted that by 2030 the number of people over 65 will increase by 45% and that the number of people over 85 will increase by 81%. These trends are undoubtedly a cause for celebration. However, they will also require a greater demand for support as levels of dependency and disability increase with age. Meeting an increased demand for domiciliary care services presents an enormous challenge for health and social care providers. Workforce planning is a key component in ensuring that there is a sufficient workforce to meet that demand and provide services to those in need, at the time of need.

1.2 Workforce Plan Methodology

In November 2014, the Director of Human Resources at the Department of Health & Social Services and Personal Safety Northern Ireland (DHSSPSNI) commissioned a workforce review of domiciliary care services within the Older People's Programme of Care, with the aim of producing an integrated regional workforce plan and associated recommendations.

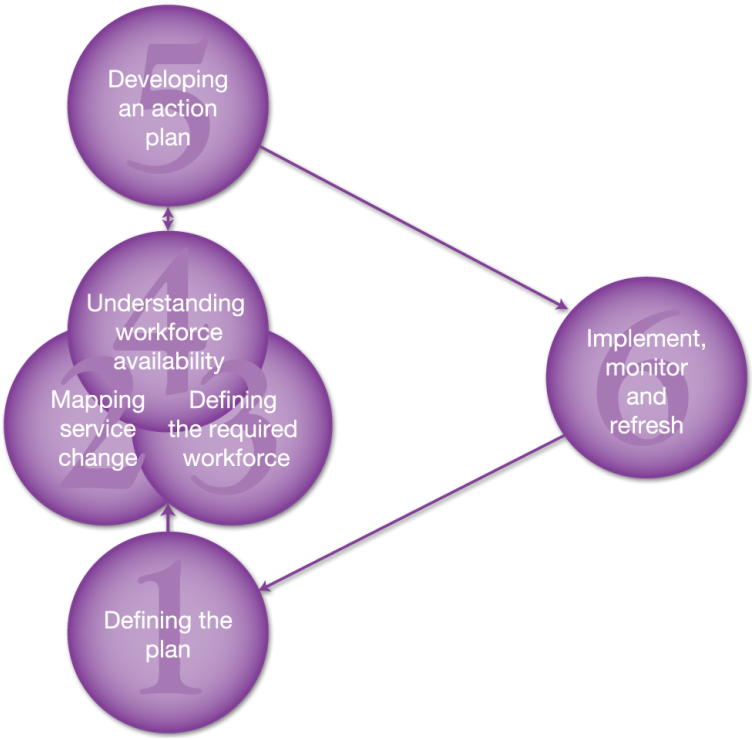
[3] A Managed Change Briefing Paper: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland November 2015

A Regional Domiciliary Care Workforce Planning Steering Group and Project Working Group were established to take this forward. **Terms of Reference** and **Membership** of both groups are set out in **Appendix 1.**

After consideration of a range of established workforce planning practices, the Six Step Methodology (Skills for Health 2009) was adopted and agreed by the Department of Health in March 2015 as the preferred tool for future workforce planning throughout the HSC.

This workforce plan is underpinned by the adapted version of the 'Six Step Methodology' (Skills for Health 2009) (Figure 1).

Figure 1: Six Step Methodology to Integrated Workforce Planning (Skills for Health)



This approach has been accepted across all HSC organisations in Northern Ireland and is a very useful tool in guiding us through the steps; gathering data on the supply and demand, identifying key issues impacting on recruitment, retention and career progression on those employed in this area.

In December 2016 the then Health Minister established an Expert Advisory Panel on Adult Care and Support to assess the many challenges facing the care and support system, and to produce a set of recommendations to reform the system and its funding structures to ensure its future sustainability. Their Report, *Power to People: Proposals to reboot adult care and support in NI* was published in December 2017.

In *Health and Wellbeing 2016 – Delivering Together* the then Minister gave a commitment to tackling many of the challenges which are present within the domiciliary care service, including the availability of a well-trained and capable

workforce. This report will supplement the work of the Expert Advisory Panel in understanding the workforce needs and issues, alongside related pieces of work including the HSC Board's report *A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary care in Northern Ireland*.

This report sets out the strategic workforce implications and makes a number of recommendations for the Region over the next five years, and an Action/Implementation Plan has been developed to ensure that recommendations are delivered in an efficient and timely manner.

It is also accepted that some HSC Trusts have already progressed procurement of domiciliary care services for the next five years, which may impact on the ability to shape service models in line with the recommendations within that period.

1.3 Meeting the Terms of Reference

While the development of this report has been undertaken at a time when the Health and Social Care system is undergoing transformation as set out in *Health and Wellbeing 2026 Delivering Together*, some uncertainty exists whilst this transformation is being rolled out.

Therefore, the information contained in this report is based on knowledge of the existing systems and structures for the delivery of domiciliary care services. The findings are framed in the context of a number of assumptions about the delivery of domiciliary care over the next five years and also some constraints impacting on the Six Step Methodology used. This work will need to the updated in line with the outcomes of the Expert Advisory Panel Report, *Power to People: Proposals to reboot adult care and support in NI*.

1.4 Assumptions and Constraints

Assumption 1 **Mixed economy** – It is acknowledged that care will continue to be provided by both the statutory and independent sectors – if that were to change then this would impact on workforce planning.

Assumption 2 **Self directed support** – The HSCB's policy of self directed support will continue with targets set for 33% of eligible service users to avail of this option by 2019.

Assumption 3 **Eligibility criteria** – Current eligibility for domiciliary care support remains the same – any policy change on this would affect projections contained in the report.

Assumption 4 **Funding** – It is acknowledged that sufficient funding will be required to meet the future demands and workforce needs.

Constraint 1 **Tendering process** – a number of HSC Trusts are or have recently been tendering for service delivery and these contracts will apply for the next 5 years.

Constraint 2 **Workforce data** – there is a lack of workforce data, especially in the independent sector, but also in the statutory sector as each HSC Trust may record job roles/titles and activity differently. The compulsory registration of domiciliary care workers will help address this and assist with more robust information being made available for workforce planning.

Constraint 3 **Service delivery models** – the absence of clarity about future service delivery models has restricted the planning process and this review has been undertaken based on existing models of domiciliary care provision.

2.0 DEFINING THE PLAN

2.1 Purpose

This workforce review has been commissioned by the DoH in recognition of the increasing demand for domiciliary care services from an ageing population and in response to current thinking as outlined in *Transforming Your Care* that '***home is the hub***'. Given our ageing population it is reasonable to project that more people will live longer with more complex needs, and the drive now is to deliver more care closer to home or at home. This will undoubtedly put additional pressure on domiciliary care services. In order to respond effectively to this pressure, it is vital that we ensure that we have a sufficient domiciliary care workforce to meet this demand.

Purpose

- ✓ To carry out a workforce review of domiciliary care which will inform planning to ensure the availability of a domiciliary care workforce to meet future demand and redesigned services.
- ✓ The Review will make recommendations for further training required to ensure a competent workforce that can deliver the agreed model(s) of domiciliary care services to support transformation of care over the next five years.
- ✓ Develop an Implementation/Action Plan to deliver recommendations.

Workforce planning is a key component in setting the direction of travel for the domiciliary care workforce over the next five years. The DoH recognised the need for change, with the impact of demographic changes and labour market challenges increasingly understood. Not only will the needs of service users continue to change and demand for services increase, but the workforce profile and characteristics of our existing staff will also change as our own workforce ages.

This workforce review focuses attention on the issues impacting on the delivery of domiciliary care services and identifies the actions necessary for securing the appropriate domiciliary care workforce with the right skills, in the right place, delivering the right care to service users.

2.2 Aim and Objectives

The overarching objective of the review is to develop a workforce plan which will support the recruitment and retention of a well-trained, skilled, motivated and sustainable domiciliary care workforce with the requisite skills to deliver domiciliary care services to the people of Northern Ireland over the next five year period. This

will enable employing organisations, both statutory and independent, to ensure sufficient numbers of staff are in post to provide care and support, and will give confidence to service users that the service has been developed taking their feedback through co-design into account.

Objectives:

Objectives

- ✓ To ensure the workforce plan is informed by co-design (developed in partnership with service users/families/carers).
- ✓ To provide an analysis of the current domiciliary care workforce in Northern Ireland.
- ✓ To provide an analysis of current and future recruitment and retention issues.
- ✓ To identify potential future recruitment and retention issues.
- ✓ To produce a Workforce Plan to include recommendations to support the outcome of the review.

2.3 Guiding Principles

The following principles were employed to guide the development of this workforce review:

Guiding Principles

- ✓ The plan will focus on an integrated approach with the service user at the centre.
- ✓ The Department, Commissioners and Employers will be central to supporting the development of the plan going forward.
- ✓ The whole of the domiciliary care workforce will be taken into account, including the numbers, skills and skill mix required across both the statutory and independent sectors.
- ✓ The plan will take account of the demographics, health, and social care needs of the service user population.
- ✓ The education and training agenda is focused on the knowledge, skills, values and behaviours required.
- ✓ Stakeholder engagement should be employed throughout the whole process including implementation.

2.4 Scope of the Workforce Review

At the outset of the process, the intention was to confine this workforce review to domiciliary care provided to 'older people', that is, persons aged 65+ receiving domiciliary care. However, it soon came to light during initial data collection that it was not possible to disaggregate the workforce information between the three main service user groups to whom domiciliary care is provided:

- Persons aged 65+;
- Adults with a range of complex care needs; and
- Children with a range of complex care needs.

It is significant however, that over 80% of recipients of domiciliary care are older people.

The Self Directed Support (SDS) model, such as Direct Payments and Managed Budgets, is an area of care that is expected to be highly impacted by further service transformation and SDS is expected to increase over the next few years.

The DoH policy to support care services at home includes the use of Self Directed Support (SDS), Reablement and Telemonitoring. In relation to SDS, it is expected that by March 2019 all service users and carers will be assessed or reassessed at review under the SDS approach, and will be offered the choice to access Direct Payments, a Managed Budget, HSC Trust arranged services, or a mix of those options, to meet any eligible needs identified. The aim is that one in three of those individuals in receipt of a social care service will be availing of SDS via a direct payment or a managed budget arrangement.

Self Directed Support budgets can facilitate individuals to purchase domiciliary care directly, shaping the service to meet their individual needs, thus maximising the opportunity of choice and control. Related support plans will allow monitoring of the budgets in line with assessed needs and agreed support.

In assessing future workforce requirements, cognisance will need to be taken of these other interacting services as they develop into the future.

2.5 Ownership

The need to ensure the support and ownership of both the statutory and independent sectors was considered critical in the development of this regional workforce review. A **Steering Group** was therefore established to oversee the workforce plan, co-chaired by the DoH Director of Workforce Policy and the DoH Deputy Chief Social Services Officer. Membership of the Steering Group was drawn from DoH, HSC Trusts (both HR and service delivery representatives), NISCC, HSCB, PHA, Independent Healthcare Providers, PCC, DfE and staff side.

A **Project Working Group** was also established, chaired by the DoH Assistant Director of Workforce Planning with membership drawn from DoH, HSC Trusts (both HR and service delivery representatives), NISCC and HSCB.

Terms of Reference for both the Steering Group and Project Working Group were agreed. A copy of the Terms of Reference and a full list of membership are attached at **Appendix 1.**

The Terms of Reference included:

- To agree a definition of domiciliary care.
- To agree the scope of the review.
- To provide an analysis of the current domiciliary care workforce in Northern Ireland.
- To test a workforce planning model on a 'Programme of Care' approach within a social care context, although recognising that the service user group includes people outside the Older People programme of care.
- To provide an analysis of current and future recruitment and retention issues.
- To identify potential future recruitment and retention issues.
- To produce a Workforce Plan to include recommendations to support the outcome of the review.

A commitment was given by the Steering Group that the review would be developed following a co-design approach. A lot of work had already been undertaken by the PHA, PCC and the HSCB in engaging with service users and staff to inform the HSCB's Regional Review of Domiciliary Care report *A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland.* It was agreed that the Project Working Group would draw upon this information to inform the review. A paper was commissioned by the Project Steering Group on this basis, copy attached at **Appendix 2**.

2.6 Definition of Domiciliary Care

This workforce review commenced alongside the HSCB's Regional Review of Domiciliary Care *A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland.* It seemed appropriate therefore that, to be consistent, the same definition would be adopted. However, it should be noted that eligibility criteria for domiciliary care is applied by HSC Trusts based on an individuals' assessed need and the Steering Group acknowledges that the definition below does not fully reflect the current range of domiciliary care services provided and therefore requires updating, which has been highlighted in the HSCB's report.

Definition of domiciliary care – *The range of services put in place to support an individual in their own home. Services may involve routine household tasks within or*

outside the home, personal care of the client and other domestic services necessary to maintain an individual in an acceptable level of health, hygiene, dignity, safety and ease in their home.

2.7 Drivers for Change

Public expectations of health and social care are changing, and service users and carers expect high-quality services to be delivered close to their homes. The demand on our services is set to increase, with people living longer, with more complex needs. There is an increased expectation for services to be personalised to meet individual needs and the ongoing rollout and promotion of the SDS service model will continue to drive this demand. Therefore, as the health and social care landscape in Northern Ireland continues to evolve, and the shift from acute to community health and social care services grows, there will be a need to ensure that the domiciliary care workforce acquires new skills to match the speed and introduction of new technologies and potentially the introduction of new roles.

At the time of writing, the NI Executive has produced a draft Programme for Government (PfG) for consultation. A significant focus of PfG is improving investment in the economy through strategies for job creation, encouraging those who are economically inactive to enter work and developing and enhancing the skills and capacity of those in employment. These outcomes, coupled with the former Health Minister's strategy for transformation in health and social care, *Health and Wellbeing 2026 – Delivering Together*, form two key strategic drivers which will have an impact on the domiciliary care workforce over the next five years. The interconnection between transforming services and skills and employment strategies should be recognised in order to support the recruitment and retention of a skilled domiciliary care workforce.

There are many other drivers for change, particularly with the recent onus on quality and patient safety which has been highlighted in a range of regional and national strategies and reports including:

- Systems not Structures: Changing Health & Social Care, 2016.
- Mental Capacity Act (NI) 2016.
- Skills Agenda and Apprenticeship.
- Registration of the social care workforce.
- The Dementia Learning and Development Framework 2016.
- A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland, November 2015.
- Domiciliary Care in Northern Ireland: A Report of the Commissioner's Summit, October 2015.

- Public Health Agency Regional Findings Relating to Care in Your Own Home (10,000 voices), March 2015.
- Introduction of new technology e.g. Human Resources Payroll Travel and Subsistence System (HRPTS) and Community Information System (CIS).
- Quality 2020 – A 10-year quality vision for health and social care in Northern Ireland.
- Improving & Safeguarding Social Wellbeing – A Strategy for Social Work in Northern Ireland 2012 – 2022.
- Pension Reform.
- Review into the quality of care and treatment provided by 14 hospital Trusts in England: Overview report Professor Sir Bruce Keogh KBE.
- The Right Time, The Right Place – An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland December 2014 Donaldson Review 2014.
- The Berwick Report – A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England August 2013.
- The Cavendish Report 2013 – an investigation into what can be done to ensure that all people using Services are treated with care and compassion by healthcare assistants and support workers in the NHS and social care settings.
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013.
- Financial Savings Plans.
- Transforming Your Care – A Review of Health and Social Care in Northern Ireland December 2011.
- Living Matters Dying Matters 2010 – A Strategy for palliative and end of life care.
- The Domiciliary Care Agencies Regulations (Northern Ireland) 2007.
- Health and Personal Social Services (Quality and Improvement and Regulation) (Northern Ireland) Order 2003.
- Carers and Direct Payments Act (Northern Ireland) 2002; Caring for Carers 2006.
- Regulation of the Domiciliary Care Workforce.

3.0 MAPPING SERVICE CHANGE

3.1 Population and Health Profile

The NI Statistics and Research Agency (NISRA) projects the population of Northern Ireland to rise from 1.85 million in 2015 to 1.91 million in 2021 (an increase of 3%) or 1.98 million by 2030 (an increase of 7% from 2015). With the majority of domiciliary care categorised as being delivered to those aged 65 and over, it is significant to note that the number of people aged 65 and over is forecast to increase by 14%, from 292,000 in 2015 to 332,900 in 2021. The projected percentage increase to 2030 is 45%, with those aged 65 and over expected to total around 423,000. Furthermore, in the period to 2021, the number of people aged 85 and over is expected to increase by 7,500 from 35,100 in 2015 to 42,600 in 2021 (an increase of 21%). The projected percentage increase to 2030 is 81%, with those aged 85 and over expected to total around 63,700 (an increase of around 28,600).

In terms of life expectancy, males aged 65 in the period 2011-2013 can expect to live for another 18.1 years whereas females can expect to live a further 20.6 years. Over the decade 2001-2003 to 2011-2013, male life expectancy at age 65 has improved by 2.2 years whereas that of females has improved by 1.7 years. (Source: Life Expectancy for areas within NI 2011-2013, NISRA http://www.nisra.gov.uk/archive/demography/vital/deaths/life_tables/2011-2013LE.pdf).

The following estimates also bear relevance to the population who might avail of domiciliary care services:

- 26,500 people are estimated to be living with a learning disability, and half are aged between 0-19 years (Bamford Action Plan 2009-11).
- 250,000 adults and 45,000 children and young people are estimated to have a mental health need at any one time in NI (Bamford Action Plan 2009-11).
- 20,000 older people are living with Dementia and this number is expected to rise to 60,000 over the next 30 years (Source: DoH Dementia Strategy).

There are increasing numbers of people with chronic or long-term conditions such as diabetes, coronary heart disease, chronic obstructive pulmonary disease and stroke survivors. The table overleaf indicates the number of patients on GP Registers in Northern Ireland across a range of conditions.

3.2 Statistics from GP Quality & Outcomes Framework 2015/16

Condition:	No. Patients on GP registers with each condition
Asthma	117,613
Atrial Fibrillation	32,701
Cancer (diagnosis since 2003)	42,454
Chronic Obstructive Pulmonary Disease	38,530
Coronary Heart Disease	74,525
Cardiovascular disease (CVD) – Primary Prevention	19,712
Dementia (diagnosis of)	13,617
Depression (patients aged 18+, since 2006)	131,776
Diabetes (patients aged 17+)	88,305
Heart Failure	15,702
Heart Failure due to left ventricular systolic dysfunction (LVSD)	4,237
Hypertension	260,032
Mental Health (schizophrenia, bipolar affective disorder, other psychoses, patients on lithium therapy)	17,114
Osteoporosis (patients aged 50+, since 2012)	4,104
Palliative Care	5,426
Rheumatoid Arthritis (patients aged 16+)	11,899
Stroke and transient ischemic attack (TIA)	36,020

Source: 2015/16 raw disease prevalence trend data for NI https://www.health-ni.gov.uk/publications/201516-raw-disease-prevalence-trend-data-northern-ireland

The 2015/16 Health Survey outlined that a rise in obesity levels, showing that Body Mass Index (BMI) levels are:

- 1% underweight
- 38% normal weight
- 34% overweight
- 26% obese

Source: https://www.health-ni.gov.uk/sites/default/files/publications/health/hsni-first-results-15-16.pdf

This can have a direct impact on the provision of domiciliary care, as the need for suitable aids or the need for additional care workers for moving and handling tasks must be assessed.

3.3 Current Eligibility Criteria

The eligibility criteria for domiciliary care are based on the DoH (GB) *Fair Access to Care Services* (2003) and have been modified to meet local circumstances. The Department developed *Regional Access Criteria for Domiciliary Care* in 2008, with the criteria based on the underlying principle that people should be supported to remain independent where possible. Each individual's assessment of need determines eligibility for services depending on the level of risk to independence. Consideration of the level of risk is determined by a number of factors including:

- Autonomy;
- Health and Safety;
- Ability to manage daily routines; and
- Involvement in family life.

3.4 Overview of Domiciliary Care Tasks

Domiciliary care workers are part of the registered social care workforce. They sustain and promote social wellbeing through the provision of a range of home and community based personal care and support services to individuals, carers and families. This includes providing care to individuals who have more complex care and support needs.

Where complex care is supporting an assessed health or social care need, the care will be prescribed and reviewed by the relevant health or social care professional, supporting the domiciliary care worker and working in partnership with the wider multi-professional team, in order to deliver well-coordinated and person-centred care.

3.5 Activity Key Facts and Figures

The Department of Health collects information on domiciliary care services provided to service users by means of an annual survey. During the survey week 11th - 17th September 2016, the following facts were recorded:

Contact Hours

- An estimated 268,883 contact hours of domiciliary care were provided by HSC Trusts in Northern Ireland, an increase of 5% (13,674) from the survey week in 2015 (255,209);

- The statutory sector provided 30% of domiciliary care contact hours, with 70% provided by the independent sector; and
- An average of 11.3 domiciliary care contact hours were provided per service user, an increase of 3% when compared to 2015 (11.0).

Service Users Receiving Domiciliary Care

- HSC Trusts provided domiciliary care services for 23,873 service users, 3% more than the number during the survey week in 2015 (23,260).

Domiciliary Care Visits

- 436,174* domiciliary care visits were provided to service users, 31% from the statutory sector and 69% from the independent sector;
- Half (50%) of all domiciliary care visits provided to service users were between 16 and 30 minutes long. Almost three in ten (29%) visits were 15 minutes or less and over one in five* (21%) were more than 30 minutes long; and
- 9,825 service users received a domiciliary care visit lasting 15 minutes or less, over two-fifths (41%) of all service users receiving domiciliary care.

Service Intensity

- Nearly nine-tenths (86%) of all service users receiving domiciliary care services received six or more visits. The proportion of service users receiving six or more visits has increased by 5% (980) since 2012.

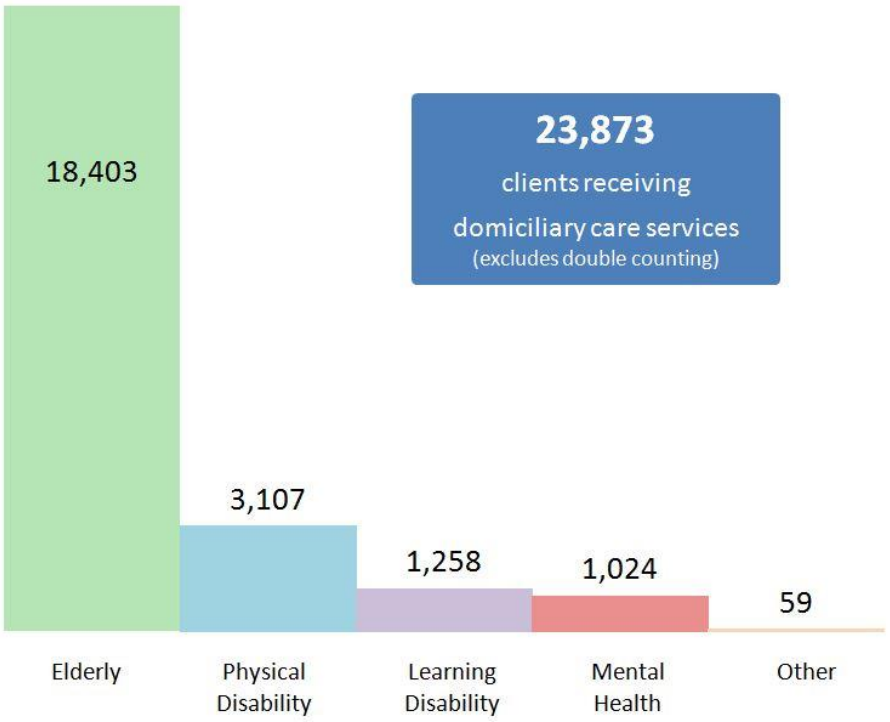
Service Users Receiving Intensive Domiciliary Care

- 8,752 service users received intensive domiciliary care services, 14% (1,059) more than during the survey week in 2015 (7,693).

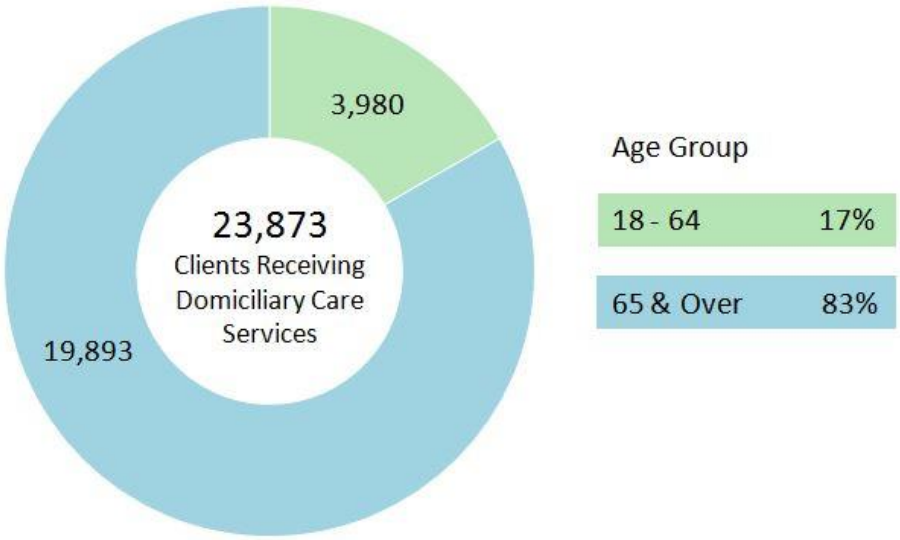
For the purposes of the survey, ***intensive domiciliary care*** *service is defined as 6 or more visits and more than 10 contact hours during the survey week*

***** The total regional visits figure includes an estimate for the number of statutory visits greater than 30 minutes in length for the Northern HSC Trust. The estimate is in line with the 2015 survey findings.

Number of Service Users Receiving Domiciliary Care Services, by Service User Group (2016) – Source: Domiciliary Care Services for adults in NI 2016.



Number of Service Users Receiving Domiciliary Care Services, by Age Group (2016) – Source: Domiciliary Care Services for adults in NI 2016.



Source: Domiciliary Care Services for Adults in Northern Ireland 2016
https://www.health-ni.gov.uk/publications/domiciliary-care-services-adults-northern-ireland-2016

3.6 Financial Challenges

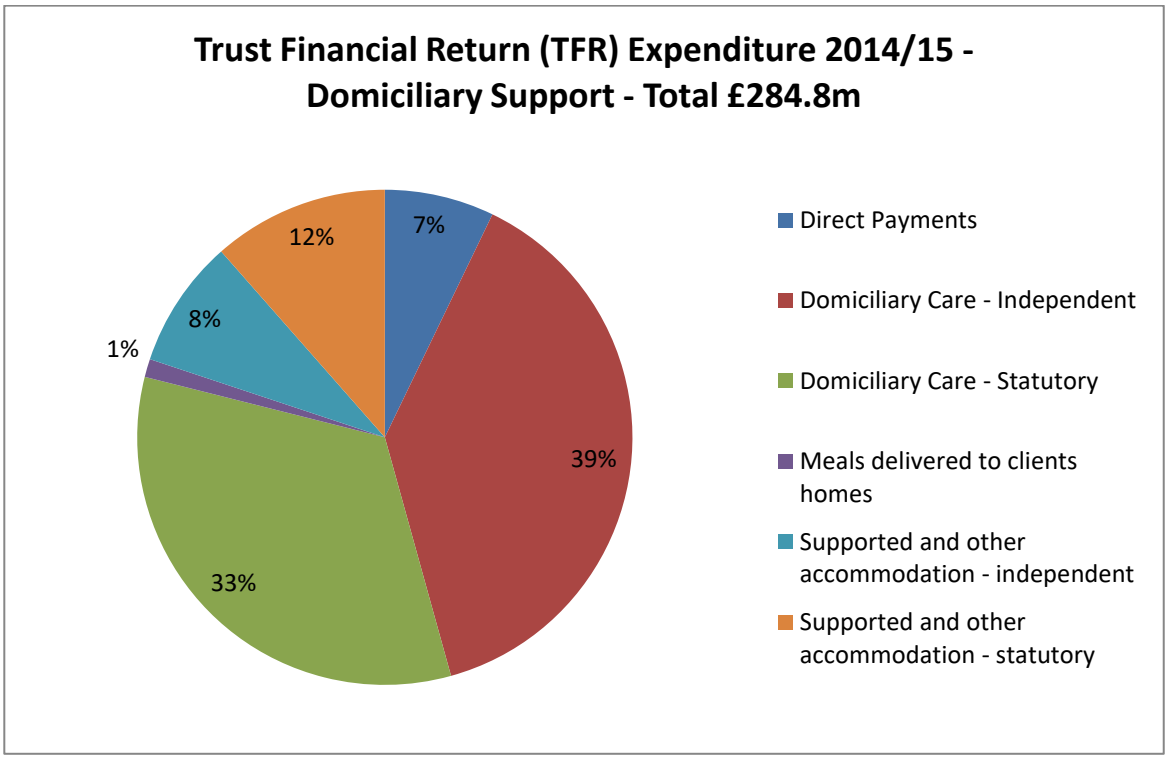
The Health and Social Care sector continues to face significant financial challenges and must work towards delivering the efficiencies required to meet the funding available. Therefore commissioners and providers should be seeking innovative ways of delivering the services required. The implications of the efficiency challenges that face each HSC Trust over the next five years will be significant, particularly in relation to meeting existing commitments.

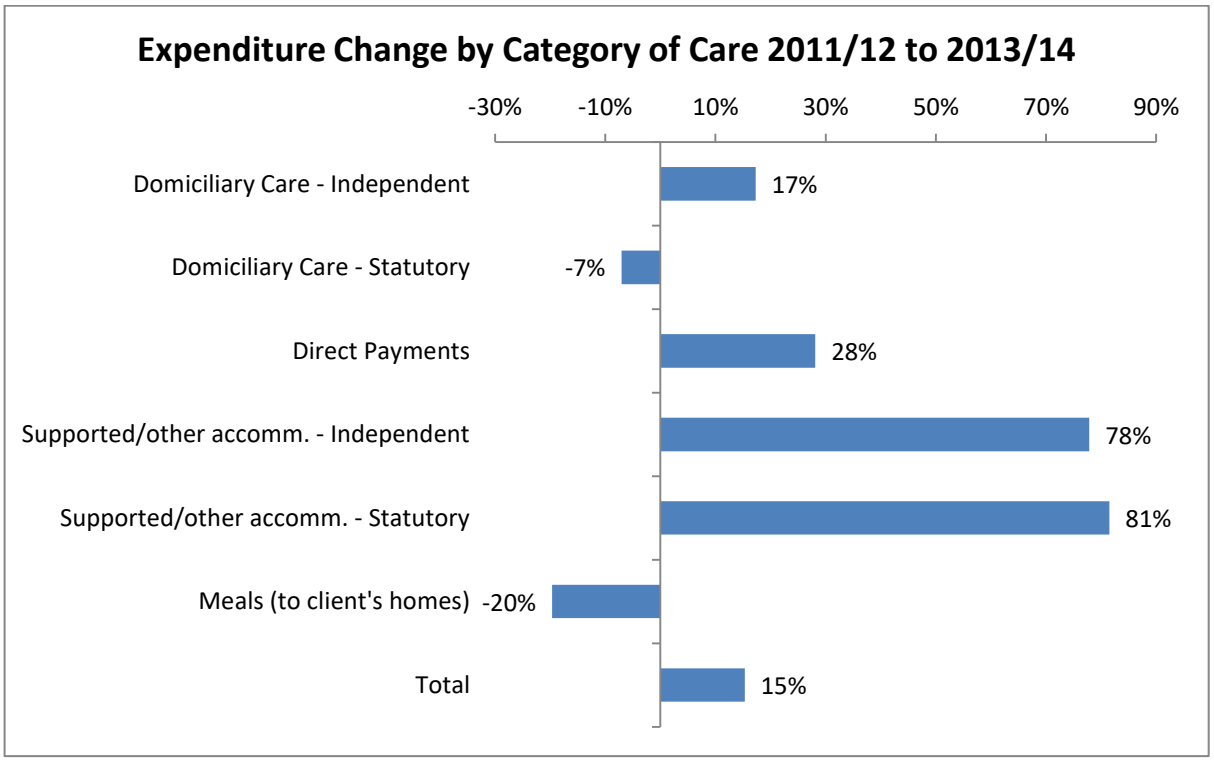
A key element of the transformation of health and social care will be to move services and associated resources into the primary and community sector to provide "***care closer to home***".

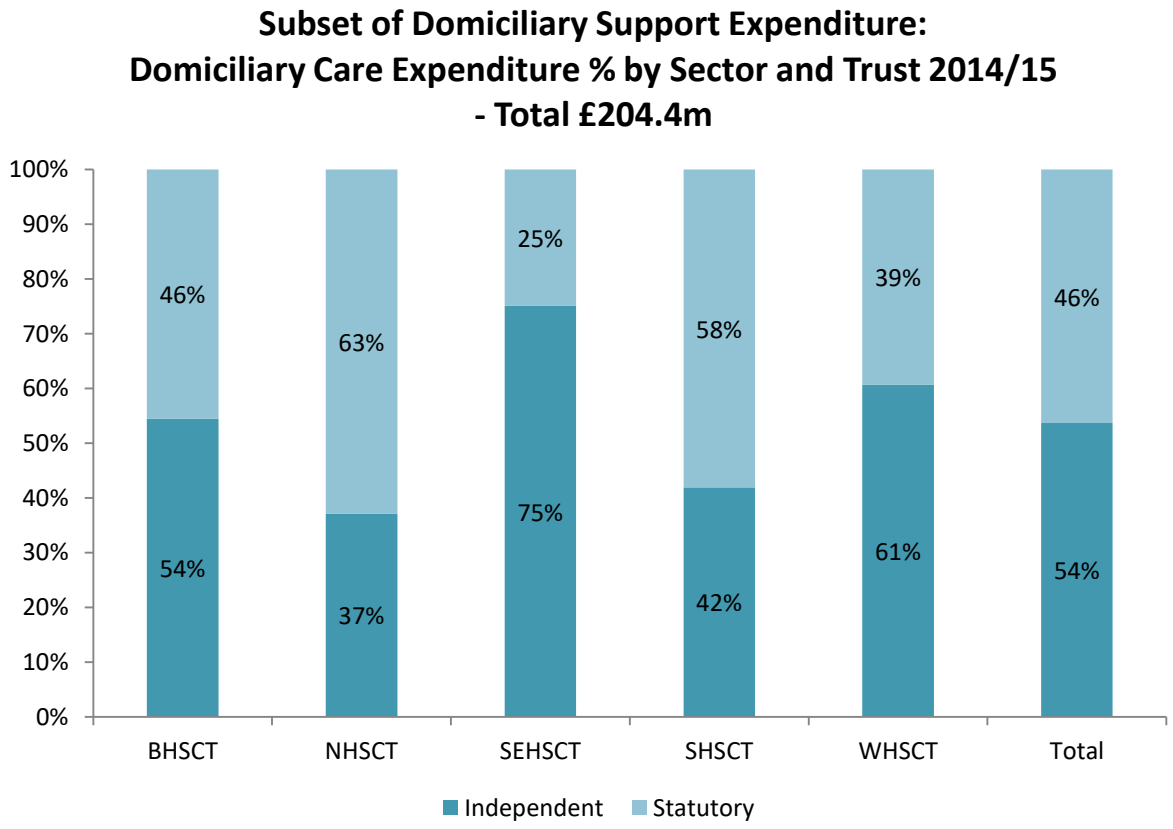
However, it is important to note this is not about seeking efficiencies; rather it is about delivering health and social care services in a different way. We need to ensure that we provide the right care in the right place to the quality standards required, using resources as effectively as possible.

3.7 Expenditure on Domiciliary Support

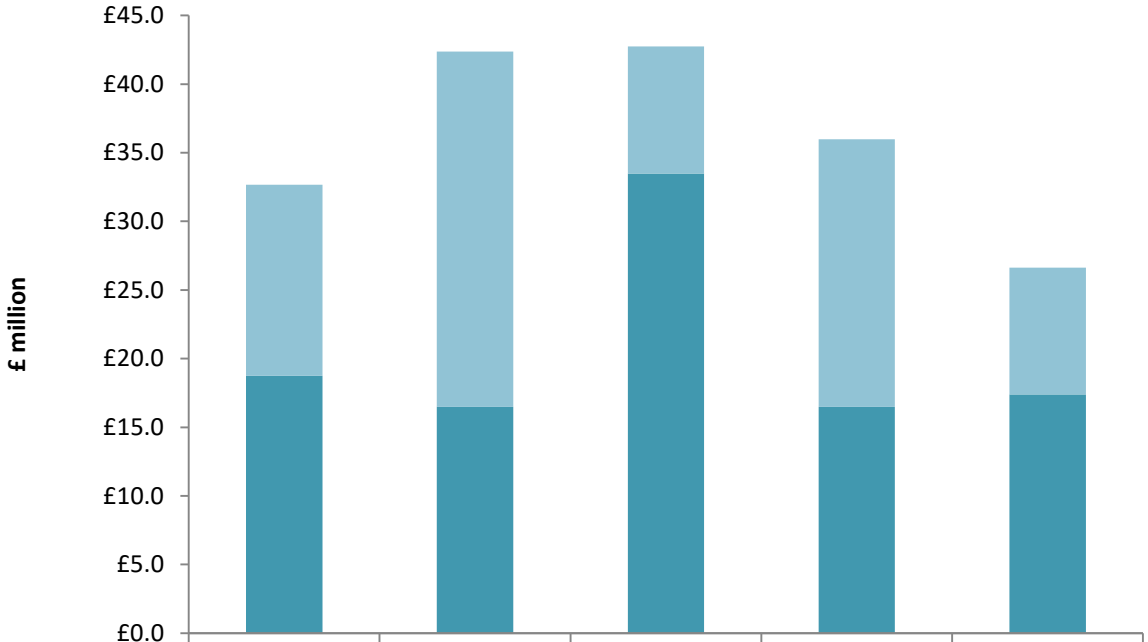
HSC Trust returns for the 2014/15 financial year indicate that a total of £284.8m was spent on a range of domiciliary support. The figure below outlines a range of expenditure including direct payments and community meals, which represent a small percentage (8%) of spend with supported housing at 20% or almost £56.6m. The bulk of the funding however is invested in mainstream domiciliary care services across statutory and independent sectors amounting to £204.4m.




Expenditure Change by Category of Care 2011/12 to 2013/14
-30%
-10%
10%
30%
50%
70%
90%
Domiciliary Care - Independent
17%
Domiciliary Care - Statutory
-7%
Direct Payments
28%
Supported/other accomm. - Independent
78%
Supported/other accomm. - Statutory
81%
Meals (to client's homes)
-20%
Total
15%


Subset of Domiciliary Support Expenditure:
Domiciliary Care Expenditure % by Sector and Trust 2014/15
- Total £204.4m
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
46%
54%
63%
37%
25%
75%
58%
42%
39%
61%
46%
54%
BHSCT
NHSCT
SEHSCT
SHSCT
WHSCT
Total
Independent
Statutory

Domiciliary Care (Direct) Expenditure 2014/15 - Total £180.4m



	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT
Statutory	£13.9	£25.9	£9.3	£19.5	£9.2
Independent	£18.8	£16.5	£33.5	£16.5	£17.4

3.8 Carers

Domiciliary care services often support both the individual being cared for, and also their carer. *Caring for Carers (2006)* highlighted that whilst the provision of services to the person being cared for is essential, "***a range of flexible, practical support services needs to be in place for the person being cared for and the carer***".

Carers are often family members or people who have a close interpersonal relationship with the person receiving care, and they provide significant amounts of essential support to the people they care for. Whilst many carers view the care they provide as being a core part of their family or relationship role, and would not want to stop caring, it is important that this care is recognised and supported.

There are 213,412 people providing unpaid care according to the 2011 NI Census.

This means that:-

- almost 12% (11.93%) of the population carries out some informal caring;
- 15% of those providing unpaid care were aged 65 and over;
- 57.2% of carers provide between 1 and 19 hours of unpaid care per week;

- 16.5% of carers provide between 20 and 49 hours of unpaid care per week; and

- 26.3% provide over 50 hours of unpaid care per week.

Source: Census 2011

Delivering Together (2016) acknowledges that families and friends take on most of the caring responsibilities for their loved ones and make an enormous contribution to health and social care and to society as a whole. This partnership working is a vital element of service delivery. The needs of carers are changing and we must therefore change the support we provide to them. Carers must be able to access up to date information and, crucially, consider how we can support them to live their own lives. The Expert Advisory Panel Report, *Power to People: Proposals to reboot adult care and support in NI* explored how we can better support carers.

4.0 DEFINING THE REQUIRED WORKFORCE

The notion that more people will live longer with more complex needs forms the basis of this workforce review. We know that:

- we will have more people requiring services;
- they want services available at home or as close to home as possible; and
- service users' expectations are increasing and that they want to have more of a say or influence in the services being provided to them.

Based on existing models of service delivery, it is therefore reasonable to project that more people will be required to deliver this increase in domiciliary care. There will be the need to develop more enhanced skills, potentially at a higher level; particularly those skills associated with supporting people with more complex needs in order to enable them to live at home, and sustain their independence, autonomy and wellbeing. It is likely that this may have a corresponding increase in the level of remuneration for the domiciliary care workforce and a shift in the skill mix.

The main findings from the DoH 2016 Domiciliary Care Services survey indicate that an estimated 268,883 contact hours of domiciliary care were provided by HSC Trusts during 436,174 domiciliary care visits. 23,873 service users were in receipt of domiciliary care with almost two-fifths (9,825) service users receiving a domiciliary care visit lasting 15 minutes or less.

This review looks at ways of ensuring domiciliary care services are provided for the future, particularly the next five years 2016 – 2021. The delivery of services is challenging and we have recognised that they will continue to be delivered in a partnership of care approach, by a mixed economy of both statutory and independent sector providers. In addition, we acknowledge the enormous contribution that family and friends make to the health and social care system and to society as a whole by caring for their loved ones.

It is anticipated that significant workforce change will be required to support predicted demand for domiciliary care over the next five years to an increasingly aged population with more complex needs.

4.1 Workforce Projections - An Illustrative Demand Projection based on Population Change

The DoH survey referred to above shows 23,873 service users receiving HSC Trust arranged domiciliary care during the survey week in September 2016 of which 83% were aged 65 and over (19,893). This represents around 7% of the 65+ population. NISRA's projection for the 65+ population by 2021 (to cover the workforce plan period) is 332,900. If 7% of the projected 2021 65+ population were to receive

domiciliary care, this would equate to an estimated additional 2,800 service users. This would represent a 14% increase in service users from 2016.

Approximate domiciliary care worker numbers are 12,000. This indicates a requirement of 0.5 staff per service user.

Assuming the same average hours per staff member, the estimated additional 2,800 service users would result in the need for a further 1,400 staff. This will require an investment of approximately £27 million.

This is an illustrative staff projection based on existing systems of domiciliary care provision (and, for example, it would need to be adjusted for increases in service users taking up SDS).

4.2 Key Factors Impacting on Workforce Projections

In planning for the future domiciliary care workforce there are a number of key factors which will have an impact on the workforce projections over the next five years and these are outlined in the sections below.

4.3 Unmet need

The welcomed fact that people are living longer, allied with the increasing emphasis on helping people to remain in or return to their own homes does inevitably result in an increasing level of demand. Domiciliary care providers' capacity to meet demand depends heavily on having the right numbers of staff in the right place at the right time and this can present particular challenges in rural areas.

Social care and health care systems are inextricably linked. Domiciliary care supports the prevention of hospital admission by providing care at home and facilitates timely hospital discharges. Pressures on the provision of domiciliary care inevitably impact on the health and social care system.

4.4 Models of Service Delivery

Future models of service delivery will impact on the number and type of care staff required:

- **Self Directed Support (SDS)**

SDS by its nature is a 'personalised' service and therefore service users will seek to procure services which most directly match their needs. These may be different to the current services provided by domiciliary care, which largely focus on personal care needs of service users. The implementation of SDS may see a shifting of skills from the current domiciliary care skills base into skill areas that can meet a 'personalised' agenda.

If we are to deliver on expectations, the future workforce will need to be flexible to meet need as agreed within the context of individual choice and control.

In line with the principles of personalisation, the role of the professional and the care worker within SDS will become less about being a 'fixer' of problems and more about being a co-facilitator of solutions working in collaboration and co-production based on power sharing and mutual respect. Doing things '**with people'** rather than '**to them**.'

As SDS moves towards full implementation, the overall profile of service responses will need to adapt to meet wide ranging personalised support goals. Flexibility will be a key focus for providers moving into the future, with the potential to recognise and recruit a new 'future care/support worker'.

- **Reablement**

Reablement is a person-centred approach which is about promoting and maximising independence to allow people to remain in their own home as long as possible. It is designed to enable people to gain or regain their confidence, ability, and necessary skills to live independently, especially after having experienced a health or social care crisis, such as illness, a deterioration in health or injury.

> "Reablement will help you to do things for yourself rather than having to rely on others".

The regional review of reablement undertaken in 2015/16 resulted in a clear service specification for the future development of the model across the region. This will be kept under review in order to assess the impact of the approach and examine its ongoing potential to reshape domiciliary care delivery. Any future model needs to consider how the reablement approach can develop within the continuum of home based support.

Reablement can deliver the benefit of reducing the need for domiciliary care (in some cases completely), or can reduce a service user's reliance on domiciliary care. A Longitudinal Study, undertaken by the HSCB in 2015, sought to quantify the length of benefit of reablement to service users, analysing a cohort of 248. The study found that 83% of those successfully reabled did not require any domiciliary care package afterwards, 12% required the same package and 5% required an increase in the previous package.

During the period to which the study related, 77% of the service users remained out of the system i.e. did not require a domiciliary care package, or admission to a residential care or nursing home. The results demonstrated, as well as the obvious

benefits for service users and carers, that reablement can contribute significantly to demand management in respect of domiciliary care and potentially avoidance of residential and nursing home admissions.

4.5 Domiciliary Care and Linkages to Reablement

Domiciliary care provides a vital support for many people who wish to remain living independently in the community for as long as possible. It does not however operate in isolation and has links with a range of other services that support this objective. The Institute of Public Care (IPC) identifies a continuum of models of home based care including:

- standard domiciliary care (which can include an independence and outcomes based approach);
- reablement and rehabilitation; and
- specialist home care.

These need to be considered when developing any proposals to reshape services.

It is important to ensure that an over simplified view is not taken of what has become a complex service. Imaginative application and redeployment of resources and not simply further investment in existing services is required.

The current regional model of reablement places an emphasis on an Occupational Therapy led approach. However, it is also heavily reliant on intensive support with back up from dedicated reablement support workers. This element of the service has mainly been delivered by HSC Trust in-house staff who are focussed on this kind of more intensive input. The current regional model suggests that reablement should be viewed as a distinct service in its own right.

- **Role Redesign**

HSC Trusts are continually evaluating the service provided to service users and redesigning is an ongoing element of this work. Some examples of good practice are cited below:

NHSCT – The HSC Trust has developed and amalgamated the reablement service and rehabilitation service to form a Recovery Service, which will deliver short term Occupational Therapy-led individual care. The focus being to ensure service users have achieved their maximum level of independence within both the reablement pathway and the rehabilitation pathway.

All long-term care delivered by the HSC Trust core services, may also have a reablement focus, to ensure service users maintain their independence.

SHSCT – In 2015 the HSC Trust commenced a pilot of a new service delivery model in the Armagh and Dungannon area, with a focus away from the "time for task" service to an "outcomes based" service. Individual goal plans are devised and occupational therapists are in post to drive this innovative domiciliary care approach. This service is now being extended to all other areas of the HSC Trust. The focus is on independence – "**doing with rather than for**", and has evidenced both efficiency and quality service provision resulting in satisfied service users.

SEHSCT – The HSC Trust plans to increase capacity of Reablement Teams and Rapid Response Teams across the HSC Trust, to aid discharge from hospitals of patients and further develop the model of care required. Going forward, domiciliary care service will focus on short term intervention work and creating specialist teams.

WHSCT – The HSC Trust has specified, in its contract with the Independent Sector contractors, the expected levels of care for its service users, whilst in conjunction re-aligning the in-house model to a caseload, with contracted hours for staff, supported by variable hours for bank staff.

4.6 User Expectations

It is essential that account is taken of service users' expectations and to ensure that domiciliary care staff in the community have the full range of skills, knowledge and competencies. The HSCB's report *A Managed Change* carried out several stakeholder engagement events to ascertain the views of service users. Individual HSC Trusts have also engaged with service users as this is a key element in the design of any service delivery models into the future. Below are some of the priorities service users identified:

- Timing of calls – same time each day;
- A preference for the same or a small number of Care Worker(s) per Service User with continuity of care a critical factor;
- The importance of adequately trained staff to meet individual Service User needs;
- The need for improved communication between the Provider, Carer and Service User;
- Allocation of sufficient time to carry out care required so that the Service Users do not feel hurried or rushed when care is being provided;

- The importance of the consistency and continuity of the quality of care delivered;[4]
- Explanation of any technology being used and why; and
- A feeling of being safe and secure because someone was calling.

The SEHSCT took part in the 10,000 Voices Initiative and the report, dated February 2015, details the findings on service users relating to their experience of care in their own home. 362 stories were captured which was 28% of the regional total. 88% of service users indicated that they were very satisfied with the level of care received. Critical to their satisfaction was:

- Timing of calls;
- Allocation of sufficient time for calls;
- Small number of carers; and
- Feeling safe and secure.

4.7 Independent Sector

Adult social care services are provided through a mixed economy of care, which includes both direct statutory provision and independent sector provision largely commissioned by the HSC Trusts. There are currently 100 registered domiciliary care providers with an associated 122 agencies in Northern Ireland, including the five Health and Social Care Trusts.

The independent sector now provides the majority of domiciliary care services in Northern Ireland (as commissioned by the HSC Trusts). The proportion of services delivered varies from HSC Trust to HSC Trust, but overall, as outlined in the table below, the direction of travel is towards an increasing independent sector usage.

Survey Week	% Domiciliary care hours provided by statutory sector	% Domiciliary care hours provided by independent sector
2008	49	51
2012	36	64
2013	33	67
2014	32	68
2015	32	68
2016	30	70

[4] Belfast Health and Social Care Trust Consultation on the Proposed Outline Procurement Model for Domiciliary Care Services 2015/16 – February 2015

Source: Domiciliary Care Services for Adults in Northern Ireland publications https://www.health-ni.gov.uk/articles/domiciliary-care

Therefore, workforce planning must take account of issues that are either specific to, or more acutely felt by, that sector. For example, variations in employee terms and conditions across the domiciliary care market, particularly between the independent and statutory sector, can create workforce pressures whereby experienced staff regularly change employer as they seek more favourable rates of pay and terms and conditions.

4.8 Terms and Conditions

Terms and conditions for workers vary across the region and are different in the independent sector and the statutory sector. In the statutory sector, staff are employed under Agenda for Change pay and terms and conditions, a national pay and grading system. The majority of domiciliary care staff are employed at Band 2 level (£14,437-£17,599 - 2016/17 pay values), with some at Band 3 level (£16,434-£19,461) delivering reablement services, and have contracts of employment that include travel time, travel expenses, and paid training time.

Terms and conditions in the independent sector are variable and include features such as workers being paid at or just above the British Government's National Living Wage, 'as and when required' contracts, paid hourly rate to include contact time only, unpaid training time, unpaid travel time, and no or limited travel expenses (often travel expenses are wrapped up in the hourly rate of pay). Terms and conditions will vary from employer to employer, but all employers must comply with the HMRC regulations on the national minimum wage.

Within HSC Trusts, the majority of staff have moved to minimum guaranteed hours contracts, with a degree of variable hours working still available. Within the independent sector, 'as and when required' contracts are the norm (though not having exclusivity clauses as with 'zero hours' contracts).

The procurement of domiciliary care services in the independent sector will be important in ensuring the stability of the workforce in this sector, e.g. procuring block contracts, allowing these organisations to employ their workforce on a more guaranteed hours basis.

The now compulsory British Government National Living Wage (£7.20 per hour [2016] rising to around £9.00 by 2020) could also have a stabilising effect on the independent sector workforce in particular by making it more attractive to new entrants.

4.9 NISCC Registration and Standards of Conduct and Practice

Mandatory registration with the Northern Ireland Social Care Council (NISCC) was introduced to the domiciliary care, day care, supported living and residential care workforces in April 2017.

In order to attain registration, individuals must complete a process that includes the following:

- Be working or have been offered a job in domiciliary care, day care, supported living or residential care services.

- Demonstrate through their application that they meet the good character, conduct and health requirements of registration.

- Agree to work in accordance with the Standards of Conduct and Practice for Social Care Workers.

Once registered, all domiciliary care workers are required to complete 90 hours of Post Registration Training and Learning (PRTL) activity over the five year period of registration. PRTL helps to develop and maintain competence and skills, and may include completion of qualifications that support workers in their job role.

The Standards of Conduct and Practice provide a framework to govern the practice of Social Care Workers. The Standards of Conduct describe the values, attitudes and behaviours expected of social care workers in their day-to-day work. The Standards of Practice describe the knowledge and skills required for competent social care practice.

4.10 Service Regulation

The regulation of domiciliary care workers aims not only to protect the public, but also to raise the standards of this workforce. *The Domiciliary Care Agencies Regulations* and *The Domiciliary Care Agencies Minimum Standards* detail the provision, below which no provider of domiciliary care is expected to operate, and focus on assuring that people are provided with safe, effective and quality assured services. The Regulation, Quality and Improvement Authority (RQIA) is the regulatory body with responsibilities and powers to regulate domiciliary care providers and agencies.

4.11 Training and Up-skilling

A well-trained domiciliary care workforce is key to the provision of domiciliary care. Currently, domiciliary care providers provide staff with Induction Training in accordance with NISCC Induction Standards and must meet RQIA's Minimum

Standard for Domiciliary Care Agencies, which stipulates that staff are appropriately trained to carry out their roles.

The DoH *Personal Social Services Development and Training Strategy 2006 – 2016* sets strategic targets for training for social care workers. While the Strategy is primarily aimed at the HSC Trusts, the voluntary and independent sectors also support the strategic priorities. The Strategy does not specify the training or qualifications required for specific roles in social care. Rather, at a strategic level, it seeks to ensure that social care workers are engaged in either training or qualification attainment appropriate to their job role and associated with continuing registration. This Strategy is currently under review.

In 2014, NISCC carried out a survey within the independent and voluntary sectors to ascertain the qualification profile of the social care workforce (across all grades) in domiciliary care, nursing home care, residential care and supported living settings. There was a 50% return from domiciliary care providers and of those, 48% of staff held a relevant qualification (excluding nursing, social work and Allied Health Professionals (AHPs)).

The survey found that domiciliary care and nursing home care settings were the two service areas where the least number of staff hold a relevant health and social care qualification. It suggested a number of reasons for this, including issues such as time available, cost, lack of confidence and no history of having achieved any formal qualifications.

Models of care for the future will need to take cognisance of the Government Skills Strategies, which can support the training, and up-skilling of the domiciliary care workforce, particularly in the independent sector. Investment for training and up-skilling needs to be secured, especially when dealing with complex care e.g. service users with dementia or more chronic health conditions.

4.12 Career Development

The domiciliary care workforce is part of a much broader social care workforce made up of social care workers and social workers. There are an estimated 33,076 social care workers employed in the statutory, voluntary and independent sectors and 6,052 social workers, the majority of whom are employed in the statutory HSC sector.

Social care workers work in a range of roles in different settings including residential care homes, nursing care homes, day care centres, local community facilities, and in people's own homes (domiciliary care). The majority of social care workers are employed in residential homes, nursing homes or in domiciliary care settings.

People who work in social care come from a wide range of backgrounds. While individuals must meet employer and regulatory requirements to gain entry into social

care work, their values, attitudes and ability to form relationships and work with people who need care and support are key attributes.

The level of competence and/or qualifications required by a social care worker is determined by: the specific job role or job function; ***and*** the nature of the care and support required by an individual; ***and*** the level of responsibility expected of the worker. An estimated 50% of social care workers hold a relevant qualification.

The table below outlines the range of different job roles in social care and the indicative competence linked to Qualifications and Credit Framework (QCF) qualification levels. This is not a prescriptive framework, rather a guide reflecting the diversity of roles at different levels and potential career development opportunities for those working in social care.

4.13 Social Care Job Roles

The wide variety of roles and the diversity of those who use social care services offer a number of avenues for career development and/or progression for domiciliary care workers within social care. The core skills and attributes required of domiciliary care workers to care and support people effectively in their own homes are transferable across social care. This means domiciliary care workers can move and/or progress within domiciliary care or into different roles within and across settings and sectors. There are also career and personal development opportunities for experienced social care workers, including those in domiciliary care, in supervisory roles and management positions.

The experience of working in social care can also support an individual's progression into professional training in social work, nursing and allied health care as detailed in the table.

Competence/ QCF Level	SOCIAL CARE JOB ROLES
QCF 5	**Registered Manager and other Management Roles**. Registered managers in regulated social care services such as Domiciliary, Day and Residential Care must hold a relevant qualification. Relevant qualifications include a number of professional qualifications as well as a QCF Level 5. Registered managers are accountable for the quality, safety and standards of social care provision within the regulated service. They are also accountable for the effective management, supervision, training, development and competence of social care workers.
QCF 4	**Social Care Co-ordinator Roles**. Social care co-ordinator roles include responsibilities for supervision of social care staff and/or co-ordination of the provision of social care services. Job titles may include deputy managers in residential care homes, home care organisers, social care co-ordinators.
QCF 3	**Senior Social Care Worker Roles**. These jobs will entail a higher level of responsibility or skills set to meet specific higher-level needs than social care worker roles and may include staff supervisory responsibilities, or roles which have more complex job functions. Job titles include Intensive Domiciliary Care Worker, Reablement Worker, Day Care Worker, Senior Care Assistant, Key Workers in Supported Living and Homecare organisers.
QCF 2	**Social Care Worker Roles**. Staff in these jobs provide personal care and/or practical support in a regulated social care service. Job titles may include Domiciliary Care Worker, Care Assistant, Driver with Caring duties.
	Initial Entry Level Roles which may require very little formal education or training. These types of role may relate to providing domestic/household services or volunteer services.

4.14 Technology and Technical Skill Demands

Changes in technology continue, and the domiciliary care workforce needs to embrace these changes in order to realise the associated benefits in terms of more efficient and effective working.

Already facilities such as video conferencing, digital dictation, e-learning, electronic prescribing, use of i-Pads and remote/home working are starting to become a reality for many in the workforce. It is difficult to predict how much technology might have changed by the end of this workforce planning period in 2021. However, in order to gain maximum benefit from future technological change it is likely the workforce will require increasing proportions of computer literate staff, many of them with advanced skills and enthusiasm to respond to on-going changes.

The introduction of new technologies will impact on the way health and social care is delivered in the future and should improve the level of services provided to our service users. Service users will be able to provide essential health information, such as blood pressure readings, through the new technologies, to the care providers without the need to leave their home.

The introduction of new technologies will require specific training for the staff delivering the services and possibly the service users and/or their carers. The Department's new Health and Social Care Workforce Strategy gives an undertaking to continue to develop workforce engagement projects for the introduction of new technologies and systems, including e-health initiatives, Encompass, etc. which are designed to support the workforce in doing their jobs. This may be challenging for those with little or no experience of such equipment.

5.0 UNDERSTANDING WORKFORCE AVAILABILITY

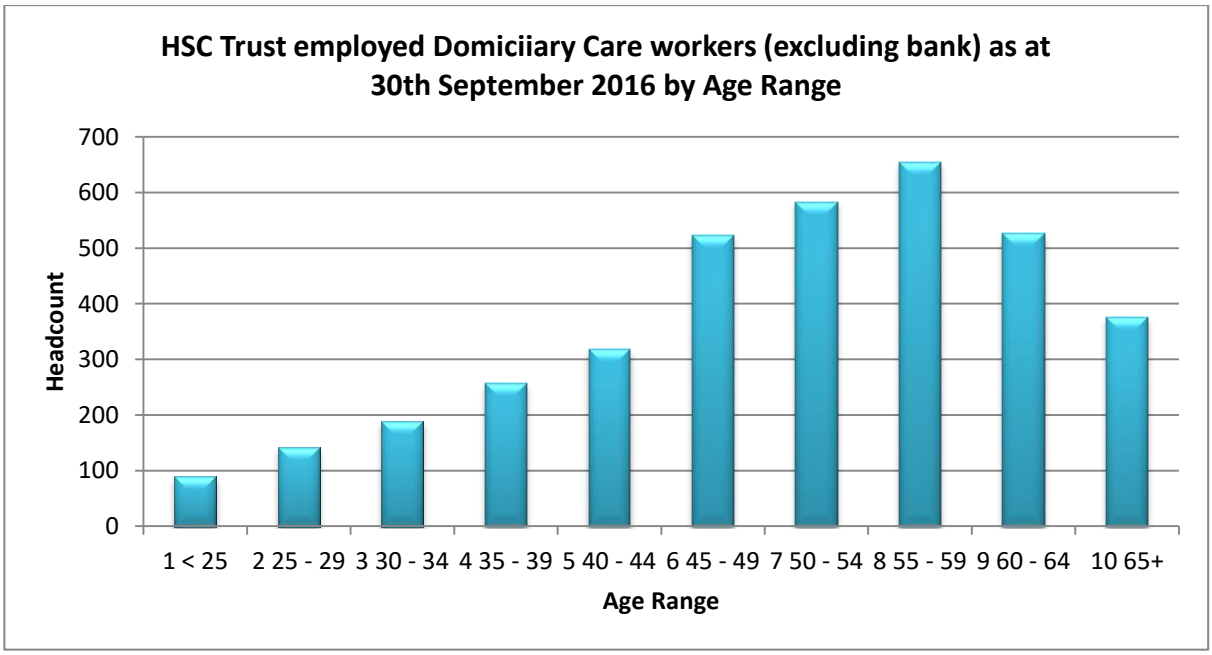
5.1 Workforce Profile

To understand the workforce that is available, it is necessary to consider and analyse the trends amongst the existing workforce.

The following workforce profile in relation to the HSC Trust employed workforce across the region has been downloaded from Human Resources, Payroll, Travel and Subsistence System (HRPTS). This system was introduced in 2013 and deployed to all HSC Trusts in the region. The HRPTS data is continually updated and managed locally by each HSC Trust. The following analysis is based on those graded as Band 2 or Band 3 domiciliary care workers, excluding bank staff, with each person only counted once. As at 30th September 2016, there were 3,659 staff graded as domiciliary care workers.

The HSC Trust domiciliary care workforce is overwhelmingly female (98%). The vast majority of staff (96%) are at Band 2 pay level, with those at Band 3 level usually being reablement workers.

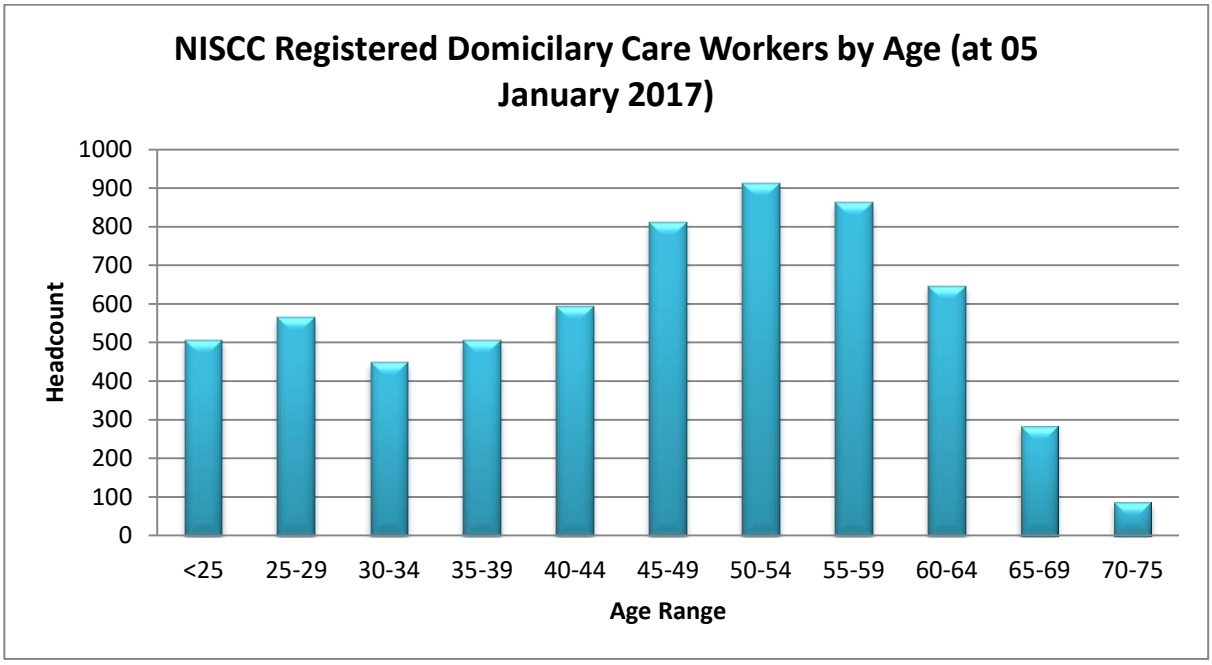
There is an older age profile within the HSC Trust domiciliary care workforce with 43% aged 55 and over as at 30th September 2016.



Comprehensive information on the independent sector workforce is not readily or centrally available; however, we have been able to make good estimates based on workforce information available through the NISCC (c 7,600). It is expected that with the conclusion of the compulsory registration roll out of the domiciliary care

workforce by March 2017 that more accurate information will be available for future workforce planning such as the age and gender profile.

In total, it is estimated that (at the time of this report) the workforce from both sectors providing HSC Trust commissioned domiciliary care is around 12,000. The age profile of those registered with NISCC to date (6,226 as at 5th January 2017) is shown in the graph below. This shows that 30% of those registered so far are aged 55 and over, 28% are aged 45-54 and 42% are aged under 45.



Robust information on the whole-time equivalent contribution of domiciliary care staff is not available at present, however using the service user hours sourced from the DoH domiciliary care services survey week (268,883) and dividing by the estimated 12,000 workforce (both sectors), the average weekly contribution per person is around 22.4 hours.

It is estimated (based on a NISCC employer survey) that while the range of hours worked per week is anywhere from 10 to 60 hours, the majority of care workers in the independent sector will be on 'as and when required' contracts.

There are around 1,000 HSC Trust staff with bank contracts recorded on the HRPTS system, though it should be noted that 18% of permanent/temporary staff also have bank contracts. Bank contracts give no minimum or guaranteed hours; hours are offered to staff on an 'as and when required' basis and staff are not obligated to accept hours. Bank contracts are used for reasons such as filling shortfalls in service delivery due to leave and sick absence. The total level of bank usage and expenditure by HSC Trust for the 12 months to 31st March 2015 was £2,427,341 as illustrated in the following table:

HSC Trust Domiciliary Care Bank Usage and Expenditure 2014/15

Health and Social Care Trust	Bank Spend	Estimated Bank Hours
Belfast	£384,481	33,031
Northern	£1,333,000	122,631
South Eastern	£98,860	7,784
Southern	0	0
Western	£611,000	50,512
TOTAL	£2,427,341	213,958

The qualifications profile of the workforce in domiciliary care suggests that 51% have a minimum QCF Diploma level 2 qualification across the statutory sector. Recent qualifications profile work for the independent sector points to 48% of staff having minimum level 2. NISCC has 435 registered domiciliary care managers who are required by the minimum standards to have at least QCF level 5 qualifications.

5.2 Projections for Retirement

Statutory Sector - On the assumption that those over the age of 60 today may retire in the next five years, there is potential for 25% of the HSC Trust domiciliary care workforce or 903 staff to retire over the next 5 years. Whilst an older age profile and working beyond normal retirement age is common amongst the HSC Trust workforce, it is possible that there will be a decrease in the proportion of staff now likely to work beyond retirement age due to the increasing demands of the job.

Independent Sector - Equivalent estimates are not currently available for this sector. The current registration of all domiciliary care staff will assist with providing more robust data in the future.

5.3 Recruitment and Retention – Statutory Sector

The table below highlights the number of new appointments made during the period 1 April 2015 – 31 March 2016 within each HSC Trust:

Health and Social Care Trust	New appointments 2015/16	Number of applicants
Belfast	23	N/A
Northern*	64 permanent, 162 bank	281
South Eastern	16	79
Southern	126	297
Western	NIL	NIL
Northern* notes that appointments figures may count individuals more than once, where they have been appointed to more than one post.		

5.4 Staff Turnover

BHSCT – The turnover rate within the domiciliary care workforce for the year ending 31 March 2016 was 5.14% based on both band 2 and 3 levels. A total of 33 domiciliary care staff left the HSC Trust during this time.

SHSCT – A total of 119 Band 2 domiciliary care workers left the HSC Trust's employment (i.e. excludes internal transfers/movers) in 2015. This represents a turnover rate of 11.7 %, which is significantly higher than the HSC Trust total turnover rate of 6.6%.

SEHSCT – Turnover of domiciliary care workers for financial year ending March 2016 is 6.06%.

NHSCT – Turnover of staff in financial year ending March 2016 is 5.9%.

WHSCT – The Western HSC Trust has been implementing the reform and modernisation of its Domiciliary Care Services. This will result in a single Western HSC Trust Homecare service working to a standard model of service delivery. It will involve transferring Home Help staff into care teams on a rota basis. This realignment will ensure current and future service user needs are able to be met by staff working in a secure, stable and sustainable working environment. Until this process is complete, the HSC Trust will not recruit new staff until existing waiting lists are fully utilised.

5.5 Recruitment and Retention – Independent Sector

The independent sector has reported repeated difficulties with recruitment and retention of the domiciliary care workforce. Many independent providers are required to undertake repeated recruitment campaigns due to the poor response and high turnover of staff. For the purposes of this review, the NISCC liaised with independent providers of domiciliary care to gain an understanding of the recruitment difficulties they face. Six independent providers supplied information in relation to their current recruitment difficulties. There was a lot of similarity across the challenges each provider faces.

The main challenges facing recruitment and retention of staff in the independent sector include:

- **High turnover of staff** – this is due to a variety of factors including limited career prospects, realisation that job wasn't for them, job being accepted as stop gap temporary employment.
- **Unfavourable terms and conditions** – low wage for an increasingly complex job, anti-social hours, travelling distances with little or no mileage allowance, poor level of job satisfaction – staff not feeling their role is valued.
- **ACCESS NI** – applicants are responsible for paying for this service and cannot take up employment until certificate has been received often resulting in delay of job being offered, by which time they have secured alternative employment.
- **NISCC Registration** – additional expense to applicant.
- **Ageing workforce** – difficulties ahead with recruiting sufficient numbers to replace a competent well-motivated workforce.

Independent sector providers also put forward suggestions as to how some of the issues cited above could be addressed:

- **Getting the funding right** – allowing staff to be paid appropriately for the work undertaken, guaranteed hours, service delivered outcome focused, not x minute time slots. In some instances funding ceases should a service user be hospitalised, resulting in workers' hours being reduced.
- **Better terms and conditions** – one provider has increased the hourly rate paid to staff and introduced Induction Training, followed by ongoing training on specific areas e.g. dementia awareness, skin care, brain injury communication skills etc. This has been well received by staff and feedback is very positive. This provider is anticipating that this will help with staff retention.

- Raising the **sector's profile** and getting the message out that this job is a professional care service being provided to people with complex healthcare needs.

- **Media campaign** – showcasing the role of the domiciliary care worker in order to attract applicants who have an understanding or experience of dealing with people's needs.

- Developing all age **apprenticeships** within the domiciliary care sector.

6.0 STAKEHOLDER ENGAGEMENT

An important element of the review involved stakeholder engagement. The Project Team comprised of representatives from DoH, HSCB, HSC Trusts and NISCC. The Steering Group comprised of representatives from DoH, HSCB, HSC Trusts, DfE, NISCC, PCC, Independent Sector and Staff Side, Carers NI were also invited.

A range of sources were used to obtain the views of stakeholders including availing of information gathered during the HSCB's review *A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland, November 2015*; the Patient and Client Council – *Care at Home: Older People's Experience of Domiciliary Care, June 2012*; and the Public Health Agency's *Regional Findings Relating to Care in Your Own Home (10,000 voices), March 2015*.

In addition, the Project Group hosted an 'Engage' event on 15 June 2016 at the Ulster University, Jordanstown Campus. Over 100 delegates registered to attend the event from across the statutory, independent sector, staff side, carers and users. The purpose of the event was to consult on the development of the draft Domiciliary Care Workforce Review NI for 2016 – 2021. The event took the format of an interactive e-participation 'Engage' session.

The engage discussion focused on three main topics:

Topic One: What do we need to do in order to both grow and retain the domiciliary care workforce across both the statutory and independent sectors over the next five years?

Topic Two: Given that domiciliary care is provided by both statutory and independent sectors, how can the commissioning process be used to stabilise the market for domiciliary care?

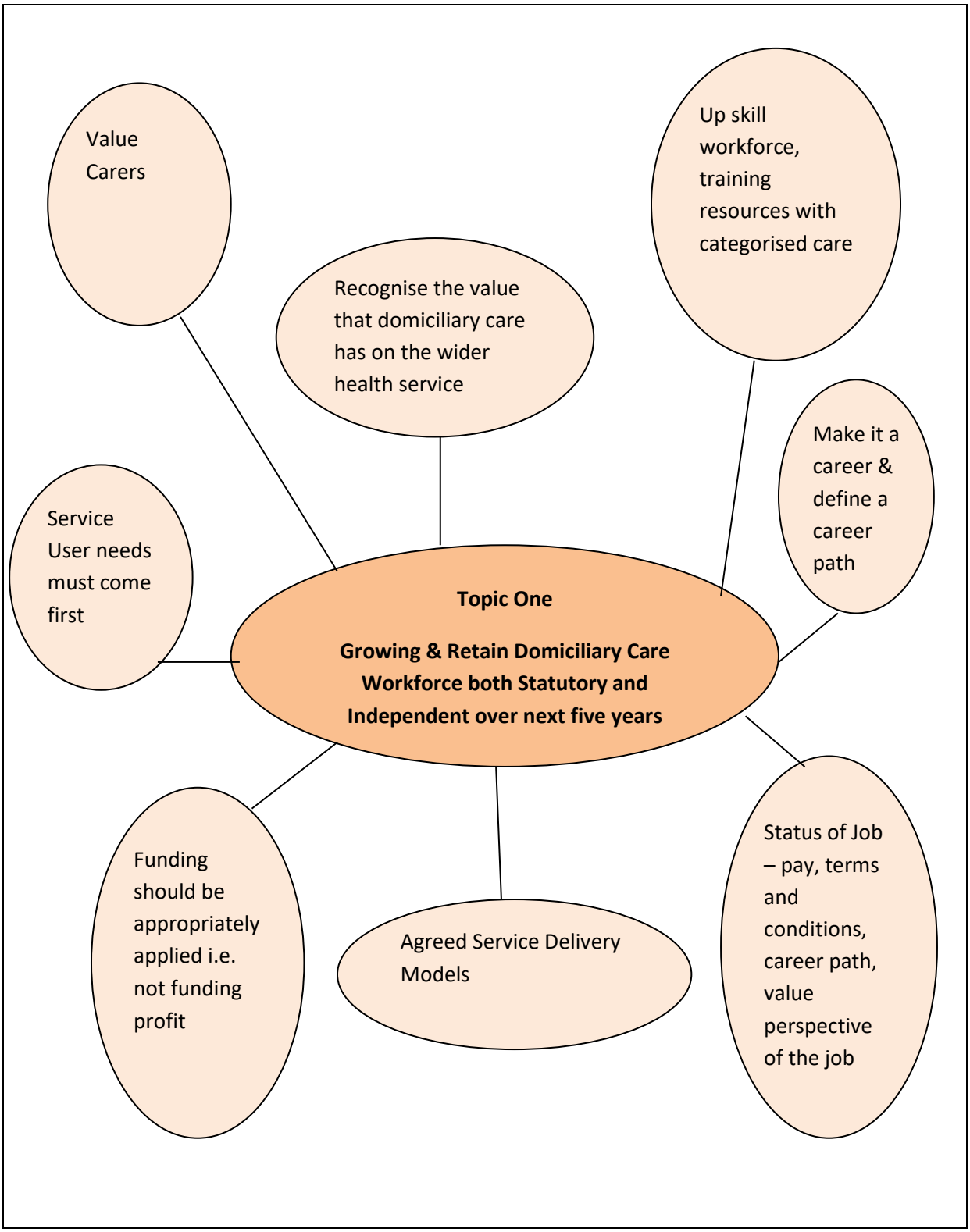
Topic Three:How can we ensure we have the appropriate skills mix and career development opportunities within domiciliary care?

The audience on the day comprised of Statutory 48%; Independent 36%; Voluntary & Community 6%; Service user and carer 3% and Other 6%.

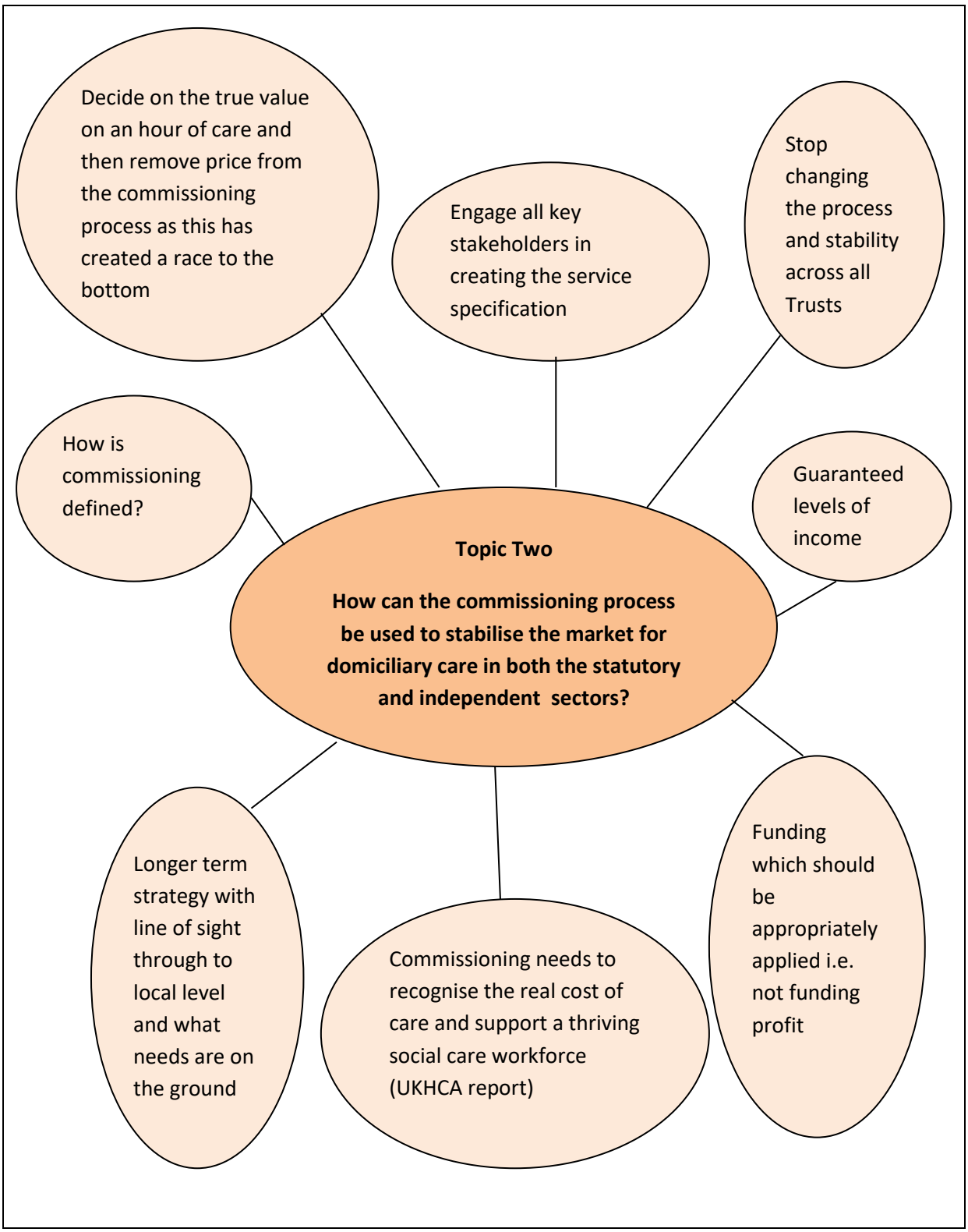
The 'Engage' method combines the live aspect of small-scale discussion with information and communication technologies; on one hand it allows rapid transmission of work-group results to a plenary assembly; while on the other it permits surveys of individual participants' opinions through a polling system. Information gathered at the engage event has been reflected in the review. Each of the round table groupings at the event were asked to prioritise their responses in each topic and the top responses captured.

The full report of the ‘Engage’ can be found at **Appendix 3**.

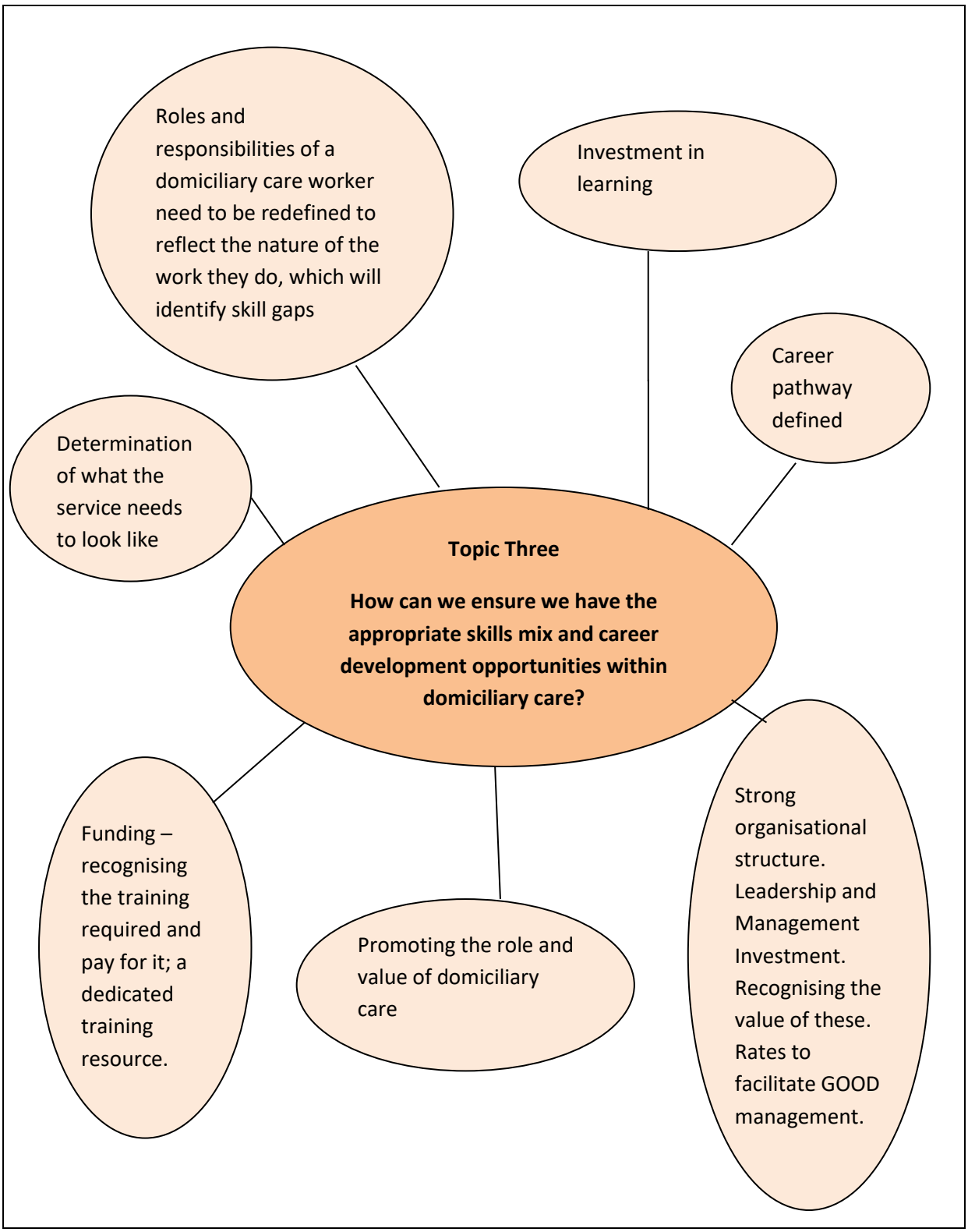
6.1 Topic One


Value Carers
Up skill workforce, training resources with categorised care
Recognise the value that domiciliary care has on the wider health service
Make it a career & define a career path
Service User needs must come first
Topic One
Growing & Retain Domiciliary Care Workforce both Statutory and Independent over next five years
Funding should be appropriately applied i.e. not funding profit
Agreed Service Delivery Models
Status of Job – pay, terms and conditions, career path, value perspective of the job

6.2 Topic Two


Decide on the true value on an hour of care and then remove price from the commissioning process as this has created a race to the bottom
Engage all key stakeholders in creating the service specification
Stop changing the process and stability across all Trusts
How is commissioning defined?
Guaranteed levels of income
Topic Two
How can the commissioning process be used to stabilise the market for domiciliary care in both the statutory and independent sectors?
Longer term strategy with line of sight through to local level and what needs are on the ground
Commissioning needs to recognise the real cost of care and support a thriving social care workforce (UKHCA report)
Funding which should be appropriately applied i.e. not funding profit

6.3 Topic Three



7.0 CONCLUSIONS

Domiciliary care services provided by the workforce both in the statutory and independent sector are highly valued. Many of our service users would find it difficult, if not impossible, to survive without the care and support which this workforce delivers 24/7. In addition to the healthcare support the service user receives, in many instances the carer is the only human interaction they may have that day and this often adds to the quality of life for the service user. We heard many voices at our stakeholder event and we know that, especially the elderly recipients of domiciliary care, have a preference for continuity of service being delivered by the same people. They like the familiar face, the regular time slot etc. This helps develop trust and confidence in the services being delivered.

We know that our society is getting older; people are living longer, often with long-term health conditions. It is estimated that by 2030, for the first time there will be more over 65s than under 16s. By 2030, the population aged 65 and over will have increased by 45% compared to the position in 2015. Similarly, the population aged 85 and over will increase by 81% over the same period, which will see their share of the population increase from 1.9% to 3.2%. These statistics alone will present a huge challenge in terms of the demands and pressures on health and social care in partnership with carers and family support. Domiciliary care will play a big part in services being delivered.

Looking to the future, the draft Programme for Government and the Health Minister's *Health and Wellbeing 2026 – Delivering Together* documents emphasise outcomes-based approaches. The providers of domiciliary care are faced with a challenging opportunity to seize the moment and help contribute to building the future of person-centred care in which people:

- are supported to keep well in the first place;
- have access to safe high quality care and are treated with dignity, respect and compassion; and
- are empowered and supported to look after themselves for as long as possible in their own home and environment.

The review has highlighted the need for growth in the domiciliary care workforce over the next five years based on existing models of care and support. The impact of other service delivery models on workforce requirements, such as SDS, Reablement and Telemonitoring will need to be further assessed.

7.1 User/Carer Engagement

This review adopted a co-design approach, taking account of the Service Users and Carers' views on their needs and expectations. A lot of information was made

available via the 10,000 Voices Report, *A Managed Change* and the stakeholder 'Engage' event held in June 2016.

We must acknowledge the responsibility families and friends take for caring for their loves ones as this makes an enormous contribution to the HSC and to society as a whole. Carers require support to enable them to be carers and the Health Minister has pledged support in working along with other government departments and their agencies to provide that support. We need to encourage and enable greater use of personalised budgets where appropriate.

7.2 A Managed Change

The HSCB carried out a review of domiciliary care services *A Managed Change: An Agenda for Creating Sustainable Basis for Domiciliary Care in Northern Ireland* published November 2015. In order to avoid duplication this review has taken account of the recommendations contained within the HSCB report especially in relation to workforce planning. The recommendations contained within the HSCB's report cover areas listed below and will not be duplicated in the recommendations of this workforce plan:

Structure – reviewing current social care procurement arrangements.

Linkages – establish formal links with the Department of Health and the NISCC to develop a coordinated approach to workforce development.

Developing the Agenda – improving information and regular formal liaison with service providers.

Investment – managed approach to funding domiciliary support services.

Costing – assess the impact of the introduction of the living wage.

Workforce Planning – work closely and in collaboration with Department of Health, HSC Trusts, NISCC.

Procurement – management of tendering processes, coordinate learning and best practice.

Innovation – explore implementation of outcomes based models of domiciliary care.

Policy – Clarifications regarding charging for services arising from current review of adult social care; seek updated Departmental Circular in relation to domiciliary care.

The full Managed Change report is available at http://www.hscboard.hscni.net/download/PUBLICATIONS/DOMICILIARY%20CARE/An-Agenda-for-Creating-a-Sustainable-Basis-for-Domiciliary-Care-in-NI.pdf

8.0 RECOMMENDATIONS AND ACTION PLAN

The Health Minister's vision for *Health and Wellbeing 2026 – Delivering Together* highlights the need to work in partnership with service users, families and staff to ensure we are delivering the best possible services to those in need of them.

It is of vital importance that any future planning of domiciliary care services is based on reliable information going forward. The aim of workforce planning is to ensure that we plan for delivering the right staff with the right skills in the right place at the right time.

This Review sets out a number of recommendations designed to ensure that the future of domiciliary care is effective and efficient, commencing with the need to develop service delivery models. The review has been hampered by the absence of service delivery models, as they would more accurately inform the future workforce needs.

Whilst it is acknowledged that there is not a 'one size fits all' model, it is of paramount importance that clear models of service delivery are in place to ensure safe practices and access and equity of service to those in need. A lot of good work is happening all around us and there are examples of good practice across employers both in the statutory and independent sectors, which could be harnessed to ensure models are developed that deliver maximum outcome focused results for users.

The Recommendations and Action/Implementation Plan aims to ensure that our objective of '***delivering the right staff with the right skills in the right place at the right time'*** is met whilst realistically looking at the horizon of a five year implementation period therefore targeting the recommendations accordingly.

The Action/Implementation Plan will be monitored by the Department's Workforce Policy Directorate. In addition, updates on the recommendations listed in the HSCB's report *A Managed Change* will be requested to inform the way ahead.

8.1 Recommendations

Based on the findings of the review the key recommendations are set out below, these have been structured under key headings and will inform the Action Plan.

	RECOMMENDATIONS	
COMMISSIONING	**1**	(a) Regional Commissioning process linked to achievement and outcome focused. (Recent procurement exercises may delay any new service models being introduced.) (b) Service delivery models need to be developed to ensure standardisation of services across the region. Service delivery models should be outcome focused to inform the commissioning process.
RECRUITMENT & RETENTION	**2**	Standardised approach to recruitment of domiciliary care workers including job descriptions and role profiles ensuring that the recruitment process is a user-friendly and efficient process with a quick turnaround from advert to appointment that will attract wider interest from the labour force.
EDUCATION & TRAINING	**3**	Employers to support social care staff to comply with NISCC Registration and post registration requirements.
	4	Employers must recognise this is a mixed skills economy and ensure staff have the appropriate skills to deliver effective high quality care in line with service delivery models. Staff should also have access to appropriate and timely training to facilitate new initiatives, including technological advancement.
	5	Employers to support managers ensuring they have the appropriate training to support staff in their roles.
CAREER DEVELOPMENT	**6**	Employers to create career pathways ensuring access to training and personal development to include: • opportunities for staff seeking to gain access to management structures. • entry into alternative careers to include nursing, social work etc. • developing apprenticeship opportunities. • recognition of experiential learning gained in the workplace by

		domiciliary care staff. • promoting the value of domiciliary care workers through awards and other celebratory events.
	7	Employers to build relationships with schools and colleges thus promoting healthcare as a viable career option.
WORKFORCE PLANNING	**8**	Better recording of workforce data, especially in the independent sector, to ensure more accurate data sets which can be used.
	9	Employers to grow the domiciliary care workforce in order to meet the increasing demand for services over the next five years aligned to the models of service delivery.
PARTNERSHIP & COMMUNITY WORKING	**10**	Develop further linkages to community services e.g. pharmacy, GPs, voluntary organisations, carers and families.

8.2 DOMICILIARY CARE WORKFORCE REVIEW - ACTION/IMPLEMENTATION PLAN 2016 - 2021

	RECOMMENDATIONS		ACTIONS	LEAD RESPONSIBILITY	IMPLEMENTATION TARGET DATE
COMMISSIONING	1	(a) Regional commissioning process linked to achievement and outcome focused; (Recent procurement exercises by some HSC Trusts may delay any new service models being introduced in the short term.)	(i) Regional overview of domiciliary care market should be undertaken by a regional body to standardise commissioning practice, provide scrutiny of contracts and promote a collegiate regional approach.	HSCB / HSC Trusts (Commissioners)	TBC
			(ii) Ensure commissioning process is more directly linked to achievements of outcomes for service users and consideration should be given to the inclusion of social clauses in procurement.		TBC
			(iii) Request Circular HSS (SS) 1/80 in relation to the future provision of the home help service in Northern Ireland is updated/revised to include an update definition of domiciliary care currently provided.	DoH	TBC
		(b) Service delivery models need to be developed to ensure standardisation of services across the region. Service delivery models should be outcome focused to inform the commissioning process.	(iv) Develop models of service provision to take account of: • Reablement. • Self directed support. • Intensive/complex domiciliary care needs.	HSCB	TBC

RECRUITMENT & RETENTION	**2**	Standardised approach to recruitment of domiciliary care workers including job descriptions and role profiles ensuring that the recruitment process is a user-friendly and efficient process with a quick turnaround from advert to appointment that will attract wider interest from the labour force.	(i) Develop a Values-based Recruitment model for pilot (similar to the Skills for Care Model). (ii) Develop materials that promote domiciliary care as a valuable career choice.	HSC Trusts NISCC	TBC
EDUCATION & TRAINING	**3**	Employers to support social care staff to comply with ongoing NISCC Registration and post registration requirements.	(i) Provide regular updates on the levels of registered social care staff. .	NISCC	Ongoing for duration of review March 2021
	4	Employers must recognise this is a mixed skills economy and ensure staff have the appropriate skills to deliver effective high quality care in line with service delivery models. Staff should also have access to appropriate and timely training to facilitate new initiatives including technological advancement.	(i) Learning and Improvement Strategy for Social Workers and Social Care Workers 2017 – 2025 to support knowledge and skills development of the domiciliary care workforce.	DoH – OSS	Ongoing for duration of review March 2021
	5	Employers to support managers ensuring they have the appropriate training to support staff in their roles.	(i) Develop a range of appropriate training and qualifications to support managers including the development of induction standards for managers.	HSC Trusts/Employers Training Providers NISCC	March 2018
			(ii) Provide development opportunities to staff and managers.	HSC Trusts/Employers Training Providers NISCC	Ongoing for duration of review March 2021

CAREER DEVELOPMENT	6	Employers to create career pathways ensuring access to training and personal development to include: • opportunities for staff seeking to gain access to management structures. • entry into alternative careers to include nursing, social work etc. • developing apprenticeship opportunities. • recognition of experiential learning gained in the workplace by domiciliary care staff. • promoting the value of domiciliary care workers through awards and other celebratory events.	(i) Staff to be provided with access to appropriate training to enable them to seek accredited social care qualifications within the QCF framework to assist with career progression.	HSC Trusts/Employers Training Providers	Ongoing for duration of review March 2021
			(ii) Work with employers, FE and HE colleges to develop qualifications to support career progression including access to higher level apprenticeships.	DoH – OSS HSC Trusts NISCC	Ongoing for duration of review March 2021
			(iii) Work with Department for the Economy to influence the Apprenticeship Framework criteria to reflect the needs of the Social Care Sector including domiciliary care.	DoH DfE NISCC	Ongoing for duration of review March 2021
			(iv) Establish recognition events to promote success and achievements among the domiciliary care workforce.	HSC Trusts/Employers	
	7	Employers to build relationships with schools and colleges thus promoting healthcare as a viable career option.	(i) Continue to work with local educational establishments and provide workplace opportunities where possible. (ii) Career materials - Cross-reference to 6 (ii).	HSC Trusts	Ongoing for duration of review March 2021
WORKFORCE PLANNI	8	Better recording of workforce data, especially in the independent sector, to ensure more accurate data sets which can be used.	(i) Improve the quality of information available on HSC Trust employed domiciliary care workers especially hours worked.	DoH/HSC Trusts	Ongoing for duration of review March 2021

			(ii) Explore registration data as a source of information on the entire domiciliary care workforce to include the independent sector.	DoH NISCC	Ongoing for duration of review March 2021
	9	Employers to grow the domiciliary care workforce in order to meet the increasing demand for services over the next five years aligned to the models of service delivery.	(i) Sufficient and timely recruitment exercises to ensure sufficient workforce to meet need.	HSC Trusts	Ongoing for duration of review March 2021
			(ii) Expand reablement – outcome focused service delivery.	HSC Trusts HSCB	Ongoing for duration of review March 2021
			(iii) Encourage uptake of self directed support initiative – cross-reference to HSCB targets.	HSC Trusts HSCB	Ongoing for duration of review March 2021
PARTNERSHIP & COMMUNITY WORKING	**10**	Develop further linkages to community services e.g. pharmacy, GPs, voluntary organisations, carers and families.	(i) Develop opportunities to enhance co-production with service users, carers and families and communities. (ii) Build on established forums, groups to encourage co-design of services by engaging with service users and carers to inform service delivery.	This will require a joined up approach across the entire HSC to include: DoH HSCB HSC Trusts NISCC PCC PHA	Ongoing for duration of review March 2021

Appendix 1

DOMICILIARY CARE
PROJECT STEERING GROUP
TERMS OF REFERENCE

WORKFORCE REVIEW – DOMICILIARY CARE

Purpose

1. The purpose of the Steering Group is to oversee and direct the Workforce Review of domiciliary care which will inform planning to ensure the availability of a domiciliary care workforce to meet future demand and redesigned services. The Review will consider the recommendations for the future skills required to ensure a competent workforce that can deliver the agreed model(s) of robust domiciliary care services into the future to support the implementation of Transforming Your Care over the next five years.

Definition of domiciliary care– *The range of services put in place to support an individual in recognition of their human rights in their own home. Services may involve routine household tasks within or outside the home, personal care of the client and other domestic services necessary to maintain an individual in an acceptable level of health, hygiene, dignity, safety and ease in their home.*

While it is not possible to disaggregate between groups (older people, adults and children with a range of care needs) without disproportionate cost, it is significant that approximately 80% of recipients of domiciliary care are Older People.

Membership/Timeline of the Project Steering Group

2 Membership of the Steering Group has been drawn from DoH, HSC Trusts both HR and service delivery representatives, NISCC, HSCB, Independent Healthcare Providers, DEL and staff side. A full list of membership is attached at **Annex A.**

The Steering Group will meet 4 – 6 weekly and at appropriate times to guide the work of the Project Working Group. Meetings will be held in Castle Buildings and secretariat to the group will be provided by DoH.

It is anticipated that the workforce review will be completed by 31 March 2016.

Role and Responsibilities of the Steering Group

3. The Steering Group has been convened to oversee and direct the review and its role will be to:-

- agree the terms of reference of the Project Working Group to include the scope of the review;
- quality assure the workforce intelligence gathered;
- advise on the strategic direction of the domiciliary workforce including the need for capacity building within the public health service to meet the need for domiciliary care;
- support and contribute to the development of the report;
- provide advice, guidance and validation to the review;
- facilitate provision of information from their organisations in a timely manner;
- input information and advice drawing from their own expertise;
- ensure effective communication and dissemination of information between participating organisations; and
- receive, make recommendations and approve the Workforce Plan on Domiciliary Care.

Annex A

WORKFORCE REVIEW DOMICILIARY CARE

STEERING GROUP MEMBERSHIP

Name	Organisation	E-mail address
Heather Stevens (Co-chair)	DoH – Workforce Policy Director	[redacted]
Christine Smyth (Co-chair)	DoH - Deputy Chief Social Services Officer	
Peter Barbour	DoH – Workforce Policy Directorate	
Erin Montgomery	DoH - Information and Analysis Directorate	
Mervyn Langtry	DEL – Head of Skills Solution	
Anne Speed	Staff Side	
Margretta Chambers		
Pauline Shepherd	Independent Health & Care Providers	
Marie Ward/Raymond Irvine	Western HSC Trust	
Melanie McClements	Southern HSC Trust	
Una Cunning	Northern HSC Trust	
Kevin Keenan	HSCB	
Patricia Higgins	NISCC	
Joanne McKissick	Patient and Client Council	
Await nominee	Carers NI	Follow up correspondence 5/10/15, advised short staffed in NI at present.

DOMICILIARY CARE PROJECT WORKING GROUP

TERMS OF REFERENCE

WORKFORCE REVIEW – DOMICILIARY CARE

Purpose

1. The purpose of the Project Group is to carry out a Workforce Review of domiciliary care which will inform planning to ensure the availability of a domiciliary care workforce to meet future demand and redesigned services. The Review will consider the recommendations for the future training required to ensure a competent workforce that can deliver the agreed model(s) of domiciliary care services to support the implementation of Transforming Your Care over the next five years.

   Definition of domiciliary care– *The range of services put in place to support an individual in their own home. Services may involve routine household tasks within or outside the home, personal care of the client and other domestic services necessary to maintain an individual in an acceptable level of health, hygiene, dignity safety and ease in their home.*

Membership of the Project Working Group

2. Membership of the Project Working Group has been drawn from DoH, HSC Trusts both HR and service delivery representatives, NISCC and HSCB. A full list of membership is attached at **Annex A**.

The Project Working Group will initially meet monthly. Meetings will be held in Castle Buildings and secretariat to the group will be provided by DoH.

Scope

3. Domiciliary care as defined above has been identified for this workforce review. This review will cover all recipients of domiciliary care as it is not possible to disaggregate between groups (older people, adults and children with a range of care needs) without disproportionate cost. However, it is significant that over 80% of recipients of domiciliary care

are Older People. It has been accepted that Older People applies to those aged 65+.

4. This review will include domiciliary care purchased directly by service users via Self Directed Support or Direct Payments. This is an area of care that is expected to be highly impacted by TYC and early evidence points to a growing demand in this service delivery area which will be critical for future profiling.

5. The Project Group should access all available data in relation to domiciliary care provision across the various occupational groups and providers so that the review can be as inclusive as possible and any recommendations coming forward have an evidence base.

6. The review should include costing any workforce implications for implementing recommendations emerging from this review to include new models of delivery, training etc.

Objectives of the review

7. The objectives of the review will be:
   - To provide an analysis of the current domiciliary care workforce in Northern Ireland.
   - To test a workforce planning model on a 'Programme of Care' approach within a social care context, although recognising that the service user group includes people outside the Older People programme of care.
   - To provide an analysis of current and future recruitment and retention issues.
   - To identify potential future recruitment and retention issues.
   - To produce a Workforce Plan **by December 2015** to include recommendations to support the outcome of the review.

Methodology

8. The methodology being applied will be the six step model contained within the Department's Workforce Planning Framework document:

   - Defining the Plan.
   - Mapping Service Change.

- Defining the Required Workforce.
- Understanding Workforce Availability.
- Developing an Action Plan.
- Implement, Monitor and Refresh.

Project Steering Group

9. A Domiciliary care Workforce Steering Group will be convened to oversee the review comprising membership from HSC Trusts, HR, DoH, HSCB, staff side, education, and the independent sector.

10. The Domiciliary care Project Group will report directly to the Steering Group who will in turn report to the Department of Health.

Annex B

WORKFORCE REVIEW DOMICILIARY CARE – OLDER PEOPLE

PROJECT WORKING GROUP MEMBERSHIP

Name	Organisation	E-mail address
Peter Barbour	DoH – Workforce Policy Directorate	[redacted]
Catherine Donnelly	DoH – Workforce Policy Directorate	
Alison Dunwoody	DoH - Information and Analysis Directorate	
Dean Looney	DoH – Elderly & Community Care	
Stephanie Read	Belfast HSC Trust	
Patrick Graham	Northern HSC Trust	
Sarah Browne	South Eastern HSCT – AD Director – Older People	
Maura Mallon	Southern HSCT -	
Gill Smith	HSCB	
Marian O'Rourke	NISCC	

Appendix 2

Applying a Co-design Approach to Regional Workforce Planning Domiciliary Care Plan

A co-design approach has been approved to effectively support the development of this workforce plan. This means that service users and staff will be involved in the development of the planning in partnership.
The approach to co-design to inform this plan will in the first instance take account of relevant available reports, surveys and all available evidence to:

1. identify common themes and key considerations for the DoH;
2. inform how the service looks based on what service users have identified is important to them; and
3. inform how the service works; how the workforce understands the model of care and their ability to deliver to it.

The evidence presented in this paper will help inform the work of the group. A number of sources have been consulted and they are detailed at the end of the paper. It is recommended that the final plan be considered by both service users and staff in a real time feedback session prior to final sign-off.

Priorities for People, Common Themes in literature reviewed:

- Having a say in the type of care they receive/involvement in care plan.
- Preference for having regular/familiar carer(s)/knowing who is providing their care/being introduced.
- Expected time of call and reason for call/care needs to be met.
- Due to high levels of loneliness, social isolation, service users value the added benefit of social contact/connection.
- Communication.
- Flexibility.
- Quality care.
- Training; Support Workers being able to provide the things people need, but also clients/service users knowing what they can expect from a visit.

A number of the above reported priorities are also identified NICE standards. Interestingly, in regards to home visits NICE specifically advise that a home visit shorter than thirty minutes should only happen if:

1. The home care worker is known to the person;
2. The visit is part of a wider package of support; and

3. It allows enough time to complete specific, time limited tasks or to check if someone is safe and well.

How the Service looks currently:

- The majority of people report they are satisfied/very satisfied with the service.
- Service users want to stay at home for as long as possible and this may suggest a further vulnerability and consequent unwillingness to complain if the service is not as expected/suitably delivered.
- Many would like more support. For some this may mean that they don't feel their current package is enough hence the role of the Key Worker, care plan provision and its regular review comes into focus.
- People have said they would like an idea of what to expect from the service and how they will be supported.

Additional identified considerations from evidence reviewed:

- Value based recruitment interviews to identify personal attributes and attitudes of staff
- Consider service user/carer involvement in recruitment panels
- Medicine management/pain management training/preventative care/ independence training for staff.

How the service works:

- Staff are under pressure to complete visits to time.
- With ever increasing level of complexities mean there are increasing demands on staff to deliver higher level care tasks
- Strategic direction to have a mixed economy of providers.

Challenges:

Many people are supported by older carers for the vast majority of the week. 50% of the 557 carers PCC spoke to were over 55 (2015:14). If we want to sustain this level of care provision we need to support those that deliver it. Central to this is completion of a carers assessment which is built on and frequently reviewed to ensure suitable support (respite) is provided within a partnership model to help support those who provide care to sustain their level of involvement. Capacity issues in all sector is a further concern. Additionally, there are recruitment and retention issues. There is an identified need to grow the workforce to increase capacity rather than appoint other providers staff.

Recommendations for this group:

1. Whole systems approach across HSC and at Government Policy Level to provide required cross-departmental working at each level to assist in seamless delivery e.g. "ensuring all benefits received can be considered in implementing a comprehensive care package"; OT liaison with NIHE colleagues to complete housing adaptations; partnership approaches with Policing and Community Safety colleagues to ensure service users feel safe and secure in their own home.
2. Implementation of a partnership model which effectively identifies need and ensures care and support for the service user by involving the family/carer, third sector and community and HSC to provide an agreed wraparound programme of support and care for the service user.
3. Reinforcement of the importance of a care plan and specific details of what is to be commissioned/delivered, completed in partnership with the service user and implemented by care staff.
4. Key Workers are essential taking embedding a person centred approach with regular reviews to manage/plan for changing circumstances.

Conclusions

To be able to deliver the above recommendations a new partnership model is a priority. Service users and staff both need to be clear on what standards they can expect and indeed the standard/type of care they are expected to deliver. A standard operating model developed in partnership is a critical success factor for this piece of work. The development and agreement of such can help inform/determine how the service is going to be delivered and procured into the future and consequently to evidence the development of an accessible workforce to maintain the delivery of a quality service that meets patient needs.

References

- Making Life Better 1st Progress Report 2014/15. PHA
- A Managed Change: An Agenda for Creating a Sustainable Basis for Domiciliary care in Northern Ireland. HSCB November 2015
- Home care: delivering personal care and practical support to older people living in their own homes. NICE guideline published: 23 September 2015
- Carers' Priorities: Carers views on future priorities for Health and Social Care in Northern Ireland, November 2015. The Patient and Client Council

- Phase 2, Regional Report Relating to Care in Your Own Home, October 2015. 10,000 Voices, PHA/HSCB
- Outcome Based Care, Domiciliary care, Case Study October 2015. SHSCT
- Domiciliary care Service User Engagements 2011/2012. SHSCT
- Domiciliary care Satisfaction Questionnaire, June 2014. SHSCT

Appendix 3

‘Draft Domiciliary Care Workforce Review NI 2016 -2021 Development’

Wednesday 15th June 2016

10.00am – 14.00 pm

Loughview Suite, Ulster University - Jordanstown Campus

engage - Instant Report

engage

This ‘engagement’ real-time e-participation engage event is facilitated by Professor Jonathan Wallace, Dr Michaela Black and Brian Cleland from Ulster University.

While all comments and votes stored in the engage system are anonymised, the final report from the event will be distributed to all participants, and may be passed to colleagues within the participating organisations, and other interested groups.

Table of Contents

The Engagement

What is an 'engagement'?

An 'engagement' has evolved out of the concept of a Town Meeting. A Town Meeting is a form of participation in local government practiced in the U.S. region of New England since colonial times, when an entire community was invited by government officials to gather in a public place to formulate suggestions or provide feedback on policy actions.

In its modern version, the electronic Town Meeting (eTM) and now an 'engagement', the most fundamental features are that information on the discussion topics are provided thanks to electronic means and the stakeholders can participate in debates and express themselves individually on those issues.

The main features

The method combines the live aspect of small-scale discussion with information and communication technologies: on one hand it allows rapid transmission of work-group results to a plenary assembly; while on the other it permits surveys of individual participants' opinions through a polling system.

The 'engagement' consists of four different work steps, all aimed at facilitating the participants' discussion of the themes at issue:

- Information and in-depth investigation, allowing the participants to gain confidence with the topics of discussion;
- Discussion in small groups, allowing reciprocal listening and the confrontation between different perspectives;
- Reflection, during which the results of group work are summarised and sent back to the whole assembly; and
- An optional polling step, in which participants may be asked to individually answer questions generated during discussion.

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Contents of the engagement

Context - Setting the Scene – why is the workshop important?

The Department of Health hosted this engagement workshop to consult on the development of the draft Domiciliary Care Workforce Review NI for 2016 – 2021.

In order to do this it was important that they gather the views of the many stakeholders involved.

The purpose of this interactive e-participation 'engage' session, which took place in the Loughview Suite at the Ulster University's Jordanstown campus, was to facilitate engagement between all attendees and encourage open discussion and debate

The engagement discussions were divided up into three main topics:

Topic One: What do we need to do in order to both grow and retain the domiciliary care workforce across both the statutory and independent sectors over the next five years?

Topic Two: Given that domiciliary care is provided by both statutory and independent sectors, how can the commissioning process be used to stabilise the market for domiciliary care?

Topic Three: How can we ensure we have the appropriate skills mix and career development opportunities within domiciliary care?

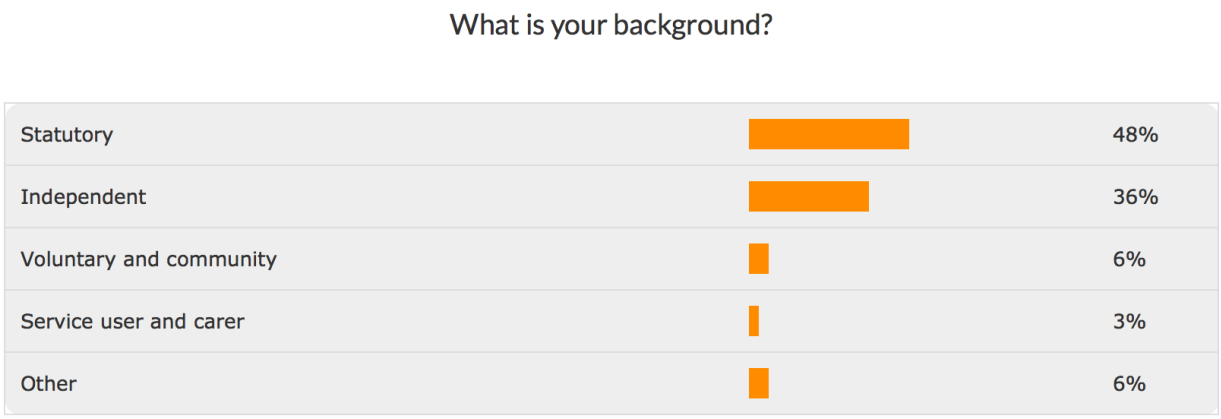
Format of the Engagement

The topics described above formed the basis for discussion on the day. The overall structure of the Implementation Workshop was as follows:

10.00am	Registration – Tea & Coffee and Networking	
10.30am	Welcome	Peter Barbour–Deputy Chief Social Services Officer - DHSSPSNI
10.45am	Introduction to the engage e-participation tool & process; and initial polling questions	Professor Jonathan Wallace, Dr Michaela Black and Brian Cleland – Ulster University
10.55am	Topic One: What do we need to do in order to both grow and retain the domiciliary care workforce across both the statutory and independent sectors over the next five years?	
11.25am	Ranking By Table for Topic One – Rank the top three things from your table's perspective needed to achieve the outcomes from Topic One.	
11.35am	Feedback on Topic One Discussion	Dr Michaela Black
11.45am	Topic Two: Given that domiciliary care is provided by both statutory and independent sectors, how can the commissioning process be used to stabilise the market for domiciliary care?	
12.15pm	Ranking By Table for Topic Two – Rank the top three things from your table's perspective needed to achieve the outcomes from Topic Two.	
12.25pm	Feedback on Topic Two Discussion	Dr Michaela Black
12.35pm	Topic Three: How can we ensure we have the appropriate skills mix and career development opportunities within domiciliary care?	
13.05pm	Ranking By Table for Topic Three – Rank the top three things from your table's perspective needed to achieve the outcomes from Topic Three.	

13.15pm	Feedback on Topic Three Discussion	Dr Michaela Black
13.25pm	Close	Heather Stevens – Director of Human Resources – DHSSPSNI
13.35 pm	Lunch and Networking	

Engagement Audience Demographics



Discussion Outcomes

Topic One: What do we need to do in order to both grow and retain the domiciliary care workforce across both the statutory and independent sectors over the next five years?

- Raise the value of social care
- Value the workforce
- Opportunities for career development
- Need to make domiciliary care a career pathway needs a greater identity
- Full career pathway to various gateways nursing, social services and allied health etc.
- Better forward planning
- Clear distinction in care staff roles
- Training and QCF resources and support
- Investment – both monetary and skills
- Positive media coverage
- Fund it!
- Need to understand the different terms and conditions of statutory and independent staff
- Service User specific comment: Service users feel we need to pay the staff appropriately, train staff appropriately and recruit staff that actually care for the service user instead of 'doing onto me' with no conversation - just the basics. Workers need to be mindful of what else is going on in my life, their presence in my home. Value based recruitment as part of it - how you interview more than an application - need questions like district nursing to suss out integrity, what your value system is. Recruiting the right people with right qualities.
- Career progression, schools and colleges to promote 'care' as a profession
- Staff terms and conditions attract independent sector staff e.g. sick pay

- Need to have a full understanding of the workforce in all sectors
- Recognise the value of domiciliary care
- What is the role of the independent sector play? - e.g. market share, service model?
- Training, is critical - communication, value of service user involvement in recruitment and meet service users as part of induction processes
- More partnership in delivering care between the statutory and independent sectors needed
- 100% statutory services in domiciliary care will not work and will not encourage the independent sector to invest until there is clarity
- Need to standardise terms and conditions for sustainable workforce
- Appropriate terms and conditions for Independent sector staff as well as statutory.
- Increased budget for training and development
- Unison rep noted from their perspective that this engagement meeting is a bit premature and had no response to-date to departmental meeting as requested and was therefore registering his disappointment.
- More partnership in delivering care between the statutory and independent sectors needed
- Open the workforce - female and male care staff, service user choice of provider/carer and offer staff security e.g. minimum guaranteed hour contracts
- Need to build in some flexibility - not just a task model as needs change day to day
- Need to raise profile of the home carer as a career starting in schools
- Recruitment needs to account for the fact that this is a vocational role
- Care staff want training - it is not just a requirement but part of their desire to deliver quality services
- Domiciliary Care staff want to be part of a team and feel like they are valued
- Staff need to be heard and listened too
- Better partnership approaches across the statutory and independent sectors
- Domiciliary care is not prioritised
- Increased budget for training and development
- Appropriate terms and conditions for Independent sector staff as well as statutory.
- Issue of comparative terms and conditions of staff in independent and statutory sectors.
- Care should be categorised - Elderly Mentally Infirm (EMI/ Memory), high dependency care and ensure staff are allocated care packages according to their abilities
- We need to define the job, what we require and the outcomes we expect
- Quality of life indicators and outcomes need to be defined
- Need to have regular partnership meetings with the Trusts - seem afraid to engage with independent providers because of the procurement legislation
- Need to utilise the potential of the Apprenticeship scheme
- Rethink the definition of domiciliary care - states personal care & other domestic services. No mention of social interaction, medication, protection and complex care - this doesn't reflect the higher acuity of services and skills required by Domiciliary Care workforce
- Need support from community nursing teams e.g. older peoples/memory for general training and support, competency / refresher and targeted service user specific care support.
- All domiciliary care workers should have the reablement ethos to prevent decompensation - delivering care with, rather than just for users.
- All dom. care providers have the same live call monitoring system to ensure face-to-face care is equitable across providers.
- Need to retain trained staff
- Increased budget for training
- Review job titles and roles

- Mileage allowance for staff need to be standardised across Statutory and Independent sectors
- Need to respond to what matters to the service user - what are their preferences - needs to be person centred service
- We should be taking the lead in the UK and not waiting for England to do it first. We have many good practice exemplars - let's grow them.
- There has to be a closer link between health care and social care
- Professionalise it - attract the right people
- Need to retain a local workforce to address defined local needs to have a sustainable service
- Change the culture of the Northern Irish public in relation to the Health Service in general and domiciliary care services specifically.
- There is a clear need to forward plan and almost start again as we have created jobs that are no longer attractive to people. Need to consider how to make domiciliary care attractive
- The Domiciliary sector would save a lot of money if investment was made into it
- Are we doing too much - need to partner with families to provide the care that they should or could be providing - the dynamics of society have changed.
- Need to promote good quality standards in domiciliary care
- Rapid response services worked and all it took was a couple of pound more an hour and it saved on A&E waiting times and bed blocking - lets apply the learning

Topic 1: Ranked

Table 1

1. Value our carers with better terms and conditions on a level playing field
2. Raise the profile of domiciliary care as a skilled and valued profession
3. Improved working partnerships with the Trust and key stakeholders, including the independent providers and Service Users

- Communication, communication, communication!!

Table 2

1. Make it a career
2. Standardise pay, terms and conditions
3. Strategic view of the service - what is provided, who should provide

Table 4

1. Service user needs must come first regardless of sector provider. Needs to be an agreed service delivery model
2. Attract a wider pool of applicants by raising the profile of social care, strategies to widen the pool of applicants and more targeted, providing career pathways, apprenticeships, equal terms and conditions for all sectors
3. The document needs a 5th scenario to state working in partnership with all sectors, where staff can develop skills needed, including use of technology. Need an outcomes matrix to measure service users needs are met. Partnership, commissioning and outcomes for service users are linked

Table 5

1. Funding which should be appropriately applied i.e. not funding profit.

2. Education and raising the profile of the service.

3. Career structure to include apprenticeships to attract the right people in to the workforce.

Table 6

- Status of the job; pay, terms and conditions, career path, value perspective of the job.
- Too much political interference in health instead of from the people that know
- The care part has been squeezed out because of time
- Promote as caring job, person centred care, training, should be a public sector but challenge is attractiveness
- Same challenge is there for independent sector, so challenge in domiciliary care sector as a whole
- Need a long-term plan for the sector
- Concern that those making decisions not fully aware of the challenge, things have changes with regard to profile of service user base and the consequences of decision making
- Is domiciliary care valued?
- Giving service user a choice of what provider provides care; if independent what independent agency, this will help place emphasis on who is best - service users to determine what agency provides care

Table 7

- Defined career path
- Ensure staff feel less vulnerable
- Fair pay structure

Table 8

1. Up skill workforce, training resources, with categorised care
2. Investment - putting the independent sector resources on a power with the 'Trusts', Independent sector have attracted younger staff where the Trusts have better retention of staff and then leading to an older workforce. Must develop younger staff new to the industry to enable them to progress their career and remain in the industry.
3. Public relations - positive public media coverage, public image to the industry and this as a career! Visible career choice and to be seen as a profession, rewarded through salary! Redefinition of Domiciliary Care

Table 10

1. Recognise the value that domiciliary care has on the wider health service.
2. Fund accordingly for sustainability for both staff members and the business and also for the effect on the acute sector
3. Partnership approach with the service users needs in mind. Removal of barriers between statutory and independent and others to ensure the best for the service users

Topic Two: Given that domiciliary care is provided by both statutory and independent sectors, how can the commissioning process be used to stabilise the market for domiciliary care?

- Engage all stakeholders to consult with regard to service specification
- Commissioning process needs to align itself to what the expectations are of the domiciliary care service.
- Needs to be a regional approach to commissioning
- There has to be a fair balance between independent & statutory provision of domiciliary care.
- Commissioning needs to recognise the real cost of care
- Commissioning should be based upon realistic funding to prevent a "race to the bottom" i.e. competing for the lowest price and compromised quality.
- What is the commissioning model? Is it purely financially driven or does it include quality of service provided?
- Procurement process should focus on quality rather than just driving the price down as seems to be the current position
- There needs to be a large statutory service operating alongside the independent sector. Can't put all of our eggs in one basket.
- There is instability in the market due to the fact that there is variance in the proportion of domiciliary care in NI sitting with independent sector providers.
- Links between acute care and domiciliary care need to be more joined up to prevent delayed discharges and the need to re-procure care packages.
- UKHCA have produced a costing model for the cost of care which should be considered
- Must consider the demographics and rurality of service users
- Decide on what is a fair price as of TYC
- Focus on partnership and quality
- Categorising care
- Tendering process - Value the quality rather than the price
- Need better information on exactly what a service user requires from brokerage or commissioners

- Better communication between agencies who deliver "dual provided" packages, information sharing, local resolution
- Remove competition - define the rate for a level playing field - understand the cost of care
- Capping how much a service provider takes on to ensure they can provide an excellent service.
- Continuity essential, new structures might create opportunity for that line of sight, top to bottom. Use the opportunity in changes to commissioning with a link in to the local knowledge.
- Should we move to means tested?
- Need to commission outcomes - not time
- Need a prescriptive piece around what domiciliary care is and what ‘good’ looks like
- Fair distribution of service users across the Trust and Independent sector
- Ensuring a safe service is provide taking into account what the service user requires on a day to day basis co-design and partnership critical to designing the care package with clear expectation set of what is and is not realistic
- Greater flexibility in the commissioning process, currently quite rigid and needs to be more flexible to respond to service user needs and outcomes
- Procurement is a legislative requirement - however there is difficulty sourcing packages with the number of ever decreasing providers - how is this going to solve commissioning of services
- Ensuring a safe service is provide taking into account what the service user requires on a day to day basis, co-design and partnership critical to designing the care package with clear expectation set of what is and is not realistic
- Look at what’s best for the service user as well as the Tax Payer
- Need to share the risk with the providers - partnership approach
- Commissioning has to be able to support service user choice particularly within Self Directed Support (SDS)
- Shouldn't be able to dictate the number of providers in a tendering process. For example only allowing 5 providers to win a tender for a whole trust area.
- Reducing the price over the last 5 years has caused the problem
- Need to commission individual care packages not hours
- Need to factor in fair and consistent hourly rate and terms and conditions for domiciliary care workers
- Stop changing the process and stability across ALL Trusts
- Tendering process, quality should be priority

Topic 2: Ranked

Table 1

1. Engage all key stakeholders in creating the service specification
2. Regional approach to commissioning services for consistency across the board
3. Tender service specification should specify terms and conditions for domiciliary care staff to match what the Trust provide so that independent providers can include this in their pricing

Table 2

1. Guaranteed level of income
2. Incentive to achieve good outcomes
3. Shared risk

Table 4

1. Commissioning needs to recognise the real cost of care and support a thriving social care workforce (UKHCA report)
2. Commissioning process needs to be more flexible to support service user choice, particularly within SDS
3. Commissioning needs to support innovation and skills development within all sectors

Table 5

1. Funding which should be appropriately applied i.e. not funding profit.
2. Education and raising the profile of the service.
3. Career structure to include apprenticeships to attract the right people in to the workforce.

Table 6

1. Longer term strategy with line of sight through to local level and what needs are on the ground
2. Increase profile of domiciliary care in DoH, and across Executive, other Depts. (Education - career path, vocational training); Communities (third sector, older peoples commissioners) et al. – a whole of government approach
3. Acknowledge that it is a hands on job and don't try to complicate it- at commissioning level

Table 7

1. How is commissioning defined?
2. Commissioning of services depends on the programme of care.
3. Commissioning decisions need to be made with knowledge of the job and what is expected from the carer.

Table 8

1. Stop changing the process and stability across all Trusts!
2. Lack of information regarding the service user, package details and their needs.
3. Trust should stop providing conventional services and 'cherry picking'.

Table 10

1. Decide on the true value on an hour of care and then remove price from the commissioning process as this has created a race to the bottom
2. Define the role each part of the sector has in delivering and commissioning the service.
3. Set this in legislation where responsibilities lie in terms of workforce - e.g. the Care Act in England
4. Learning from other countries that have been more successful.

Topic Three: How can we ensure we have the appropriate skills mix and career development opportunities within domiciliary care?

- Start at schools / FE colleges level to attract people into apprenticeships.
- Need a clear career pathway
- Redefine the roles and responsibilities of a domiciliary care worker
- Domiciliary Care minimum standards need to be reviewed
- Provide Clinical facilitator to Domiciliary Care in the same way as Nursing Homes
- Linking with schools and colleges
- Better coverage in the media to encourage people to show an interest
- Identifying a career path
- Domiciliary can have an impact on reablement / independence of service users
- QCF is very expensive - necessary for certain roles! Discounted/free places available if under 25 yrs. old but working <21 hrs. p/w, not considering the aged workforce, discounting people from the industry.
- Self Directed Support (SDS) - can people focus on the social side instead of the health side
- Support providers to have more control over the needs and skills of the staff and support with funding.
- Ensure clear practise based competencies are developed for the job
- Ensure a Career Pathway is defined
- Ensure a standardised generic induction programme is available
- The role has changed so much that it needs redefined role to future proof it.
- Transferable police check
- Develop creative ways to look at learning outcomes - vocational learning
- Essential Independent providers provide learning and development opportunities beyond that which is mandatory and that these align with career paths.
- Once the roles and responsibilities of a domiciliary care worker are redefined to reflect what the job has become, training must be provided and the commissioners fund to address skill gaps

- Support providers to have more control over the needs and skills of the staff and support with funding.
- Registration of the workforce can be a driver to support skills development
- Standard regional guidelines a "suite of training" / competency framework for domiciliary care staff to provide clarity on tasks undertaken by dom. care staff for both statutory & independent sector.
- Carry out a comprehensive costing of training to include release costs / backfill / programme costs so that the requirement for funding can be recognised.
- Learning based approach to redefine training
- Mentoring and shadowing mix of on the job and focussed training
- Ensure resources are available for training - new technologies.
- Use of technology to make learning and development more accessible e.g. mobile apps etc.
- Training costs should be recognised in the contract specification and hourly rate for commissioned services.
- "Price driven" procurement does not allow for care staff to be properly invested in - lower level care staff need developed as a professional
- Determination of what the service being delivered is - movement from a more social orientation and household tasks to a more clinical delivery based on more complex needs/multimorbidities
- Build in flexibility within role of carer support with ability to work in a number of settings, perhaps on rotation or based on needs of service- this broadens skill mix and profile of staff and capacity of service to deliver.
- A pin / badge for recognised achievements and skills.
- Explore with universities and FE colleges the possibility of progression courses for domiciliary care staff that can move through to Social Work, Nursing, Management and AHPs.
- What is the training pathway after level 5 QCF?
- Develop training academies for Dom Care including e-learning
- Funded secondment.
- Management and leaders should understand/be competent in tasks if they expect staff member to complete them
- Develop a training hub - something we could log in to share information on courses
- What can our universities do to promote career in care?
- Partnership with the Trusts - Open up their training to everyone
- More structured approach to training from the Trusts to include other providers
- Different levels - staff can progress up through the levels. This would be different pay scales which could also help with SDS budgets
- Training for the manager of the company as well. Train the trainer accredited for the manager - everyone across the board will then be delivering the same level of service
- Introduce a 'charge hand' / team leader role Band 3?
- Invest in leaders and managers to drive the service forward!
- Giving care staff the confidence in themselves and their training, to stick to policy, procedure and relevant legislation. Not to be controlled by others including families.

Topic 3: Ranked

Table 1

1. Roles and responsibilities of a domiciliary care worker need to be redefined to reflect the nature of the work they do, which will identify skill gaps
2. Funding needs to be available to provide the standard of training required and career pathways
3. Domiciliary care providers need to engage more with each other in terms of training to ensure a high standard of delivery and to support each other in creating efficiencies

Table 2

1. There needs to be investment in learning
2. Define the roles and competencies required at each level
3. Develop skill set for specialist areas.

Table 4

1. Promoting the role and value of domiciliary care
2. Skills strategies and resources need to support social care skills and career development e.g. Apprenticeships
3. Clarity about the model of care to inform skills development

Table 5

1. Funding - recognise the training required and pay for it; a dedicated training resource.
2. Career pathways with buy-in / support from the department to open up secondment opportunities for those who demonstrate abilities to progress into Social Work / Nursing / AHP careers
3. Competency framework / suite of training to provide clarity of tasks undertaken & training required across both statutory and independent sectors.

Table 6

1. Determination of what the service needs to look like
2. Determination of skills mix to deliver said service
3. Don't complicate it, build in flexibility and apply a co-design orientation to get it right

Table 7

1. Career pathway defined
2. Standard generic induction programme
3. Specific professional training for individual service users needs

Table 8

1. Strong organisational structure. Leadership and management investment. Recognising the value of these. Rates to facilitate GOOD management.
2. Educational/clinical facilitator
3. Provision of low cost training available to everyone!

Table 10

1. Investment for more training and development.
2. Linking with schools and colleges to encourage more interest in the care industry and to provide people with the skills needed to do the job. Run a course within the college for domiciliary.
3. With the correct investment from the department we could create different levels within the company so a staff member can progress and develop their career and skills.


Push bar to open
Ulster University

engage

Department of Health

Workforce Review Report

Prosthetics

2019 - 2029

Foreword

Since October 2016, Health and Social Care workers and the Department of Health have been cooperating to deliver the transformation set out in ***Health and Wellbeing 2026: Delivering Together***. This ambitious ten year plan was our response to the report produced by an Expert Panel led by Professor Bengoa, who were tasked with considering how best to re-configure Health and Social Care Services in Northern Ireland.

The aim is a health and social care system that helps people to stay well for longer, with services delivered in the community or at home, where possible. Allied Health Professions (AHPs) will play a key part in responding to this challenge, particularly as we expand the role of innovative, multidisciplinary teams across a range of integrated care pathways within health and social care settings. No matter how or where AHP staff work, they will continue to maintain their clear professional focus: supporting people, who are ill, have disabilities or special needs, to live the fullest lives possible.

Since these AHP workforce reviews commenced, the landscape across Health and Social Care has changed considerably. Opportunities for AHPs have been created across a range of primary care multi-disciplinary teams. These are to be welcomed, but it is important to have the highly skilled workforce required to take these opportunities as they arise. This series of workforce reviews are written with a view to identifying and quantifying the workforce required to meet these challenges and help drive the transformation agenda forward.

The AHP workforce reviews will help to address one of the immediate priorities set out in the ***New Decade, New Approach*** document published at the time of the establishment of the new Northern Ireland Executive. The commitment being that the Executive will transform HSC services through reconfiguration of services.

There is however currently a bigger challenge facing the HSC system in the guise of the current Covid-19 pandemic. This is challenging us in many ways, including the immense pressures placed on our workforce and the need to think and act differently, and to consider how we currently work and how we may work in the future.

In this changing environment, it is even more essential that we have an understanding of our workforce needs, so that we can plan effectively to maintain and develop our services into the future. This was recognised in ***Health and Wellbeing 2026: Delivering Together*** and appears as a key theme in the associated ***Health and Social Care Workforce Strategy 2026: Delivering for Our People.*** Recognising that the HSC is a changing environment and will continue to evolve, this series of workforce reviews are "living documents" which will be reviewed throughout the period of the reviews.

This Workforce Review Report, and the clear recommendations it contains, is the result of a wider Workforce Review Programme covering all thirteen AHPs in Northern Ireland. Since March 2017, Project Groups comprising representatives from across the health and social care service, professional bodies, staff side representatives and the Department of Health, have been meeting regularly to consider how these professions / services are likely to develop in the period 2019 – 2029. Their work has been overseen by the AHP Workforce Review Programme Steering Group and applies the ***Regional HSC Workforce Planning Framework's*** six step methodology.

This process and its resulting Workforce Review Reports are the products of active co-design and co-production, delivering together to ensure the workforce needs of the HSC are met. Project Groups have engaged with their stakeholders, including service users and carers, both in formal engagement events and through ongoing involvement with relevant individuals and organisations. Their input has been invaluable in producing this final document and its recommendations.

We would like to thank everyone who has contributed to the work of the AHP Workforce Review Programme.

Our vision is for Northern Ireland to have an AHP workforce that has the capacity and capability to deliver the best possible care, for patients and clients, and has the leadership skills and opportunities to lead and transform services to improve population health. The Prosthetics Workforce Review Report and its recommendations set us on course to do just that for this profession.

Charlotte McArdle

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Preeta Miller

Director of Workforce Policy

Department of Health

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Chief AHP Officer

Department of Health

Contents

Introduction

Limb loss and any related co-morbidities are life-long conditions, it is recognised that limb loss can be managed effectively through specialised rehabilitation services. The Regional Amputee Rehabilitation Service at Musgrave Park Hospital is a contracted service through a private sector provider. Belfast Trust tenders the service provision contract for the Regional Northern Ireland Service every 7 Years. The tender specification places the patient at the heart of everything the rehabilitation service centres does. It focuses on maximising their independence, achievement of their individual goals and improving their quality of life. The service specification empowers and liberates clinicians to innovate, with the freedom to focus on improving healthcare services.

The Amputee Rehabilitation Service contract has been delivered at Musgrave Park Hospital for the past 20 years by Opcare Ltd. Opcare Ltd delivers a complete range of Prosthetic Services for both upper and lower limb loss, working in conjunction with theHSC. Opcare Ltd employ the Prosthetist and Prosthetic Technicians (who manufacture the artificial limbs) and Administrators in the centres where they operate and provide central support regarding Logistics, Human Resources and Quality Management.

Defining the plan

The purpose of this plan is to review current prosthetist staff employed in Northern Ireland and ensure future service sustainability. Prosthetist numbers are small but the importance of ensuring people entering the profession from Northern Ireland is important. This means applicants will apply if a prosthetist position becomes available.

This plan will examine the prosthetists currently employed at the Amputee Rehabilitation Service only. It will look at drivers within Northern Ireland that create new graduate prosthetists who will enter the profession.

Stakeholders who have a stake in the prosthetic service would be Belfast Trust who manage the Regional Service on behalf of the region. Their Disability Services Manager is responsible for managing this contract. Opcare Ltd is the service provider, locally managed by the Prosthetic Manager and nationally by the Clinical Service Director.

The main driver for change in the prosthetic service is the contract specification when the service goes out to tender. This defines the service specification for the Regional Service and is what private companies tender their bids against. Staffing levels will also be specified in this contract. Length of the service contract, which currently is 7 years, is important to allow service providers time to develop staff and the service without the impending risk of re-tendering.

Having a Regional Service consolidates all the skills and facilities into one location. This allows users to gain rapid access to appointments within 24 hours to address mechanical issues with their prosthesis. It allows a full multidisciplinary team approach to patient care in one location and flexibility to meet the changing demands of service users.

Mapping Service Change

For many years the prosthetic staff has been relatively static in Northern Ireland, with the majority of prosthetists having over 10 years' service.

Table 1 illustrates the age range of the 5 prosthetists currently employed.

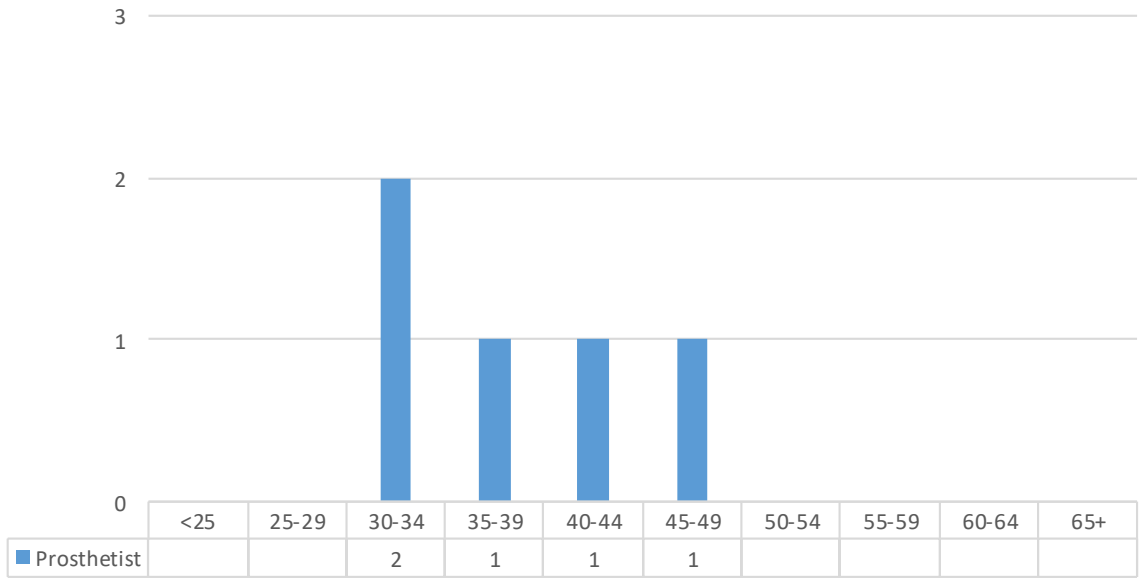


Table 1

The prosthetist population remains healthy with a total of 8 hours lost to sickness over the financial year 2016/17. The gender of the prosthetist population is 3 male and 2 female staff.

These 5 staff look after a patient population for 1880 active users, however only 50% of users attend the prosthetic service on an annual basis – see *Table 2*.

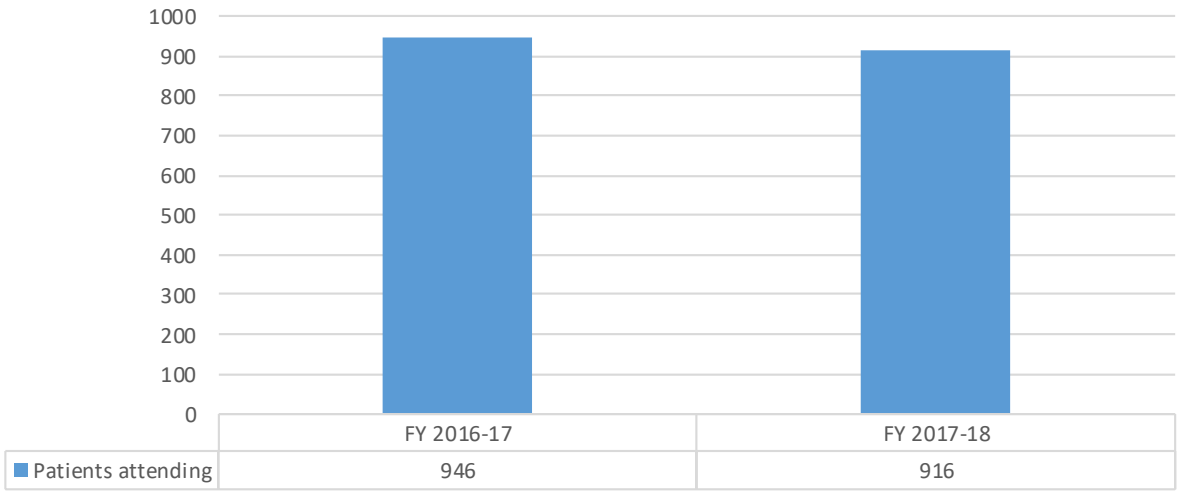


Table 2

With the aetiology of the condition, all patients are lifelong users of the service.

The prosthetic service currently is regionally located at Musgrave Park Hospital in Belfast. All patients throughout Northern Ireland are initially referred into the service by hospital doctors or GP's and remain on open referrals for life. This allows patients to self-refer when they think service intervention is required.

Defining the required workforce – skills mix

The Amputee Rehabilitation Service relies on referrals from Hospitals and GP's around the province to maintain its population. Over the last three financial years, the number of individual patients being referred with amputation has slightly decreased, as illustrated in table 3. This may be due to other initiatives in Northern Ireland which are working to prevent amputation in diabetics or improvement in surgical techniques.

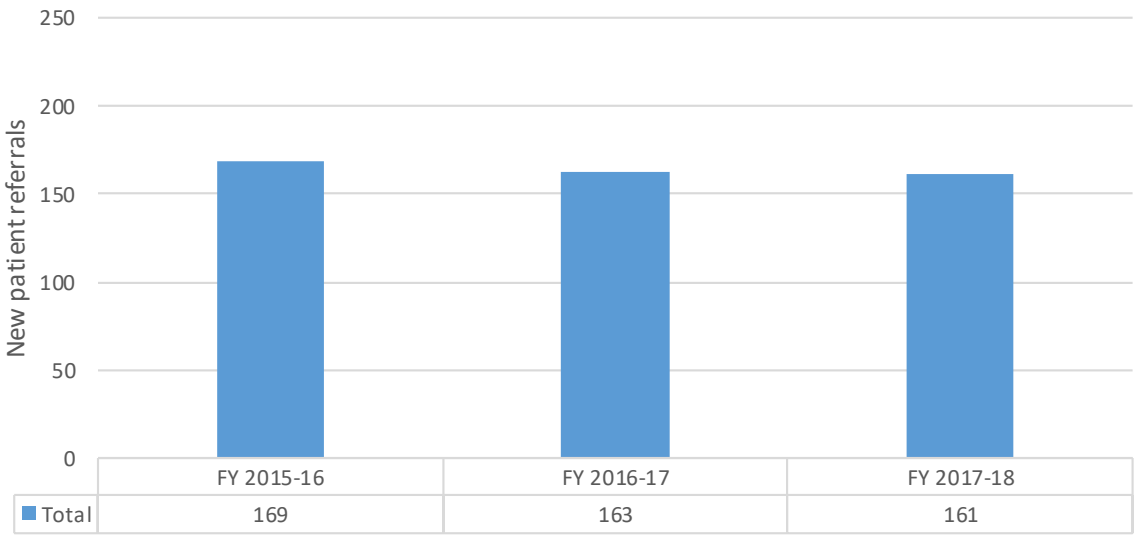
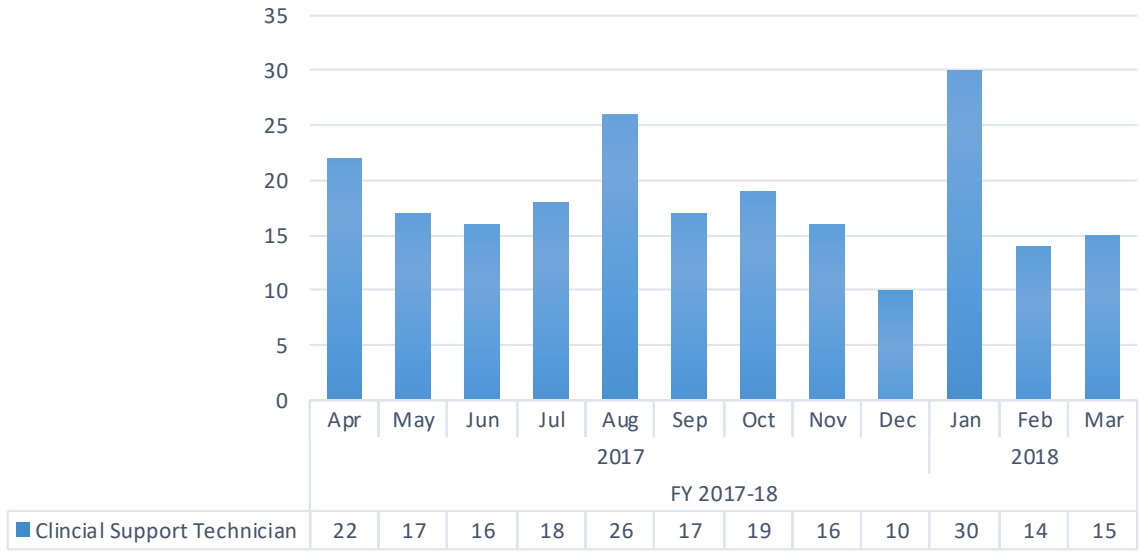


Table 3

The prosthetic service has 5 full time prosthetists employed. 3 Years ago there were 6 prosthetists, however following retirement it was decided not to replace this role. Instead an additional prosthetic technician was employed to allow further utilisation of the clinical support technician within the service. This role allows the prosthetic technician to deal with patients' mechanical repair issues, allowing service users to access the person with the best skill set to resolve their problem. This also frees up prosthetist time to deal with other complex clinical issues.

During the financial year 2017/18 the clinical support technician role saved 220 clinical appointment slots for the service as illustrated in *Table 4.*

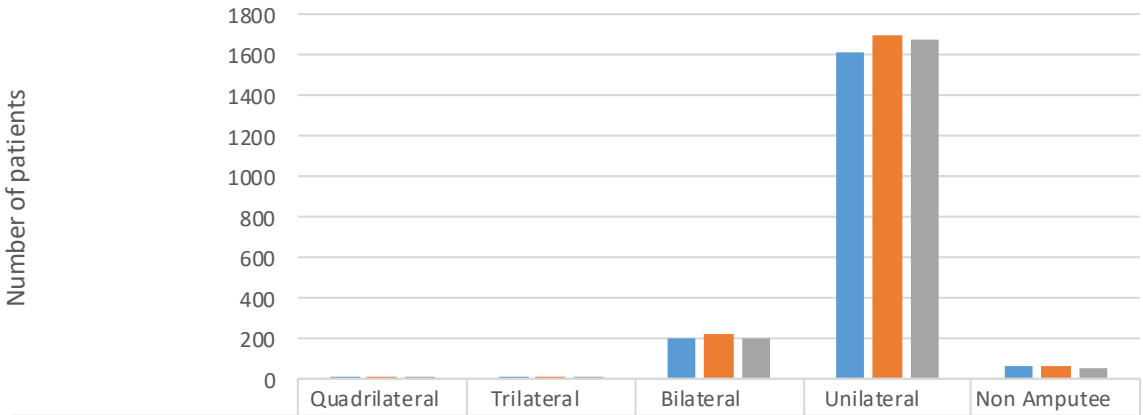


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Clincial Support Technician	22	17	16	18	26	17	19	16	10	30	14	15

Table 4

Following completion of a 1-year trial on this project, the new service model was adopted in February 2018.

There has also been a reduction in the number of active patients who attend the Regional prosthetic service. This has been due to cleansing of the database – see *Table 5*.



	Quadrilateral	Trilateral	Bilateral	Unilateral	Non Amputee
Year 2017-18 (Total 1880)	5	8	201	1607	59
Year 2016-17 (Total 1987)	5	7	218	1695	62
Year 2015-16 (Total 1944)	5	8	202	1679	50

Table 5

Over the last 3 years, computer aided design (CAD) has heavy influenced prosthetist productivity and how they work. The traditional method of plaster bandage and plaster of paris for production of patient models was labour and time intensive. A transtibial (below knee) prosthetic model would on average take 3 hours of prosthetist time from start to finish, transfemoral (above knee) would take 4 hours.

With the introduction of CAD, prosthetists have been on a learning curve to develop new skills that have influenced their practice. Plaster bandage for shape capture has been replaced by a white light scanner (Figure 1).

Figure 1

Figure 2

Omega Software (Figure 2) has replaced plaster of paris for model creation and rectification. This allows the prosthetist to manipulate the model on computer before emailing to a robot CNC machine to carve the physical model for production.

A transtibial prosthetic model now takes 1 hour 30 minutes and transfemoral 1 hour. While not all work can be done using CAD over plaster, 70% of new limbs and new sockets are now produced using the CAD method impacting on prosthetist productivity.

Understanding workforce availability

For prosthetics, two undergraduate courses are available in the United Kingdom as detailed below.

University of Strathclyde Glasgow		BSc Prosthetics & Orthotics
University of Salford MANCHESTER		BSc Prosthetics & Orthotics

These courses provide the main workforce that will apply for prosthetic jobs in Northern Ireland when they become available. 60 students per year are trained through both UK undergraduate courses however recent statistics show that almost 30% do not enter the profession. Northern Ireland takes two 4 month student placement from either university per year.

Another important driver to the university courses is students from local Northern Ireland schools attending work placement during their lower sixth year. Career awareness in the schools means the prosthetic department receives numerous requests each year for work placement.

It would be important to maintain a professional presence at local career fairs within Northern Ireland to ensure the prosthetist profession continues to attracted interested students to follow this as a career path. Having a reasonable pool of graduated prosthetists working in the United Kingdom from Northern Ireland should ensure any future vacancies would receive applications.

Current prosthetists employed range from 30 to 49 years of age (*Table 1*). Retirement is not expected to be a major factor on staffing levels in the near future.

In England, Skills for Health is currently developing Healthcare Apprenticeships for both Prosthetic Technicians and Prosthetists (https://haso.skillsforhealth.org.uk/?s=prosthetics&lvl=all). At the time of this report, both programmes are at the "In development" stage, with no know completion date.

The service has no issues currently with retention as the majority of prosthetists have been employed for over 10 years.

Stakeholder Engagement

During this workforce review a stakeholder event was organised on the 7th September 2018 at University of Ulster, Jordanstown. This presented

an opportunity to gain insight into what users, other clinical professions and management thought was important in prosthetist workforce planning by asking 4 questions and then ranking them in priority.

Question 1:

Recruitment – What needs to be done to attract the right people with the right skills into these professions?

Answers question 1:

- Awareness of profession
- Career progression
- Involve patients in sharing their stories in relation to how these professions can make a difference

Question 2:

Retention – What needs to be done to make people aspire to remain working in these professions?

Answers question 2:

- Ability to progress...
- Feeling valued expressed in similar Terms and Conditions
- Working with NOT for - i.e. equality within MDT - mutual respect

Question 3:

The future of the service you provide or the service you receive – How should it develop and be delivered in the future?

Answers question 3:

- Using technology more effectively - more online access
- Asking service users what they want and keeping up to date information
- Look at different models of delivery via inclusion of all relevant parties

Reflection:

Having discussed all of this today, what would you now suggest as the top priority for the AHP workforce reviews to deliver?

Answers to reflection:

- Recognition of professional autonomy

Conclusion and Recommendations

The prosthetic profession in Northern Ireland is currently in a good place with no workforce issues at present. Retention levels remain high. New CAD working practices have increased productivity, leaving more clinical appointment time. Development of the Clinical Support technician role has assisted clinical capacity and provided a new service initiative for patient care.

Having a regional service model located in one location, allows users to access one place and have all prosthetic issues dealt with in a timely manner.

No threats to service provision and the workforce have been identified to date, a continuing strategy of student and under-graduate engagement along with professional promotion should encourage a healthy interest in prosthetics in Northern Ireland for the future. We would welcome the opportunity to become involved in the work of the new Regional Health and Social Care Careers Service.

	Recommendations
Undergraduate training	• Continue student placements from both universities. • Offer work experience to school leavers
Post graduate training	• Service Contract length should continue as currently. This time scale allows stability and encourages service and staff investment and development. This also allows opportunity for career progression. • Allow prosthetists to access regional AHP courses.
Recruitment and retention	• Increase presence in AHP career literature for school students considering healthcare profession • Contribute to service development and contract specification. • Recognition that prosthetists are autonomous professionals
Transformation	• Healthcare Apprenticeships is a new development for prosthetics. While the

	Recommendations
	delivery time scale and outcome is currently unknown for this new initiative, it does offer a new career pathway into prosthetics. This will continue to be monitored and utilised if it does come to fruition. • Development of the CST role.

An appropriate action/implementation plan will be developed and published on the Department of Health's website and the Workforce Strategy Programme Board will be updated on progress.

Department of Health

Workforce Review Report

Dietetics

2019 – 2029

Table of Contents

Foreword

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The Covid-19 pandemic challenged us in many ways including the immense pressures placed on our workforce, but there are others pressures challenging us to think and act differently and to consider as to how we currently work and as to how we may work in the future.

In this changing environment, it is even more essential that we have an understanding of our workforce needs, so that we can plan effectively to maintain and develop our services into the future. This was recognised in ***Health and Wellbeing 2026: Delivering Together*** and appears as a key theme in the associated ***Health and Social Care Workforce Strategy 2026: Delivering for Our People.*** Recognising that the HSC is a changing environment and will continue to evolve, this series of workforce reviews are "living documents" which will be reviewed throughout the period of the reviews.

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Professor Suzanne Martin
Chief AHP Officer
Department of Health

Philip Rodgers
Acting Director of Workforce Policy
Department of Health

Executive Summary

The aim of the Northern Ireland Regional Dietetics Workforce review led by the Regional Dietetic managers Forum and supported by the Department of Health, Public Health Agency and stakeholders is to rethink, rebuild and plan to improve the nutritional health of the people of Northern Ireland at both individual and population levels by planning for sustainable dietetic services in the wake of the global pandemic and seismic changes to the delivery of health and social care. Tackling the nutritional needs (under and over nutrition) is "one of the greatest long term health challenges this country faces"[1]

Registered dietitians are qualified health professions who assess, diagnose and treat diet and nutrition problems both at individual and population levels. Dietitians interpret the science of nutrition to improve health and treat diseases / conditions by educating and giving practical, personalised advice to clients, patient's carers and colleagues[2]. They are registered professional with the Health and Care Professions Council, the regulator of Allied Health Professions[3] Dietitians support people along the course of their lives with complex conditions and are integral to multidisciplinary teams supporting clinical pathways from cradle to grave e.g. supporting babies with cow's milk allergy, stroke pathways, diabetes, care homes support teams and palliative care. Supporting the nutritional needs of people in Northern Ireland comes with a fiscal challenge. In 2019/20 £30.17 million was spent on prescribing of nutritional products and vitamins in primary care in Northern Ireland, significantly greater spend than other UK nations[4]. Complex regional challenge dietitians can offer solutions to assist with regulation.

The Dietetic workforce of 365 dietitians is predominantly female (98%), work on a part time basis (57%), aged under 40 years old (65%), maintains a regionally high maternity rate (currently 7.42% of workforce, compared to HSC regional average of 3%) and low retirement rate. Regionally, there has been a sustained high vacancy rate over 5 years greater than the regionally recognised vacancy of 5% which is deemed "acceptable" to maintain service. In September 2019, there was a regional average vacancy rate of 15.6%, an unsustainable challenge to a relatively small specialist service. As a consequence Dietetic staff are overstretched due to higher demands and the need to cope with staff shortages and prioritise workloads.

The current education provider for Human Nutrition and Dietetic qualification within Northern Ireland is Ulster University, providing undergraduate and postgraduate Dietetic courses. At present 21 dietetics places are commissioned at undergraduate level, with Ulster University providing an additional 5 self-funded post graduate places. In 2017/18 the retention rate of undergraduate dietitians graduating from Ulster University going to working in HSCNI was 57% and 20% at Masters Level indicating significant challenges in providing a sustainable workforce. A review of commissioned places at various entry levels and delivery of education to support the Dietetic workforce within the health and social care system in Northern Ireland is recommended.

High vacancy rates within the Dietetic services, along with increased demand and referrals to Dietetic services and an overall decline in the nutritional health and wellbeing of the population have all led to considerable workforce challenges. This has resulted in diminished capacity to deliver core Dietetic services, as well as secure investment for quality improvements and transformational initiatives which includes focus on the wider determinants of nutrition related population health, prevention and wider public health messaging. It also limits the ability to support the needs of staff supervision, mandatory and professional training needs in addition to the provision of specialist training and succession planning.

This workforce report outlines that an additional 144 WTE Dietitians is required to stabilise current service provision and a further 226 WTE over a 10 year period to meet projected demands of service.

455 graduates coming to work in HSCNI is required over the next ten years to meet demand for services.

Strategic context

The COVID-19 pandemic has reset health and social care services, identified the need to rebuild and reform services and prevent siloed working. The dietetic profession has a significant role in supporting the nutritional needs of the people of Northern Ireland, delivering innovative models of anticipatory care within primary care (GP and nursing/ care home settings), public health and promotion thereby relieving capacity on secondary care by preventing hospital admissions as well as supporting early discharge from hospital services.

Malnutrition is a major public health issue, most prevalent in the community setting and affecting 29% of patients admitted to hospitals throughout Northern Ireland[5] Malnutrition both over and under is associated with reduced life expectancy and poorer outcomes. Conversely, people who are obese are more likely to be admitted to hospital, to intensive care and to die from COVID-19 compared with those a healthy body weight status[6]. Empowering the people of Northern Ireland to maintain a healthy weight and address food poverty is one of the most important things we can do to improve our nation's health[7]. Supporting the nutritional challenges of the people of Northern Ireland places fiscal pressure on the Health and Social Care System. In 2019/20 £30.17 million was spent on prescribing of nutritional products and vitamins in primary care in Northern Ireland significantly greater spend than other UK nations[8].

Current changes to secondary prescribing rights in Northern Ireland and expansion of extended roles ensure that dietitians are working to improve the outcomes, recovery and rehabilitation of people of Northern Ireland and relieve capacity into the health and care system Dietetic led services and pilots have demonstrated the following benefits and savings:

- Fewer acute hospital admissions and shorter length of stays
- Delivering nutritional services and prescribing medications thereby releasing capacity for other specialties
- Cost saving of prescription only medications via appropriate Dietetic assessment and treatment
- Improved patient quality of life outcomes.
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Workforce

At the time of this report, the HSC Dietetic workforce is comprised of 365 Dietitians (288 whole time equivalents). The workforce is predominantly female (98%), aged under 40 years old (65%) and work on a part time basis (57%).

The Dietetic Workforce has faced long term sustainability challenges with higher than average vacancy rates (see figures below provided by DoH workforce planning). This is recognised as being a significantly high vacancy rate, with 5% considered "acceptable" (DoH)

- 15% vacancy rate across all Trusts (March 2019)
- 7.42 % vacancy rate across all Trusts (March 2020)
- Average regional Dietetic vacancy rate between 2017- 2020 ~ 11%

The impact of higher than average sustained vacancy rates on the regional dietetic service over several years has been significant in the context of higher demand and worsening population nutritional health status. There has been considerable impact on capacity and delivery of core services, access to specialist dietetic services, implementation of transformation, reform and strategic models of change e.g. prevention and shifting the focus of nutrition to public health. Crucially, high dietetic vacancy rates have implications for overstretched workers as well as significantly delaying provision of treatment for patients. The establishment of peripatetic staffing within some HSCTs has shown to mitigate the impact of high vacancy rates and associated capacity challenges.

In Northern Ireland, Ulster University offers two routes for qualification as a registered Dietitian; undergraduate BSc Hons in Dietetic (four years) and postgraduate MSc Dietetics (two years). In 2020/21 Minister Swann announced an increase to the numbers of AHP undergraduate training places, of which Dietetics was not a beneficiary. Presently Department of Health NI commissioning for Dietetics is 21 undergraduate places Department of Health NI, 2020.

Given the projected demographic population changes for NI (i.e. 4.68% increase for <65 yrs and 28% for >65 yrs by 2027) it is predicted that the need for dietetic services will increase further given the aging population and high prevalence rates for childhood and adult obesity in Northern Ireland.

As recently recognised by the DoH Transformational Implementation Group (TIG), the dietetic profession has a significant role in delivering services locally, preventing hospital admissions and supporting early discharge.

Introduction and background

In August 2017 the Department of Health (DoH) Northern Ireland (NI) embarked on a number of regional workforce reviews across a range of Allied Health Professional (AHP) groups including Dietetic services. These workforce reviews were deemed necessary to ensure AHP services delivered across NI will be sustainable to meet future demands, meet the needs of the population and to ensure services are delivered to an appropriate standard in line with strategic policy directions. It is well acknowledged that there are a range of challenges faced by the health and social care system which supports the need for the workforce to be balanced correctly in term of size and skills, ensuring there is an adaptive workforce organised well, and deployed in the correct way to provide the best possible care for service users and their families.

The review completed a horizon scanning exercise to determine future service needs. This involved:

- Analysis of demographic trends
- Analysis of complexity of need
- Predicting subsequent need
- Predicting service developments; and
- Identifying potential partnerships with other agencies in the delivery of services.

In doing so the Dietetic services workforce review aims to ensure sufficient workforce for services to provide commissioned support for clients at both population and specialist levels.

Drivers for change

Dietitians are crucial in delivering outcomes for key strategies within NI and are well placed to lead specific aspects of the transformation of care required to prevent ill health and reduce pressures within the health service, as recommended in the Bengoa report and DoH Delivering Together strategy. Key areas include:

- Outpatient reform and transformation
- Preventing hospital admission and early supported discharge
- Preventative care

Appendix 1 provides a summary of the key regional documents including reference to the current strategic context which informs the potential future dietetic workforce needs.

During the COVID-19 outbreak international and national evidence highlighted the active role of Dietitians in the prevention, acute treatment and rehabilitation of individuals at risk or affect by Coronavirus, further supporting the unique role and need for enhancement of the regional workforce.

Description of Dietetic Services

Registered dietitians are qualified health professions who assess, diagnose and treat diet and nutrition problems both at individual and population levels. Dietitians use the most up to date research on diet and health which they translate into practical guidance to enable people to make appropriate lifestyles and food choices (Ulster University, 2020). They are registered with the Health and Care Professions Council, the regulator of Allied Health Professions. Dietitians support people along the course of their lives. They are integral to multidisciplinary teams (MDTs) which assess and treat complex conditions from birth to end of life such as within paediatric; renal, critical care, prescribing support and care home teams. Dietitians have a key role within the associated clinical care pathways and provide education and treatment for service users who are diagnosed with a cow's milk allergy, stroke, diabetes, renal disease and those with palliative care needs.

In Northern Ireland, the majority of Dietitians work within Health and Social Care (HSC) with a wide range of health professionals, across a range of settings including: hospitals, community services, general practices, patients' own homes, and care homes.

Appendix 2 provides additional information and describes the unique role of a dietitian.

Methodology for workforce planning

The methodology for this workforce planning review is outlined in Appendix 3.

Ownership

Relevant professional and workforce leads were identified as nominated members of the AHP Workforce Review Programme Steering Group and the regional Dietetic Service Sub-Group.

Refer to Appendix 4 for full membership and associated terms of reference.

Service user involvement was in line with requirements of the Public and Personal Involvement (PPI) legislative frameworks.

Assumptions and Constraints

Due to the challenging nature in completing a workforce review it was important to consider any possible assumptions, constraints and/ or risks early in the process. This was particularly important due to the wide and varied nature of Dietetic services which not only work within HSC but also in partnership with other statutory and non-statutory agencies. A number of assumptions and constraints were identified and are listed below. Measures were taken to help manage these and reduce their implications throughout the process of the workforce review.

Subject of assumption/ constraint	Measures taken
Engagement	Active involvement and engagement of key stakeholders at each stage, in a co-produced way.
Consensus	Active involvement at all levels across the wide range of organisations to achieve widespread consensus.
Timeframe and professional capacity	Development of a time bound programme plan; defining responsibilities and agreeing a shared work plan amongst the sub-group members.
Access to and lack of consistency of relevant data	Information is based on current data systems available from a variety of sources. Need to influence and be involved in the development of a universal information system.
Impact of current and future developments	Dietetic practice and service opportunities are continuing to develop. The extent of some of these developments were not fully realised at the time of the workforce review but were taken into consideration.
Future population health care needs and the impact of technological advances	Predicted demographic trends and needs of the population, as well as technology advances, were used to inform future service models and workforce required.
The future HSC and political structures	NI is in a state of system change and uncertainty, which is, in part, dependent upon the political arena. Associated financial uncertainty was also considered for its impact on the potential dietetic workforce needs.
Implementation of the agreed action plan	Recommendations made within this review are fully endorsed by senior DoH, HSCB and Public Health Agency (PHA), in collaboration with Trusts to ensure they are supported and implemented.

Mapping Service Change

Goals/ benefits of change

There are many strategic drivers which support the need for workforce planning and which recommend proactive management. Some of the drivers for change include:

- The recognition of the changing nature of health and social care needs and the link to local changes in demography, with a greater emphasis placed on prevention and self-care
- Transformation and the associated revision of service delivery models to meet the needs of patients, clients, carers and HSC staff
- The need to consider career progression and succession planning requirements of the present and future HSC workforce;
- Enhancement of patient safety and quality of care;
- Ensuring affordability of services given the challenging financial context for all organisations.

Population statistics and health profile

Population data provides a clear indication that there will be greater numbers of young children and older people within the next 10 years. In addition, these population cohorts will have more complex health and social care needs.

It is predicted that the proportion of older age groups will continue to rise and by 2027 the over 65 population is expected to increase by 28% (see table page 14).

Key strategies evidence that the prevalence of long-term conditions such as diabetes, stroke, asthma, chronic obstructive pulmonary disease (COPD) and hypertension is increasing and the number of people coping with multiple co-morbidities has and continues to increase. With malnutrition and functional decline through to end of life care, this will have a significant impact on Dietetic Services.

N Ireland Resident Populations by Local Commissioning Group – comparison 2017- 2027 (Source: NISRA, Based on 2014 Population Mid-Year estimates)

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI (2017)	NI(2027)	% Increase / decrease
0-15	69,177	69,773	71,920	87,195	64,884	**389,889**	392,546	**0.67**
16-39	124,799	141,288	102,990	120,503	92,609	**582,189**	569,195	**-2.23**
40-64	108,043	155,239	117,759	118,606	97,475	**597,122**	609,461	**2.94**
65+	54,371	82,130	68,823	55,427	46,551	**304,302**	390,039	**28**
All ages	**356,330**	**475,430**	**358,492**	**381,731**	**301,519**	**1,873,502**	**1,961,241**	**4.68**
%	**19**	**25.4**	**19.1**	**20.4**	**16.1**	**100**		

Emerging Transformation and Reform Models

As recently recognised by the DoH Transformational Implementation Group (TIG) and following the COVID-19 pandemic, the dietetic profession has a significant role in delivering services locally, preventing hospital admissions and supporting early discharge. The information provides an overview of the service models identified as improving health service delivery (including efficiencies and effectiveness) and are categorised into three overarching headings.

Outpatient reform and transformation
Preventing hospital admission and early supported discharge
Preventative care

(See appendix 5 for further information on transformational working models of service delivery)

Defining the Required Workforce

As health demands continue to increase, regionally agreed professional models will need to be developed and implemented. Ensuring equitable commissioning arrangements are in place throughout NI is therefore essential for the Dietetic workforce to provide service users with a consistent standard of care, regardless of their place of residence. Currently the dietetic workforce is commissioned on the basis of 42 weeks per year leading to gaps in cover for specialist clinics and inpatient wards which is impacting on patient flow.

As well as transformation opportunities, health and social care services are currently asking the dietetic profession to work towards a 52 week service and the provision of 7 day working models. The latter currently presents itself as a challenge to the relatively small Dietetic workforce across HSC, so an extended working week for specific clinical areas (e.g. acute unscheduled care, stroke services) may be more appropriate, and a more efficient and effective use of resources.

Significant additional enhancement is required to ensure a minimal staffing allocation across acute sites and within areas of clinical specialism to ensure patients receive an extended 52 week service.

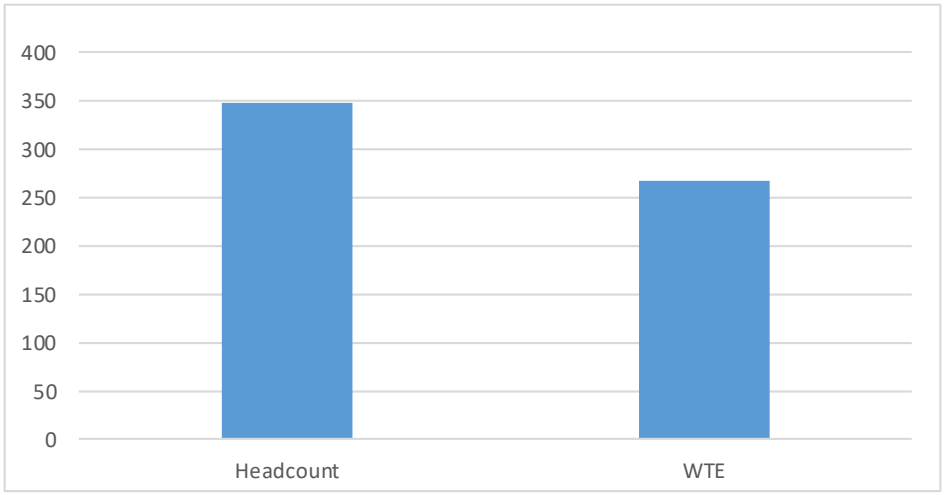
NOTE - Enhancement of Service Continuity over 52 weeks

- Posts funded for 52 week service provision to enhance continuity 52/42 = ***1.24 WTE***

As the Dietetic workforce increases, so too will the need for enhancement of skill mix, utilising dietetic support workers, assistant practitioners, advanced practitioners and leadership and governance roles to maximise opportunities and succession planning.

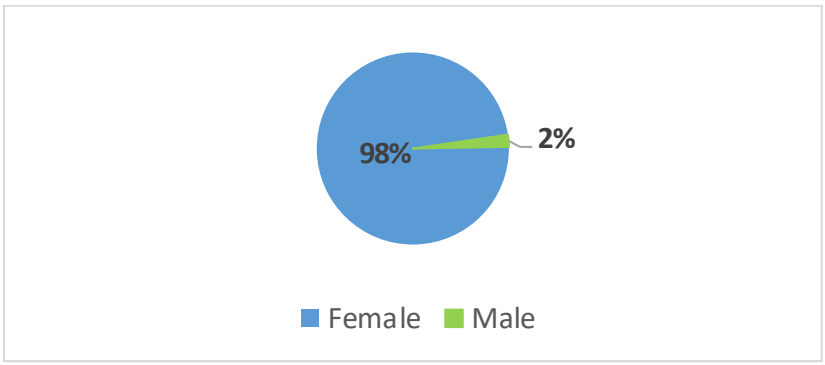
Understanding Workforce Availability

Dietetics Workforce Statistics (head count/ WTE profile 2019)

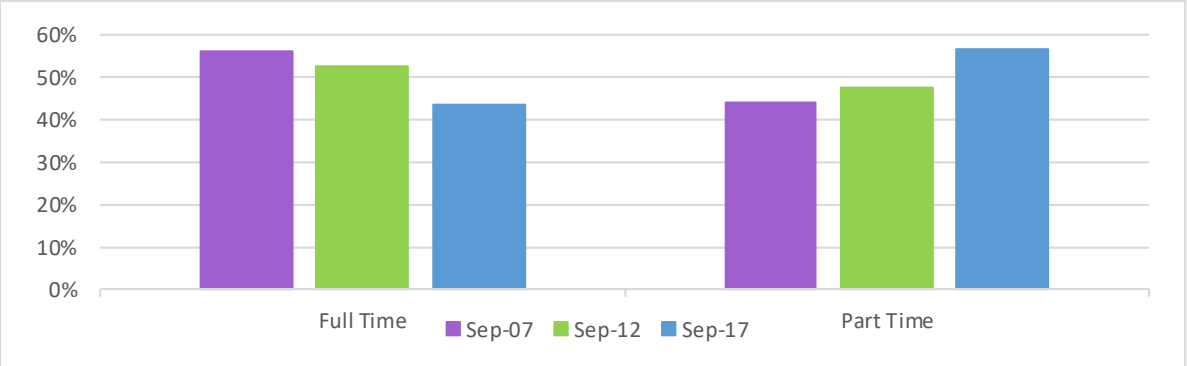


On the basis of the DoH HSC workforce information (31st March 2019) the Dietetic HSC workforce is comprised of 365 Dietitians (headcount) with 288 whole time equivalents (W.T.E.)

Gender and work pattern profile



98% of the Dietetic workforce is female with 57% of the total Dietetic workforce currently being part-time staff as illustrated below.



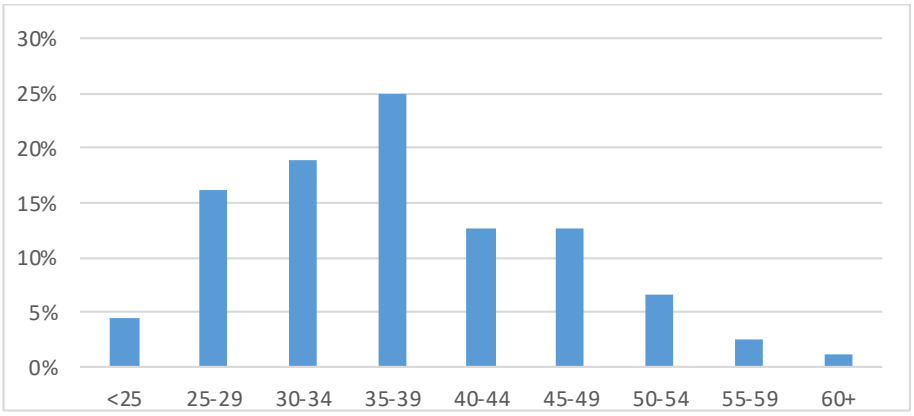
In a recent analysis of the HSC workforce data in NI it was identified that AHPs were the most notable group in HSC to have the greatest increase in part-time working over the past 10 years.

In comparison with other professions, Dietitians have a significantly higher proportion working part-time:

Other Professions	Full-Time	Part-Time
Dietitians	43.0%	57.0%
AHP's	60.2%	39.8%
Qualified Social Workers	80.9%	19.1%
Qualified Nursing Staff	59.2%	40.8%

The Dietetic profession has demonstrated great flexibility in supporting the workforce with part time working. This however, creates the added challenge for the service in terms of the higher head count, release of staff for supervision, managerial support for all staff as well as part time staff meeting their mandatory and professional training needs.

Age profile and retirement impact



The Dietetic workforce is predominantly a young female workforce with 65% of the Dietitians aged <40 years old and only 10% of the overall workforce being aged 50 years or over. This equates to a minimum of 29 potential retirements in the next 10 years i.e. 2.9 WTE per year.

Parental leave

The overall percentage of HSC staff on maternity/ adoption/ paternity/ shared parental leave is currently 3%. This percentage is higher at 7.1% for all AHPs with the current percentage of Dietitians on parental leave equating to 7.42%. This indicates the need to train more Dietitians to create a larger pool of staff to cover parental leave than might otherwise be necessary for a profession that has more male staff. Nationally there is a drive to create a more gender balanced workforce.

NOTE – Maternity rate

*Bas*ed on current staffing of 288 this equates to 21 W.T.E. posts (288 x 7.42%)

Sick leave

In 2017/18 the percentage of hours lost due to sickness absence/ industrial injury in Dietetics was 3.95%.

Vacancy rates

The Dietetic workforce has faced long term sustainability challenges with higher than average vacancy rates (see figures below). This rate is recognised as being a significantly high vacancy rate, with 5% considered "acceptable" (DoH).

- 15% vacancy rate across all Trust (March 2019)
- 7.42 % vacancy rate across all Trust (March 2020)
- Average vacancy rate across all Trusts ~ 11%

NOTE – Vacancy rate

*Bas*ed on current staffing of 288 this equates to 32 W.T.E. posts (288 x 11%).

Contract profile by Trust

Overall 89% of Dietitians have permanent contracts and 11% have temporary contracts:

Trust	**Permanent**	**Temporary**
Belfast*	94.1%	5.9%
Northern	75.0%	25.0%
South Eastern	91.2%	8.8%
Southern*	96.4%	3.6%
Western	87.7%	12.3%
Total	**88.8%**	**11.2%**

*Trusts have peripatetic pools of staff and demonstrate a lower percentage of staff with temporary contracts.

NOTES Peripatetic posts

Staffing requirements are calculated at 10% of current workforce equating to 44 W.T.E. for cumulative service stabilisation based on maternity rates and staff turnover to address vacancy rate.

First destination of dietetic students from Ulster University

Ulster University provides a 4 year undergraduate commissioned course (21 commissioned places) and a 2 year student self-funded postgraduate course (5 places) for Dietitians with registration to practice. From data 2017/18 the retention rate of Dietitians (at undergraduate level) working in Health & Social care NI was 57%, with other Dietitians working in England, Scotland and Wales (14.3%), private practice (7.1%) or continuing further study (21.4%).This is related to the higher number of permanent posts in mainland UK versus NI and the ongoing high level of temporary contracts (11.2%) for new graduates in HSC NI due to temporary initiatives being commissioned. In 2017/2018, 80% of Dietitians (4/5) at post-graduate level (Masters level) did not stay to work in NI.

In an attempt to address these retention issues Dietetic Managers have progressed to earlier advertisement of the Regional Band 5 Dietitian waiting list and would like to progress to a model of commitment to work in HSC for 2 years post qualifying from Ulster University/DoH commissioned pre-registration programmes.

To date, many students from the Republic of Ireland (RoI) undertake their Dietetic qualifications within Northern Ireland, which includes a supported HSCNI clinical work placement. In addition to the above developments in RoI, there has been a significant pay differential between mainland UK, RoI and NI which has impacted on the recruitment and retention of Dietitians within HSCTs. There is a financial incentive for graduates to work in the ROI which places NI Dietetic services at a disadvantage. Furthermore, the Dietetic ROI workforce review has indicated workforce challenges and significant development in community services. This will particularly have an impact on the WHSCT where 30% of the dietetic workforce travels from the South to employment in NI.

It is also anticipated that Brexit will have an impact on recruitment and retention of Dietetic positions within NI and may impact potential funding opportunities, including research and/ or cross border initiatives.

Regional Band 5 recruitment has resulted in better use of professional time however unfortunately it has not produced a sufficient pool to meet service needs, and has required top up in each of the last 3 years.

Specialisms and succession planning

With the changing complexity of medicine and clinical care, Dietitians are more often working in specialist roles within a MDT. There is limited capacity to support succession planning for specialist roles and there is a requirement for capacity to be available to facilitate upskilling new post holders.

Demographic changes and impact on dietetic capacity

It is projected that the population in NI will increase as follows by 2027:

Population < 65 years to increase by 4.68%

Population > 65 to increase by 28%

Applying these projections to current demand for dietetic services would indicate a need for an additional 6.96 WTE Dietitians for < 65 year olds and 28.7 WTE Dietitians for > 65 year olds i.e. 35.66 WTE in total.

Other considerations

Other significant challenges facing the profession are outlined in the table below:

Challenges	Description	Solutions
Service commissioning	Non recurrent monies leading to high number of temporary posts and associated staff turnover e.g. gastroenterology transformation projects Capacity required for succession planning Ability to recruit to part time posts for newly funded services	Peripatetic posts Recurrent commissioning Commissioned time for upskilling for specialist posts Commission a minimum of 0.6 W.T.E. for new resources
Post registration education commissioning	Smaller workforce leading to challenge of delivering specialist Dietetic training locally ECG budget constraints Lack of dedicated professional dietetic training capacity	Enhancement to AHP ECG budget for dietetic training to meet needs of profession Protected capacity to train others
Increasing clinical demand	Commissioned workforce is not growing to meet demand	Regular review of commissioning arrangements
Increasing complexity of conditions	Service users increasingly have multiple comorbidities and are therefore more complex e.g. critical care for Covid19 patients, multiple allergies in Paediatrics.	Regular review of commissioning arrangements
Reduced length of stay for patients	Staffing challenges and higher patient turnover impacting on ability to ensure appropriate and timely nutritional intervention to reduce bed days.	Regular review of commissioning arrangements to reflect changes in acute services regionally
Unmet need	Evidence suggests that referrers are gatekeeping referrals due to current waiting times. Patients are thus missing the opportunity to achieve best nutritional outcomes	Promotion of inpatient, specialist out-patient and elective access criteria

Stakeholder Engagement

Regional engagement

An important element of this workforce review involved stakeholder engagement in the spirit of co-production and co-design. The project team comprised of representatives from DoH, PHA, and Trusts. The Steering Group comprised of representatives from DoH, PHA, Trusts, Patient Client Council (PCC) and Staff Side.

Full details of the stakeholder engagement process are outlined in Appendix 6.
The process involved creating an engagement strategy which included:

- Use of social media, newsletters and events by the PCC
- A regional engagement event with over 150 delegates
- Local professional engagement

Information gathered through these engagement activities have been reflected in the review.

Recommendations and Action Plan

The following table summarises the projected demand for the dietetic profession over the next 10 years.

Descriptor	W.T.E.	Cumulative W.T.E.
2020 Regional HSCT commissioned baseline	**288**	**288**
To meet current staffing needs in consideration of vacancy rates plus 52 week service		
Staffing required to meet current demand (i.e.11% average regional vacancy rate x 288.3) (refer to page 20)	(32)	288
Average 7.42% maternity leave (refer to page 18)	21	309
52 week workforce (refer to page 16)	81	390
Peripatetic workforce (10%) (refer to page 20)	42	432
Demography (Pg 8 and 22)	36	468
Total	212	
Service Reform		
Outpatient reform, rebuilding and transformation (appendix 5)	23	491

Preventing hospital admission and early supported discharge (appendix 5)	123	614
Preventive care (appendix 5)	44	658
Career Progression (appendix 5)		
Total service reform	**190**	
Total numbers required to meet current service needs and service reform.	**402**	**658**

This additional dietetic capacity will also address the following:

- Reduction in projected workforce deficit caused by increased flexible working, staff maintaining a work life balance and an ageing workforce
- Reduction in workforce deficit created by an increasingly complex caseload, with increased numbers of patients with co-morbidities
- The requirement to ensure there are sufficient team lead/management roles to provide professional support and leadership across the region, providing safe and effective services.
- Figures in the table above have been adjusted to take account of dietitians currently in posts related to temporary transformational funding.

Ten year projection (2020-2030) of Dietetic workforce numbers in consideration of current DOH commissioned UU places.

Workforce commissioning considerations	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30
Maximum UU graduates available* to HSCNI based on current (21+5) 26 commissioned places. **incorporating attrition rate**	15	15	21	21	21	26	26	26	26	26
Stabilisation of 20/21 workforce	35	35	35	35	35	-	-	-	-	-

Retirements (pg 19)	3	3	3	3	3	3	3	3	3	3
Demographic demand (Pg 8/22)	3	3	3	3	3	3	3	3	3	3
Service reform	19	19	19	19	19	19	19	19	19	19
Shortfall (UU out-turn versus HSC stabilise and overall workforce requirements)	45	45	39	39	39	-1	-1	-1	-1	-1
Cumulative need beyond current DOH commissioned level through UU	**45**	**90**	**129**	**168**	**207**	**206**	**205**	**204**	**202**	**202**

* increase in dietitians available takes account of actions to address retention of students in HSC workforce.

Recommendations

Based on the findings of this workforce review the key recommendations are set out below. These have been structured under key headings and will inform the action plan.

	RECOMMENDATIONS	
Stabilise workforce capacity by reducing the current vacancy rate		

PRE-REGISTRATION TRAINING	**1**	**There is a requirement to consider unique workforce challenges faced by Dietetics Services over a sustained period and maximise the Pre-Registration Dietetic places annually to meet current and future predicted demand for graduates entering the HSCNI workforce.** **It is recommended that the following are considered in order to ensure that the workforce demand is met:** - To explore with the UU the potential to increase both the Dietetic pre-registration programmes at UU by graduants per year for the next 10 years to workforce stabilization (455), the transformation and reform agenda. -The Dietetic Profession and DOH with Education to explore alternative routes to BSc -UU, as the local provider to scope the increase in 2 year post graduate routes in partnership with the Dietetic professional leads and the DOHNI as the commissioner of education and training sources. -Professional body (BDA) to scope Open University Dietetic Degree course or apprenticeship route
RECRUITMENT & RETENTION	**2**	**Promote Dietetics within HSC as a profession of choice for prospective and current students in line with HSC workforce strategy which includes:**

		-To formalise the commitment process of UU graduates funded by DoH in line with the Welsh model to be secured for HSC NI employment for two years on qualification. This will help mitigate against the loss of new graduates from the pool to other markets/employers. - Explore the Apprenticeship model being piloted in UK. - Work is undertaken to raise the profile of Dietetics in post primary education schools and with members of the public, in line with the HR strategy. It is important to educate and inform on the full scope of the profession and communicate the benefits and positive clinical outcomes Dietitians achieve. - Review the process for Band 5 regional recruitment to include pre-registration appointments.
POSTGRADUATE TRAINING	**3**	**Prioritise Post-Graduate (PG) training and secure required funding to support the transformation agenda and Delivering Together Strategy to support Specialist and Advanced Practitioner progression including:** – Develop a proactive and robust PG training programme to support advanced clinical, public health and management roles for the transformation and reform agenda. – Develop clinical academic, research and Consultant roles which will enhance professional leadership across the profession. – Attract investment in the PG training budget to meet the needs of the transformational agenda. – DoH to ratify the training and funding for an ECG, budgeted, 3 year planning cycle to enable - implementation of the transformation agenda from a knowledge & skills context.

		– ECG budget is required to be based on the Head count of Dietitians.
WORKFORCE DEVELOPMENT & STABILITY	**4**	**Continue proactive succession planning for all levels of staff and provide access to leadership training schemes.** – There is a need to further develop peripatetic posts in dietetics across HSC to meet the constantly evolving workforce gaps and reduce the number of temporary posts.
WORKFORCE DEMOGRAPHY	**5**	– Improved workforce intelligence is crucial to the effectiveness of workforce planning – the Health and Social Care Workforce Strategy notes that action will be taken to identify and reduce gaps in workforce data.
E-HEALTH	**6**	– Ensure the current and future workforce is equipped to maximise use of E-health technologies and this is embedded in the education and training programme.

Action plan

Dietetic workforce review – action/ implementation plan 2020 – 2030

DMF = Dietetic Managers Forum (5 Heads of service) **DMNI = Dietetic Managers Northern Ireland (15 Heads of service/ managers/ team lead)**

	RECOMMENDATIONS	ACTIONS	LEAD RESPONSIBLE	TARGET DATE

Appendix 1: Regional strategies and frameworks which influence Dietetic workforce needs

The Bengoa (Expert Panel) Review was tasked with producing proposals to remodel the HSC in order to deliver safe, high quality, and sustainable services for the population in Northern Ireland. The **Bengoa Report (2016)** 'Systems not Structures: Changing Health and Social Care' states 'invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on accountable care systems for defined population based planning and service delivery'.

Health and Wellbeing 2026-Delivering Together (the government response to the Bengoa Report) focuses on putting people at the forefront of services, to enable them to stay well for longer and that any specialist interventions required are delivered to a high standard in a safe and timely manner.

This document has been developed to help shape HSC over the next 10 years to ensure services can meet the predicted demographic needs and challenges facing the region This report re-affirmed that effective workforce engagement and planning are key enablers to HSC transformation and that the far-reaching transformation journey needs the commitment and engagement of workers across every grade if it is to succeed.

The 'Delivering Together' strategy proposes a whole system transformation plan which requires cultural and operational change in order to meet future demand. This proposed transformation of HSC services is a long term goal.

'Delivering Together' provides the roadmap to take forward the work of the transformation, reform and modernisation with the overarching aim to:

- Improve the health of the population;
- Improve the quality and experience of care;
- Ensure sustainability of the services delivered; and
- Support and empower staff delivering HSC service

The Northern Ireland Programme for Government (PFG) (2017) contains 14 strategic outcomes which set a clear direction of travel and enable continuous improvement on

the essential components of societal wellbeing. They touch on every aspect of government, including the attainment of good health and education, economic success and confident and peaceful communities.

AHP Strategy 'Achieving Health and Well-being Through Positive Partnerships' 2012-2017 sets a clear framework for the key strategic directions for AHP's across NI. Within the Strategy 40 actions were identified under 4 key themes;

- Promoting person-centred practice and care;
- Delivering safe and effective practice and care;
- Maximising resources for success, and
- Supporting and developing the AHP workforce

In addition to the strategic documents mentioned above there are a range of other strategic documents which may specifically influence the future Dietetic workforce requirements.

Promoting Good Nutrition Strategy (2011)

Promoting Good Nutrition (PGN), a strategy for good nutritional care for adults in all care settings in NI, aims to ensure that any adult identified as being at risk of malnutrition will have a nutrition care plan appropriate to their needs to work towards their agreed outcomes. It identifies the ethical duty of HSC staff to recognise and treat malnutrition. The strategy covers malnutrition prevention, early identification, treatment with fortified foods through to specialist dietetic treatment including enteral feeding and parenteral nutrition. PGN outlines the steps to help participants in the decision making to understand the assessment of patient's requirements for nutrition and hydration.

Medicines Optimisation Quality Framework (2016)

The DHSSPS Medicines Optimisation Quality Framework aims to support better health outcomes for our population by focusing attention on gaining the best possible outcome from medicines every time that they are prescribed, dispensed or administered.
The Framework supports quality improvement through the consistent delivery of recognised best practice and supports the development and implementation of new, evidence based best practice. Implementation involves an innovation and change programme involving multi-disciplinary professionals working together and with patients.

The Medicines Optimisation Regional Efficiencies (MORE) Programme Board has identified nutritional products as an area to scope opportunities for further efficiencies. Work is underway to understand the current system for ordering and supply of nutritional products across primary and secondary care as well as the associated costs.

Improving Dementia Services in Northern Ireland – A Regional Strategy (2011) and the Dementia learning and development framework (2016) - make recommendations aimed at improving the services and support arrangements currently available for people with dementia, their families and their carers.

Reshaping stroke services in NI, HSCB (2017) - this strategy is currently undergoing public consultation. It is part of the recommendations made in Delivering Together which places a high priority on improving stroke services.

The plan is to reconfigure and streamline acute stroke services with specialist units that draw on national guidelines and best practice in prevention, rapid 7 day access, better emergency care including mechanical thrombectomy and clot busting treatment and better equipped Hyper-acute and Acute Stroke Units. Current services do not provide 7 day service for stroke and timely assessment is an ongoing challenge.

Diabetes Strategic Framework, DoH (2016) – this framework (and implementation plan) has been developed as a result of a review of diabetes services commissioned in 2012 and led by the Department's Chief Medical Officer. It takes account of key policies and strategies including *Transforming Your Care* (2011), *Living with Long Term Conditions* (2012) *Making Life Better* (2014). The review report made 11 recommendations to improve diabetes care in NI. One of its recommendations was for the development of a strategic direction or 'roadmap' to address the gaps in services and emerging priorities identified by the review group and inform service development. The aim of the Diabetes Strategic Framework is to realise a vision of care which improves outcomes for people living with diabetes, or at risk of developing Type 2 diabetes, including services that are:

- evidence-based and co-designed with people living with diabetes to achieve best clinical outcomes;
- person-centred and encouraging self-management;
- seamless from the service user perspective, responsive and accessible.

Children and Young People Strategy 2017-2027 –The aim of the new Strategy is "To work together to improve the well-being of all children and young people in Northern Ireland - delivering positive long lasting outcomes, which encompasses the well-being of children and young people against eight characteristics including: physical and mental health; living in safety and with stability; learning and achievement; economic and environmental well-being; the enjoyment of play and leisure; living in a society in which equality of opportunity and good relations are promoted; the making by children and young people of a positive contribution to society; and living in a society which respects their rights.

Making Life Better 2012 – 2023 Public Health Strategy - The main objective of this strategy is about people being enabled and supported to take control of their full health and wellbeing potential and to reduce inequalities in health.

A Fitter Future for All (FFFA) 2012 - a cross-Departmental framework for preventing overweight and obesity across the life course of the population of NI.

The overall aim of the framework is to:

Empower the population of Northern Ireland to make healthy choices, reduce the risk of overweight and obesity related diseases and improve health and well-being, by creating an environment that supports a physically active lifestyle and a healthy diet.

Power to People (2017) –This report highlights the impact of loneliness and isolation on wellbeing and the key role communities play in building resilience, supporting individuals and families to stay well and stay connected.

Appendix 2: Descriptor of Dietetic profession, unique role and associated service provision

Dietitians use the most up-to-date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. They use a range of communication methods and techniques, including behaviour change skills, to help people achieve positive nutritional outcomes. Their work covers prevention, treatment, education, research and development.

Clinical Practice

Dietitians are autonomous practitioners and work as integral members of multi-disciplinary teams to treat complex clinical conditions such as malnutrition, diabetes, irritable bowel syndrome, eating disorders, kidney disease, food allergy and intolerances, stroke, intestinal failure, symptom control for cancer patients, hypertension, bowel disorders and many more.

Dietitians treat people on a one-to-one basis as well as delivering education to groups of individuals with the same condition to support self-management.

Dietitians demonstrate person-centred care by using the Process for Nutrition and Dietetic Practice (British Dietetic Association, BDA) to create nutritional diagnoses, focusing on the specific problem for each individual person, agreeing goals for intervention and measuring clinical outcomes achieved. This is in line with the outcomes based accountability in the Programme for Government.

During 2016-2017 dietetic services delivered 200,000 contacts across the region.

Current service provision

- Dietetic services follow regional access criteria for inpatients and outpatients/ community services, ensuring consistency of service provision across the region.
- Dietitians in HSC have developed an extensive suite of evidence based dietetic care pathways to ensure consistent clinical practice within adult and paediatric outpatient/ community services.
- In addition to their local service provision across a range of clinical conditions, the Belfast Trust hosts the majority of regional specialist services such as Intestinal Failure and Cystic Fibrosis.
- Dietitians utilise a wide range of technology to support patient care including electronic care records such as Northern Ireland Electronic Care Record (NIECR). Telehealth systems are proactively used for remote monitoring of clients for services such as nutrition support and weight management.
- With the changing health and social care environment, advanced, extended and leadership roles have developed regionally within the profession and is an area for future growth. Advanced practitioner roles have been established in areas such as:
  - Paediatrics specialist services such as neonatal, allergy, diabetes and for children with complex needs
  - Adult services such as pre-pregnancy, diabetes including antenatal and structured diabetes education.
- Extended roles have enabled specialist Dietitians to lead the service, rather than the traditional model of being medically-led. Such services include: Gastroenterology, Paediatric Allergy services and Home Enteral feeding.

Public Health

Within this remit Dietitians advise on, plan and implement programmes to promote health and prevent nutrition related diseases. To achieve this, Dietitians work in collaboration with Government departments, local councils, community and voluntary groups. Activities include addressing inequalities in health related to food, such as food poverty and access to healthy food, and the design and delivery of health improvement programmes. Current key public health priorities for Dietitians include obesity, diabetes, cardiovascular disease, food poverty and sustainability.

Training and Education

A significant aspect of the role of the Dietitian is to provide training and education. There are three key areas within which this education may take place:

Clinical care: Supporting individuals in their clinical care through the education of patients, family members and/or carers to maximise outcomes associated with their dietary treatment and promoting self-care.

Health Care Professionals (HCPs): Enhancing the knowledge and skills of HCP colleagues in relation to nutrition and dietary information, enabling them to support clients according to their particular nutritional needs. This applies across all clinical areas and age spectrums, to ensure supportive and safe delivery of nutritional care by all.

Public Health: Educating a wide range of health care professionals, teachers and individuals/groups within other organisations including the voluntary and community sector e.g. training others to deliver nutrition programmes such as Cook-It (a healthy cooking programme) and adult weight management programmes. The aim is to expand nutritional knowledge and practical skills to empower people to make better food choices across the population.

The difference between a Dietitian and a nutritionist/ nutritional therapist

Dietitians are the only nutrition professionals regulated by law, and are governed by an ethical code to ensure that they always work to the highest standard. Only those registered with the statutory regulator, the Health and Care Professions Council (HCPC) can use the title of Dietitian/ Registered Dietitian (RD). Nutritionists, Nutritional Therapists, Clinical Nutritionists or 'Diet Experts' are not registered with HCPC. Appropriately qualified nutritionists are however, required to register with the Association for Nutrition to work in HSC.

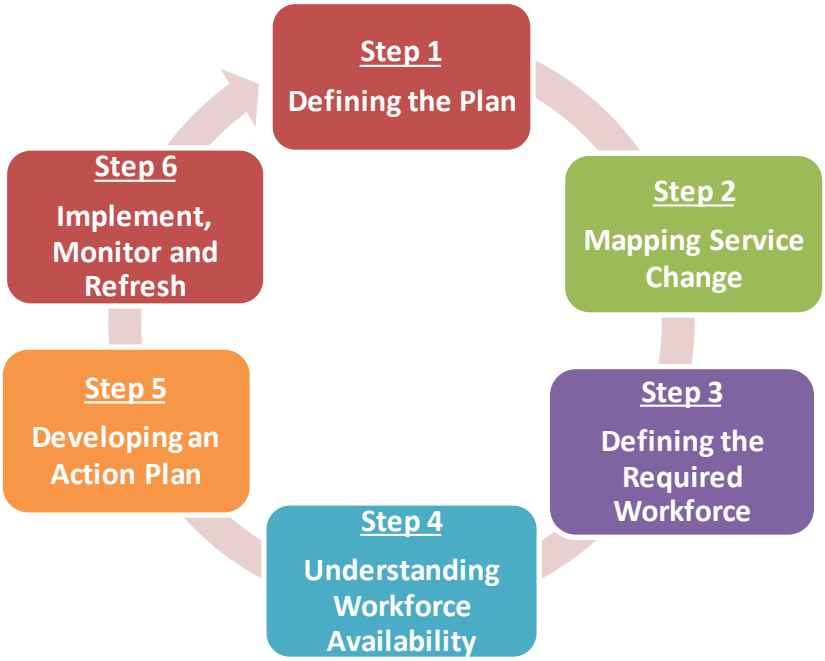
There are currently 2 registered nutritionists employed within HSC, who are professionally managed by dietetic services.

Appendix 3 Methodology for workforce planning

The Dietetic services workforce review was completed in line with the 6 step methodology outlined within the Skills for Health Regional Health and Social Care (HSC) Workforce Planning Framework as denoted in the diagram below. This allowed a sequenced framework to be adopted to complete all aspects of the workforce review.

Skills for Health

Regional HSC Workforce Planning Framework



Purpose, Aims and Objectives

The focus of the review is to ensure services across NI are both sustainable and delivered to an appropriate standard. The range of challenges faced by the HSC system including the recent transformation agenda has reinforced the need to ensure that the dietetic workforce is adequate in terms of staffing establishment and also skill set, thereby providing effective and responsive services.

To achieve this vision a number of key actions were set within the Terms of Reference, including to:

- Review the specialisms and skill set within the current HSCT services in consideration of the wider HSC transformation agenda, thereby making recommendations on workforce profile to ensure service sustainability
- Make recommendations on regional recruitment processes to ensure service sustainability and the ability to maximise capacity to deliver services
- Review the commissioning of pre-registration training places to make recommendations to the DoH, via the AHP workforce steering group to help ensure a viable recruitment pool in the future.
- Make recommendations regarding post-registration training requirements

Appendix 4: Terms of reference

Department of Health
www.health-ni.gov.uk

ESTABLISHMENT OF
ALLIED HEALTH PROFESSIONS (AHP) WORKFORCE REVIEW
DIETETICS SUBGROUP
TERMS OF REFERENCE

The Project Steering Board has been established to undertake a workforce review to support AHP practice within the HSC.

To achieve this uni-professional allied health professions working groups will be established to undertake individual professional AHP workforce reviews to inform the commissioning process.

These will function within the following terms of reference:

1. Produce a programme plan and agree processes and timescales for delivery of project outputs.

2. Ensure effective communication and engagement with key stakeholders including dissemination of information relevant to the project within each of the participating organisations.

3. Make recommendations on workforce profile to ensure service sustainability

4. Make recommendations on recruitment processes to ensure service sustainability and maximum capacity to deliver services.

5. Make recommendations on measures, including structures and skills, to align and develop information on the AHP workforce to assist with HSC-wide service transformation.

6. Make recommendations to the Department of Health regarding the commissioning of pre-registration training.

7. Make recommendations regarding post- registration training requirements.

Note: The subgroups will aim to complete their work in **12 months**.

Membership of Project Steering Group is non-transferrable, however deputies **will be acceptable** and with prior agreement of the Chair or Project Lead.

Membership of Regional Dietetic Profession Workforce Steering Group

Hazel Winning	DoH AHP Lead
Peter McAuley	DoH
Gerard Tinney	DoH Workforce planning
Catherine Donnelly	DoH Workforce planning
Alison Dunwoody	DoH Finance
Joanne O'Hagan	DoH Finance
Corrina Grimes	PHA AHP Lead
Carmel Harney	SHSCT AHP Professional Governance Lead
Eamon Farrell	SHSCT Acting AHP Professional Governance Lead
Jill Curry	NHSCT Dietetic Services Manager
Mandy Gilmore	SHSCT Head of Nutrition and Dietetics
Anne Gormley	WHSCT Dietetic Services Manager
Lucy Hull	BHSCT Dietetic Services Manager
Pauline Mulholland	SEHSCT Dietetic Lead
Ruth Balmer	British Dietetic Association (BDA) Policy Officer (Scotland and N. Ireland)
Niamh Collins	Trade Union representative, BDA

Appendix 5 Models of working and service reform

This provides a full description of a number of current service models and specialist service areas, which were introduced in response to the regional HSC strategic direction (including recent transformation monies). Some of these examples have yet to be commissioned on a regional and/or recurrent basis and if progressed will impact on future workforce needs.

As these transformation service models develop, so too will the need for Advanced Practitioner and Research Dietitians. It is estimated that there are approximately 20 Consultant Dietitian posts across the UK, whereas currently there are none in NI.

Outpatient reform and transformation

The table below summarise the key service areas, development required, benefits and outcomes.
A full detailed explained can be found after the table.

Outpatient Reform and Transformation				
Service area	**Service development / proposal**	**Benefits / Outcomes**	**Capacity & demand analysis / Evidence base**	**Staffing requirement**
Coeliac Disease Services	Implementation of Dietetic-led Coeliac review clinics.	• Release Consultant capacity • Reduce medical gastroenterology review waiting lists • High levels of patient satisfaction • Cost benefits	Based on 0.25% diagnosed incidence of coeliac disease in the NI population	16 Dietitians

Irritable Bowel Syndrome (IBS) Services	Implementation of Dietetic-led irritable bowel syndrome (IBS) service.	• Release Consultant and GP capacity • Reduce medical gastroenterology waiting lists • Support early access for diagnosis of Crohn's disease/ Ulcerative colitis • Cost savings	Gastroenterology OP targets were used and estimated % of IBS patients applied at 35% and applied as a factor of Trust population. Also anticipated to release an estimated 4,398 Gastroenterology new patient slot per year	
Cow's milk allergies (CMA)	Development of Dietetic-led services for infants with cow's milk allergy (CMA)	• Early and timely intervention • Release Consultant and GP capacity • Reduction in lengthy dietetic waiting lists • High % infants meet nutritional outcomes (90%+) • High levels parent satisfaction • Cost savings	Based on pilot in SEHSCT, modelled on population. 1.5 WTE per 70k population 0-15 year olds.	7 Dietitians

In response to the regional transformation agenda gastroenterology has been identified as a priority by the HSCB. The work plan includes prioritising Dietitian-Led Coeliac review and Irritable Bowel Syndrome (IBS) services to release consultant capacity and support early access to diagnosis for Crohn's Disease and Ulcerative Colitis. Regional multidisciplinary care pathways and the supporting business planning proposals have been developed. These are based on % of IBS patients referred to secondary care

Gastroenterology Consultants and incidence of Coeliac Disease. At present these services sit in secondary care however, they could easily be realigned to the role of the Primary Care Practitioner / First Contact Dietitian. Examples which illustrate the benefits of the dietitian led pathways are as follows:

Coeliac Disease

Gastroenterology services face increasing demand and longer waiting times for consultant gastroenterology appointments. This is a trend which is expected to continue.

In order to address long waiting times Western Trust established a dietetic led review clinic for patients with Coeliac Disease. A pilot project was set up whereby a suitably experienced and skilled advanced dietetic practitioner undertook medical review of all stable coeliac patients.

Evaluation of the project showed that it was an effective and cost effective method of review for this patent group, freeing 90% of the consultant review capacity for this patient group to address more complex gastroenterology conditions. Patients reported high levels of satisfaction with this review method.

Significant cost benefits were achieved in relation to staff pay and improvements in service delivery for gastroenterology outpatients waiting times. Clinic cost effectiveness demonstrated a 50% cost saving over a medical model.

Irritable Bowel Syndrome

South Eastern Trust piloted the proposed new pathway for IBS which involved identifying suitable patients on gastroenterology waiting lists with suspected IBS to be directed to specialist dietetic treatment. This led to a reduction in the gastroenterology waiting list and released medical outpatient capacity.

This short pilot (January to March 2017) identified 10 patients per month from one Consultants list for specialist dietary treatment. All patients who received dietary treatment achieved their nutritional outcomes including significant reduction of their IBS symptoms. Cost savings were identified as potentially £200 per patient for specialist dietetic treatment as opposed to £1,400 for the medical investigations and consultations.

Cow's milk allergies

The Programme for Government identifies one of its strategic objectives as being "We give our children and young people the best start in life". In addition Delivering Together proposes transformational change including delivering more services within primary care.

The NI Infant Feeding Guidelines (HSCB) launched in 2013 led to significant increase in referrals to dietetic services for infants with Cow's Milk Allergy (CMA). CMA for infants < 1 year requires treatment with a strict avoidance of cow's milk. Inadequate or delayed treatment increases psychological stresses with the family and can increase the likelihood of persistence of CMA and/or development of further food allergy. In response to this increased demand and with funding from The Health Foundation the South Eastern Trust piloted a multidisciplinary clinic incorporating group education and individual assessment to provide early intervention. The pilot was designed to shift the acute treatment model to primary care settings in line with transforming care. During the pilot the service also transitioned from being Consultant led to Dietitian led. The outcomes included reduction in dietetic waiting times from 52 to 6 weeks, 90% of babies met 100% of their nutritional outcomes and parent feedback demonstrated 100% satisfaction with the service. Plans are being explored to spread this model across all 5 Trusts.

Preventing hospital admissions and early supported discharge

Primary care based practitioners:

Dietitians have a critical role to play in supporting primary care services. Diet and obesity are the main factors or one of the main factors in the aetiology of many long-term conditions including diabetes, hyperlipidaemia, hypertension, stroke, heart disease and mental health conditions. This means that dietary treatment is key to the management of these conditions. Also 96% of people living with malnutrition are in the community and more needs to be done to prevent people ending up in hospital with malnutrition. In paediatrics, Dietitians can improve diagnosis and management of food allergy in infants and children.

Dietitians have a number of important impacts:

- Enable patients to self-manage their condition

- Reduce demand on GP time
- Make 'prevention' possible in community
- Manage medicines effectively and efficiently
- Reduce the need for referrals to secondary care and the need for hospitalisation
- Be part of the multi-disciplinary primary care team

Community services

By providing rapid assessment and treatment, Dietitians can reduce the number of unplanned admissions to hospital, attendances to the emergency department (ED), whilst supporting patients in the community setting in the following key areas:

- Prescribing support services
- Acute Care at Home/ Anticipatory care services
- Community stroke rehabilitation
- Enhanced Nursing Home support
- Home Enteral Feeding
- Diabetes
- Palliative Care

The elderly population are known to be at a greater risk of malnutrition and frailty. The cost associated with malnutrition within NI equates to £800 million and is projected to increase to £1.91 billion. The NICE guideline on Nutrition Support (CG32) provides Grade A evidence recommending proactive prevention and management of malnutrition, provided by healthcare professionals who are skilled and trained in nutritional requirements and methods of nutrition support. These NICE recommendations are not currently being met within NI. A relatively small investment in the Dietetic workforce (including Dietetic support workers (DSWs) and/or Dietetic assistant practitioners (DAPs)) would provide significant health economic returns as well as clinical outcomes including

- increased nutritional status,
- increased weight,

- reduced infections,
- reduced pressure ulcers and
- reduced admissions to hospital,

Thereby improving the health and quality of life for a significant percentage of the population.

Frailty rates in NI are higher than in the Republic of Ireland and there is evidence that nutrition can have a positive impact. A combination of muscle strength training and protein supplementation was found to be the most effective intervention to delay or reverse frailty and the easiest to implement in primary care (Delaying and reversing frailty: a systematic review of primary care interventions, British Journal General Practice 2018).

Diabetes affects at least 90,000 people in NI at a cost of about £1 million per day with a projected rise from 10-17% of the total HSC budget by 2025 (diabetes Strategic Framework, November 16).

Dietitians are core to the delivery of the Diabetes Strategic Framework in achieving real and significant improvement in outcomes for people living with diabetes and meeting the recommendations of relevant NICE guidelines.

The table below summarise the key service areas, development required along with the associated benefits and outcomes. Further detail is provided in the narrative following this table.

Preventing Hospital admissions and early supported discharge				
Service area	**Service development/ proposal**	**Benefits/ Outcomes**	**Capacity & demand analysis/ evidence base**	**Staffing requirement**
Primary care based practitioners/ first contact Dietitians: – Paediatric services – Adults services	To introduce paediatric and adult Dietitians within GP practices as part of GP federation	• More timely Dietetic intervention for elective services • Facilitating care closer to the service user	BDA Dietitians in primary care paper Based on 0.5 WTE per 10k GP Practice population i.e. 98 WTE (2027 population)	123 (Coeliac and IBS deducted)
Oral nutrition support in the community Prescribing support services	Expansion of regional prescribing support dietetic team. *PAAT: Currently 4.0wte B3 Dietetic*	• Currently supporting primary care services, patients who are currently not under HSCT dietetic services. This may be negated if First Contact and Care home models are in place • Expand to other prescribing areas such as gluten-free products,		

Dietetic services providing enhanced nutritional care for residents in care homes - Prevent, Anticipate and Avoid, Treat (PAAT) model - Healthcall Undernutrition service	*Support workers SEHSCT* *Healthcall: remote monitoring service currently in care homes across SHSCT, with rollout in WHSCT and within the NHSCT–led regional Prescribing Support Dietetic Team and NHSCT anticipatory care (acute care at home) service*	paediatric ONS and milk substitutes • Training/education support to HCPs • Cost benefits • Early assessment and proactive focussed dietetic treatment • Appropriate prescribing of ONS • Improved efficiency of service, appropriate skill mix use • Increased weight and improved nutritional status of residents • Appropriate nutrition care planning • Reduction in pressure ulcers, infections • Reduced GP visits/contacts • Ongoing training provided • Cost benefits	4.0 B3 DSWs in SEHSCT for care homes 5.0wte Band 3 DSW to support approx. 8,000 contacts/ year 1 additional Dietitian/ Trust and requirement for Dietetic Support workers	

Home Enteral Feeding Coordinator Service	Development of Home Enteral Feeding Co-ordinator service. *Currently 1.1wte B7 Dietitian (adult services) SHSCT.*	• Support hospital discharges and provide care in the patient's own home • Avert ED attendances • Reduce hospital admissions • Minimise tube-related problems (replacements, blockages, broken) • Ongoing training and support to patients, carers and staff	Based on model of service delivery in SHSCT. National benchmarking of 1.0wte Dietitian per 80-100 patient caseload (adults & paediatrics)	
Enteral Tube Feeding and Parenteral Nutrition services	Implementation of Nutrition Support Teams (NST) to include Dietitians in acute HSCTs	• Dietitians involved in care of all patients requiring these alternative feeding methods, to assess and monitor nutritional requirements • Reduce complications • Reduce unnecessary treatments • Reduce costs	Based on NICE Clinical Guideline 32 – Nutrition support – all acute hospitals should have a multi-disciplinary NST, with Dietitians as key members 1.0 WTE per Trust for NST.	

Acute Care at Home	Acute Care at Home model and/or Multidisciplinary 'frailty' models of care in Emergency departments (ED) and supporting medical assessment units/ hubs	• Rapid dietetic assessment and treatment in patients own homes/ED services • Reduce number of unplanned hospital admissions • Reduce the number of attendees in the ED or GP Out of Hours • and/or introduction of 'frailty' screening in ED • Support earlier discharge from hospital • Reduce the demand for nursing home based care and intermediate care services	1.0wte/MDT Acute Care @ Home model – approx. 35 - 40/caseload. Require 1.0wte B7 for every 30 patients, based on current service models i.e. 5 WTE 1 wte B4 Dietetic Assistant Practitioner (DAP)/ professional WTE	
Stroke Rehabilitation - Acute - Community	Dietitians as core members of Acute and Community Stroke Rehabilitation teams	• Prioritised care/ timely intervention for dysphagic/ malnourished patients • Support continuous service transition to home	Based on national recommendations: 0.3wte Dietitian and 0.3wte Dietetic Support Worker (DSW) per 10	

	Currently 0.3 wte Dietitian SEHSCT (providing a limited service).	setting, following an acute stroke episode	patients i.e. 10 WTE	
Diabetes patient care	Development of dietetic services within diabetes across key work streams including inpatient care, pregnancy services, transition, patient education, foot care, insulin pumps and other technological services, primary prevention	• Improved quality of life • Improved blood glucose control • Reduced hospital admissions/amputations • Reduction in long term conditions • Enhanced self-management • Reduced spend on inappropriate medications • Consistent approach for structured patient education (SPE) • Reduction in rise in obesity	As per Diabetes Strategic framework modelling and anticipated 35% increase in incidence i.e. 9 WTE	
Specialist Palliative Care (SPC)	To meet recommendations within the interdisciplinary specialist palliative care workforce review in term of	• As part of the SPC team, Dietitians help improve the quality of life for those with complex palliative and end of life care needs and improve the experience of those important to	REF interdisciplinary Specialist Palliative Care Workforce review 2018 10 WTE Dietitians as per Specialist	

	increasing WTE and post graduate qualification in palliative care	them as in addition to reduced unscheduled care use. Specialist Palliative Care (SPC) Dietetics are involved in the care of individuals with more complex and demanding care needs. Their job plan includes the four key elements of the specialist practitioner role: – Expert clinical practice – Provision of formal and informal education – Research audit and development of best practice guidelines – Service improvement and leadership. • Specialist Palliative Care AHPs require a greater degree of	Palliative Care Workforce Planning Report Oct 2019 Palliative Care in Partnership	

		training and expert knowledge.		

Promoting Good Nutrition strategy – Dietetic services

Within the HSC settings much is being progressed to improve the care of individuals who are either at risk of or have malnutrition. The Promoting Good Nutrition (PGN) strategy is currently being applied within the community setting, focussing on older individuals in receipt of HSC services. In addition to the Dietitian's role in provision of awareness sessions and training of other health care professionals, the services provide individualised assessment and treatment.

In addition to PGN and as previously mentioned the MORE programme board has identified nutritional products as an area to scope for further efficiencies. The following examples illustrate where Dietitians are already contributing to this strategic agenda that demonstrate improvements for the nutritional care of patients that may be built upon in the future.

Prescribing Support Dietetic Team

The NHSCT-led regional Dietetic Prescribing support team is currently reviewing nutritional status and associated needs of patients within primary care who are on oral nutritional supplements, with the view to improving their nutritional status. There is potential for this role to expand into other health conditions where individuals are "prescribed" nutritional products such as gluten free foods or milk substitutes. Depending on the model applied, this may lead to an increased need in workforce to deliver education and training, as well as direct service user care.

Admission avoidance and early supported Discharge

The above term refers to a number of approaches which provide high quality treatment and care for people in acute crisis who would normally be sent to a local emergency department (ED) for assessment and admission. The service may provide short-term support to elderly patients in their own homes through the provision of rapid assessment and treatment.

An “Acute Care at Home” (anticipatory care) service is one such model, which would provide triage, assessment and treatment where appropriate as an alternative to in-patient care specifically to those at risk of or potentially requiring admission to hospital, i.e. in the absence of such care, they would otherwise require inpatient treatment. The Acute Care at Home Team, which should include Dietitians will also support appropriate earlier hospital discharge for those who have required hospital admission. The service aims to:

- Adopt a patient focused holistic approach to care to support
    - assessment of need,
    - patient empowerment,
    - patient choice and control,
    - rehabilitation,
    - medical diagnosis and management.
- Reduce the number of unplanned hospital admissions as well as ED and Out of Hours (OOH) attenders
- Impact on bed days in both acute and non-acute facilities
- Reduce the demand for nursing home based care and intermediate care

Community stroke rehabilitation team

Dietitians have a role in specialist assessments and interventions for nutrition for stroke patients.

An early supported dietetic discharge service was set up within the Community Stroke Rehabilitation Team in South Eastern Trust in 2016. The aim of the service was to provide continuous service transition to the home setting for patients following admission for an acute stroke. Prioritized patients were those with malnutrition or at high risk and those with dysphagia. Within the 6 week rehabilitation period the majority of patients achieved their nutritional outcomes.

Current dietetic capacity for stroke services across NI is below national recommendations of 0.3wte dietitian and 0.3 DSW per 10 patients with stoke. Thus to fully realise these outcomes across all stroke services additional dietetic workforce capacity would be required.

Enhanced Nursing Home support

With the growing ageing population and the high incidence of malnutrition in care homes, new ways of working to support patient's nutritional needs have been tested as described below:

Prevent, Anticipate and Avoid, Treat (PAAT)

A pilot project in care homes in South Eastern Trust in 2013/2014 demonstrated that there was minimal or no proactive review of the nutritional care plans of patients after discharge from dietetic care. This led to 70% of patients having a nutritional care plan that was not in line with their nutritional need. To address this, the 'Prevent, Anticipate and Avoid, Treat (PAAT) model was developed. Dietitians, Dietetic Support Workers (DSW) and care home staff jointly manage the care of residents with monthly reviews of nutritional information via a virtual electronic data set. Dietitians anticipate and avoid deterioration of patient's nutritional status through early identification of potential problems and direct DSW's and care home staff in appropriate treatment to address this. DSW's review nutritional information and support care home staff with treatment plans. They only escalate patients to the dietitian for assessment or review when required, thus demonstrating skill mix and efficient use of staff resources.

The positive outcomes from this service include:

- Early assessment and treatment
- More appropriate use of fortified food
- Appropriate use of oral nutritional supplements (ONS)
- Increased weight and improved nutritional status of residents
- All patients are on an appropriate nutritional care plan
- Reduction in pressure ulcers
- Reduction in infections
- Reduced GP visits/contacts
- Direct referrals by care home staff
- Ongoing training of care home staff
- Improved relationships with care home staff and relatives
- Up to date nutritional information for Social Care Managers and RQIA
- Actual cost savings per year of £83,000 on nutritional supplement across care homes in South Eastern Trust area as well as estimated health economic savings of £146,000 with more appropriate nutritional care

Healthcall Undernutrition service

A service is in place in care homes across Southern HSC Trust 'Health Call Undernutrition Service' which uses an automated remote monitoring service for adult patients identified as at risk of malnutrition and/or are prescribed oral nutrition supplements (ONS).

Information is collected via a secure web portal about patients' weight, appetite and compliance with taking their prescribed ONS. The service then assesses the data and raises alerts based on changes in weight, risk of undernutrition (MUST) and compliance with ONS or appetite. The majority of review care is undertaken by a Dietetic Support Worker (DSW).

Overall the service demonstrates:

- *Improved safety* i.e. improved accuracy of 'MUST' recording, improved nutritional status
- *Improved quality* i.e. staff/families feel better supported, there is improved joint working with care homes, Dietitians provide proactive focused intervention when problems are identified, driving good nutritional care
- *Improved cost effectiveness* i.e. there is more appropriate prescribing of ONS with associated cost savings, and also a reduction in domiciliary appointments with associated travel cost savings
- *Improved efficiency* i.e. improved access to dietetics for care home staff, Care homes are only contacted about residents that require input thereby reducing intervention time. There was improved skill mix with the use of the DSW, enabling Dietitians to focus on more complex work and meet other demands.

With the appropriate dietetic capacity the above models of working and their benefits could be expanded to other Trusts across NI.

Enteral tube feeding and Parenteral Nutrition

Enteral tube feeding is a treatment used to feed people artificially via a feeding tube through the nose into the stomach or directly into the stomach or bowel. People needing this treatment usually have lost their ability to swallow or may need nutritional support due to underlying medical or surgical problems. Parenteral nutrition is treatment for

patients who rely partially or totally on artificial nutrition via an intravenous route into their bloodstream. All enteral and parenteral nutrition patients should have their nutrition requirements assessed and monitored by a Dietitian.

The majority of patients on an enteral feed are under the care of a dietitian who will assess and monitor their nutritional requirements and manipulate their feeding regimen accordingly as per care standards.

The assessment and management of patients on parenteral nutrition by a Dietitian varies across Trusts. NICE Clinical Guideline 32 – Nutrition Support - recommends that all acute hospital Trusts should have a multi-disciplinary Nutrition Support Team (NST) with Dietitians as one of the key members. Across the region there is only 1 HSCT which has a NST.

NICE advises that a NST will decrease complications and costs through reductions in unnecessary treatments and prevention of complications. Additional dietetic workforce capacity is required to realise these benefits.

Home Enteral Feeding Co-ordinator service

The role of the Home Enteral Tube Feeding (HEF) Co-ordinator is to lead the planning and co-ordination of the adult enteral tube feeding service supporting hospital discharge and those adults who are enterally tube fed in the community.

Within Southern HSCT, the established adult HETF service supports over 100 adults who are receiving enteral tube feeding in their own home, in nursing homes or in supported living.

From 1/4/16 to 31/3/17 this service averted 206 attendances at Emergency Departments. There were:

- 158 planned tube replacements
- 29 unplanned tube replacements
- 2 feeding tubes unblocks
- 17 broken tube repairs

The HEF Co-ordinators also provide significant ongoing training and support to patients/carers and staff.

This is a service that continues to demonstrate major benefits to patients and carers in the community and should be available across all the Trust areas for both paediatric and adult services.

Diabetes

The implementation of the Regional Diabetes Strategic Framework is being led by a Regional Diabetes Network via 13 work streams. Priorities for the first 3 years that impact on dietetic services include pregnancy, patient education, foot care pathway, primary prevention, pumps and other technological services. Significant dietetic resource will be required to support this implementation and achieve positive outcomes for people with diabetes.

Public health/ preventative Care

The development of the role of the Dietitians in Public Health supporting prevention programmes is crucial for the Public Health agenda, particularly with the obesity crisis.

'Health and Wellbeing 2026 - Delivering together' paper outlines the need to support people to lead healthy and active lifestyles focusing on a preventative and person centred models. "Our Hearts Our Minds" in WHSCT is a pan vascular prevention programme developed by researchers at Imperial College, London and at Crios, Galway that reduces the risk of heart disease and stroke. The foundation of the programme is

healthy lifestyle changes (smoking cessation, healthy diet, regular physical activity) delivered in a family based model.

Patients with chronic long term conditions such as diabetes need the support to be empowered to self-care.

NICE guidelines 'Weight management: lifestyle services for overweight or obese adults', 2014 (PH53) recommend weight management lifestyle services are commissioned and developed with the input from a registered Dietitian. These guidelines also recommend training for lifestyle weight management programme staff is delivered by registered Dietitians. NICE guidelines 'Weight management: lifestyle services for overweight or obese children and young people', 2013 (PH47) also recommend all lifestyle weight management programmes are designed and developed with input from a registered Dietitian. These NICE guidelines are not currently being equitably met across NI.

The table below summarise the key service areas, development required, and the associated benefits and outcomes. It is recognised that prevention will have an impact on obesity levels however this will take more than 10 years to realise the population level impact.
A full detailed explained can be found after the table.

Preventative Care

Service area	Service development/ proposal	Benefits/ Outcomes	Capacity & demand analysis/ Evidence base	Staffing requirement
'Our Hearts Our Minds' programme	Vascular prevention - programme for those with established cardiovascular disease or those who are a high risk of developing the disease. Dietitians are an integral part of the multidisciplinary team.	The fundamental principles of the My Action programme are derived from the successful EUOROACTION study ; Programme foundation is the promoting of a healthy lifestyle- smoking cessation, healthy food choices, regular physical activity in community settings Risk factor management and adherence to prescribed cardio protective medications.	Pan European model, currently transformation project in WHSCT 21 WTE Dietitians based on 1 WTE per 90K population as per Our Hearts Our Minds modelling	44 Dietitians
Specialist weight management services	Regional bariatric services		WHSCT development bid based on Canadian pilot of bariatric services	

			6 WTE – 1 WTE Band 7 per Trust for Tier 3 obesity management plus 1 WTE 8a for Tier 4 surgery.	
Public Health and Obesity	Development of the Public Health Dietitian role and dietetic services in prevention programmes, such as: – Early years nutrition programmes – Nutrition standards for school meals – Cook It programmes (to develop cooking skills) – Weigh to a Healthy Pregnancy weight management programme	▪ Equity of access to these services across HSCTs ▪ Dietetic support for communities to increase their nutritional knowledge and skills ▪ Dietetic education, support and resources to food poverty schemes, including Food Banks ▪ Reduction in overweight/obesity levels across the population ▪ Improvement in uptake of healthier food choices ▪ Improvement of nutrition provision in HSC facilities	Dietitians/ DSWs to be involved in all programmes (planning through to implementation, based upon yearly commissioned plans from PHA) Some posts are already funded internal by Trusts and some are funded recurrently by PHA/ DE	

	(for patients with a Body Mass Index >38) – Community adult weight management programme – Minimum Nutritional Standards for Catering in HSC *Currently variable wte across HSCTs, across the various programmes.*	for staff and visitors	However over the last 2-6 years team have grown, but this growth has not been matched with adequate staff at Band 7 team lead level, to operational and professional manage the current staff in some Trusts 1 WTE per GP Federation are i.e. 17 WTE	

Public Health and Obesity

At present access to these prevention programmes is limited by location and criteria for engagement set by Community and Voluntary provider organisations. The FFFA programme report (June 2016 - June 2017) recognises the following changes since the 2010/2011 position:

- Slight reduction (1.7%) in overweight and obesity in P1 school children
- 4% increase in children reporting eating 5 portions of fruit and vegetables per day
- 1% increase in overweight and obesity in adults
- 2% reduction in overweight in adults
- 3% increase in obesity in adults

The Regional Obesity Prevention and Implementation Group (ROPIG) is a multiagency strategic group which was set up to facilitate the implementation of the Fitter Futures for All (FFFA) strategy. Annual action plans have been agreed for the past few years and include many aspects which require Public Health Dietitian involvement including:

- Early years nutrition programmes
- Nutrition Standards for school meals
- Cook It! programmes
- Weigh to a Health Pregnancy
- Adult weight management programmes
- Minimal Nutrition Standards for catering in HSC

Additional Public Health Dietitians and DSWs are required to deliver the expansion and spread of the above programmes to fully realise the aspirations of FFFA in prevention of obesity in the population in NI. This additional capacity will enable Public Health Dietitian to equip a wider range of communities with the knowledge and skills to plan, purchase and prepare healthy food choices for individuals and families.

ROPIG recognises that the poverty agenda in NI influences food choices, healthy eating and thus obesity. With current pressures on household budgets there has been an expansion in the number of food banks and food poverty schemes in operation. Public Health Dietitians work collaboratively with a range of these organisations to provide education, support and resources which promote donation, selection and preparation of healthy food choices.

One example is where Public Health Dietitians from Belfast Trust currently offer Good Food Toolkit training to food banks volunteers in the Belfast locality. These Public Health Dietitians have also worked collaboratively to coproduce suitable recipe booklets to promote healthy food to clients using food banks. Again to realise the aspirations of FFFA this work needs to be expanded and spread across the whole of NI.

<u>Minimum Nutritional Standards for catering in Health and Social Care</u>

The Food Standards Agency, the Public Health Agency and *Safe*food led the development of minimum nutritional standards for HSC settings through the ROPIG programme. The standards apply to all facilities that serve food and/ or beverages to staff and visitors operating within HSC settings including catering facilities as well as private retail and vending machines. A regional post for a Registered Dietitian/

Nutritionist has been created to support the roll out and implementation of the standards across HSCNI.

This post is being supported by Public Health Dietitians to provide accredited training for catering staff to enhance their knowledge of healthy food provision.

Succession planning and career progression

The following table provides information on the need for succession planning and career progressions:

Service area	Service development / Proposal	Benefits/ outcomes	Capacity & demand analysis / Evidence base
Research and development	Commissioning and implementation of dedicated dietetic roles within the area of research and development	▪ Provides new or additional evidence which will direct clinical practice and commissioning ▪ High quality clinical practice informed by the best available, up to date evidence ▪ Improved patient care and outcomes ▪ New ways of working ▪ Collaborations with research institutions	Development of joint posts with research institutions

Dietetic Support Worker (DSW) & Assistant Practitioner (AP) roles	Enhancement of DSW opportunities and commissioning and development of Dietetic Assistant Practitioner roles	▪ Leadership and strategic visioning across HSC and for the profession ▪ Clearly defined career pathway ▪ Ability to release time of other health care professionals, particularly Consultants/GPs, enabling them to focus on their workloads on areas requiring their expertise ▪ Appropriate skill mix ▪ Profession fit for new ways of working and transformational care ▪ Efficient and effective working	B3 and B4 positions will be required in order to support and enhance skill mix across Trust wide Dietetic services
Dietetic Apprenticeships	Development of Apprenticeships – currently under exploration by the British	▪ Sustainable supply of Dietitians	Provides opportunity for B3/B4 development to registered status - whilst

	Dietetic Association		supporting professional workforce needs
Management roles			Need for assistant/deputy manager positions to support service development/ improvement and strategic planning and protect clinical time.
Supplementary prescribing status for Dietitians	Development of a new skill set for Dietitians to enhance clinical care *New service development*	▪ Developments in new service areas such as parenteral nutrition, diabetes, kidney disease and gastroenterology ▪ Prevent delays in obtaining prescriptions ▪ Resolve diet and medication issues at an earlier stage, without requiring a hospital visit	Backfill to support the training of these Dietitians

		▪ Patients have a single point of contact ▪ Reduce burden on Consultant /GP time for prescriptions	

Non-medical prescribing

The dietetic profession across the UK has achieved primary legislation to enable dietitians to be supplementary prescribers. Secondary legislation is awaited in NI. The dietetic profession are awaiting legislation to be passed in NI for Dietitians to become supplementary prescribers. Examples of where this new skill set will be utilised include for prescribing of parenteral nutrition and medications for diabetes, kidney disease and gastroenterology conditions.

Dietitians in the UK who are supplementary prescribers are making a significant difference to patient care, clinical services and dietetic practice including:

- Prevent delays in obtaining prescription following dietetic advice
- Resolve issues with diet and medication at an earlier stage without the need to visit the hospital
- Patients have single point of contact
- Decrease burden on consultant clinic time and GP appointments solely to obtain a prescription.

Appendix 6: Regional Stakeholder Engagement

Regional Stakeholder Engagement

An important element of the review involved stakeholder engagement in the spirit of co-production and co-design. The Project Team comprised of representatives from DoH, PHA, and Trusts. The Steering Group comprised of representatives from DoH, PHA, Trusts, Patient Client Council (PCC) and Staff Side.

An engagement strategy was discussed at Steering Group level. It was agreed a collective communications effort regionally would be important to encourage service user and carer involvement. This input to the review process would ensure solutions were coproduced appropriately.

The PCC undertook a digital communications strategy to support the involvement agenda. This included social media postings across Facebook and Twitter; published article updates in PCC monthly newsletter with a reach of 15,000 across Northern Ireland and event listings on PCC website for 'Engage' events.

In addition, the Project Group hosted an 'Engage' event on Friday 13th April 2018 at Craigavon Civic Centre. Over 150 delegates registered to attend the event from across the statutory, independent sector, staff side, carers and users. The purpose of the event was to consult on the development of the draft Allied Health Professions Workforce Review with a Focus on Dietetics, Podiatry, Orthotics and Radiography. The event took the format of an interactive e-participation 'Engage' session.

The engage discussion focused on four main topics:

Question 1 – Recruitment – What needs to be done to attract the right people with the right skills into these professions?

Question 2 – Retention – What needs to be done to make the HSC a brand that People aspire to work for?

Question 3 – Workforce Planning Process – Are there any gaps in the process that you would wish to have addressed?

Reflection – Having discussed all of this today, what would you now suggest as the top priority for the AHP workforce reviews to deliver?

The 'Engage' method combines the live aspect of small-scale discussion with information and communication technologies; on one hand it allows rapid transmission of work-group results to a plenary assembly; while on the other it permits surveys of individual participants' opinions through a polling system. Information gathered at the engage event has been reflected in the review. Each of the round table groupings at the event were asked to prioritise their responses in each topic and the top responses captured.

The Public Health Agency (PHA) is carrying out an extensive piece of work across all Health and Social Care Trusts (HSCTs), with the aim of introducing a more patient-focused approach to services and shaping future healthcare in Northern Ireland. The '10,000 Voices' project now '10,000 more voices', gives patients, as well as their families and carers, the opportunity to share their overall experience highlighting anything important, such as what they particularly liked or disliked about the experience. The project is supported by a software package called sensemaker & the National Health Service in Northern Ireland are among the earliest users of SenseMaker®.

Personal and Public Involvement (PPI) is the active and effective involvement of service users, carers and the public in the design, development, delivery and evaluation of Health and Social care (HSC) services. Personal and Public Involvement (PPI) is now a

legislative requirement for Health and Social Care organisations as laid down in the Health and Social Services (Reform) Northern Ireland Act 2009. While PPI may be relatively new term, the concept is not. The HSC system has long recognised the benefits of meaningful and effective engagement of service users, carers and the public. Within all Trusts in the region Dietitians are actively involved in building partnerships and networks with service users, adults and children, carers, families, charitable organisations, user forums, voluntary organisations and other agencies including councils, education, police, Ambulance and Fire Services, to identify some areas.

Local professional engagement

The profession itself leads on engagement with all staff members, support and professionally qualified who in turn are potential service users as well as providers of services.

Innovative approaches have enabled partnership development of quality improvement projects/services through the use of service user stories, reflection, learning and joint working with service users and Dietitians. As a result of events like these new service models have been implemented and learning from what works for service users has resulted in service user centred services.

Throughout the process, Dietetic managers have engaged with HSCT colleagues e.g. consultants, HSCB, network managers, assistant directors and AHP Leads. Other partners such as service users, local commissioning groups/ integrated care groups, community and voluntary organisations and care home providers have been involved in discussions and encouraged to submit their views on professional workforce development needs. Social media, such as Facebook and Twitter, has been used to highlighted the workforce review and encourage service users to view their opinion and engage within the stakeholder event.

As a means of engagement with the potential future Dietetic workforce, Dietetic services within the HSCTs link with 'Work Inspiration' in providing career workshops targeting students within secondary/ grammar schools to promote and explain the remit of the profession.

Appendix 7: List of abbreviations.

List of abbreviations

AHP - Allied Health Professions

AP – Assistant Practitioner

BDA – British Dietetic Association

BHSCT – Belfast Health and Social Care Trust

CMA – Cow's Milk Allergy

COPD – Chronic Obstructive Pulmonary Disease

CVD – Cardio Vascular Disease

DAP – Dietetic Assistant Practitioner

DE – Department of Education

DHSSPS – Department of Health and Social Services

DMF – Dietetic Managers Forum

DoH – Department of Health

DSW – Dietetic support Worker

ECG – Education Commissioning Group

ED – Emergency Department

FFFA – A Fitter Future for All

GP – General Practitioner

HCPC – Health and Care Professions Council

HCPs – Health Care Professionals

HEF – Home Enteral Feeding

HR – Human Resources

HSC – Health and Social Care

HSCNI – Health and Social Care Northern Ireland

IBS – Irritable Bowel Syndrome

MDT – Multidisciplinary team

MORE – Medicines Optimisation Regional Efficiencies

MUST – Malnutrition Universal Screening Tool

NHSCT – Northern Health and Social Care Trust

NICE – National Institute for Health and Care Excellence

NIECR – Northern Ireland Electronic Record

NISRA – Northern Ireland Statistics and Research Agency

NST – Nutrition Support Team

ONS – Oral Nutrition Supplements

OOH – Out of Hours

PAAT – Prevent, Anticipate and Avoid, Treat

PCC – Patient Client Council

PFG – Programme for Government

Pg – page

PG – Postgraduate

PGN – Promoting Good Nutrition

PHA – Public Health Agency

PPI – Personal and Public Involvement

RD – Registered Dietitian

RoI – Republic of Ireland

ROPIG – Regional Obesity Prevention and Implementation Group

SEHSCT – South Eastern Health and Social Care Trust

SHSCT – Southern Health and Social Care Trust

SPC – Specialist Palliative Care

SPE – Structured Patient Education

SWDG - Strategic Workforce Development Group

TIG – Transformation Implementation Group

UU – Ulster University

WHSCT – Western Health and Social Care Trust

WTE – whole time equivalent

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