

# **PRIORITIES FOR ACTION**

**2009-10**

**March 2009**

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## FOREWORD BY THE MINISTER

I am issuing these Priorities for Action at a momentous point in the development of Health and Social Care in Northern Ireland. The year 2009-10 marks the completion of the fundamental reform of planning, commissioning and delivery of care to our population. April 2009 should see:

- The five new HSC Trusts begin their third year of providing integrated health and care
- The establishment of the new Health and Social Care Board, with the remit to plan and commission services across Northern Ireland, and with its Local Commissioning Groups ensuring that the services available reflect the differing needs and priorities in each of the five localities. A key priority for the Board will be to lead the continuing drive for improved efficiency and performance
- The establishment of a new Public Health Agency. In pursuit of its aim to improve health in general and to reduce health inequalities, the Agency will focus on better co-ordination of health and social care interventions. Part of its function will be to allow the views of local government to influence health improvement programmes.

The new structure of the HSC system is the product of much thought, discussion and consultation. It is designed to endure, and to support a longer term push for improvement in overall health and in the treatment and care that we can offer the individual. In the last two years we have made striking progress in the responsiveness of service – most obviously in transforming hospital waiting times, but also in access to other forms of professional treatment, in substituting for institutional care a greater reliance on community-based services, closer to people's homes and their families.

We have also witnessed sustained improvement in the outcomes for patients in a large number of serious conditions – for example, in various forms of cancer and in coronary heart disease. Our investment in state-of-the-art facilities and equipment, combined with the skill and evidence-based approach of HSC professionals, is paying off.

My 2009-10 Priorities for Action will, therefore, build on a secure organizational foundation and will gain from the momentum of improvement generated over recent years. In progressing towards the commitments and standards set out in the Programme for Government 2008-2011, my Priorities will benefit patients and other service users across the

full spectrum of HSC programmes of care. But if I had to single out one beneficial outcome from among the many that the HSC produces, it would be this: a more equal quality of life for all.

There are many aspects to that ideal, and many contributory factors – most of which are now firmly in place: a trained and dedicated workforce, functioning in a fit-for-purpose working environment; an ethos that stresses not just professional expertise but that respect for individual dignity which is crucial to the service user's experience; and access to the latest technology to enable staff to give of their productive best.

All of these will move us further along the road to a society where health status is not so aligned with economic status. There are, however, two additional and essential ingredients. The first, which is within the HSC's own gift, concerns the need for balance in the commissioning and delivery of services. We no longer tolerate the existence of 'cinderella services', where under-investment is fatalistically accepted as a fact of life. The priority we now give to mental health and learning disability, for example, shows that we have indeed moved on.

The second essential ingredient is not something we can control, but it is something we must influence. The attitude of the individual is critical to his or her prospects for health and well-being. People need to take personal responsibility for their own and their family's health. Without that core sense of responsibility, all the efforts of HSC professionals – however prompt, however skilled, however caring – will not have their full effect. We can – and I certainly expect that we shall – meet all the standards specified in this document, but prevention is proverbially better than cure.

The new Public Health Agency will undoubtedly have a leading role to play in helping people improve their physical and mental health and quality of life. But everyone working in the field of health and social care has a part to play in curbing unhealthy habits such as smoking, bad diet and lack of exercise. By doing so we not only reduce the incidence of disease associated with those habits; we also release resources and energy for even better and more immediate treatment of unavoidable conditions. That is the prize to be gained in meeting the standards and targets contained in my Priorities for Action 2009-10.

I want the message to be very clear – I have high ambitions and high demands for improvement in the services we deliver – because the people we serve deserve and expect

no less, and I am extremely proud of the major successes that have been achieved in the last few years, notably by the new Trusts. And I also recognise very clearly that there are many other responsibilities which the HSC organisations must fulfil in addition to the priorities and targets set out here. The challenges are great, but I believe we can and will deliver.



**Michael McGimpsey**

Minister of Health, Social Services & Public Safety.

## **1. INTRODUCTION**

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

The Minister's expectation, for 2009-10 and beyond, is that the public will see continuing and substantial improvement to services in 10 priority areas, with resultant progress towards the objectives and targets set out in the Programme for Government (PfG) 2008-11 and associated Public Service Agreements (PSAs).

### **PSA Targets 2008-11**

The vast majority of the targets specified in PSA (see Annex 1) are to be achieved over a three-year timeframe i.e. by March 2011. It is essential that Commissioners and Trusts ensure that satisfactory progress continues to be made towards each PSA target; to this end, this PFA document specifies the interim milestones to be achieved and/or the associated actions to be taken by March 2010. Commissioners and Trusts must also ensure that the substantial additional development monies that have been made available for 2009-10 are translated as quickly and effectively into additional services on the ground.

### **Performance focus for 2009-10**

In addition to the PSA target milestones, this PFA document specifies a number of areas where the Minister requires particular focus is to be given during 2009-10 to secure:

- The maintenance of minimum standards of performance, typically rolling forward the March 2009 target positions; and
- The achievement of improvements in performance, typically with targets to be achieved by March 2010.

Taking account of the above, Commissioner and Trust performance over the 12 months to March 2010 will be judged on the basis of:

1. Satisfactory progress towards each of the PSA targets for March 2011, in particular the achievement of the specified March 2010 milestones and associated actions
2. The ongoing maintenance of the minimum standards of performance for 2009-10 detailed in this document
3. The achievement of the targets and actions for 2009-10 detailed in this document.

## 2. MINISTERIAL STANDARDS AND TARGETS FOR 2009-10

### PRIORITY AREA 1: IMPROVING HEALTH AND WELL-BEING

It is estimated that preventable ill health accounts for over 6,500 avoidable deaths per annum in Northern Ireland. There are, moreover, unacceptable inequalities in health often associated with socio-economic status and disadvantaged areas. Addressing these issues through the promotion of good health and well-being, the prevention of illness and injury, early intervention and good long term care remains a key priority for the Department and the HSC, in particular the new Public Health Agency.

The central aims of the 20-year Strategy 'A Healthier Future' are encapsulated in several of the Department's PSA targets for 2011 within the Programme for Government.

Commissioner and Trust plans will be expected to demonstrate how satisfactory progress will be made during 2009-10 towards the achievement of these targets. Particular focus should be given to addressing the continuing health inequalities in NI.

The specific standards and targets to be achieved in 2009-10 are as follows:

- **Life Expectancy (linked to PSA 1.1):** by March 2010, the Public Health Agency should produce a health improvement plan to address health inequalities at both regional and local levels, clearly identifying actions to be taken by key stakeholders and taking account of any issues emerging from the review of Investing for Health.
- **Smoking (linked to PSA 1.2):** by August 2009, the Public Health Agency should develop an action plan to improve access to smoking cessation services for manual workers.
- **Obesity (linked to PSA 1.3):** from April 2009, the Public Health Agency should continue to ensure that effective arrangements are in place for the collection and recording of BMI data through the School Nursing Service. By December 2009, the Agency should ensure that a pilot programme is in place in each Trust area to provide support for those children identified through the monitoring process as being obese or at particular risk.
- **Reducing the harm related to Alcohol and Drug Misuse (linked to PSA 1.4, 1.5, 1.6, and 1.7):** by March 2010, the Public Health Agency should produce an integrated action plan to take forward the relevant regional and local elements

contained within the overarching New Strategic Direction for Alcohol and Drugs, the Young People's Drinking Action Plan, and the Hidden Harm Action Plan.

- **Suicide (linked to PSA 1.8):** from August 2009, the Public Health Agency should ensure that updated local suicide prevention action plans are in place and being implemented.
- **Births to teenage mothers (linked to PSA 1.9):** by March 2010, Commissioners and Trusts should achieve a 40% reduction in births to mothers under 17.
- **Bowel cancer screening (PSA 1.11):** by December 2009, Commissioners and Trusts should establish a comprehensive bowel screening programme for those aged 60-69 (to include appropriate arrangements for follow-up treatment).
- **Screening for abdominal aortic aneurysm** – by March 2011, Commissioners and Trusts should establish screening arrangements for abdominal aortic aneurysm.
- **Screening for foetal anomalies** – by March 2011, Commissioners and Trusts should extend the scope of antenatal screening for foetal anomalies.

## **PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES**

For 2009-10 the main focus in this priority will be on continuing to tackle healthcare associated infections and on improving quality in other specific identified areas. Commissioners and Trusts should continue to take forward appropriate actions at local level and, in support of these, a number of actions to be agreed regionally will also be pursued. The aim will be to build on progress made in 2008-09 in embedding international evidence-based methodologies and in raising each organisation's baseline performance, and to begin implementation of the new Service Frameworks and NICE guidance/technology appraisals endorsed by the Department.

The specific standards and targets to be achieved in 2009-10 are as follows:

- **Healthcare associated infections:** in the year to by March 2010, secure a 35% reduction in MRSA, MSSA and Clostridium Difficile infections compared to 2007-08.
- **Trust quality initiatives:** from April 2009, Trusts should ensure that satisfactory progress is made towards the full implementation of approved quality

improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash calls rate and mental health inpatient care. By 30 June 2009, Trusts should submit to the Department for approval and monitoring, quality improvement plans to prevent venous thromboembolism (VTE) through risk assessment and adherence to local policies on VTE prophylaxis.

- **Patient Experience:** by September 2009, Trusts should adopt Patient and Client Experience Standards in relation to Respect, Attitude, Behaviour, Communication, and Privacy and Dignity, and have put in place arrangements to monitor and report performance against these standards on quarterly basis.
- **Service Frameworks:** by March 2010, ensure the implementation of agreed standards from (i) the Cardiovascular Service Framework and (ii) the Respiratory Service Framework, in accordance with guidance to be issued by the Department in April 2009 and June 2009 respectively.

### **PRIORITY AREA 3: IMPROVING ACUTE SERVICES**

During 2009-10 the priority will be to improve acute services, ensuring that patients have timely access to responsive high quality care. It is expected that the ongoing implementation of major strategies will continue, including implementation of the recommendations from the Review of Pathology, the Cancer Plan and the Stroke Strategy.

By the end of March 2009 no patient should be waiting longer than 9 weeks for a first outpatient appointment, no longer than 9 weeks for a diagnostic test, and no longer than 13 weeks for inpatient or daycase treatment. These minimum standards should be maintained in 2009-10, coupled with continued exacting standards for life-threatening conditions where speed of access is essential. Achieving these targets will require Trusts to further embed the reform agenda, including the further improvement of hospital booking processes, reducing cancelled appointments and operations, and improving theatre utilisation. During 2009-10 Commissioners and Trusts should also take steps to ensure that outpatients are reviewed in accordance with the clinically indicated timeframe and that planned procedures are undertaken within a month of their intended procedure date.

In addition, maximum waiting time targets will continue to apply for access to services provided by Allied Health Professionals (AHPs) such as physiotherapy and occupational therapy.

Equivalent improvements have been achieved in access to emergency care, through a focussed effort on all parts of the emergency care pathway, beginning with the ambulance journey (if required), continuing through the emergency care department and the hospital system itself, and ending when the patient is discharged. This programme of reform needs to continue in 2009-10 to ensure that this enhancement of the patient experience is sustained in all A&E departments, and that all parts of the emergency care pathway operate efficiently.

The specific standards and targets to be achieved in 2009-10 are as follows:

- **Specialist drug therapies for arthritis (PSA 3.1):** by March 2010, no patient should wait longer than nine months to commence specialist drug therapies for the treatment of severe arthritis, reducing to 21 weeks by March 2011.
- **Elective care (consultant-led) (PSA 3.2):** from April 2009, no patient should wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 13 weeks for inpatient or day case treatment.
- **Diagnostic reporting:** from April 2009, all urgent diagnostic tests should be reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.
- **Elective care (AHP):** from April 2009, no patient should wait longer than 13 weeks from referral to commencement of AHP treatment, reducing to 9 weeks by March 2010.
- **Fractures (PSA 3.3):** from April 2009, 95% of patients should, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.
- **Cancer (PSA 3.4):** from April 2009, all urgent breast cancer referrals should be seen within 14 days, 98% of cancer patients should commence treatment within 31 days of the decision to treat, and 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.
- **Radiotherapy services:** by March 2011, radiotherapy capacity for an additional 600 patients per annum should be available.

- **A&E:** from April 2009, 95% of patients attending any A&E department should be either treated and discharged home, or admitted within four hours of their arrival in the department.
- **Stroke services (linked to PSA 3.5):** by March 2011, ensure that 50% of patients attending hospital within one hour of the onset of stroke symptoms receive a CT scan and report within a maximum of two hours to inform the appropriate use of thrombolysis.
- **Renal services (PSA 3.6):** all patients should continue to have timely access to dialysis services. From April 2009, at least 50% of patients should receive dialysis via a fistula, increasing to 60% by March 2010. And by March 2010, following the identification of an appropriate donor, no patient should wait longer than six months for a live donor transplant.
- **Critical care:** by March 2011, increase critical care capacity by two beds, or by the outreach equivalent of two beds, compared to the position in March 2008.
- **Neonatal transport:** from April 2009, ensure that a dedicated paediatric and neonatal intensive care transport service is in place on a 24/7 basis.
- **Ambulance services (PSA 3.7):** from April 2009, an average of 70% of Category A (life-threatening) calls should be responded to within eight minutes, increasing to an average of 72.5% by March 2010 (and not less than 65% in any LCG area).

#### **PRIORITY 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY**

We must continue to build a continuum of integrated primary and community care services that focus on people at greatest risk, supporting them to live independent lives and reducing unnecessary and inappropriate reliance on hospitals or other institutional care. It is important that decisions about continuing health and social care needs are taken in the right environment and at the right time. Assessments of longer-term care needs should normally take place outside a hospital setting. The further development of intermediate care is crucial to the achievement of this objective, promoting rehabilitation and independent living in a way that will see a shift away from traditional residential and nursing home care towards flexible and responsive domiciliary care services wherever possible.

The assessment and planning of health and social care provision for patients should ensure that appropriate support is available in the right place, at the right time, so that patients' continued independence – and, where appropriate, their return home – is facilitated in the most timely manner. The support provided by informal or family carers is a key component of the vision for independent living. HSC Trusts should support carers by offering them an assessment of their individual needs as carers, and the continuing implementation of the carers' strategy, *Caring for Carers*, should be a priority for Commissioners and Trusts. Similarly, Trusts will be expected to ensure that palliative care teams are put in place to provide support and care to palliative and end-of-life patients in the community on a 24x7 basis, with the aim of decreasing the number of inappropriate admissions to hospital for these patients and wherever possible allowing them to be cared for and die in their place of choice in the community. In establishing multi-disciplinary palliative care teams, Trusts will need to put in place service improvement programmes to support them; these should be considered in the context of the Gold Standards Framework, Care Pathway for the Dying and the best standards of multi-professional education.

In parallel, the HSC needs to identify people with long term health conditions and provide person-centred care plans tailored to individual needs and wishes, supported through a case management approach that will improve the quality of care and support available to users and their carers and obviate frequent, but fundamentally avoidable, admissions to hospital. The case management approach is most appropriate to patients with complex or multiple long-term conditions, and Commissioners and Trusts should have identified and introduced this approach to at least 5,000 patients by March 2011.

Patient education in the self-management of their own condition will be a key part of care plans, with telehealth/monitoring offering new opportunities to support people with long term health conditions at home. Trusts, working with the European Centre for Connected Health, will be expected to ensure the successful implementation of the remote telemonitoring service which is currently being procured, and meet their share of the Ministerial target to provide access to remote telemonitoring to at least 5,000 people by December 2011. Multi-disciplinary working, providing flexible and responsive services co-ordinated through the case manager to meet person-centred care plans, will be integral to this approach.

As medicines constitute a key aspect of care management every effort must be made to optimise their safe, effective and economic use, including actions to secure further

improvements in generic prescribing and the extension of repeat dispensing and minor ailment services in line with the Pharmaceutical Clinical Effectiveness Programme.

Finally, Commissioners should ensure that additional dental capacity is established in designated areas to be identified by the Department, and that appropriate arrangements are in place to provide urgent or emergency dental care.

The specific standards and targets to be achieved in 2009-10 are as follows:

- **Supporting people at home (PSA 4.1):** 45% of people in care management should have their assessed care needs met in a domiciliary setting by March 2010.
- **Assessment and treatment of older people (PSA 4.2):** from April 2009, older people with continuing care needs should wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.
- **Unplanned admissions (PSA 4.3):** early intervention approaches should be further developed to support identified patients with severe chronic diseases (e.g. heart disease and respiratory conditions) so that exacerbations of their disease which would otherwise lead to unplanned hospital admissions are reduced by 50% by March 2010.
- **Hospital discharges (PSA 4.4):** from April 2009, 90% of complex discharges should take place within 48 hours, with no discharge taking longer than seven days. All other patients should be discharged within six hours of being declared medically fit.
- **Palliative care:** by March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.
- **Direct payments:** by March 2010, the number of direct payment cases should increase to 1,250 (rising to 1,500 by March 2011).
- **Primary care access:** from April 2009, 70% of patients should receive an appointment within 48 hours with a GP or appropriate practice-based primary care practitioner.

- **Dental access:** by March 2010, Commissioners should ensure that additional dental services are deployed in designated areas in accordance with Departmental targets.
- **Referrals management:** by September 2009, Commissioners should establish robust arrangements for the ongoing monitoring and management of GP referral rates to Trusts.

## **PRIORITY 5: IMPROVING CHILDREN'S SERVICES**

The policy emphasis continues to be on earlier intervention to help families in need stay together and reduce the number of children who have to be taken into care. Trusts should continue to increase the use of family-friendly approaches such as family group conferencing and mediation to determine families' needs and identify family-specific support packages. Family support services should be being commissioned in partnership with other key stakeholders, such as the voluntary sector, through children's services planning.

All Trusts should continue to ensure the effectiveness of child protection arrangements and services to families through the operation of gateway teams and the production of high quality assessments of need using the UNOCINI assessment tool. Trusts should also continue to ensure that supervision standards, information sharing protocols and recording standards are complied with on a consistent basis. Commissioners and Trusts should also continue to work positively with police colleagues to play their full part in the operation of statutory public protection arrangements to be introduced by the NIO in October 2009.

Trusts must achieve greater permanence for children in care – primarily through long-term foster/residential care, returning children home or through adoption. Regarding adoption, Trusts must eliminate unnecessary delay in progressing adoptions and provide better support to all parties involved including birth families, adopters and children and young people themselves. The Department also expects to see improvements in outcomes for children and young people in care or on leaving care. Trusts should ensure that young people in care from age 13 are able to participate in an accredited preparation for adulthood programme and, working in partnership with other agencies such as the careers service, must encourage more young people in care and care leavers to seek and attain employment, education and training opportunities. They should also provide, for those young people who wish it, the opportunity to continue living in their foster home until they are aged at least 21 and take steps to improve therapeutic support to residential children's

homes. These initiatives are intended to underpin a longer term strategic focus on improved outcomes for 18-21 year old care leavers in line with the Care Matters agenda. The establishment of Throughcare Transition Teams is an essential mechanism to ensure the provision of dedicated support services and provide a gateway to other key services. A range of other collaborative initiatives are also being progressed to support this objective, including the development of guidance and protocols on the accommodation needs of care leavers, employability schemes, and the prospective introduction of delegated authority for foster carers and kinship care. Trusts are expected to support the relevant Departments and agencies in the development and implementation of these initiatives to provide a strong foundation for 2009/10.

The specific standards and targets to be achieved in 2009-10 are as follows:

- **Children in care (PSA 5.1):** by March 2010, 90% of all children admitted to residential care should, prior to their admission: (i) have been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process. For every child taken into care, a plan for permanence and associated timescale should be agreed within six months.
- **Family support interventions (PSA 5.2):** by March 2010, provide family support interventions to 2,000 children in vulnerable families each year (increasing to 3,500 each year by March 2011).
- **Care leavers in education, training or employment (PSA 5.3):** by March 2010, ensure that at least 70% of all care leavers aged 19 are in education, training or employment.
- **Care leavers living with former foster carers or supported families (PSA 5.4):** by March 2010, increase to 175 the number of care leavers aged 18-20 living with their former foster carers or supported family.
- **Children on the child protection register (PSA 5.5):** by June 2009, Commissioners and Trusts should agree regional policies, procedures and thresholds for the management of cases onto and off the Child Protection Register.
- **Family group conferencing:** during 2009-10, ensure that at least 500 children participate in family group conferences.

- **Assessment of children at risk and in need:** from April 2009, all child protection referrals should be allocated within 24 hours of receipt. All Child Protection and Looked After Children pathway assessments should be allocated immediately following completion of the initial assessment. By March 2010, 90% of family support referrals should be allocated to a social worker within 20 working days for initial assessment. On completion of this initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days. All initial assessments and pathway assessments should be completed within 10 and 20 working days respectively.

## **PRIORITY 6: IMPROVING MENTAL HEALTH SERVICES**

For mental health, the aim should be to provide person-centred services predominately within primary and community care, with prevention and early intervention being key priorities. This must be achieved through a coherent approach that enhances people's ability to live full lives within their own community. Inappropriate admission to hospital must be avoided and, where admission is necessary, early discharge must be facilitated. The expansion of psychological therapies through primary care orientated models should enable common, mild to moderate, mental health problems to be addressed in a timely and sensible manner. All of this accords with the vision set out by the Bamford review for the reform and modernisation of mental health services, reinforced in the Government's response to the Review, which was consulted on during 2008, and its subsequent Action Plan, due to issue in 2009.

Risk assessment and management is a core element of mental health services and work is nearing completion on regional guidance on risk assessment and management in mental health services, with adoption of the guidance and implementation of supporting tools across NI expected during 2009. Regional principles are also being developed to guide the provision of services for those in crisis and at risk of suicide or serious harm.

The specific standards and targets to be achieved in 2009-10 are as follows:

- **Unplanned admissions (PSA 6.1):** by March 2010, the number of admissions to mental health hospitals should reduce by 5%, with a further reduction to 10% by March 2011.

- **Resettlement (PSA 6.2):** by March 2010, resettle 60 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 30 by March 2011).
- **Assessment and treatment (PSA 6.3):** from April 2009, implement a stepped care model and ensure no patient waits longer than 13 weeks from referral to assessment and commencement of treatment for mental health issues including psychological therapies, reducing to nine weeks by March 2010, other than psychological therapies.
- **Discharge:** from April 2009, ensure that 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. All patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge.
- **Respite – dementia:** provide an additional 1,200 dementia respite places by March 2010 compared to the March 2008 total (and a further 800 by March 2011).
- **Domestic violence:** a Local Domestic Violence Partnership should be established in each Trust area which should, by September 2009, have produced and begun the implementation of a local DV action plan based on the regional DV strategy and action plan. By March 2010 each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences held in their area during the year.

## **PRIORITY 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY**

For both learning and physical/sensory disability services the aim should be to provide person-centred, seamless community-based services, informed by the views of service users and their carers. It is vital that people are supported to live in the community and that inappropriate admission to hospital is avoided. Where admission is necessary, early discharge must be facilitated. Carers have an important role to play in providing community support. Increased respite provision will support them and help prevent care settings from breaking down. Local and fully inclusive access to services must also be increasingly available; people should be provided with services close to their own home and should not be excluded from mainstream services. The improvement of services for people of all ages affected by autism is a key priority; the strategic direction for the next three years is set out in the ASD Strategic Action Plan which was issued for consultation in September 2008. The

improvement in services for children who need Speech and Learning Therapy is also a key priority. The strategic direction for the next three years is set out in the Speech and Learning Therapy action plan, issued for consultation in September 2008.

For people with brain injury, the objective is to provide community based services to meet the needs of service users and informed by the views of service users and their carers to reduce the time spent by people with a brain injury in hospital based facilities. These principles accord also with the vision set out by the Bamford Review for the reform and modernisation of learning disability services and will be echoed in the resulting Action Plan.

The specific standards and targets to be achieved in 2009-10 are as follows:

- **Resettlement (PSA 7.1):** by March 2010, resettle 90 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 30 by March 2011).
- **Respite – Physical/ Sensory Disability (PSA 7.2):** by March 2010, improve access to physical/sensory disability care by providing an additional 100 respite packages a year compared to the March 2008 total (and a further 100 by March 2011).
- **Specialised wheelchairs (PSA 7.3):** by March 2010, ensure an 18-week maximum waiting time for 90% of all wheelchairs.
- **Housing adaptations:** by March 2010, all lifts and ceiling track hoists are to be installed within 22 weeks of the OT assessment and options appraisal as appropriate, and all urgent minor housing adaptations are to be completed within 10 working days.
- **Respite – Learning Disability (PSA 7.4):** by March 2010, improve access to learning disability care by providing an additional 100 respite packages a year compared to the March 2008 total (and a further 100 by March 2011).
- **Discharge:** from April 2009, ensure that, 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days.
- **Autism:** by March 2010, ensure that all children wait no longer than 13 weeks for assessment following referral and a further 13 weeks for commencement of specialised treatment.

- **Acquired Brain Injury:** by March 2010, ensure a 13-week maximum waiting time from referral to assessment and commencement of specialised treatment.

## **PRIORITY 8: ENSURING EFFECTIVE FINANCIAL CONTROL AND IMPROVED EFFICIENCY**

Making the best possible use of the finance available, and maintaining strong financial control are integral to the proper provision of health and social care. A weakening of such discipline would mean that the Minister's service priorities would become distorted, and the public would lack assurance that the most infirm and vulnerable were receiving their needful treatment. It is important that the existing degree of control – resulting in, among other things, the delivery of planned efficiency savings – continues into 2009-10. Corrective action must be taken to resolve potential deficits as soon as any threats emerge, in line with existing guidance.

The Department's plans in 2009-10 include the development of mechanisms for funding services – through potential tariffs and other activity-based means – that align more closely to the activity and outcomes actually delivered by Trusts and other providers. Individual organisations will need to monitor and control their costs in order to manage the risks to financial stability.

The specific targets to be achieved in 2009-10 are as follows:

- **Finance:** the Department and all HSC organisations should live within the resources allocated and achieve financial balance.
- **Timely implementation of service developments:** Commissioners and Trusts should ensure that not less than 90% of the monies – but ideally, of course, 100% – allocated for service developments in 2009-10 are expended during the course of the year in accordance with agreed plans, and assuming full resources are required to deliver the targets and commitments. This aim will be kept under review between the Department, Commissioners and Trusts to secure the best available balance between the overriding aim of actually improving services and the need to secure economy, efficiency and effectiveness in the full and proper use of the money available.
- **Efficiency targets:** Commissioners and Trusts should, during 2009-10, achieve the efficiency targets specified by the Department. As part of the efficiency programme

Commissioners and Trusts should ensure that that all initiatives within the Regional Pharmaceutical Clinical Effectiveness Programme, including the specifically dedicated investments, are implemented in accordance with Departmental targets.

## **PRIORITY 9: IMPROVING PRODUCTIVITY**

The Executive has shown its commitment to the workforce and to service-users by significant funding injections for Agenda for Change, the consultant's contract and the new General Medical Services contract, modernizing their terms and conditions and increasing the numbers of frontline staff working in the HSC. It is expected that improvements in productivity, as expressed in both throughput and effectiveness of care, will result from the changed professional working practices, etc made possible by that investment. Trusts should continue to tackle issues of absenteeism, workforce productivity (including the achievement of target ratios for qualified to unqualified nurses and AHPs respectively), reducing the proportion of Administrative and Clerical staff, and reducing expenditure on Agency staff.

The specific standards and targets to be achieved in 2009-10 are as follows:

- **Hospital productivity (PSA 9.1):** each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.
- **Daycase rate (PSA 9.1):** each Trust should secure improvements in daycase rates for a defined range of procedures in accordance with Departmental targets for March 2010 and 2011.
- **Pre-operative length of stay (PSA 9.1):** each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2010 and 2011.
- **Absenteeism (PSA 9.1):** each Trust should reduce its level of absenteeism to 5.5% in the year to March 2010, reducing to 5.2% in the year to March 2011.
- **Greater use of generic drugs (PSA 9.1):** the level of dispensing of generic drugs should increase to at least 59% by March 2010, and to 64% by March 2011
- **Cancelled operations:** from April 2009, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.

## **PRIORITY 10: MODERNISING THE INFRASTRUCTURE**

A high quality service demands modern, fit-for-purpose facilities and equipment. Within the available budget, action is underway to maintain, renew and develop the health and social care infrastructure across Northern Ireland. In addition, investment in the supporting ICT systems and in the NI Fire and Rescue Service will assist in modernising our current provision. Developments are in line with extant policies such as “Developing Better Services”, “A Healthier Future”, the Bamford Review and “Caring for People Beyond Tomorrow”. Trusts will be required to comply with HSC-wide procurement and programme management requirements for infrastructure investment through, for example, close liaison with the Health Estates Centre of Procurement Expertise and active participation in the Strategic Investment Groups established for each organisation. Risks to the current infrastructure will be identified so that mitigating action can be taken. These arrangements will include provision of timely and complete information on capital expenditure, risks associated with the current infrastructure, business case development and production, project management and project resources. Trusts must engage effectively with the Department in their management of capital budgets, post-approval monitoring, post-project evaluations, and implementation of the Department’s Asset Management Strategy.

The specific target to be achieved in 2009-10 is as follows:

**Investment programme** – during 2009-10, Trusts must ensure that, for all key strategic projects, agreed timescales are met for the completion of business cases, project procurement, and project delivery.

## **ANNEX 1 – PSA TARGETS**

### **Priority 1: Improving Health and Well-being – Related PSA Targets 2008-11**

- 1.1 By March 2012, increase average life expectancy by 2 and 3 years for women and men respectively, and facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the NI average.
- 1.2 By March 2011, reduce to 21% and 25% respectively the proportion of adults and manual worker subset who smoke.
- 1.3 By March 2010, halt the rise in obesity.
- 1.4 By March 2010, ensure a 5% reduction in the proportion of adults who binge drink.
- 1.5 By March 2010, ensure a 10% reduction in the proportion of young people who drink and who report getting drunk.
- 1.6 By March 2010, ensure a 5% reduction in the proportion of young adults taking illegal drugs.
- 1.7 By March 2011, ensure a 10% reduction in the number of children at risk from parental alcohol and/ or drug dependency.
- 1.8 By March 2011, achieve a reduction of at least 15% in the suicide rate.
- 1.9 By March 2010, achieve a 40% reduction in the rate of births to mothers under 17.
- 1.10 By September 2008, ensure that a comprehensive HPV immunisation programme is in place, with a view to achieving a long term reduction of 70% in incidence of cervical cancer.
- 1.11 By December 2009, ensure that a comprehensive bowel screening programme for those aged 60-69 is in place, with a view to achieving a 10% reduction in mortality from bowel cancer by 2011.
- 1.12 By March 2009, extend the regional breast cancer screening programme to cover those aged 65-70.

### **Priority 2: Ensuring Safer, Better Quality Services – Related PSA Target 2008-11**

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

### **Priority 3: Improving Acute Services – Related PSA Targets 2008-11**

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

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

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

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

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

3.6 By March 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula, and no patient should wait longer than nine months for a live donor transplant (six months by 2010).

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

### **Priority 4: Ensuring Fully Integrated Care and Support in the Community – Related PSA Targets 2008-11**

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

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

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

4.4 From April 2008, 90% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being declared medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support. All other patients will, from April 2008, be discharged from hospital within six hours of being declared medically fit.

### **Priority 5: Improving Children's Services – Related PSA Targets 2008-11**

- 5.1 By 2011, reduce by 12% the number of children in care.
- 5.2 By 2011, provide family support interventions to 3,500 children in vulnerable families each year.
- 5.3 By 2011, increase by 50% the proportion of care leavers in education, training, or employment at age 19.
- 5.4 By 2011, increase by 25% the number of care leavers aged 18-20 living with their former foster carers or supported family.
- 5.5 By 2011, reduce by 12% the number of children requiring to be placed on the child protection register.

### **Priority 6: Improving Mental Health Services – Related PSA Targets 2008-11**

- 6.1 By 2011, ensure a 10% reduction in admissions to mental health hospitals.
- 6.2 By 2011, ensure a 10% reduction in the number of long-stay patients in mental health hospitals.
- 6.3 By 2009, ensure a 13-week maximum waiting time for defined psychotherapy services.

### **Priority 7: Improving Services for People with a Disability – Related PSA Targets 2008-11**

- 7.1 By 2011, ensure a 25% reduction in the number of long-stay patients in learning disability institutions.
- 7.2 By 2011, improve access to physical/sensory disability care by providing an additional 200 respite packages a year.
- 7.3 By 2011, ensure a 13-week maximum waiting time for specialised wheelchairs.
- 7.4 By 2011, improve access to learning disability care by providing an additional 200 respite packages a year

## **Priority 8: Effective Financial Control and Improved Efficiency – Related PSA**

### **Targets 2008-11**

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

## **Priority 9: Improving Productivity – Related PSA Targets 2008-11**

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

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

## **Priority 10: Government's Three-Year PSA Targets – Modernising the Infrastructure**

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

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