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Assembly

## Research and Library Service Research Paper

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December 2010

# Health and social care: plans, priorities and performance.

NIAR 530-10

This paper provides an overview of the high level plans and priorities pertinent to health and social care in Northern Ireland. These plans are inextricably linked to the Budget and include: 1) the Executive's Programme for Government (PfG) and 2) the DHSSPS *Priorities for Action* (PFA). The performance of the Department is highlighted in terms of delivering against a number of targets established within the PfG strategy. Given existing efficiency pressures, it is inevitable that the DHSSPS will have to function in an extremely challenging fiscal environment. In turn, several innovative approaches to healthcare delivery are also considered.

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## Executive Summary

At the time of writing, the Executive Budget for Northern Ireland has yet to be agreed. Funding allocations for all NI Departments are agreed by the Executive at the outcome of the budget process and set in accordance with the Executive's priorities. Funding allocated to the DHSSPS budget is distributed to relevant health and social care bodies. This funding is determined by the priorities set out by the Minister for Health, Social Services and Public Safety.

Two strategic plans which are inextricably linked to the Budget outline the government's key priorities. These include: the Executive's Programme for Government (PfG) - *Building a Better Future* 2008-2011, which takes a more long-term strategic approach, and the DHSSPS *Priorities for Action* (PFA) 2010/2011 which are revised annually. This paper focuses on priority two within the Programme for Government and the seven priorities contained within Priorities for Action. Together, these priorities outline the vision for delivering improved health and social care outcomes and services to the people of Northern Ireland.

In order to realise this vision, a range of targets have been set. In the Programme for Government, targets are underpinned by cross-cutting Public Service Agreements (PSAs). The DHSSPS Priorities for Action also incorporate PSA targets into its priority areas, in addition to setting a number of its own targets. This adds a layer of complexity as to how both sets of targets interlink. Of relevance in this paper are the three PSAs within Programme for Government which are led by the DHSSPS. Performance in relation to the progress of PSA targets are monitored regularly both at Departmental and Ministerial level using a RAG (Red/Amber/Green) rating system.

The most recent Delivery Report on Programme for Government shows that progress has been made on DHSSPS-led targets in some areas; however there is cause for concern regarding deterioration in many other target areas. This is particularly evident in the targets under PSA 6 relating to 'Children and family' and PSA 8 relating to 'promoting health and addressing health inequalities'.

More generally, targets in relation to alcohol consumption or abuse have reportedly progressed well, whilst less improvement has been noted in targets relating to smoking, drug use, physical exercise, obesity. Several targets relating to treatment times and waiting lists also show a lack of progress. This raises questions as to whether these targets can be achieved within the current Programme for Government timeframe. A more complete picture on the overall year-on-year performance will not be available until later in 2011.

The final section of this paper considers a number of innovative approaches to healthcare delivery, given the likely pressures the health service will face in the future. New ways of working might include: redesigning the workforce, reducing hospitalisation, more joined up methods of procurement, increasing incentives and greater utilisation of information technology. Some examples of these initiatives are considered in the paper.



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## 1 Introduction

With the creation of the devolved administrations, distinct approaches to funding and delivery of health and social care services have been developed in each of the four UK healthcare systems.<sup>1</sup> Following the Review of Public Administration, health structures in Northern Ireland have been streamlined in an attempt to make the health and social care system more efficient and effective.<sup>2</sup>

### 1.1 Spending Review

As part of the 2010 Spending Review, the coalition government made a pledge to ring-fence healthcare spending in England and at the same time, announced an increase in the healthcare budget. After allowing for inflation, this means that there will be no cuts to the English healthcare budget. Nevertheless, the increase, which only translates to 0.4% in real terms over the Spending Review period,<sup>3</sup> will result in unprecedented spending challenges for their health service.

At the time of writing, the Executive Budget for Northern Ireland has yet to be agreed. In November 2010, Northern Ireland's Minister for Finance and Personnel was reported saying that the local health budget (which includes day-to-day budgets, hospitals and GP surgeries) should, like England, be protected.<sup>4</sup> However the Minister also hinted that Social Services and Public Safety, two other important aspects of the health department's budget, are likely to face budgetary reductions.<sup>5</sup> Acquiring savings will not be an easy feat for the local health and social care system. Moreover the HSSPS Minister has consistently put forward the view that health and social care in Northern Ireland has historically been underfunded in comparison with other parts of the UK.

### 1.2 How is funding allocated?

- Funding allocations for all NI Departments are agreed by the Executive at the outcome of the budget process and set in accordance with the Executive's priorities, as outlined in the **Programme for Government (PfG)**.
- Allocations from the **DHSSPS budget** to relevant funded bodies are then determined by the **Health Minister's priorities**. These are apportioned in accordance with agreed targets and the Health and Social Care Board (HSCB)/Public Health Agency (PHA) **Commissioning Plan**.<sup>6</sup>

<sup>1</sup> Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge, page 8.

<sup>2</sup> Further information of the structures is available online at [www.dhsspsni.gov.uk/index/hss.htm](http://www.dhsspsni.gov.uk/index/hss.htm). Website accessed 16.11.10

<sup>3</sup> The Nuffield Trust (Oct 2010) NHS Resources and Reform, Briefing Paper. Available online at: [www.nuffieldtrust.org.uk/publications/detail.aspx?id=145&prID=742](http://www.nuffieldtrust.org.uk/publications/detail.aspx?id=145&prID=742) Website Accessed 2.12.10

<sup>4</sup> BBC News online Health 'should be saved from cuts' - Finance Minister (10 November 2010). Available online at: [www.bbc.co.uk/news/uk-northern-ireland-11726013](http://www.bbc.co.uk/news/uk-northern-ireland-11726013) Website accessed 14.11.10

<sup>5</sup> Newsletter, Healthcare 'should be saved from cuts' (11 November 2010). Available online at: <http://www.newsletter.co.uk/news/Healthcare-39should-be-saved-from.6621685.jp>

<sup>6</sup> Legislation enacted in April 2009 signalled the way forward for a new Commissioning system with the establishment of a region-wide Health and Social Care Board (HSCB), which included: 5 Local Commissioning Groups and a Public Health Agency.

- The current Commissioning Plan (2010-11), which is the first of its kind in the region, outlines how the HSCB and the PHA will approach commissioning in relation to health and social care needs and service provision. It proposes that this will be achieved by taking account of budget objectives, performance management and **Priorities for Action** targets.<sup>7</sup>
- Funding provided to HSC Trusts and the Ambulance Service is allocated via the HSCB and the PHA.<sup>8</sup>
- The DHSSPS also has centrally managed budgets for bodies such as the Fire Service and holds a small number of central grants for training and other provisions.

## 2 Strategic Plans and Priorities

Over the last 3 years, despite overall improvements in many areas of health care delivery (for example childcare services, access to specialist drugs) the Health and Social Care (HSC) system has been required to make an overall 9% reduction in funding through improved efficiency.<sup>9</sup> Simultaneously, it has also had to absorb significant increases in demand, estimated to be as much as 2%.<sup>10</sup>

The financial constraints facing the DHSSPS are exacerbated by a plethora of demands posed by an ageing population, rising drug prices, lifestyle-related problems such as obesity and patient expectations.<sup>11</sup> Such factors are likely to impact how policies and priorities can be achieved and developed in the future.

As shown in the model presented in Figure 1 overleaf, the next section of this paper provides an overview of two key plans concerning the government's strategic priority areas. These include:

- 1) *Programme for Government - Building a Better Future*; and
- 2) *Priorities for Action*

Both plans, which are discussed in turn, contain information relating to the delivery of improved health and social care outcomes through a range of associated targets.

<sup>7</sup> Health and Social Care Board/Public Health Agency Commissioning Plan 2010-11. Available online at [www.publichealth.hscni.net/sites/default/files/HSCB%20PHA%20Joint%20Commissioning%20Plan%202010-2011.pdf](http://www.publichealth.hscni.net/sites/default/files/HSCB%20PHA%20Joint%20Commissioning%20Plan%202010-2011.pdf) Website accessed 19.11.10

<sup>8</sup> DHSSPS Briefing paper on Budget 2010: Funding Allocation Process Annex A, part 3, page 3.

<sup>9</sup> Health and Social Care Board/Public Health Agency Commissioning Plan 2010-11 page 6. Available online at [www.publichealth.hscni.net/sites/default/files/HSCB%20PHA%20Joint%20Commissioning%20Plan%202010-2011.pdf](http://www.publichealth.hscni.net/sites/default/files/HSCB%20PHA%20Joint%20Commissioning%20Plan%202010-2011.pdf) Website accessed 19.11.10

<sup>10</sup> Ibid

<sup>11</sup> Ramesh R. and Campbell D. NHS cuts to run deep as spending goes up. Guardian Newspaper 10.10.10 Available online at [www.guardian.co.uk/society/2010/oct/17/nhs-cuts-spending](http://www.guardian.co.uk/society/2010/oct/17/nhs-cuts-spending) Website accessed 11.11.10



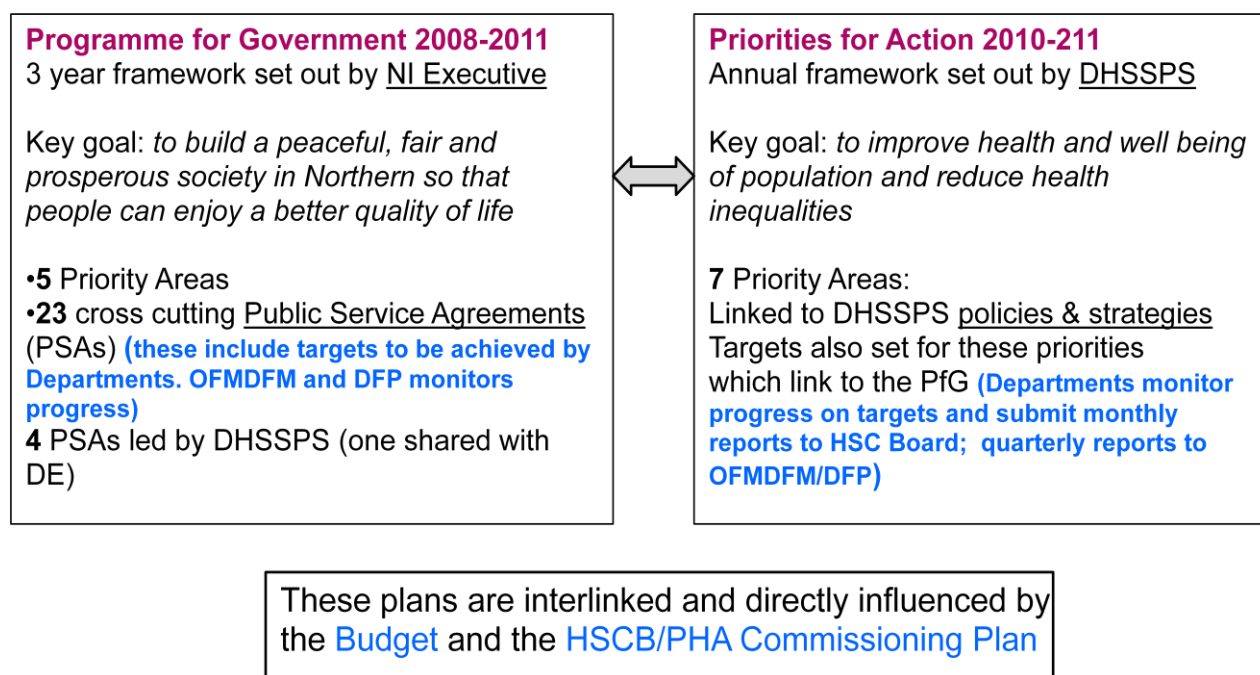


Figure 1. Key Government Plans relevant to Health and Social Care in NI

## 2.1 NI Executive Priorities: Programme for Government (2008-2011)

Developed by the Northern Ireland Executive, **Programme for Government (PfG)**<sup>12</sup> 'Building a Better Future' (2008-2011) sets out a relatively *long-term* strategic context for the Budget and the Investment Strategy for Northern Ireland.<sup>13</sup> Its key priorities are to pursue *an innovative and productive economy and a fair society that promotes social inclusion, sustainable communities and personal health and well-being*.<sup>14</sup>

To ensure that the Government is clearly focused on achieving this vision, the Executive has framed its priorities under five main headings:<sup>15</sup>

- 1) growing a dynamic, innovative economy
- 2) promote tolerance, inclusion and health and well-being**
- 3) protect and enhance our environment and natural resources
- 4) invest to build our infrastructure
- 5) deliver modern high quality and efficient public services

Of interest to this paper is the second priority regarding the promotion of *tolerance, inclusion, health and well-being*. Within this priority area, several key issues are identified:

<sup>12</sup> Programme for Government available online at: [www.northernireland.gov.uk/pfgfinal.pdf](http://www.northernireland.gov.uk/pfgfinal.pdf). Website accessed 23.11.10

<sup>13</sup> The Investment Strategy for Northern Ireland (ISNI) sets out the strategic direction for investment in public sector infrastructure over the next decade.

<sup>14</sup> NI Executive Programme for Government available online at: [www.northernireland.gov.uk/pfgfinal.pdf](http://www.northernireland.gov.uk/pfgfinal.pdf). Page 5. Website accessed 23.11.10

<sup>15</sup> Ibid page 6

*The overall health status of our population needs urgent attention. We continue to have **higher than average mortality** from **coronary heart disease, cancer and stroke**, while **obesity levels**, particularly among our children, **are rising** at an alarming rate. **Waiting times for treatment are still too long** and the **outcomes** from treatment should be better. In **mental health and learning disability**, we are **over-reliant on long-stay hospitals** and the range of **primary and community services is limited**. All of this places a considerable **strain on public services**, and impacts on the social and economic wellbeing of those affected. We must take **action to prevent illness and improve physical and mental health**, promoting healthier lifestyles and changes in physical activity.<sup>16</sup>*

### 2.1.1 PfG Public Service Agreements (PSAs)

In an attempt to address these issues and to bring about the wider changes envisaged by the Executive's five main priority areas, 23 cross-cutting **Public Service Agreements** (PSA) and associated targets have also been developed within the PfG framework. These confirm the key actions to be taken by each Department who work together with other Departments towards achieving the targets.<sup>17</sup>

Each PSA is underpinned by a *Delivery Agreement* which details how different objectives and targets will be measured and monitored.<sup>18</sup> Delivery Agreements have been drawn up collaboratively and guided by the leadership of the Department responsible for the appropriate PSA.

The DHSSPS leads on **three** PSA Delivery Agreements, and shares leadership of a fourth. These include:

#### **PSA 6: Children and family**

Aim: to ensure that children are cared for, live in safety, are protected from abuse, receive the support they need to fulfil their full potential, become more independent and grow into well adjusted adults, taking their place in the community.

#### **PSA 8: Promoting health and addressing health inequalities**

Aim: promote healthy lifestyles, address the causes of poor health and well-being and achieve measurable reductions in health inequalities.

#### **PSA 16: Investing in the health and education estates** (shared with Department of Education)

<sup>16</sup> Ibid page 12

<sup>17</sup> Programme for Government Document 2008-11 update. Available online at: [www.dhsspsni.gov.uk/gm\\_programme\\_fg\\_latest.doc](http://www.dhsspsni.gov.uk/gm_programme_fg_latest.doc) Website accessed 23.11.10

<sup>18</sup> Further details on the Delivery Agreements can be found online at: Programme for Government Document 2008-11 update. Available online at [www.dhsspsni.gov.uk/gm\\_programme\\_fg\\_latest.doc](http://www.dhsspsni.gov.uk/gm_programme_fg_latest.doc) Website accessed 23.11.10

Aim: to take forward a programme of investment to provide a modern fit-for-purpose health and education estate in line with best practice and ensuring value for money.

### **PSA 18: Deliver high quality health and social services**

Aim: to provide timely and appropriate access to high quality, integrated and cost effective health and social services, to deliver improved outcomes.

For brevity, details of the associated targets for these DHSSPS-led PSAs are provided in **Appendix 1**.

The DHSSPS has a support role in relation to six other PSAs namely: PSA 7; PSA 10; PSA 12; PSA 20; PSA 21; and PSA 22.<sup>19</sup>

## **2.2 DHSSPS: Priorities for Action (2010-2011)**

The second document associated with the delivery of health priorities and improved health outcomes in Northern Ireland is entitled '**Priorities for Action**' (**PFA**). This plan, produced annually, sets out the DHSSPS's own priorities, subject budget resource approval by the NI Executive and the NI Assembly. The seven Priorities for Action for the year 2010-11 are shown in Table 2.<sup>20</sup>

<b>DHSSPS Priorities for Action 2010-2011</b>
1. Improve the <b>health status</b> of the population and reduce health <b>inequalities</b>
2. Ensure <b>services are safe and sustainable</b> , accessible and patient-centred
3. <b>Integrate</b> primary, community and secondary care <b>services</b>
4. Help <b>older people</b> to live independently
5. Improve <b>children's health</b> and well-being
6. Improve <b>mental health services</b> and services for <b>people with disabilities</b>
7. <b>Ensure financial stability</b> and the <b>effective use of resources</b> .

Table 1. Priorities for Action 2010/11

These priority themes also directly, although in a rather complex fashion, overlap with the PfG strategy priorities and the Public Service Agreements (as outlined in section 3.1.1).

The key objective of the DHSSPS as outlined in Priorities for Action is:

<sup>19</sup> NI Assembly Committee for Health, Social Services and Public Safety Official Hansard Report: Programme for Government End-year Delivery Report: available on line at:

[www.niassembly.gov.uk/record/committees2009/HSSPS/090924\\_PfG\\_EndYear.pdf](http://www.niassembly.gov.uk/record/committees2009/HSSPS/090924_PfG_EndYear.pdf) page 4

<sup>20</sup> DHSSPS Priorities for Action 2010-2011. Available online at: [www.dhsspsni.gov.uk/priorities\\_for\\_action\\_2010-12.doc](http://www.dhsspsni.gov.uk/priorities_for_action_2010-12.doc) page 3

*...to improve outcomes through a reduction in preventable disease and ill health by providing effective and high quality interventions and services, equitably and efficiently, to the whole population.<sup>21</sup>*

In effect, PFA sets out a *short-to-medium term* strategic direction for the DHSSPS and places year-by-year requirements on Boards and Trusts to make improvements. These requirements include a number of output and outcome targets. Details of the targets associated with the current 2010-11 PFA are provided in **Appendix 2**.

In addition, the DHSSPS has developed a wide range of policies [several of which are illustrated in **Appendix 3**] which serve to address and support the key health issues relevant to the Priorities for Action.

### **2.3 Priorities for Action: Strategies and Action Plans**

PFA contains a variety of strategies and associated action plans within each of the seven priority areas. These include:

#### **Priority 1: Improve the health status of the population and reduce inequalities**

This priority focuses on public health issues and lifestyle behaviours (such as smoking, drinking and physical inactivity). In addition, reducing inequalities by addressing the social determinants of ill-health (employment, housing, education, poverty etc) is a key goal. A number of strategies have been developed to compliment the awaited and revised *Investing for Health Strategy* - such as the *Sexual Health Promotion Strategy* 2008-13, and the *Mental Health and Wellbeing Promotion Strategy*. Action plans have also been developed, for example, the *Young People's Drinking Action Plan*, and the *Protect Life Action Plan* relating to suicide prevention.<sup>22</sup>

#### **Priority 2: Ensure services are safe and sustainable, accessible and patient-centred**

In line with best practice guidance (e.g. NICE), Service Frameworks for the major causes of ill health and disability - such as *Cardiovascular Health and Wellbeing* have been developed. HSC bodies will also contribute to a 10 year quality strategy focussing on *safety, standards and the patient/client experience*. Action plans like *Changing the Culture 2010* have been prepared to ensure that the occurrence of preventable healthcare associated infections in all HSC settings are eliminated.<sup>23</sup> This priority area also addresses accessibility and waiting times and advocates the effective use of IT.

<sup>21</sup> DHSSPS Priorities for Action 2010-2011. Available online at: [www.dhsspsni.gov.uk/priorities\\_for\\_action\\_2010-12.doc](http://www.dhsspsni.gov.uk/priorities_for_action_2010-12.doc) page 3

<sup>22</sup> DHSSPS Priorities for Action 2010-2011. Available online at: [www.dhsspsni.gov.uk/priorities\\_for\\_action\\_2010-12.doc](http://www.dhsspsni.gov.uk/priorities_for_action_2010-12.doc) page 9

<sup>23</sup> Ibid page 14

### **Priority 3: Integrate primary, community and secondary care services**

Clinicians and practitioners will be supported in facilitating the integration of primary, community and secondary care services and in providing more effective partnership working for the whole population. An example of this would be the *Living Matters: Dying Matters A Palliative and End of Life Care Strategy (2010)*. Improvements in other aspects of service delivery are also planned, for example, generic prescribing and the extension of repeat dispensing, in line with the *Pharmaceutical Effectiveness Programme*.<sup>24</sup>

### **Priority 4: Help older people to live independently**

This priority emphasises that Commissioners and Trusts should continue to provide support to help older people live independent lives, and this can be achieved by ensuring access to day care, respite services, targeted domiciliary care support, in addition to appropriate management of long term conditions and end of life care. To ensure consistency, decisions on patients' long term care needs should be made by all relevant professionals within the framework defined in the *NI Single Assessment Tool*.<sup>25</sup> Carers support needs are also considered in this priority.

### **Priority 5: Improve children's health and well-being**

Emphasis is placed upon early intervention and prevention to help families be confident and responsible in supporting their children to reach their potential, and to reduce the number of children taken into care. This priority is guided by DHSSPS policy frameworks *Families Matter (2009)* and *Care Matters*.<sup>26</sup> Child protection is also at the fore with the establishment of an independently chaired Safeguarding Board for Northern Ireland and the development of guidance on the use of child protection procedures for looked-after children. Such measures should facilitate more co-ordinated and effective services, protect vulnerable children and reduce delays in care system.

### **Priority 6: Improve mental health services and services for people with disabilities**

The key document for improving services for people with a mental health need or learning disability is the *Bamford Action Plan (2009-2011)*. Strategic drivers will include the *Personality Disorder Strategy (2010)* and the *Psychological Therapies Strategy (2010)*. Other strategies under this priority include an *Acquired Brain Injury Action Plan (2010)* and an *ASD Strategic Action Plan* to help improve services for people with autism. Yet to be published is a *Disability Strategy* and a *Dementia Strategy* and

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<sup>24</sup> Ibid page 24

<sup>25</sup> Ibid page 27

<sup>26</sup> DHSSPS Priorities for Action 2010-2011. Available online at: [www.dhsspsni.gov.uk/priorities\\_for\\_action\\_2010-12.doc](http://www.dhsspsni.gov.uk/priorities_for_action_2010-12.doc) page 29. Website accessed 23.11.10

accompanying action plan. The focus for learning disability will be a “whole life approach” to early intervention, assessment, diagnosis, treatment, and care planning.<sup>27</sup>

### **Priority 7 Ensure financial stability and the effective use of resources**

Under existing Comprehensive Spending Review 2007 plans (for 2008/09 – 2010/11), the HSC has been required to deliver cumulative savings of £249m by the end of 2010-11.<sup>28</sup> This was recently increased by a further £105m following the Executive’s decision to cut the planned 2010-11 budget for health and social care - in response to the UK government’s June 2010 emergency budget.

Within priority 7 it is recognised that a substantial reduction in resources for service developments exist which

*...will severely limit the progress that can be made across a number of the key PfA themes in 2010/11....The focus should be on securing value for money for every pound invested, prioritising the most effective treatments, reducing errors and waste and keeping people healthy and independent for as long as possible. **This will require innovation and radical thinking, as well as consistent sharing of best practice and the rolling out of the best examples of providing routine healthcare that is efficient and effective.***<sup>29</sup>

This priority reaffirms the importance of the HSC Board and Trusts having effective programme planning arrangements in place in order to secure their break-even duty (in March 2011) and to ensure that the required savings and efficiency improvements are delivered. It further stipulates that these arrangements will need to make the best use of resources especially in relation to the work force (e.g. staff development and well-being), facilities and equipment (e.g. capital budgets, assets and so forth).

## **2.4 Monitoring PfG and PFA targets**

In order to monitor progress and improvements, PfG and PFA targets are quantifiable and time bound. For example **Priority for Action 6.1** stipulates a target of “By 2011, ensure a 10% reduction in admissions to mental health hospitals”.

Both PfG and PFA targets are monitored as follows:

Programme for Government’s **five priority areas** are monitored directly by OFMDFM Ministers, the Minister for Finance and Personnel and supported by a Central Delivery Team.<sup>30</sup>

<sup>27</sup> Ibid page 35

<sup>28</sup> Ibid page 43

<sup>29</sup> Ibid page 43

<sup>30</sup> NI Executive Programme for Government. Available online at: [www.northernireland.gov.uk/pfgfinal.pdf](http://www.northernireland.gov.uk/pfgfinal.pdf) page 21

Programme for Government PSAs are monitored by the DHSSPS according to Delivery Agreements. These targets within Priorities for Action are regularly monitored by the DHSSPS and reported to OFMDFM and DFP on a quarterly basis.<sup>31</sup>

The DHSSPS reports the results of its **seven Priorities for Action targets** on a monthly basis to the **HSCB and PHA**.





### 3 Performance

Monitoring and managing the performance of the health and social care system in relation to the priorities and targets set by both the Executive and the DHSSPS is crucial. The next section of this paper considers this via two reporting mechanisms:

- Programme for Government Delivery reports and
- Northern Ireland Audit Office report (NIAO).

#### 3.1 Programme for Government Delivery Reports

Within the PfG, each Department self-assesses the delivery of objectives and targets against a **RAG (red/amber/green)** system. RAG provides a visual overview of the progress and contains four colour-coded ratings:

-  **Red** status illustrates that little or no progress has been observed
-  **Amber** status demonstrates either a lack of robust information on progress or that the rate of progress is less than planned or anticipated.
-  **Amber/Green** status indicates progress that is broadly on track and meeting interim milestones with small but redeemable deviations from the plan
-  **Green** status indicates targets that have already been met and are on track and where there is significant confidence in delivering the targeted.

Results from the RAG indicators are compiled into a PfG progress report which record progress at a certain point in time. To date, there have been two *Delivery Reports* published by OFMDFM's Economic Policy Unit regarding progress on the overall delivery of the Programme for Government priority and PSA targets.<sup>32</sup> The first PfG Year End Delivery Report documents progress from April 08-March 09. The second (midway) progress Delivery Report covers a 6 month timeframe from April 09-September 09.

<sup>31</sup> Health, Social Services and Public Safety Committee Hansard Report: Programme for Government End-year Delivery Report (24 Sept 2009) Available online:

[www.niassembly.gov.uk/record/committees2009/HSSPS/090924\\_PfG\\_EndYear.pdf](http://www.niassembly.gov.uk/record/committees2009/HSSPS/090924_PfG_EndYear.pdf)

<sup>32</sup> Further information available at [www.northernireland.gov.uk/index/programme-for-government-and-budget-v1.htm](http://www.northernireland.gov.uk/index/programme-for-government-and-budget-v1.htm)

Between the first and second report a **'further deterioration'** in the PfG position was reported<sup>33</sup> (see Appendix 4 for comparisons between the initial report and the midway report). At the time of writing, the Delivery Report for 2009/2010 is unavailable and awaiting clearance with the Executive,<sup>34</sup> therefore the most recent midway report will be used to demonstrate to members the latest performance of the three DHSSPS-led PSA's.

### 3.1.2 RAG Delivery Status: PSAs

The midway Delivery Report (up until September 2009) highlights concerns with five PSAs (out of a total 23 PSA's).<sup>35</sup> More worryingly, out of the five PSAs, **two are DHSSPS led**. These are: PSA 6: **Children and Family** and PSA 8: **Promoting health and assessing health inequalities**. Cause for concern is determined when more than half of the targets within PSAs are rated as either 'Red' or 'Amber', therefore signifying issues around the level of progress.

Table 3 below illustrates the RAG status of PSA 6 in relation to 'children and family'. This has caused concern because five target objectives are rated Amber, one is Amber/Green and two are rated Green, clearly demonstrating that at the midway point, some of the targets are not adequately progressing.

Target	R	A	A/G	G
1. Deliver targets as set out in 10 Year Strategy for Children and Young people				
2. Re-establish the Ministerial Sub-Committee on Children by April 2008	<b>COMPLETED</b>			
3. By 2011 to have 125,000 children participating in sport and physical recreation				
4. By 2011, increase the number of children in the 11-16 age range accessing youth work services				
5. By 2011 reduce by 12% the number of children in care	<b>CLOSED</b> <sup>36</sup>			
6. By 2011 provide family support interventions to 3,500 children in vulnerable families each year				
7. By 2011 increase by 50% the proportion of care leavers in education, training, or employment at age 19.				
8. By 2011 increase by 25% the number of care leavers aged 18-20 living with their former foster carers or supported family				
9. By 2009 establish the Safeguarding Board for Northern Ireland				
10. By 2011 reduce by 12% the number of children requiring to be placed on the Child Protection Register				

Table 3. PSA 6: Children and family RAG delivery status

<sup>33</sup>Programme for Government Delivery Report (Sept 2009) [www.northernireland.gov.uk/pfgdeliveryreport-apr08sep09.pdf](http://www.northernireland.gov.uk/pfgdeliveryreport-apr08sep09.pdf) page 4

<sup>34</sup> Personal correspondence with DHSSPS DALO and OFMDFM on 21/10/10

<sup>35</sup> Programme for Government Delivery Report (Sept 2009) [www.northernireland.gov.uk/pfgdeliveryreport-apr08sep09.pdf](http://www.northernireland.gov.uk/pfgdeliveryreport-apr08sep09.pdf) page 13.

<sup>36</sup> It was approved by the Executive that this target would be removed due to the 'Baby P' case; as it may have been perceived to influence/impact certain behaviour.



Table 4 presents PSA 8. Since the initial progress report, PSA 8 has **further deteriorated** and been identified as “at risk” due to the number of Red ratings it has received. In an attempt to address the issues associated with PSA 8 ‘Review Meetings’ at both Ministerial and official level have been initiated.

Target	R	A	A/G	G
1. From Sept 2008, ensure comprehensive HPV is in place, with view to achieving long term reduction of 70% in incidence of cervical cancer	COMPLETED			
2. From 2009, establish comprehensive bowel screening programme for 60-69 yr olds with a view to achieving a 10% reduction in mortality from bowel cancer by 2011				
3. By 2009, extend the regional breast screening programme to cover those aged 65-69	COMPLETED			
4. By 2012, increase average life expectancy by 2 years for women				
5. By 2012, increase average life expectancy by 3 years for men				
6. Facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the Northern Ireland average				
7. By 2011, reduce to 21% the proportion of adults who smoke				
8. By 2011, reduce to 25% the proportion of the manual worker subset of adults who smoke				
9. By 2011, halt the decline in adult participation in sport and physical recreation				
10. By 2011, halt the rise in obesity				
11. By 2010, ensure a 5% reduction in the proportion of adults who binge drink				
12. By 2010, ensure a 10% reduction in the number of young people who drink and report getting drunk				
13. By 2010, ensure a 5% reduction in the proportion of young adults taking illegal drugs				
14. By 2011, ensure a 10% reduction in the number of children at risk from parental alcohol and/or drug dependence				
15. Achieve a reduction of at least 15% in the suicide rate				
16. Achieve a 40% reduction in the rate of births to mothers under 17				

Table 4. PSA 8 Promoting health and addressing health inequalities

As can be seen in Table 4, most of the Red or Amber targets in PSA 8 relate to healthy lifestyles. Whilst targets in relation to alcohol consumption or abuse have reportedly progressed well, less improvement has been noted in targets relating to smoking, drug use, physical exercise and obesity. Likewise, target 15 pertaining to “*reducing by 15% the suicide rate by 2010*” remains unmet and the DHSSPS have indicated that there is a significant risk that this will not be achieved.<sup>37</sup>

<sup>37</sup> The NI Programme for Government 2008-11 Delivery Report up to 30 September 2009, page 22.

Table 5 provides the latest available status regarding PSA 18. It is apparent that this PSA is making better progress than PSA 6 and PSA 8 in terms of 'on target' (Green) indicators. However, there are still four 'Red' and four 'Amber' rated targets, mainly in relation to patient waiting times in terms of accessing treatments, and this also gives rise for concern.

Target	R	A	A/G	G
1. By 2010, 45% of people with assessed community care needs supported at home				
2. From April 2008, no older person with continuing care needs will wait more than eight weeks for a completed assessment				
3. From April 2008, no older person with continuing care needs will wait more than twelve weeks for a completed assessment				
4. By 2011, 50% reduction in unplanned hospital admissions for case managed patients with severe chronic diseases (e.g. heart disease conditions)				
5. From April 2008, 90% of patients with continuing complex care needs will be discharged from acute settings within 48 hours of being medically declared fit, and				
6. From April 2008, no complex discharge will take longer than seven days – in all cases with appropriate community support.				
7. All other patients will, from April 2008, be discharged from hospital within six hours of being medically declared fit				
8. By 2011, ensure a 21-week waiting time for drug therapies for treatment of severe arthritis				
9. By March 2009, no patient will wait longer than 9 weeks for a first outpatient appointment				
10. By March 2009, no patient will wait longer than 9 weeks for a diagnostic test				
11. By March 2009, no patient will wait longer 17 weeks for inpatient or day case treatment				
12. By 2009, 95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment				
13. By 2009, 98% of cancer patients will commence treatment within 31 days of decision to treat				
14. By 2009, 95% of patients referred with suspected cancer will begin treatment within 62 days				
15. By 2011, ensure a 10% reduction in mortality and disability from stroke				
16. By 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula				
17. By 2009, and no patient should wait longer than nine months for a transplant (reducing to 6months by 2010).				
18. By 2009, ensure a 10% in the number of hospital patients with staphylococcus aureus bloodstream infections (including MRSA)				
19. By 2009, ensure a 20% reduction in cases of clostridium difficile				

Table 5 PSA 18 Deliver high quality health and social services

In summary, in spite of improvements in several areas, many targets within the three DHSSPS led PSA agreements are not being adequately met at the midway point in the

PfG. Moreover, it is unlikely that the majority of these can be realised within the current PfG timeframe. A more complete picture will not be available until 2011 as to whether targets have definitively been achieved or not. By that time, the data should indicate whether there have been year-on-year increases or decreases in performance.<sup>38</sup> By 2012, a full overview of the achievements of the DHSSPS-led PSAs associated with the current 3 year PfG (2008-2011) should be available for analysis.

### 3.2 Comptroller and Auditor General Report

Reports by the Comptroller and Auditor General (NIAO) in 2008 and 2009 have been published regarding the financial performance of the HSC sector (which includes 16 HSC bodies: former health and social care boards, health and social care trusts, and a number of agencies established by the DHSSPS).<sup>39</sup> The report states that that the sector's performance has undergone "*a step change improvement in recent years and that it is delivering a markedly better service than five years ago*".<sup>40</sup>

The report further comments that the performance against a number of financial targets (including the Capital Resource Limit, the commission administration ceiling, management costs and the prompt payment policy) were all generally considered as 'sound'.<sup>41</sup>

Nevertheless, in terms of **operational performance** which relates to the targets set in PfG/PFA, further improvements are required in a number of areas such as:

- waiting times in Accident and Emergency
- the delays in screening (such as bowel cancer screening)
- resettlement of increasing number of long stay mental health and learning disability patients in the community
- reducing healthcare associated infections
- reducing obesity and type 2 diabetes and other chronic conditions<sup>42</sup>

## 4 Innovative Healthcare Initiatives

Having considered the pressures the HSC currently faces, it is difficult to envisage how quality of care, service provision and patient outcomes can be sustained in line with patient safety and expectations. Reform of the structures and methods in which healthcare will be delivered, where and to whom, is not likely to be a choice but a necessity. In looking to the future, this section, which is not exhaustive, highlights a

<sup>38</sup> Health, Social Services and Public Safety Committee Hansard Report: Programme for Government End-year Delivery Report (24 Sept 2009) Available online:

[www.niassembly.gov.uk/record/committees2009/HSSPS/090924\\_PfG\\_EndYear.pdf](http://www.niassembly.gov.uk/record/committees2009/HSSPS/090924_PfG_EndYear.pdf) p17

<sup>39</sup> 2009 Report available online at [www.niauditoffice.gov.uk/pubs/2010/8632HealthSocialCarefinal.pdf](http://www.niauditoffice.gov.uk/pubs/2010/8632HealthSocialCarefinal.pdf). Website accessed 2.12.10

<sup>40</sup> General Report on the Health and Social Care Sector by the Comptroller and Auditor General for Northern Ireland (NIAO) (2009). Available online at: [www.niauditoffice.gov.uk/pubs/2010/8632HealthSocialCarefinal.pdf](http://www.niauditoffice.gov.uk/pubs/2010/8632HealthSocialCarefinal.pdf) p3

<sup>41</sup> Ibid p6-7

<sup>42</sup> Ibid p9-10

number of innovative approaches that could help the health and social care sector deliver more cost effective care.

#### 4.1 New Ways of Working

UK Think Tanks, such as The Smith Institute,<sup>43</sup> amongst others, have recently examined a range of opportunities for more innovative working practices within the healthcare system. Instead of remaining a “sickness service”, it is suggested that the NHS will need to evolve into a service that proactively intervenes to keep people well; one which buys services from the best provider available (including the public, private and voluntary sector). In order to secure the best price for goods and services, the health and social care sector could become far more competitive through joined-up procurement strategies. A recent example of this was demonstrated by ‘Audit Scotland’ who found that savings of £2 million per year could be achieved if health boards ceased to procure ‘hip and knee’ joints from different suppliers.<sup>44</sup>

##### 4.1.1 Incentives:

In essence, incentives enable organisations to improve.<sup>45</sup> In the future, funding streams will need to provide incentives for new and different new models of care, service reconfiguration and changes in workforce planning. As adopted in the United States, the government could consider stronger incentives to encourage more co-ordination between primary and secondary care in order to achieve better quality and value. Healthcare services could also be rewarded and kept motivated if they are able to retain the finances they gain through efficiency savings. The Nuffield Trust advocates that reward systems (and consequences) linked to outcome indicators could be developed.<sup>46</sup> Results would mean that organisations could be held to account for what they achieve. This could be made publically available as an incentive for healthcare services to continually seek to make improvements.

##### 4.1.2 Reducing hospitalisation:

Estimates suggest that the NHS could save £3.2 billion per year if performance levels were improved, with half of those potential savings stemming from a reduction in the average length of stay in hospital and reducing pre-operative bed days.<sup>47</sup> With the increasing aging population, a large number of preventable hospitalisations exist. Health systems in the future could be incentivised towards earlier diagnosis of chronic conditions in primary care (which currently take up 70% of NHS spend). As a result, patients would be supported to remain at home and receive integrated/multiagency

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<sup>43</sup> Churchill, N (Editor) 2010 Health Innovations: more for less in healthcare. The Smith Institute. Available online at: [www.smith-institute.org.uk/file/Health-Innovations.pdf](http://www.smith-institute.org.uk/file/Health-Innovations.pdf) Page 18.

<sup>44</sup> BBC news (25 March 2010) ‘NHS ‘could save £2m’ on joint implants’ Available online at: [www.news.bbc.co.uk/1/hi/scotland/8586351.stm](http://www.news.bbc.co.uk/1/hi/scotland/8586351.stm)

<sup>45</sup> Ibid Page 20.

<sup>46</sup> The Nuffield Trust Briefing (October 2010) NHS Resources and Reform: Response to the White Paper *Equity and Excellence: Liberating the NHS*, and the 2010 Spending Review. Page 3

<sup>47</sup> Ibid page 5

care from teams in the community.<sup>48</sup> Likewise countless cases are reported each year of people attending Accident and Emergency sites, when a considerable number would, in reality, be better treated in out-of-hours services.

#### 4.1.3 IT and Tele-health technologies

Use of IT has revolutionised care delivery over the last number of years. With the advent of the internet and improved telecommunications, information can be instantly exchanged between patients and healthcare staff. Examples of tele-health technologies include sophisticated home monitoring systems which record patient information and provide feedback, or more simple automated medication/ appointment reminder systems. This model lends itself to patient self-management so that patients can remain longer at home. Such advances are important not only for older people, but those living in more rural communities. Technologies also provide innovative opportunities for clinical decision making, decision support and electronic medical record keeping. For example, clinical case discussions via videoconferencing enable central medical expertise to be relayed to more peripheral sites.

Results from a number of tele-health studies report savings in terms of time, money, travel for care providers and patients, reduced admissions and earlier detection and prevention of complications. However, up-take rates from pilot projects vary and operational costs can be expensive.<sup>49</sup> If widely adopted in the future, innovative use of these technologies will require a shift both in terms of policy and in practice.

#### 4.1.4 Pharmaceutical industry

With the ever increasing pressure on the health service in relation to the cost of drugs and both the relatively high levels of prescribing<sup>50</sup> and free prescription services currently available in Northern Ireland, buying cheaper versions of drugs could be an option. In France, it is estimated that recent pharmaceutical reforms will generate vast savings including: €27 million per year by decreasing antibacterial prescribing; €670 million per year from pharmaceutical company rebates and approximately €1 billion per year from increased prescribing and dispensing of generic drugs. Additional savings of €1.5 billion per year are also thought possible from increased use of generics such as statins and ACE inhibitors instead of branded products.<sup>51</sup>

Collaborative research ventures between pharmaceutical companies, scientists, universities and hospitals would also enable a wider range of expertise to progress treatments and drug discoveries. Incentives could be given to industry to conduct

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<sup>48</sup> Churchill, N (editor) 2010 Health Innovations: more for less in healthcare. The Smith Institute. Available online at: [www.smith-institute.org.uk/file/Health-Innovations.pdf](http://www.smith-institute.org.uk/file/Health-Innovations.pdf) Page 18.

<sup>49</sup> Speedie, S. et al. (2008) Telehealth: The promise of new care delivery models. *Telemedicine and e-Health*. 14(9): 964-967

<sup>50</sup> DHSSPS Review of Health and Social Care Services in Northern Ireland (by Appleby, J. 2005): Family Health Services. Available online at: [www.dhsspsni.gov.uk/appleby-section3-4.pdf](http://www.dhsspsni.gov.uk/appleby-section3-4.pdf). page 79

<sup>51</sup> Sermet, C, (2010) Ongoing pharmaceutical reforms in France: Implications for key stakeholders. *Applied Health Economics and Health Policy*. 8(1):7-24

research in areas of clinical need and to healthcare bodies in administering clinical trials.<sup>52</sup>

#### 4.1.5 Redesigning the workforce:

Taking on new and innovative practices and models of care will require a motivated and skilled workforce. Another innovative way of working would be to extend the role and skill sets of particular employees through training and education. For example specialist nurses could be given capability to act as the first point of contact in primary care consultations, or be given extended powers to prescribe.<sup>53</sup> Reliance on agency staff to cover staff shortages could be replaced with 'in-house' staff cover.

## 5 Conclusion

This paper provides an overview of the targets set out within the NI Executive's Programme for Government and the DHSSPS Priorities for Action. Both plans seek to improve the health and well being of the local population and are highly dependent on the resources allocated from the Executive Budget. The paper also considers the recent performance of the DHSSPS against PfG targets and concludes that progress in several areas is lacking, giving cause for concern. Given that health and social care demands are increasing, the budget constraints envisaged are likely to negatively impact on the number of targets being reached, and ultimately, on performance. In looking to the future, health and social care will require greater efforts to work more effectively in terms of illness prevention and treatment. More innovative ways of working hold the key to enabling the health and social care sector to begin to address some of these challenges.

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<sup>52</sup> Churchill, N (editor) 2010 Health Innovations: more for less in healthcare. The Smith Institute. Available online at: [www.smith-institute.org.uk/file/Health-Innovations.pdf](http://www.smith-institute.org.uk/file/Health-Innovations.pdf) Page 31.

<sup>53</sup> Astles, J. (2006) Extended nurse prescribing: improving care for older people. British Journal of Nursing 15(3): 150 – 154.

## Appendix 1. PSAs led by the DHSSPS

### PSA 6 Children and family

Objective	Actions	Target
<b>Improve the outcomes and life chances of children and young people</b>	<p>Implement the 10 year strategy for children and young people;</p> <p>Take forward the development of an Early Years Strategy;</p> <p>Support exemplar projects of area-based interventions for children and young people;</p> <p>Deliver Sport Northern Ireland's investment programmes;</p>	<p>Deliver targets as set out in 10 Year Strategy for Children and Young people;</p> <p>Re-establish the Ministerial Sub-Committee on Children by April 2008;</p> <p>By 2011 to have 125,000 children participating in sport and physical recreation</p> <p>Increase the number of children in the 11-16 age range and this accessing youth work services</p>
<b>Reduce the number of children in care</b>	<p>Provide multidisciplinary family support and intervention services</p> <p>Expand family group conferencing</p> <p>Provide additional specialist salaried foster carers</p>	<p>By 2011:</p> <ul style="list-style-type: none"> <li>- reduce by 12% the number of children in care</li> <li>-provide family support interventions to 3,500 children in vulnerable families each year</li> </ul>
<b>Improve the life chances of children leaving care</b>	<p>Expand the scheme to enable care leavers to live with their former foster carers or supported family</p> <p>Provide dedicated transition workers and wrap around services between children and adult services</p> <p>Develop effective referral processes between HSS Trusts and NI Careers Service</p>	<p>By 2011:</p> <ul style="list-style-type: none"> <li>-increase by 50% the proportion of care leavers in education, training, or employment at age 19.</li> <li>-increase by 25% the number of care leavers aged 18-20 living with their former foster carers or supported family</li> </ul>

### PSA 8 Promoting health and addressing health inequalities

Objective	Actions	Target
<b>Promote uptake in screening and immunisation programmes to forestall avoidable disease and reduce mortality rates</b>	<p>Introduce a comprehensive HPV immunisation programme</p> <p>Introduce a regional bowel screening programme for people over 50</p>	<p>From September 2008, ensure that a comprehensive HPV immunisation programme is in place, with a view to achieving a long term reduction of 70% in incidence of cervical cancer</p> <p>From December 2009, ensure that a comprehensive bowel screening programme for those aged 60-69 is in place, with a view to achieving a 10% reduction in mortality from bowel cancer by 2011.</p> <p>By 2009, extend the regional breast cancer screening programme to cover those aged 65-69</p>
<b>Promote smoking cessation and measures to tackle obesity and physical inactivity, particularly among children, and reduce health inequalities</b>	<p>Deliver community based health programmes within the 10% most disadvantaged areas</p> <p>Deliver Sport NI's investment programmes</p>	<p>By 2012, increase average life expectancy by 2 and 3 years for women and men respectively, and facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the NI average</p> <p>By 2011:</p> <ul style="list-style-type: none"> <li>-reduce to 21% and 25% respectively the proportion of adults and manual worker subset who smoke</li> <li>-halt the decline in adult participation in sport and physical recreation</li> <li>-halt the rise in obesity</li> </ul>

**PSA 16 Investing in the health and education estates (shared with DE)**

<b>Objective</b>	<b>Actions</b>	<b>Target</b>
<b>To secure better clinical outcomes and safe, high quality treatment and care, by means of a reformed and modernised integrated hospital infrastructure</b>	Take forward a programme of capital investment designed to deliver a more efficient, responsive and accessible NI-wide network of modern, fit-for-purpose hospital facilities	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
<b>Achieve improved levels of morbidity, access and services responsiveness and less need for hospitalization, by a wider range of integrated health and care services in the community, closer to where people live/ work.</b>	Deliver a NI-wide Primary and Community Care Investment (PCCI) programme, establishing a new network of health and care centres, learning disability and mental health facilities, children's residential homes, adult centres etc	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 Gransha Mental Health Crisis Centre due to be completed Regional Adolescent Psychiatric Unit & Child and Family Centre due to be completed
<b>Better clinical care and treatment, improved patient experience and health outcomes, through more effective use of ICT, and the provision of modern emergency services.</b>	Implement strategic capital development programmes for the NI Ambulance and Fire & Rescue Services including, by 2009, delivery of Mobile Data and Automatic Vehicle Location systems to help ensure achievement of national targets for response times and enhanced delivery of effective emergency services Install a Picture Archiving & Communications System (PACS) – a computerised system for storing and sharing diagnostic imaging.	By 2011: NIAS to respond to 75% of life-threatening calls within eight minutes  Reduce by 5% the number of accidental fires in dwellings  Delivery of PACS to be completed

**PSA 18 Deliver high quality health and social services**

<b>Objective</b>	<b>Actions</b>	<b>Target</b>
<b>Promote independent living and a reduction in avoidable admissions to hospital</b>	Enhanced and wider range of community services, through e.g. active management of long term conditions, intermediate care, more flexible and responsive domiciliary care services, expansion of assistive technology and continued growth of direct payments.	By 2010, 45% of people with assessed community care needs supported at home  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  By 2011, 50% reduction in unplanned hospital admissions for case managed patients with severe chronic diseases (e.g. heart disease and respiratory conditions)
<b>Shorter waiting times for access to specialist drugs,</b>	Enhance the provision of specialist drugs for cancer and other treatments such as anti TNF  Improve access to a range of specialist	By 2011, ensure a 21-week waiting time for drug therapies for treatment of severe arthritis



<p><b>to a range of specialist hospital services, and to elective treatment</b></p>	<p>hospital services such as neonatal, paediatric and adult critical care, and major trauma services</p>	<p>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</p> <p>By 2009, 95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment</p>
<p><b>Improve outcomes and survival rates in key specialisms</b></p>	<p>Develop key specialisms and infrastructure in cancer (e.g. oncologists and radiotherapy capacity), stroke (earlier diagnosis, access to 24/7 CT scanning, post-stroke rehabilitation, etc) and renal services.</p>	<p>By 2011, ensure a 10% reduction in mortality and disability from stroke</p> <p>By 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula, and no patient should wait longer than nine months for a transplant (reducing to 6months by 2010).</p>

## Appendix 2. DHSSPS Priorities for Action: Related PSA Targets 2008-2011

**PFA Priority 1:** Improve the health status of the population and reduce health inequalities

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

**PFA Priority 2:** Ensure services are safe & sustainable, accessible & patient-centred

- 2.1 By 2009, ensure a 10% reduction in the number of hospital patients with staphylococcus aureus bloodstream infections (including MRSA), and a 20% reduction in cases of clostridium difficile infections.
- 2.2 By March 2011, ensure a 21-week waiting time for drug therapies for treatment of severe arthritis.
- 2.3 By March 2009, no patient will wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 17 weeks for inpatient or day case treatment, working towards a total journey time of 25 weeks by March 2011.
- 2.4 By March 2009, 95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.

- 2.5 By March 2009, 98% of cancer patients will commence treatment within 31 days of decision to treat, and 95% of patients urgently referred with suspected cancer will begin treatment within 62 days.
- 2.6 By March 2011, ensure a 10% reduction in mortality and disability from stroke
- 2.7 By March 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula, and no patient should wait longer than nine months for a live donor transplant (six months by 2010).
- 2.8 By March 2011, NIAS to respond to 75% of life-threatening calls within eight minutes.

**PFA Priority 3: Integrate primary, community and secondary care services**

- From April 2008, 90% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being declared medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support. All other patients will, from April 2008, be discharged from hospital within six hours of being declared medically fit.
- 3.2 By 2011, 50% reduction in unplanned hospital admissions for case managed patients with severe chronic diseases (e.g. heart disease and respiratory conditions).

**PFA Priority 4: Help older people to live independently**

- 4.1 By 2010, 45% of people with assessed community care needs supported at home.
- 4.2 From April 2008, no older person with continuing care needs will wait more than eight weeks for a completed assessment, with the main components of care met within a further 12 weeks.

**PFA Priority 5: Improve children's health and well-being**

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

**PFA Priority 6: Improve mental health services and services for people with disabilities**

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

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

**PFA Priority 7:** Ensure financial stability and the effective use of resources

- 7.1 By 2011, reduce administration costs within the health and social care system by £53m a year.
- 7.2 Improve productivity, efficiency and effectiveness in the HSC as measured by such indicators as:
  - Patient throughput per bed
  - Ratio of day cases to inpatient cases
  - Use of more effective drug therapies
  - Greater use of generic drugs
  - Improved procurement practices
  - Proportion of people with community care needs supported at home
  - Staff absenteeism.
- 7.3 Ensure the timely modernisation of the HSC infrastructure to include:
  - By 2009, Downe Enhanced Local Hospital due to be completed.
  - By 2010, Ulster Hospital Phase A due to be completed.
  - By 2011, first stage of Altnagelvin Phase 3 due to be completed.
  - By 2011, Royal Phase 2 B due to be completed
  - By 2008, Craigavon Crisis Resource Centre due to be completed
  - By 2009, Castlereagh Community Treatment and Care Centre due to be completed
    - By 2010, Portadown Health & Care Centre due to be completed
    - By 2010, Gransha Mental Health Crisis Centre due to be completed
  - By 2010, Regional Adolescent Psychiatric Unit & Child and Family Centre due to be completed
    - By 2011, Health & Wellbeing Centres Phase 2 due to be completed
    - By 2011, delivery of PACS to be completed.

In order to tackle these issues a number of health goals/targets have been established for example:

- Increasing to 125,000 the number of children and young people participating in sport and physical recreation by 2011; and by 2013 having at least a third of people with disabilities participating.

- Ensuring that, by 2013, anyone with a mental health problem or learning disability is promptly and suitably treated in the community and no-one remains unnecessarily in hospital.
- By 2009, no-one should wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 17 weeks for treatment – a cumulative reduction of 12 weeks from the present standard.
- Reducing mortality from bowel cancer by 15% and acting to reduce cervical cancer by 70% by 2013.
- By 2013, helping people with chronic illnesses to live more active lives and reducing unplanned hospital admissions for such patients by 50%.<sup>54</sup>

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<sup>54</sup> <http://www.northernireland.gov.uk/pfgfinal.pdf> page 13

### Appendix 3. Examples of DHSSPS policy areas linked to PfG and PFA

#### **A Healthier Future (2004) - A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025.**<sup>55</sup>

This regional strategy contains 5 themes and a range of policy aims as follows **1) Investing for Health and Well-being**, (e.g. improve physical and mental health, social wellbeing; tackling heart disease, cancers, increasing breastfeeding rates, reducing smoking, alcohol and drug misuse, obesity, reducing health inequalities. **2) Involving People**: development of people and caring communities who will: actively promote health and wellbeing; have a central role in managing chronic conditions; and be partners in designing and managing healthcare services. **3) Responsive Integrated Services**: deliver community-based accessible services with a focus on managing chronic conditions and the disadvantaged. **4) Teams that deliver**: ensure employers in health and social services become 'employers of choice' and create plans which provide for changing roles and skills across the health and social services. **5) Improving quality**: meeting quality standards in line with a new legal duty of quality which has been placed on boards and trusts; continue to develop a positive and responsive relationship with private, community and voluntary sectors.

**Caring for People Beyond Tomorrow (2005)**<sup>56</sup> sets out the Department's Vision Statement for a future Primary Care Service, and policy framework designed to steer the development of policies and services in primary care. Key aspects include:

- Services focused on providing comprehensive person-centred care.
- Readily accessible point of contact, responsive to meet people's needs
- A co-ordinated, integrated service employing a team approach with multi-agency linkages.
- An emphasis on engagement with people and communities about their care and the way services are designed and delivered.
- A focus on prevention, health education and effective self-care.

Although not an exhaustive list, further examples of relevant DHSSPS policy areas linked into the priority areas include:

- Developing Better Services;
- Caring for Carers;
- Families Matter;
- Adult Safeguarding in NI;
- Aging in an Inclusive Society (cross government);
- Children and Young People's Strategy (cross government);
- Best Practice Best Care;
- Safety First; and
- Regional Decontamination Strategy.

<sup>55</sup> Publication available online at [www.dhsspsni.gov.uk/healthyfuture-main.pdf](http://www.dhsspsni.gov.uk/healthyfuture-main.pdf)

<sup>56</sup> Publication available online at [www.dhsspsni.gov.uk/show\\_publications?txtid=14302](http://www.dhsspsni.gov.uk/show_publications?txtid=14302)

## Appendix 4. Delivery Report Comparisons between RAG indicators for 1<sup>st</sup> PfG Delivery Report (April 08-March 09) and midway report (April 09-September 09).

### PSA 6 Children and Family

Target	Midway Report Apr 09-Sept 09				1 <sup>st</sup> Delivery Report Apr 08-Mar 09			
	R	A	A/G	G	R	A	A/G	G
1. Deliver targets as set out in 10 Year Strategy for Children and Young people								
2. Re-establish the Ministerial Sub-Committee on Children by April 2008								
3. By 2011 to have 125,000 children participating in sport and physical recreation								
4. By 2011, increase the number of children in the 11-16 age range accessing youth work services								
5. By 2011 provide family support interventions to 3,500 children in vulnerable families each year								
6. By 2011 increase by 50% the proportion of care leavers in education, training, or employment at age 19.								
7. By 2011 increase by 25% the no care leavers aged 18-20 living with their former foster carers/supported family								
8. By 2009 establish the Safeguarding Board for Northern Ireland								
9. By 2011 reduce by 12% the number of children requiring to be placed on the Child Protection Register								
<b>Total</b>	<b>0</b>	<b>5</b>	<b>1</b>	<b>3</b>	<b>0</b>	<b>4</b>	<b>2</b>	<b>3</b>

### PSA 8 Promoting health/addressing health inequalities

Target	Midway Report Apr 09-Sept 09				1 <sup>st</sup> Delivery Report Apr 08-Mar 09			
	R	A	A/G	G	R	A	A/G	G
1. From Sept 2008, ensure comprehensive HPV in place, with view to achieving long term reduction of 70% in incidence of cervical cancer								
2. From 2009, establish comprehensive bowel screening programme for 60-69 yr olds with a view to achieving a 10% reduction in mortality from bowel cancer by 2011								
3. By 2009, extend the regional breast screening programme to cover those aged 65-69								
4. By 2012, increase avg life expectancy by 2 yrs for women								
5. By 2012, increase avg life expectancy by 3 yrs for men								
6. Facilitate a 50% reduction life expectancy differential between the most disadvantaged areas and NI average								
7. By 2011, reduce to 21% the proportion of adults who smoke								
8. By 2011, reduce to 25% the proportion of the manual worker subset of adults who smoke								
9. By 2011, halt the decline in adult participation in sport and physical recreation								
10. By 2011, halt the rise in obesity								
11. By 2010, ensure a 5% reduction in the proportion of adults who binge drink								
12. By 2010, ensure a 10% reduction in the number of young people who drink and report getting drunk								
13. By 2010, ensure a 5% reduction in the proportion of young adults taking illegal drugs								
14. By 2011, ensure a 10% reduction in the no of children at risk from parental alcohol and/or drug dependence								
15. Achieve a reduction of at least 15% in the suicide rate								
16. Achieve a 40% reduction in the rate of births to mothers under 17								
<b>Total</b>	<b>6</b>	<b>3</b>	<b>1</b>	<b>7</b>	<b>2</b>	<b>4</b>	<b>3</b>	<b>7</b>

**PSA 18 Deliver high quality health and social services**

Target	Midway Report Apr 09-Sept 09				1 <sup>st</sup> Delivery Report Apr 08-Mar 09			
	R	A	A/G	G	R	A	A/G	G
1. By 2010, 45% of people with assessed community care needs supported at home								
2. From April 2008, no older person with continuing care needs will wait more than eight weeks for a completed assessment								
3. From April 2008, no older person with continuing care needs will wait more than 12 weeks for a completed assessment								
4. By 2011, 50% reduction in unplanned hospital admissions for case managed patients with severe chronic diseases (e.g. heart disease conditions)								
5. From April 2008, 90% of patients with continuing complex care needs will be discharged from acute settings within 48 hours of being medically declared fit,								
6. From April 2008, no complex discharge will take longer than seven days – in all cases with appropriate community support.								
7. All other patients will, from April 2008, be discharged from hospital within six hours of being medically declared fit								
8. By 2011, ensure a 21-week waiting time for drug therapies for treatment of severe arthritis								
9. By March 2009, no patient will wait longer than 9 weeks for a first outpatient appointment								
10. By March 2009, no patient will wait longer than 9 weeks for a diagnostic test								
11. By March 2009, no patient will wait longer 17 weeks for inpatient or day case treatment								
12. By 2009, 95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment								
13. By 2009, 98% of cancer patients will commence treatment within 31 days of decision to treat								
14. By 2009, 95% of patients referred with suspected cancer will begin treatment within 62 days								
15. By 2011, ensure a 10% reduction in mortality and disability from stroke								
16. By 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula								
17. By 2009, and no patient should wait longer than nine months for a transplant (reducing to 6months by 2010).								
18. By 2009, ensure a 10% reduction in the number of hospital patients with staphylococcus aureus bloodstream infections (including MRSA)								
19. By 2009, ensure a 20% reduction in cases of clostridium difficile								
<b>Total</b>	<b>4</b>	<b>4</b>	<b>2</b>	<b>9</b>	<b>0</b>	<b>2</b>	<b>9</b>	<b>8</b>