FROM THE MINISTER OF HEALTH

Mr Keith McBride
Clerk
Committee For Health

Committee.Health@niassembley.gov.uk

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: 028 9052 2556
Email: private.office@health-ni.gov.uk

Our Ref: COR-0075-2025

Date: 10 February 2025

Dear Keith,

HEALTH COMMITTEE INQUIRY ON ACCESS TO PALLIATIVE CARE - FOLLOW UP TO ORAL BRIEFING ON 16 JANUARY 2025

Thank you for your correspondence of 17 January 2025, following the briefing session with officials on access to palliative care held the previous day. Following on from the evidence session, the Committee has asked that the Department provide detail of the PHA needs assessment on short breaks for children, once available, and confirmation on the legal requirement on commissioning palliative care services in Northern Ireland.

In terms of the needs assessment on respite short breaks for children, members were advised that this assessment has been undertaken by the Public Health Agency and is currently going through a review and sign-off process within my Department. I welcome the Committee's intention to consider this report as part of its ongoing inquiry, which has considered all short break demand and provision and makes recommendations on how that service could be enhanced and provided on a more equitable basis across the region. The report will be shared with you through separate correspondence, and I have asked officials to make arrangements for this to be actioned as soon as practicable.

Regarding the Committee's request for confirmation about the legal requirement on commissioning palliative care services in Northern Ireland, I can confirm that the relevant statutory provisions which underpin the commissioning of all health and social care services in Northern Ireland are contained in Section 2 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 ("The Reform Act").

Section 2 of the Reform Act sets out the Department's general duty in relation to the provision of health and social care in Northern Ireland. This includes the duty to promote an integrated system of health and social care designed to secure improvement in the

physical and mental health and social well-being of people in Northern Ireland. It also includes the duty to secure the commissioning and development of programmes and initiatives conducive to the improvement of the health and social well-being and the reduction of health inequalities. Section 3 provides that the Department may provide or secure the provision of such health and social care as it considers appropriate to the discharge of its duty.

I have noted the Committee's reference to recent legislation in England, the Health and Care Act 2022, which introduced a statutory requirement for Integrated Care Boards (ICBs) there to commission palliative care services. In Northern Ireland, as outlined above, the Reform Act already provides the necessary statutory basis and duty which underpins the commissioning of all health and social care services, including palliative care services, by my Department in accordance with the needs of patients. I can therefore assure the Committee that there is no requirement for further legislative provision to enable or to require these services to be commissioned. Currently, the only area of public health provision in Northern Ireland which is subject to a specific legislative duty to commission is abortion services.

The Reform Act put in place new structures for the planning and delivery of health and social care and provides the legislative framework within which the new structures would operate for commissioning health and social care services.

This included the establishment of the Regional Health and Social Care Board (HSCB) whose responsibilities included commissioning the provision of health and social care and other related interventions, as well as the appointment of Local Commissioning Groups. These functions are now taken forward through the Department's Strategic Planning and Performance Group (SPPG), further to the Health and Social Care Act (Northern Ireland) 2022 which dissolved the HSCB and moved its statutory functions into the Department with effect from 1 April 2022.

My Department has discharged this duty, in terms of planning health and care services, by agreeing a Strategic Outcomes Framework (SOF), of which palliative care is an element. The SOF sets the strategic direction for the system, with responsibility for the planning and management of health and social care services residing with SPPG in partnership with the Public Health Agency (PHA). I wrote to the Health Committee on 9 July 2024 advising of a new approach to setting priorities for the year ahead and enclosing a copy of the Strategic Outcomes Framework for 2024/25 – a copy of my letter and the SOF for 2024/25 are provided.

To support this approach, multi-disciplinary planning teams have been established which are co-chaired by SPPG and PHA and cover the spectrum of health and social care from primary care, secondary care and community care. Of the eight teams established, one is specifically focused on community older, frailty and palliative.

The teams will adopt an evidence-based, outcomes-focused approach, inclusive of the input from across the system, networks, communities, and service users, in line with the underlying principle of integration. They will be key to providing support to the system to ensure effective planning of services to optimise the use of resource to improve outcomes.

In summary, the statutory basis for commissioning outlined above relates to all health and social care services. This includes the commissioning of palliative and end of life care services. It is under these statutory arrangements that the Department

commissions specialist palliative care services from Trusts and hospices across Northern Ireland, including both community specialist palliative care services provided by hospice nursing teams and inpatient hospice beds.

While the majority of health and social care in Northern Ireland is delivered by HSC Trusts, other providers including the voluntary and community sector, care homes and hospices are also commissioned to deliver care in line with population needs under the duty as set out in the Reform Act.

I trust you find this information helpful.

Yours sincerely

Mike Nesbitt MLA
Minister of Health

FROM THE MINISTER OF HEALTH

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Ms Liz Kimmins MLA
Chair, Committee for Health
Room 410
Parliament Buildings
Stormont
BELFAST
BT4 3XX

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: 028 9052 2556
Email: private.office@health-ni.gov.uk

Our Ref: SUB-1435-2024

Date: 9 July 2024

Dear Liz

STRATEGIC PRIORITIES 2024/25

The Committee will be aware that following the closure of the Health and Social Care Board (HSCB) on 31 March 2022, and its migration to the Strategic Planning and Performance Group (SPPG) within the Department of Health, the statutory requirement to produce a Commissioning Plan, and consequently a Commissioning Plan Direction (CPD), ended.

Work has been ongoing in defining a new method for setting the priorities to the system that would replace the CPD, which originated from a process that had become administratively burdensome and resulted in over two hundred targets and indicators, many of which had lost their relevancy.

The development of the Integrated Care System for Northern Ireland (ICS NI) as the new planning framework provided an opportunity to embed both a population health and an Outcomes-Based Accountability (OBA) approach into this work, and ensure that the planning, management, and delivery of services be more agile, flexible, and responsive to identified local needs, as well as less bureaucratic and process-driven as a result.

The purpose of this letter is to advise you that I have now approved the new approach to setting the strategic direction for the year ahead, which is articulated across two distinct but fully aligned levels:

i. the population accountability is reflected in the introduction of the Strategic Outcomes Framework (SOF), a suite of strategic outcomes depicting the condition of health and wellbeing that we want to achieve for our population in the long-term, and associated key indicators; and

ii. the system-level performance accountability, reflected in the System Oversight Measures (SOMs) which will provide the short-term Ministerial and Departmental priorities to the HSC system.

A copy of the SOF and SOMs is enclosed for your information, setting out the outcomes and objectives for 2024/25, which have been developed in the context of the continuing pressures on financial resources.

It is anticipated that this strategic direction will be disseminated to service providers in shadow form from September 2024, before work is initiated on defining the strategic priorities for 2025/26.

Yours sincerely

Mike Nesbitt MLA
Minister of Health

HSC Health and Social Care

Department of Health
An Roinn Sláinte
Mànnystrie O Poustie
www.health-ni.gov.uk

Integrated Care System NI

Strategic Priorities 2024/25

Incorporating Strategic Outcomes Framework and System Oversight Measures

July 2024

Overview

The following document provides an overview of the strategic priorities for 2024/25, which have been established through a new approach following the closure of the Health and Social Care Board (HSCB) in March 2022and subsequent standing down of the Commissioning Plan Direction (CPD)/Commissioning Plan process for setting the strategic direction to the system.

In the context of the development of the Integrated Care System for Northern Ireland (ICS NI), which is underpinned by both a population health and an Outcomes-Based Accountability (OBA) approaches, the strategic direction to the system has been developed over two distinct but fully aligned levels:

i. the population accountability is reflected in the introduction of the Strategic Outcomes Framework (SOF), a suite of strategic outcomes depicting the condition of health and wellbeing that we want to achieve for our population in the long-term, and associated key indicators; and
ii. the system-level performance accountability, reflected in the System Oversight Measures (SOMs) which will provide the short-term Departmental priorities to the HSC system.

This new process aims at ensuring that the planning, management, and delivery of services is more agile, flexible, and responsive to identified local needs, as well as less bureaucratic and process-driven.

Strategic Outcomes Framework – Strategic Outcomes

The Strategic Outcomes Framework (SOF) reflects, in the context of Outcomes-Based Accountability (OBA), the population accountability of the system, and depicts the condition of health and wellbeing that we want to achieve for the whole population, whether they use our services or not.

It consists of a suite of nine thematic outcomes and supporting key indicators. It should be looked as a whole and not be defined by considering each outcome in isolation. Figure 1 below provides the draft visualisation that was produced at the back of the developmental work, acknowledging the need for further design work to emphasise that all those outcomes are connected, and that the whole population of Northern Ireland can identify with the framework.

Figure 1 – Draft visual illustration of the Strategic Outcomes Framework

It was co-produced through a bespoke engagement programme, and conveys people's perceived needs and priorities in relation to their health and wellbeing, and provides an expansion of the draft PfG outcome *"We all enjoy long, healthy active lives"*.

The concept behind it is as follows:

- a core outcome, to ensure the whole population can identify themselves in the strategic direction and desired outcomes and offering a straight link to the PfG;
- seven thematic outcomes reflective of the key priorities identified through the engagement programme, representing the life course and life journey of an individual through their potential interactions (or non-interactions) with the system; and
- a cross-cutting outcome focusing on health inequalities, linking to the overall public health and ICS objectives, with a particular focus on the wider social determinants of health.

It should be noted that there is no hierarchy between the outcomes, but instead a certain level of complementarity and overlap. Indeed, in many cases, will relate to more than one aspect of health and wellbeing.

Strategic Outcomes Framework – Headline and Secondary Key Indicators

In order to enable the quantification of the impact made by the system on the population's health and wellbeing, existing or desired key indicators were identified and selected through a process of thematic focus groups articulated around the main themes of the strategic outcomes.

The finalised measures are presented in Figure 2 below, with Headline Key Indicators are displayed in bold.

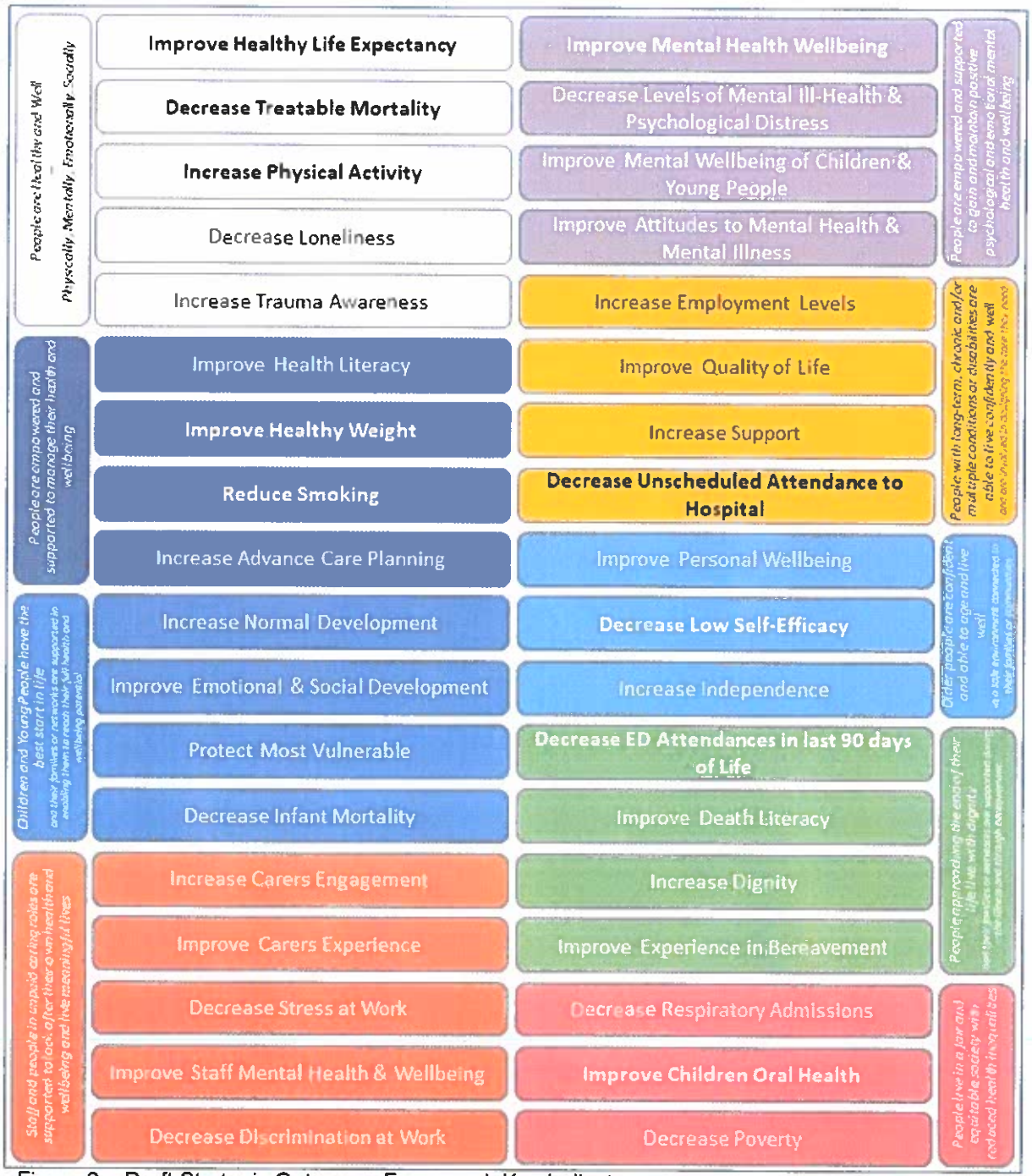

Figure 2 – Draft Strategic Outcomes Framework Key Indicators

System Oversight Measures (SOMs) 2024/25

While the Strategic Outcomes Framework provides the long-term direction to the system, it was essential to also develop a vehicle to convey the shorter-term priorities to the system.

Again, in the context of OBA, these represent the performance accountability of the system's service providers, and while each organisation, each programme, strategy or initiative will have set their own performance expectations in relation to the people or communities they will deliver this service to, those also convey the key Departmental and Ministerial priorities for the year ahead.

In line with the recognised necessity to have a less bureaucratic and more outcome-focused approach, a series of System Oversight Measures (SOMs) were produced through engagement with policy leads and SPPG colleagues.

Those have been articulated around six key domains thus instilling multi-faceted approach to setting the short-term priorities and direction and providing a more comprehensive view of performance across the system, facilitating a better understanding of what is driving current issues and challenges:

- Performance;
- Safety & Quality;
- Finance & Governance;
- Efficiency & Productivity;
- Access Improvement & Tackling Health Inequalities; and
- Workforce.

Whilst the intention from the onset was to provide a more concise and targeted approach, specifications have been added as supporting annexes to ensure the measures are clearly defined and clear baselines and benchmarking rates that providers will be assessed against are set.

The finalised SOMs are presented in Figure 3 below, with the supporting specifications for Acute, Community and Primary Care in the Performance domain as well as specifications for the Safety & Quality domain provided from page 8 onwards.

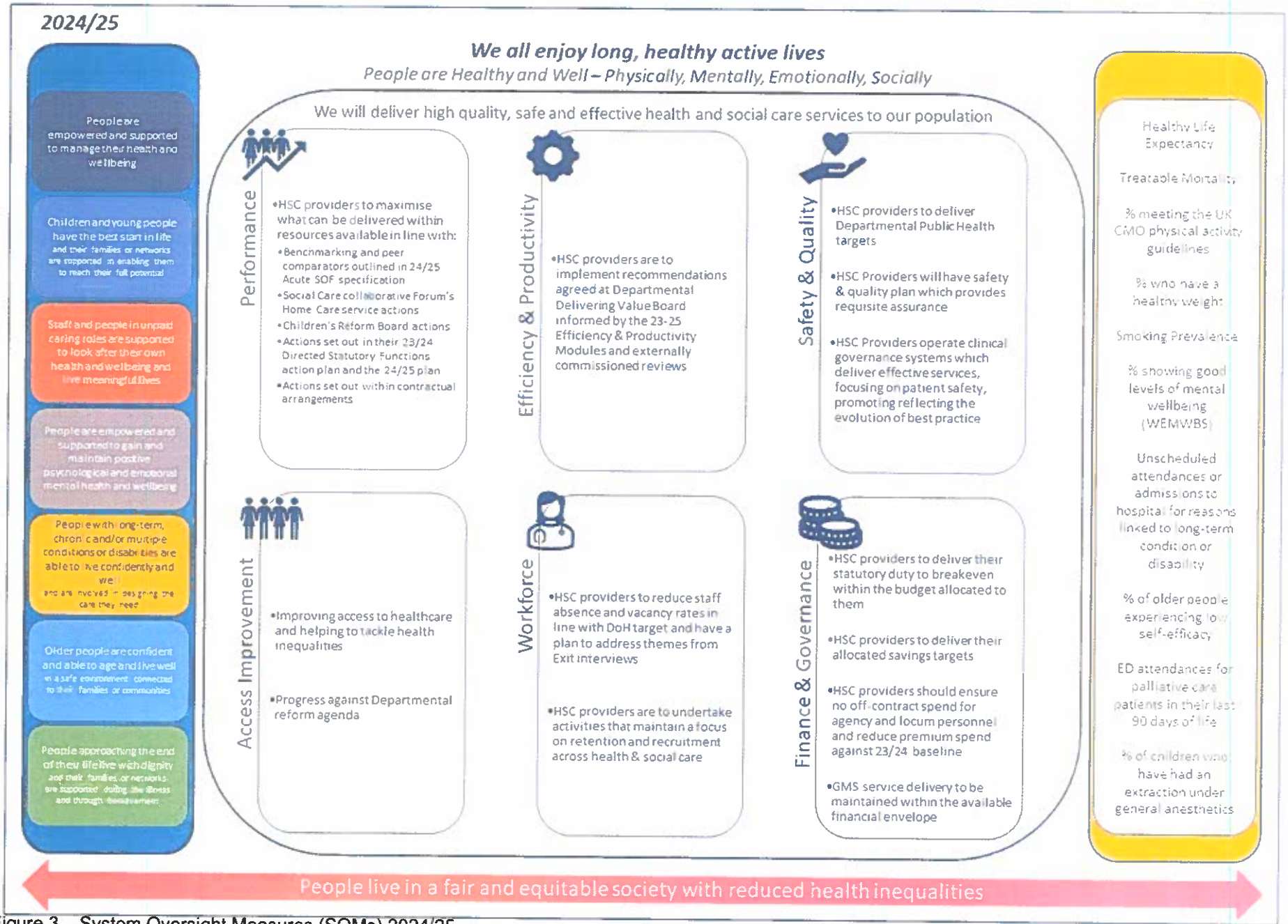

Figure 3 – System Oversight Measures (SOMs) 2024/25

Accompanying Specifications

Acute Specification

Unscheduled Care	**Indicators**
NIAS	
Ambulance Response Times Category 1 and 2	% improvement against 8 min and 18 min standard
Ambulance handover Times	% improvement against 15 min handover standard
Hear and Treat Rates	Achieve 10% rate
Provider Trust	
Patients not waiting in ED	Reduce number of patients who do not wait in ED
12 hour ED delay (delay related harm)	Reduce the number of admitted patients who wait > 12 hours in ED
Simple Delays	Reduce patients waiting >4 hour for discharge
Complex Delays	Reduce patients waiting >48 hours for discharge
Re-admission rates	Reduce number of patients readmitted within 7 days and between 8 and 30 days from discharge
Fracture Neck of Femur – reduce number of patients > 48 hours	Achieve 95% of patients treated within 48 hours
Other Fractures – reduce number of patients > 7 days	Achieve 95% of patients treated within 7 days
Outpatient	**Indicators**
DNA / on the day cancellation rates	- New appointment: 5% (max.) - Review appointment: 8% (max.)
Review appointments - reduce the number of outpatient follow-ups being added to waiting list	25% reduction (against 2019/20 activity levels for agreed specialties)
Expand the use of patient-initiated follow-up (PIFU)	Move 5% of outpatient review attendances to PIFU pathways
Theatres / Inpatients / Day Case	
DNA / on the day patient / hospital cancellations (combined)	All theatre types – main, DPU, endoscopy: 5% (max.)
Theatre utilisation – run and op times	- Run times - main / DPU / endo theatres: 90% - Op time - main theatres: 85%

	- Op time - DPU theatres: 80%
Theatre throughput - ensure adherence to GIRFT recommended theatre throughput rates	As per GIRFT Guidance PowerPoint Presentation (gettingitrightfirsttime.co.uk)
Day case rates – as per British Association of Day Surgery (BADS) recommended rates	- Procedure room/OPP rates for individual procedures – as per BADS rates - Procedures with zero length of stay as per BADS rates NB link below requires log-in: BADS Directory of Procedures and National Dataset
Admissions on day of inpatient surgery	Increase across those specialties currently below CHKS peer group levels
Average length of stay for elective inpatients	Decrease across those specialties currently above CHKS peer group levels (reduce average LOS)

Community Specification

Social Care Collaborative Forum Home Care Service Actions	Indicators
Maximize Home Care Capacity	
Early Review of new and increased packages of care and recycling of unused hours to address unmet need	10% reduction in unmet need hours by each HSC Trust by 31 March 25
Digital solution introduced for Trust Home Care Service to manage and reduce unused hours, to strengthen governance and communication and improve the experience for the Service user and their carers	Increase capacity within existing resources by 5% -10% by 31 March 25
Promotion of Direct Payments as an alternative to a traditional package of home care	5% increase in Direct Payments by 31 March 25
Home Care Project Steering Group	
Minimum Regional Definition & Data Set	A detailed regionally consistent Home Care data return to be in place by 31 March 25
Review of Home Care Standards and Access Criteria for home care	Review and agreement reached by all key stakeholders. To be rolled out by 31 March 25
Detailed Drill down on investment in Home Care Services/Demand & Capacity and VFM	Full financial breakdown of costs and spending investment Full Transparency – by 31 March.25
Children's Social Care Reform Board Actions	**Indicators**
Ensure consistent governance around the management of unallocated cases within Children's Services.	Development of regional guidance and a clear accountability framework for HSC Trusts for the management and oversight of unallocated cases in LAC/CWD/GATEWAY/FS by Sept 2024
Agree a regionally consistent model for CAMHS Intellectual Disability	Review current service profile in each Trust by September 2024. Identify what steps each Trust will take to move towards a regionally agreed model by February 2025
Develop an implementation plan for Children with Disability Framework for approval by Reform Board	Develop costs implementation plan with each Trust by September 2024.
Agree a regionally consistent model for Children's with Disabilities Teams	Review current service profile in each Trust by September 2024.

	Identify what steps each Trust will take to move towards a regionally agreed model by February 2025
Work with HSC Trusts to address significant deficits in placement capacity for children in care and short breaks.	Finalise assessment of need through residential workstream of the Children's Services Reform Board Set up monitoring system to track high cost cases and ensure when placement is no longer required funding can be repurposed by February 2025.
Social Care and Children's Statutory Functions	**Indicators**
All Trusts to complete Directed Statutory Function Reports for 2023/24 by end March 2024.	All Trusts DSF Reports to be reviewed and Action Plans to be developed for each of the 5 Trusts by end June 2024. All plans to be implemented and reviewed end March 2025.

Primary Care Specification

Area	Indicators
GMS Activity	
	Compliance with NICAF across a range of domains and indicators, including historic activity levels.
GDS Activity	
	Reduce the percentage of five year old children with caries experience
	Increase the number of newly registering patients with general dental practitioners (under the GDS) over the last 24 months
	GDS activity as measured by the value of item of service (IoS) claims as a proportion of the value of IoS claims in 2019/20 when corrected for SDR fee uplifts.
Pharmacy	
	Number of Community Pharmacy Assurance Framework Declarations (CPAF) completed (target: 100%) and Number of targeted visits (the need for visits is identified from scrutiny of the declarations returned or not returned – required actions would be identified and followed up.) Measure: 100 of required visits.
Ophthalmic	
	Numbers of those certified as Sight-Impaired (SI) or Severely Sight Impaired (SSI)
	Number and nature of Severe Adverse Incidents (SAIs) associated with Ophthalmology services

Safety & Quality Domain Specification

Area	Indicators
HSC Providers	Compliance with SAI Processes
	Level of complaints (trend analysis)
	Reduce severe, avoidable, medication-related harm by 50%
Provider Trust	Reduced acute medical conditions or surgical readmissions to the same hospital <30 days of discharge
	Reduced antimicrobial consumption
	Reduced hospital acquired infections
	Compliance with falls prevention
	Skin bundles for pressure ulcers