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## DIRECTION

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### 2017 No. X

## The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2017-2018

The Department of Health (DoH) <sup>(1)</sup>, makes the following Direction in exercise of the powers conferred by sections 6, 8(3) and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009 <sup>(2)</sup>:

### Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan Direction (Northern Ireland) 2017- 2018 and shall come into operation on 1 XXX 2017.

(2) In this Direction—

“the Act” means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

“LCG” means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

“Commissioning Plan” means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

### Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission, for the period 1 April 2017 to 31 March 2018, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include a summary of the financial allocations and set out how commissioning will serve to support the implementation of the Minister’s strategic vision (as set out in Delivering Together) to transform the delivery of health and social care services. It should set out clear timescales and milestones for the delivery of commissioning intentions and the transformation of services.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board align with and support the implementation of the Minister’s vision and delivery of priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998<sup>(3)</sup>,

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<sup>1</sup> Departments Act(Northern Ireland) 2016 c.5

<sup>2</sup> 2009 c.1 (N.I.) as amended by 2014 c.5

<sup>3</sup> 1998 c.47

the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); and key Departmental standards, policies, strategies and guidelines.

**3.** The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will deliver the four overarching strategic themes:

- (a) *To improve the health of our citizens.*
- (b) *To improve the quality and experience of health and social care.*
- (c) *To ensure the sustainability of health and social care services provided.*
- (d) *To support and empower staff delivering health and social care services.*

### **Performance indicators**

**4.** In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the objectives and associated quality and performance indicators for the period April 2017 to March 2018.

**5.** The Regional Board shall record the information against the objectives and associated quality and performance indicators for the period April 2017 to March 2018

### **Commissioning and the use of financial allocations**

**6.—(1)** The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from April 2017 to March 2018, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

**(2)** This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

Sealed with the Official Seal of the Department of Health on xxxxxx

Permanent Secretary  
A senior officer of the Department of Health

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## **SCHEDULE**

### **Objectives and Indicators for 2017 - 2018**

#### **Introduction**

This Direction sets out the priorities, aims and improvement objectives for the HSC for the 2017/18 financial year. The achievement of the objectives set out in this Direction will; support the realisation of the Minister's vision for the future of health and social care as set out in "Health and Wellbeing 2016: Delivering Together"; contribute to the attainment of the aims of the 2016 – 2021 Programme for Government and in particular Outcome 4 – "We enjoy long, healthy, active lives", and underpin the Executive's population health framework "Making Life Better".

The Direction is structured around four overarching and linked aims identified in Delivering Together, which acknowledge the challenges facing HSC organisations in the North and health and social care systems across the developed world, namely:

- to improve the health of the population;
- to improve the quality and experience of care;
- to ensure the sustainability of the services delivered; and
- to support and empower the staff delivering health and social care services.

Set out under each of the four aims are key outcomes that balance improvement in the delivery of existing services with support for transformation actions that will bring about the person centred model of care set out in Delivering Together: moving from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

To allow progress towards each outcome to be tracked over time a number of associated quality and performance indicators have been identified against which the HSC should monitor progress and take improvement action as required. It is important to note that these indicators do not represent the totality of the information available to the HSC and the Department to ensure the smooth running of the system or inform the development, implementation and evaluation of policy.

The Commissioning Plan, developed in response to this Direction, must demonstrate how the services commissioned regionally and by LCG's in 2017/18 and beyond will contribute to the delivery of the four aims, contribute to the identified outcomes, sustain the pace of transformation and meet or exceed the specific objectives set out below in response to opportunities, such as approval for the implementation of the Elective Care Plan.

## **Aim: To improve the health of the population**

A key aim of the entire health and social care system in Northern Ireland is to improve the overall health and wellbeing of the population and to prevent ill-health. Whilst improvements have been noted, too many people still die prematurely or live with conditions that could have been prevented.

The Minister's strategic vision for future health and social care services seeks to support people to take greater control over their own lives and enable them to make healthy choices about how they live their lives as well as helping to create an environment that makes such choices easier.

As highlighted in the 2016-2021 Programme for Government, the health and social care service cannot do this in isolation. Successful achievement of this aim means working with other partners across government and other sectors to tackle the root causes of ill-health and reduce health inequalities in the North. Maximising the potential of the local government community planning process will be an important enabler. Through empowering people to maintain their own health through initiatives such as; active ageing and age-friendly communities; increasing physical activity & active travel; improving mental health & wellbeing, & improving the early years of life we can promote healthier communities.

The population health framework "*Making Life Better*" set the strategic context for the actions required from health organisations and other public bodies to improve health and reduce inequalities. Through implementation of this strategic framework, the Department of health and other public bodies can create the conditions for individuals, families and communities to take greater control over their lives and be enabled and supported to lead healthy lives.

Key actions required of the HSC for the period 2017/18 and beyond, to improve the health of the population, are contained in the objectives set out in Outcome 1 – Reduction of Health Inequalities.

## Outcome 1: Reduction of health inequalities

Successful implementation of Delivering Together will see the creation of the circumstances for people to stay healthy, well, safe and independent. Health and Social Care services should strive to anticipate the needs of individuals for support and care and this new model of person-centre care should seek to intervene early to avoid deterioration.

Work to support and enable healthy lives and tackle the causes of health inequality spans the entire life course—for example helping pregnant women and their partners to make the choices that are best for them and their babies; ensuring that all children grow up in a stable and healthy environment, ensuring our young people are equipped for a healthy adulthood; and supporting people to continue to live active and healthy lives as they age.

### Objectives/ goals for improvement:

#### Population Health

- 1.1 By March 2018, to have delivered the “Choose to Lose” community weight loss programme. This programme as one element of the Departmental strategy A Fitter Future For All, aims, by March 2020, to reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children
- 1.2 By March 2020, in line with the Department’s ten year Tobacco Control Strategy, to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.

#### Supporting Children and Young People

- 1.3 By March 2018, to have further developed, tested and implemented a “Healthier Pregnancy Programme” to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation
- 1.4 By March 2019, ensure the full delivery of the universal child health promotion programme for Northern Ireland, *Healthy Child Healthy Future*. By that date:
  - The antenatal contact will be delivered to all first time and vulnerable mothers.
  - 95% of two year old reviews must be delivered.

These activities will include the delivery of core contacts by Health Visitors and School Nurses, which will enable and support children and young adults to be successful healthy adults through the promotion of health and wellbeing.

- 1.5 By March 2018, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers are offered a place. The successful delivery of this objective will directly contribute to the PfG Outcome to provide “a Healthier Pregnancy” and give our children and young people the best start in life.
- 1.6 By March 2018, to increase the number of families utilising Family Support Hubs by 5% over the 2016/17 figures and work to deliver a 10% increase in the number

of referrals by March 2010. By improving access to, co-ordination of, and awareness of early intervention family support services the aim is to create the conditions to enable families to remain together and to provide loving, caring and nurturing environments for their children.

1.7 By March 2018, the proportion of children in care for 12 months or longer with no placement change is at least 85%; and 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer them greater stability while in care.

#### Improving Mental Health

1.8 By March 2018, to have enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis. This is an important element of the work to reduce the differential in suicide rates between the 20% least deprived areas and 20% most deprived areas by March 2020.

#### Supporting those with Long Term Conditions

1.9 By March 2018, to have devised an agreed implementation plan and outcome measures for the delivery of Phase 1 of the Diabetes Strategic Framework along with establishing a Diabetes Network Board and governance arrangements to support the Framework. Phase 1 will focus on implementation of a foot care pathway and revision of structured education.

## **Associated quality and performance indicators**

### Population health (general)

- A1 Healthy life expectancy.
- A2 Average life expectancy for men and women.
- A3 Life expectancy differential between the least deprived and most deprived areas in Northern Ireland, for men and women.
- A4 Potential years of life lost from causes considered amenable to healthcare.
- A5 Infant mortality.
- A6 Age standardised death rate for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas.
- A7 Maintenance of population vaccination coverage as reported in PHA Annual Report.
- A8 Proportion of adults (aged 16+) consuming the recommended five portions of fruit and vegetables each day.
- A9 Level of overweight and obesity across the life course (2 – 15) year olds and 16+.

### Smoking

- A10 Proportion of adults who smoke.
- A11 Number of pregnant women, children and young people, and adults from deprived areas (lower quintile) who set a quit date through cessation services.
- A12 Proportion of pregnant women who smoke.

### Alcohol and substance misuse

- A13 Proportion of adults who report having reached or exceeded the recommended weekly alcohol limit.
- A14 Standardised rate of alcohol-related admissions to hospital within the acute programme of care.
- A15 Standardised rate of drug-related admissions to hospital within the acute programme of care.

### Child health and wellbeing

- A16 Rate of births to mothers under 17 years of age (with breakdown against most deprived areas).
- A17 Breastfeeding rate at discharge from hospital.
- A18 Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.
- A19 Proportion of looked after children who have experienced more than two placement changes. (Source is OC2)



- A20 Length of time for best interest decision to be reached in the adoption process.
- A21 Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type.
- A22 Proportion of school-aged children who have been in care for 12 months or longer, who have a personal education plan.
- A23 Percentage of care leavers aged 16 – 18 in education, training or employment by placement type.
- A24 Percentage of care leavers at age 18, 19 and 20 years in education, training or employment.

#### Suicide and self-harm

- A25 Achievement of the full implementation of Protect Live 2 Strategy Action Plan (source Quarterly Project Board Highlight Reports)
- A26 Number of ED repeat presentations due to deliberate self-harm.
- A27 Self-reported mental health. (GHQ12 survey)

#### Long Term Conditions

- A28 The number of unplanned admissions to hospital for adults with specified long-term conditions.

## **Aim: To improve the quality and experience of health and social care.**

Delivering Together set out the Minister's intention to transform health and social care services to deliver an integrated service capable of responding to future needs. Everyone in Northern Ireland will make use of those services at different points in their lives.

It is important that the HSC listens to and learns from those experiences, whether services are delivered well or things go wrong, and ensures that everyone has a positive experience of the care or treatment they receive.

Quality 2020 provides the framework for the delivery of such services that are:

- centred on the needs of the patient/ client—everyone using HSC services should be treated with dignity and respect and should be fully involved in decisions about their treatment, care and support.
- safe—the care, treatment and support the HSC provides should never result in avoidable or preventable harm;
- effective—everyone accessing HSC services should have the most appropriate treatment or care, in the most appropriate setting, with the best possible outcome; and

“Delivering Together” confirmed the Minister's intention to build on Q2020 and other quality improvement work and to establish an Improvement Institute to better align existing resources in this important area.

Objectives to improve the quality and experience of health and social care are contained in Outcomes:

- 2 - People using health and social care services are safe from avoidable harm
- 3 - Improve the quality of the healthcare experience
- 4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use them
- 5 - People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them
- 6 - Supporting those who care for others

## **Outcome 2: People using health and social care services are safe from avoidable harm**

It is widely recognised that the design and delivery of health and social care must have quality and safety at its heart. The Expert Panel that produced “Systems not Structures” report were clear that “any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this”.

To meet this challenge the HSC needs to ensure alignment between quality improvement, partnership with those who use our services, and how we regulate those services. HSC working practices should proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs.

### **Objectives/ goals for improvement:**

#### Safe in Primary Care Settings

- 2.1 By March 2018, 100% of GP practices to have access to a practice based pharmacist.

#### Safe in Hospital Settings

- 2.2 By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services.
- 2.3 By 31 March 2018, to secure a regional aggregate reduction of 15% in the total number of in-patient episodes of Clostridium Difficile infection in patients aged 2 years and over and in-patient episodes of MRSA infection compared to 2016/17.
- 2.4 By March 2018, to ensure that all patients treated in Type 1 Emergency Departments and identified as “at risk of Sepsis” receive the “Sepsis bundle”
- 2.5 Throughout 2017/18 the clinical condition of all patients must be regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.
- 2.6 By March 2018, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016. Reports to be provided every six months through the Medicines Optimisation Steering Group.

#### Safe in Community Settings

- 2.7 During 2017/18 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.

## Associated quality and performance indicators

### Hospital Care

- B1 Staffing levels as reported in regular reports from PHA Delivering Care Implementation Board.
- B2 Number of records audited achieving 95% compliance of the accurately completed NEWS charts in all adult in-patient wards (excluding theatres and critical care departments).
- B3 Number of incidents of hospital-acquired pressure ulcers (grade 3 and 4) occurring in all adult inpatient wards, and the number of those which were unavoidable.
- B4 Percentage compliance with the falls safe improvement bundle.
- B5 Number of emergency admissions returning within seven days and within 8-30 days of discharge.
- B6 Clinical causes of emergency readmissions (as a percentage of all admissions) for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF).
- B7 Number of emergency readmissions with a diagnosis of venous thromboembolism.
- B8 Number of emergency admissions and readmissions in which medicines were considered to have been the primary or contributing factor.

### Community Care

- B9 Number of revisits required to achieve compliance in (i) residential homes, (ii) nursing homes, in 2015/16 and 2016/17, as published by RQIA.

### **Outcome 3: Improve the quality of the healthcare experience.**

The Health and Social Care system belongs to everyone and those providing services or availing of services can bring valuable insights into how it can best be organised and improved. Through working in partnership and utilising coproduction techniques - patients, service users, families, staff and politicians – can participate in the development of a person centred service which benefits us all. In undertaking such work everyone who uses and delivers health and social care services should be treated with respect, listened to and supported to work as real partners.

Staff and patient voices from across the system should be aligned closely to the quality improvement, inspection and regulation systems to ensure issues are raised in as timely a manner as possible and addressed early before they escalate to a complaint.

#### **Objectives/ goals for improvement:**

- 3.1 By March 2018, to have reported on the evaluation of the impact of Understanding the Needs of Children in Northern Ireland (UNOCINI) on improving outcomes for children and families.
- 3.2 During 2017/18 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.
- 3.3 By March 2018, patients in all Trusts will have access to the Dementia portal.
- 3.4 By March 2018, to have arrangements in place to identify individuals with a palliative care need in order to support people to be cared for in a way that best meets their needs. In 2017/18, the focus will be on undertaking and evaluating a pilot identification project.

## Associated quality and performance indicators

### Mixed Gender Accommodation

C1 PHA report on compliance with same gender accommodation by Trusts.

C2 PHA report on Trust compliance with requirement to have policy in place for the provision of Safe and Effective Care and Treatment in Mixed Gender Accommodation, which reflects the DHSSPS Guiding Principles for Mixed Gender Inpatient Accommodation.

### Palliative Care

C3 Implementation of a protocol to support the identification of patients with palliative and end of life care needs in Primary Care systems. [Source: PHA/ HSCB evaluation report of agreed protocol]

## **Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them**

Timely access to the most appropriate services is considered a key indicator of quality and the patient experience. People rightly have an expectation that they should be seen and treated within a reasonable time in the most appropriate location. Prompt, early diagnosis and intervention can avoid the need for scarce acute sector services while supporting a high quality of life.

The way services are designed and delivered will change, focussed on providing continuity of care in an organised way. Such transformation will increasingly require working across traditional organisational boundaries and to develop an environment characterised by trust, partnership and collaboration.

However during the period of transition to the new model of care it will be important that existing services continue to be delivered in a safe and timely fashion.

### **Objectives/ goals for improvement:**

#### Primary Care Setting

4.1 By March 2018, to increase the number of available appointments in GP practices compared to 2016/17

4.2 By March 2018, to have 95% of acute/ urgent calls to GP OOH triaged within 20 minutes.

The NI Ambulance Service faces growing demand for the services they provide. In response to this and other challenges the NIAS are transforming how they deliver their services. Although the introduction of new ways of working, such as Alternative (or Appropriate) Care Pathways, has contributed to a reduction in the use of Acute Care facilities demand remains high for a prompt response to life threatening events.

4.3 From April 2016, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.

#### Hospital Care Setting – Acute Care

When patients and service users need urgent treatment only provided in acute sector settings they often are frustrated by apparently lengthy treatment delays due the failure of the current service delivery model to provide a high quality service in a timely fashion.

In responding to the objectives below it will be essential for the Commissioning Plan to demonstrate how such services are being transformed, with alternative models of care embedded across Northern Ireland. Thus ensuring more people can be seen and treated effectively (including on a same/ next day basis), preventing unnecessary

admissions to hospital, and supporting people to recover following periods of ill-health.

Proposals should include working towards the provision of the same level of care for inpatients seven days a week, the deployment of ambulatory care models, the utilisation of technology to provide timely access to specialist advice, and the scaling up and rollout of proven new ways of care delivery.

- 4.4 By March 2018, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.
- 4.5 By March 2018, at least 80% of patients to have commenced treatment, following triage, within 2 hours.
- 4.6 By March 2018, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.
- 4.7 By March 2018, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.
- 4.8 By March 2018, all urgent diagnostic tests should be reported on within two days.
- 4.9 During 2017/18, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

#### Hospital Care Setting – Elective Care

Often patients are referred to specialists for medical or surgical treatment of non-urgent or non-life threatening conditions that nevertheless require medical or surgical intervention. People rightly have an expectation that they should be seen and treated within a reasonable time. However, over the last number of years meeting the rising demand has been challenging and it is clear that the current service model is no longer suitable.

The longer term goal set out in Delivering Together is to significantly reduce the current waiting times for assessment, diagnosis and treatment, which have been described by the Minister as unacceptable. The aim of the introduction of new ways of working, such as Elective Care Centres and Assessment and Treatment Centres, is to return to the maximum waiting times of nine, nine and thirteen weeks that have previously been achieved.

In recognition that the introduction of a sustainable model, in a safe manner, must be undertaken methodically, the goals below represent realistic and achievable objectives that deliver stability prior to the implementation of the Elective Care Plan.



- 4.10 By March 2018, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.
- 4.11 By March 2018, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.
- 4.12 By March 2018, 55% of patient should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.
- 4.13 By March 2018, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

## Associated quality and performance indicators

### Primary Care

- D1 Number of available appointments per 1,000 patients per week, for each GP practice as reported in HSCB annual survey of GP practices.
- D2 Percentage of routine GP “out of hours” calls triaged within one hour.
- D3 Total out of hours GP attendances.
- D4 Number of GP referrals to emergency departments.

### NI Ambulance Service

- D5 Number of ambulance responses where the outcome is that the patient does not attend hospital.
- D6 (i) Patient handover times and (ii) ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes).
- D7 Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital.

### Acute Care

- D8 Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to 12 hours and 12 hours or more, before being treated and discharged or admitted.
- D9 Total time spent in emergency departments including the median, 95th percentile and single longest time spent by patients in the department, for admitted and non-admitted patients.
- D10 (a) Number and percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes; (b) time from arrival to triage (initial assessment) for (i) ambulance arrivals and (ii) all arrivals; and (c) time from triage (initial assessment) to start of treatment in emergency departments.
- D11 Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage scale at Type 1 or 2 Emergency Departments.
- D12 Time waited in emergency departments between decision to admit and admission including the median, 95th percentile and single longest time.
- D13 Percentage of people who leave the emergency department before their treatment is complete.

- D14 Percentage of unplanned re-attendances at emergency departments within seven days of original attendance.

Stroke

- D15 Average length of stay for stroke patients.

Elective Care

- D16 Number of GP and other referrals to consultant-led outpatient services.

- D17 Percentage of routine diagnostic tests reported on (i) within two weeks and (ii) within four weeks of the test being undertaken.

Specialist drug therapies

- D18 Number of patients waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.
- D19 Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for Multiple Sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.
- D20 Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye, and six weeks for the second eye.

Maternity

- D21 Intervention rates, including percentage of babies born by caesarean sections.
- D22 Number of babies born in midwife-led units.

## **Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them**

Successful implementation of Delivering Together to provide a person centred model of care, focussed on prevention, early intervention, supporting independence and wellbeing requires the creation of the circumstances for people to stay healthy, well, safe and independent.

It will be important that the principle of coproduction is at the heart of new initiatives for those with long term conditions, and that patients and service users are partners in the care they receive with a focus on increased self-management and choice.

### **Objectives/ goals for improvement**

#### Sustaining Good Health

5.1 By October 2017, to have Healthier Care Programme objectives set for the first phase of work to reorient services to better support those living with long term conditions. Proposals developed by local partnership to enable early adopters to implement from February 2018..As the work underpins the delivery of Programme for Government Outcome 4, reporting will be through established PfG mechanisms.

#### Increased Choice

5.2 By March 2018, secure a 10% increase in the number of direct payments to all service users.

5.3 By March 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.

#### Access to Services

5.4 By March 2018, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

#### Care in Acute Settings

5.5 During 2017/18, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

## **Outcome 5 - Associated quality and performance indicators**

### Supporting Independence

E1 Number of client referrals passed to reablement; number of clients starting a reablement scheme; and number of clients discharged from reablement with no on-going care package required'.

### Patient Discharge

E2 Percentage of learning disability and mental health discharges that take place within seven days of the patient being assessed as medically fit for discharge.

E3 Number of learning disability and mental health discharges that take place after 28 days of the patient being assessed as medically fit for discharge.

## **Outcome 6: Supporting those who care for others**

For an increasing number of people who require additional support and assistance the primary care or community care teams cannot fully meet their needs but it isn't appropriate for them to be admitted to a hospital or residential accommodation. In such cases ongoing support is provided by family or friends. The contribution of these informal carers is crucial to the ability of such people to live independently in the community.

Delivering Together is clear that the HSC should be organised to support that independence and to provide appropriate assistance to those who care.

It is important that these carers are supported to enable a balance to be struck between the duties of the caring role and their right to live their own life and pursue their own goals and interests.

### **Objectives/ goals for improvement**

- 6.1 By March 2018, secure a 10% increase (based on 2016/17 figures) in the number of carers' assessments offered to carers for all service users.
- 6.2 By March 2018, secure a 5% increase (based on 2016/17 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.
- 6.3 By March 2018, secure a 5% increase (based on 2016/17 figures) in the number of short break hours (i.e. non-residential respite) received by young carers
- 6.4 By March 2018, secure a 10% increase in the number of Understanding the Needs of Children in Northern Ireland (UNOCINI) assessments provided to young carers (against the 2016/17 figures)

## **Outcome 6 - Associated quality and performance indicators**

F1 Number of carers assessments offered, by Programme of Care.

F2 Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.

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## **Aim: Ensure the sustainability of health and social care services provided**

The objectives set out under the first two aims seek to improve the health of the Northern Ireland population and the quality of health and social care services provided to patients and service users. It is essential that these overarching aims are achieved within the resources available to the HSC.

The existing pressures and challenges arising from growing demand, patients living longer with complex needs and an aging population have not diminished therefore services must operate as efficiently and effectively as possible and result in the best possible outcome for patients.

However operating existing services efficiently is not enough to meet the growing demand and the Minister is clear that the HSC must change how health and social care services are delivered.

The Commissioning Plan therefore should demonstrate that currently commissioned services represent the most efficient use of resources and outline how benchmarking of productivity and efficiency measures across providers has informed commissioning decisions. In addition, it should detail the steps being taken to bring about change that will provide the highest quality care in a cost effective manner—on the basis of single solutions for the region.

Key actions required of the HSC for the period 2017/18 and beyond, to provide sustainable health and social care services, are contained in the objectives set out in Outcome 7 – Ensure the sustainability of health and social care services.



## **Outcome 7: Ensure the sustainability of health and social care services**

Established health and social care services are often accompanied by a plethora of checks, lists and forms developed over time to address particular issues. Transforming such services and the bureaucracy around them through making better use of technology to collect and analyse such information is essential as we move to a person centred model.

While these new solutions are being designed and introduced it remains important that we operate effective services, to prioritise all urgent patients and, thereafter, that all routine patients are seen in strict chronological order.

To reduce the impact of long waiting lists it will be important to minimise non-attendance rates, with outpatient appointment dates booked no more than six weeks in advance, and outpatient review appointments only taking place where there is a clear clinical need.

### **Objectives/ goals for improvement**

#### Primary and Community setting

- 7.1 By October 2017 extend access to the Electronic Care Record (ECR) to Community Pharmacists and to have a pilot programme in place to test appropriate access for independent optometrists. Reporting to be provided via ECR Project structures
- 7.2 By March 2018 to have concluded discussions on the future of community pharmacy services; to have new arrangements agreed, and commenced implementation of contract arrangements or frameworks.
- 7.3 By March 2018, to review the reporting arrangements for Delegated Statutory Functions (DSF), to produce an interim reporting framework that will demonstrate the impact and outcome of services on the health and wellbeing of service users, and by March 2019 to have established the outcomes framework and the baseline activity to measure this.

#### Hospital Setting

While demand for services continues to grow it is imperative that, in the short term, the HSC makes efficient use of the resources available. In the medium term the transformation set out in Delivering Together will introduce new ways of working that will provide a health and social care system capable of withstanding future demands.

- 7.4 By March 2018, reduce by 20% the number of hospital-cancelled consultant-led outpatient appointments.
- 7.5 By March 2018, to reduce the percentage of funded activity associated with elective care service that remains undelivered.
- 7.6 By March 2018, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

7.7 By March 2018, to obtain savings of at least £38m through the Regional Medicines Optimisation Efficiency Programme as a portion of the £90m prescribing efficiencies sought, separate from PPRS receipts by March 2019.

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## **Associated quality and performance indicators**

### Hospital efficiency

- G1 Number, rate and ratio of new and review outpatient appointments cancelled by hospitals.
- G2 Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient.
- G3 Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust.
- G4 Number of outpatient appointments with procedures (for selected specialties).
- G5 Day surgery rate for each of a basket of 24 elective procedures to continue monitoring performance and enable continued benchmarking with rest of UK.
- G6 Percentage of patients admitted electively who have their surgery on the same day as admission.
- G7 Elective average pre-operative stay.
- G8 Percentage of operations cancelled for non-clinical reasons.
- G9 Elective average length of stay in acute programme of care.
- G10 Excess bed days for the acute programme of care.
- G11 Cost of a basket of 24 elective procedures (Day surgery as per G5) by Trust.

### Prescribing efficiency

- G12 Level of compliance of GP practices and HSC Trusts with the NI Medicines Formulary; and prescribing activity for generic prescribing and dispensing rates.

## **Aim: Support and empower staff delivering health and social care services**

The Minister is clear on her support for those who work to provide our health and social care services and considers that the most valuable resource the HSC has is its people. It is vital that the HSC while investing in their future ensures their health and wellbeing is valued and protected.

As the implementation of Delivering Together moves forward it is important to have a workforce, with the right skills mix in place to deliver both the existing, commissioned services and support the transformation work. Therefore the Commissioning Plan must provide assurances to the Department that commissioners have worked with providers to ensure that appropriate staff are in place. It will be important that any longer-term workforce implications be notified to the Department.

While HSC staff include some of the most capable, committed and enthusiastic people in the public sector the Bengoa Report was clear that in order to bring about the required transformation they would be asked to change how they undertake their work and would need to develop new skills.

In order to embed the required culture of learning, quality improvement and partnership working throughout the HSC it will be necessary to develop Leadership and Change Management skills, critical to the successful delivery of the required transformation, across the range of health and social care staff and key independent practitioners. These skills will be delivered through the implementation of the HSC-wide Leadership Strategy and the Commissioning Plan should detail how resources will allocated to support the implementation of this work.

Finally as many HSC staff work directly with patients and service users they often see opportunities to improve “what we do and how we do it”. It will be important, going forward, that an infrastructure that capable of developing and distributing those ideas is provided.

Key actions required of the HSC for the period 2017/18 and beyond, to support and develop the capabilities of HSC staff, are contained in the objectives set out in Outcome 8 – Supporting the HSC workforce.

## **Outcome 8: Supporting the HSC workforce**

The Minister is clear in her wish that the HSC becomes an employer of choice; leading by example; investing in the wellbeing of staff, and making a tangible and positive contribution to the health and wellbeing of not only health and social care staff but society as a whole.

The HSC can realise these goals through supporting staff who deliver vital health and social care services, seeking to bring about positive change. Continued investment in training and development initiatives, such as the Quality 2020 Attributes Framework, along with the development of new multidisciplinary training programmes that maximise the effectiveness of the workforce will assist in achieving those outcomes.

### **Objectives/ goals for improvement**

#### Supporting our staff

- 8.1 By December 2017, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.
- 8.2 By March 2018, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2016/17 figure.

#### Investing in our staff

- 8.3 By March 2018, 30% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2.
- 8.4 By March 2018, to enhance the programme of suicide awareness and intervention training for staff across the HSC.

## **Associated quality and performance indicators**

### Sickness Absence

H1 Uptake of seasonal flu vaccine by frontline health and social care workers (as reported in PHA return to Dept).

H2 Percentage of HSC hours lost due to sick absence.

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**EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE  
(COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2017**

1. The Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.
2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister's vision and priorities during the year 1st April 2017 to 31st March 2018.
3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2017/18 financial year are resourced.
4. The objectives and indicators included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.
5. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.