DIRECTION

2018 No. X

The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2018-2019

The Department of Health (DoH) [(a)], 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 [(b)]:

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2018- 2019 and shall come into operation on 1 XXX 2018.

(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 2018 to 31 March 2019, 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[(c)],

(a) Departments Act(Northern Ireland) 2016 c.5
(b) 2009 c.1 (N.I.) as amended by 2014 c.5
(c) 1998 c.47

the discharge of statutory duty of quality, 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 contribute to 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 2018 to March 2019

5. The Regional Board shall record the information against the objectives and associated quality and performance indicators for the period April 2018 to March 2019

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 2018 to March 2019, 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 2018 - 2019

Introduction

This Direction sets out the priorities, aims and improvement objectives for the HSC for the 2018/19 financial year. The achievement of the objectives set out in this Direction will; support the realisation of the 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 draft 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 the four overarching and linked aims identified in Delivering Together, which acknowledge the challenges facing health and social care 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 Delivering Together aims are key objectives/goals that will progress the work to meet the future needs of the population and 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 2018/19 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.

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 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 as well as helping to create an environment that makes such choices easier.

It is accepted that the health and social care service cannot do this in isolation and that in order to achieve this aim will require us to work with other partners across government and other sectors in tackling the root causes of ill-health and reducing health inequalities. Maximising the potential of the local government community planning process will be an important enabler. We will support the development of thriving and inclusive communities through working in partnership with communities and with other sectors.

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 empowered and supported to lead healthy lives.

Key objectives/goals for the HSC for the period 2018/19 and beyond, to improve the health of the population, are set out at Outcome 1 – Reduction of Health Inequalities.

Outcome 1: Reduction of health inequalities

Achieving the aims of Delivering Together will result in the creation of an environment where people are supported to keep well in the first place. Through ensuring that people have the information, education and support to make informed choices around lifestyle, healthy eating, and the adoption of preventative actions such as maintaining good oral health we will empower people to take control of their own health and wellbeing and support them to stay healthy, well, safe and independent.

Work to support & enable healthy lives and tackle the causes of health inequality spans the entire life course; 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; intervening early to provide support to families before issues become complex and difficult to reverse; supporting infant mental health; ensuring our young people are equipped for a healthy adulthood, and supporting people to continue to live active and healthy lives as they age. Although we seek to address the needs of the entire population there are those who, at times, may require more focussed support such as prisoners, the homeless, the travelling community and LBGT people.

Objectives/ goals for improvement:

<u>Population Health</u>

1.1 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%.

1.2 By March 2019 to have expanded the "*Weigh to a Healthy Pregnancy*" to now include women with a BMI over 38. This programme is one element of the Departmental strategy "*A Fitter Future for All*", which 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.

1.3 By March 2019, through continued promotion of breastfeeding to increase in the percentage of infants breastfed, (i) from birth, and (ii) at 6 months. This is an important element in the delivery of the "*Breastfeeding Strategy*" objectives for achievement by March 2025.

1.4 By March 2019, establish a minimum of 2 "Healthy Places" demonstration programmes working with General Practice and partners across community, voluntary and statutory organisations.

1.5 By March 2019, to ensure appropriate representation and input to the PHA/HSCB led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach.

1.6 By March 2019, to establish a baseline of the number of teeth extracted in children aged 3-5 years - as phase 1 of the work to improve the oral health of young children in Northern Ireland over the next 3 years and seek a reduction in extractions of 5%, against that baseline, by March 2021.

Supporting Children and Young People

1.7 By March 2019, to have further developed, and implemented the "*Healthier Pregnancy*" approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation.

1.8 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 mothers.
- 95% of two year old reviews must be delivered.

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

1.9 By March 2019, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 "We give our children and young people the best start in life".

1.10 By March 2019, 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

1.11 By March 2019, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a "street triage" pilot and a "Crisis De-escalation Service" pilot. This work builds on previous investments in community mental health crisis teams and is an important element of the work to reduce the suicide rate by 10% by 2022 in line with the draft "*Protect Life 2 Strategy*".

1.12 By September 2018, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol and drug related harm and to reduce drug related deaths.

Supporting those with Long Term Conditions

1.13 By July 2018, to provide detailed plans (to include financial profiling) for the regional implementation of the diabetes feet care pathway. Consolidation of preparations for regional deployment of the care pathway will be an important milestone in the delivery of the "*Diabetes Strategic Framework*".

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 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 roadmap for the transformation of 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 their experiences, whether services are delivered well or things go wrong, and strives to ensure 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; and
- effective—everyone accessing HSC services should have the most appropriate treatment or care, in the most appropriate setting, with the best possible outcome;

"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/goals to address the quality and experience of health and social care are contained in the following 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 who produced the "*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:

<u>Safe in all Settings</u>

2.1 By March 2019 all HSC Trusts should have fully implemented phases 2, 3 and 4 of *Delivering Care*, to ensure safe and sustainable nurse staffing levels across all emergency departments, health visiting and district nursing services.

2.2 By 31 March 2019:

- Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 2%, as per the established recurring annual targets, taking 2015/16 as the baseline figure; and
- Taking 2017/18 as the baseline figures, secure in secondary care:
    - a reduction in total antibiotic use of 1%, measured in DDD per 1000 admissions;
    - a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions;
    - a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions, and
    - EITHER
        - that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category,

        OR

        - an increase of 3% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use.

With the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 10% by 31 March 2021.

**For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.*

Safe in Hospital Settings

Reducing Gram-negative bloodstream infections

2.3 By 31 March 2019 By 31 March 2019 secure an aggregate reduction of 11% of *Escherichia coli*, *Klebsiella spp*. and *Pseudomonas aeruginosa* bloodstream infections acquired after two days of hospital admission, compared to 2017/18.

2.4 In the year to March 2019 the Public Health Agency and the Trusts should secure a reduction of 7.5% in the total number of in-patient episodes of *Clostridium difficile* infection in patients aged 2 years and over, and in-patient episodes of Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection compared to 2017/18.

2.5 Throughout 2018/19 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.

2.5 By March 2019, review and regionally agree standardised operational definitions and reporting schedules for falls and pressure ulcers.

2.6 By March 2019, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group.

Safe in Community Settings

2.6 During 2018/19 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 are classed as unavoidable from the current baseline data.

B4 Percentage compliance with the falls safe improvement bundle specified settings including adult acute inpatient and elderly care settings.

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; 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 2019, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment.

3.2 During 2018/19 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 2019, patients in all Trusts should have access to the Dementia portal.

3.4 By March 2019, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.

3.5 By March 2019 the HSC should ensure that the Co-production model is adopted when designing and delivering transformational change. This will include integrating PPI, co-production, patient experience into a single organisational plan.

Associated quality and performance indicators

Palliative Care

C1 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 continue to change, focussed on providing continuity of care in an organised way. Transformation will increasingly require working across traditional organisational boundaries within and outside the HSC and the development of an environment characterised by trust, partnership and collaboration.

It will be important during the transition period that existing services are delivered to agreed standards, in a safe and timely fashion. The introduction of new performance/ accountability arrangements and associated Performance Improvement Trajectories will assist in securing steady improvement in existing services. Initially introduced in mid-2017/18 (covering elective, ED, Cancer services, mental health services and ambulance response times) the intention is to expand the arrangements to cover other, CPD standards during 2018/19.

Objectives/ goals for improvement:

<u>Primary Care Setting</u>

4.1 By March 2019, to increase the number of available appointments in GP practices compared to 2017/18

4.2 By March 2019, 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 2018, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.

<u>Hospital Care Setting – Acute Care</u>

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.

The reform of community and hospital services so that they are organised to provide care where and when it is needed, in the most efficient manner, is a high priority. It is inevitable

that the role of our hospitals will change as they focus on delivering the highest quality of specialist and acute care for patients across Northern Ireland. 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: 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, cross trust collaboration, and the scaling up and rollout of proven new ways of care delivery.

4.4 By March 2019, 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 2019, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

4.6 By March 2019, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

4.7 By March 2019, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

4.8 By March 2019, all urgent diagnostic tests should be reported on within two days.

4.9 During 2018/19, 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 that have been described 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.

4.10 By March 2019, 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 2019, 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 2019, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.

4.13 By March 2019, 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 The number of contacts per 1,000 patients per week, for each GP practice contracting to provide the NILES Demand Management, through submission of a survey to HSCB.

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 a person centred model of care will rely on a comprehensive understanding of what is important to those delivering care and those receiving that care. It will therefore 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

Increased Choice

5.1 By March 2019, secure a 10% increase in the number of direct payments to all service users.

5.2 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

5.3 By March 2019, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

5.4 By March 2019, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.

5.5 By March 2019, Direct Access Physiotherapy service will be rolled out across all Health and Social Care Trusts.

5.6 By May 2018, to have delivered the Children & Young People's Developmental & Emotional Wellbeing Framework along with a costed implementation plan

Care in Acute Settings

5.7 During 2018/19, 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.

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

Carers are vital partners in providing care and it is important that they are supported while carrying out their caring responsibilities. The contribution of informal carers is crucial to the ability of people who require assistance to live independently in the community. As the needs of carers continues to change, the type of support required must keep pace with that change. It will be important that they can strike a balance 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 2019, secure a 10% increase (based on 2017/18 figures) in the number of carers' assessments offered to carers for all service users.

6.2 By March 2019, secure a 5% increase (based on 2017/18 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 2019, to create a baseline for the number of young carers receiving short breaks (ie non-residential respite).

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.

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 provide in the best possible outcome for patients.

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

The Commissioning Plan 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 2018/19 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 investment in technology enabled business solutions such as Encompass, will harmonise and standardise care and information processes. Such investment will ensure our staff have the required information at hand and are empowered to efficiently deliver a person centred model of care.

While awaiting the introduction of new business solutions it remains important to maximise the impact of the available resources to deliver the best patient outcomes, particularly in the facing of increasing financial pressures. HSC Trusts should therefore continue to develop multi-disciplinary, team-based approaches to delivering care aligned with GP Practices.

The HSCB, PHA and Trusts should demonstrate how they ensure services are operated in an optimal manner and that all urgent patients referrals are prioritised 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 maximise -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 March 2019, to have commenced implementation of new contractual arrangements for community pharmacy services.

7.2 By March 2019 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users 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.

7.3 By March 2019, to establish a baseline of the number of hospital cancelled, consultant led, outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment and by March 2020 seek a reduction of 5%.

7.4 By March 2019, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

7.5 By March 2019, 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.

7.6 By March 2019, to have obtained savings of at least £90m through the 2016-19 Regional Medicines Optimisation Efficiency Programme, separate from PPRS receipts.

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

Those who work tirelessly, and with great skill and dedication, to provide our health and social care services are the HSC's most valuable resource. It is vital that the HSC invests in their future and ensures their health and wellbeing is valued and protected.

As the implementation of Delivering Together moves forward it is important to have an optimally sized and resourced workforce, with the right skills mix in place to deliver both the existing, commissioned services, promote health and wellbeing and support the transformation work.

In 2018, the Department will, as an outworking of Delivering Together, publish a Workforce Strategy, which aims to meet our workforce needs – and the needs of the workforce. The Commissioning Plan will need to take the aim, objectives, themes and actions of the strategy into account, and detail how resources will be allocated to support the implementation of the strategy.

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 Collective Leadership Strategy and the Commissioning Plan should detail how resources will allocated to support the implementation of this work.

Key actions required of the HSC for the period 2018/19 and beyond, to support and develop the capabilities of HSC staff, are contained in the objectives set out in Outcome 8 – Supporting and transforming the HSC workforce.

Outcome 8: Supporting and transforming the HSC workforce

The HSC competes with other employers to secure the skills and talents of the best people. It must therefore become an employer and trainer 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 the staff who deliver vital health and social care services and seeking to bring about positive change. Continued investment in training and development initiatives, 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

The implementation of the Workforce Strategy will demonstrate to our health and social care workers that the transformation set out in Delivering Together is underway. The actions for 2018/19 described below will contribute to ensuring that an adequately-resourced and skilled workforce is available to take forward work to discharge departmental Programme for Government commitments.

Implementing the Workforce Strategy

8.1 By June 2018, to provide appropriate representation on the programme board overseeing the implementation of the health and social care Workforce Strategy.

Attracting, recruiting and retaining staff

8.2 By June 2018, to provide appropriate representation on the project board to establish a health and social care careers service.

Effective workforce planning

8.3 By March 2019, to have completed the first phase of the implementation of the domiciliary care workforce review.

8.4 By June 2018, to provide appropriate representation to the project to produce a health and social care workforce model.

Build on, consolidate and promote workforce health and wellbeing and staff engagement

8.5 By March 2019, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10 – 14 of the Workforce Strategy.

Improving business intelligence

8.6 By December 2018, to provide the information required to facilitate the proactive use of business intelligence information and provide appropriate personnel to assist with the analysis.

Supporting our staff

8.7 By December 2018, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.

8.8 By March 2019, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2017/18 figure.

8.9 By March 2019, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG.

8.10 By March 2019 to pilot an OBA approach to strengthen supports for the social work workforce

Investing in our staff

8.11 By March 2019, 50% 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 by March 2020.

8.12 By March 2019, to have developed and commenced implementation of a training plan on suicide awareness and suicide intervention for all HSC staff with a view to achieving 50% staff trained (concentrating initially on frontline staff) by 2022 in line with the draft Protect Life 2 strategy.

8.13 By March 2019, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts.

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.

H3 Percentage of HSC staff trained in suicide awareness / prevention.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2018/19

1. The 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 vision and priorities during the year 1st April 2018 to 31st March 2019.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2018/19 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.