



Transforming Your Care

Vision to Action

A consultation document
9 October 2012 - 15 January 2013

Minister's foreword



I am pleased to announce for consultation a response to the proposals set out in *Transforming Your Care*, a review of Health and Social Care in Northern Ireland.

The provision of safe, sustainable and resilient services to meet the needs of the population of Northern Ireland is a key priority for me. As Minister for Health, Social Services and Public Safety, I want to ensure that I do everything I can to deliver on that priority. To do that, I need to take account of all of the factors which impact on our ability to deliver services effectively, and then respond to those in a planned and responsible way.

My vision is to drive up the quality of care for patients, clients and service users, improve outcomes, and enhance the patient experience so that people are treated in the right place, at the right time and by the right people. To achieve this vision, we need to look at how we can improve health and social care and, in so doing, reshape how we interact with all of those who use our services. That is, I believe, an aim that is also shared by people who deliver services daily throughout our health and social care system.

In that context a major consideration is to ensure that we have a clear understanding of the needs of our population. Our society is changing which means that the needs of our society may also be changing. We have a growing and ageing population with people living longer. This is something to celebrate but it also means that there are more people with long term conditions and this inevitably places more demand on our health and social care services, including our hospitals and other resources. Although these changes present us with challenges, they also offer us opportunities to look innovatively at how we can reform and modernise our services to meet the changing needs of our society now and into the future.

In June 2011, I announced a review of the provision of Health and Social Care (HSC) services in Northern Ireland to provide a strategic assessment across all aspects of health and social care. The review was asked to examine the present quality and accessibility of services and the extent to which the needs of patients, clients, service users and the wider community were being met.

The HSC Review Report *Transforming Your Care* (TYC) was published in December 2011. The Report sets out a compelling case for change and a strategic direction for the future of health and social care services in Northern

Ireland which has the potential to make a huge difference to how we plan and deliver our services into the medium and long term.

Transforming Your Care proposes significant and major changes across Health and Social Care in Northern Ireland. It focuses on reshaping how services are to be structured and delivered in order to make best use of all resources available to us, and in so doing ensure that our services are safe, resilient and sustainable into the future.

I believe the strategic direction set out in *Transforming Your Care* and the potential changes arising from it support my vision for Health and Social Care and aligns fully with the existing policy framework for health and social care services.

I published the *Quality 2020* strategy in 2011, to ensure that we can effectively protect and improve quality of services going forward in all we do. The key principles underpinning the approach in *Transforming Your Care* are all reflected in *Quality 2020*. My Department is also consulting on the draft public health strategic framework – “*Fit and Well -Changing Lives*” - which will help shape and influence the implementation of the proposals arising from *Transforming Your Care*, with ultimately positive health outcomes for our citizens.

It is vital that we continue to make the decisions and take the actions that are necessary to improve the outcomes for patients and clients. The proposals in *Transforming Your Care* are about change; change in how we plan services and in how we deliver them. It is about reforming and modernising services so that they are focused on people rather than institutions.

This consultation document seeks your views, as patients, clients, services users, service providers and citizens - about how we respond to the proposals arising from *Transforming Your Care*. During the consultation process there will be a series of public engagement events. We will aim to ensure that everyone is informed and involved in this process and has the opportunity to make their views known. I would therefore encourage you to engage with this important consultation, let us know your views, and so contribute to the delivery of improvements to our Health and Social Care services.



Edwin Poots MLA
Minister for Health, Social Services and Public Safety

Chairman and Chief Executive's foreword

The Minister has asked the Health and Social Care Board (HSCB) to lead consultation about the specific implications of *Transforming Your Care* (TYC), and how they might affect the population. This document has been prepared with that objective in mind. Change is inevitable in how health and social care is provided to the population. That should be properly balanced with the personal experience which is the principal interest of most individuals. What is clear is that everyone wants a safe, sustainable service which delivers quality and best outcomes.

This consultation presents a way forward to achieve this but it is important that if the proposals are to become firm propositions they do so after a full debate. The document describes how this debate will happen. The HSCB would encourage an open and frank debate. It is in everyone's interest that well informed decisions about the future of Health and Social Care are taken so that transition can be understood and managed.



John Compton
Chief Executive
HSCB



Dr Ian Clements
Chair
HSCB

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Part 1.

Transforming Your Care: From Vision to Action

Following the publication, in December 2011, of the Review of Health and Social Care in Northern Ireland, *Transforming Your Care (TYC)*, the Health and Social Care Board (HSCB) was asked by the Minister for Health, Social Services and Public Safety to take forward many of the proposals set out in TYC. In response to this request, draft Plans were developed outlining the key service changes which arise from the TYC proposals over the next 3 to 5 years. These draft Plans are:

- draft local Population Plans reflecting local needs; and
- a draft Strategic Implementation Plan which gives a wider Northern Ireland overview.

The Minister also asked the HSCB to prepare a consultation document, and lead the public consultation on these key service changes. **Your views are very important, as the changes we propose in this document are substantial to the services used by you and your family.**

This document summarises the key proposals for change to be considered in the context facing Health and Social Care (HSC) in Northern Ireland. The changes that are needed in Health and Social Care will be challenging, but if the Northern Ireland population is to have safe, resilient, high quality and sustainable health and social care services for future generations then change is necessary. TYC gives focus to a process of on-going change that has already started and is happening across the service, as well as bringing forward some new proposals to accelerate that change.

In this section we tell you about:

1. *The background to TYC*
2. *What this document is about*
3. *Who the consultation is aimed at*
4. *Why we are doing the consultation*
5. *The scope of the consultation*
6. *How this document is structured*

1.1 Background

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, asked for a Review of the Provision of Health and Social Care (HSC) Services in Northern Ireland. The Review was to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, users, carers and communities are being met. Crucially it was to bring forward proposals for the future shape of services and provide an implementation plan.

The Review team was asked to ensure that available resources were used to best effect, and this continues to be a major driver for TYC.

Overwhelmingly the Review was about making changes which would have the greatest beneficial impact for patients, users and carers, and about ensuring we have a safe, resilient, high quality and sustainable health and social care system for the future.

There is much to be proud of in our Health and Social Care system but there is a stark reality ahead. We have a growing and ageing population and those with disabilities are living longer. While these are facts to celebrate this, together with:-

- the rising cost of technologies and drugs;
- lifestyle issues such as obesity and alcohol; and
- family structures and pressures leading to rising demand for children's services

means that we need to think differently to meet the demands that lie ahead. Without change there is a growing potential for instability in the Health and Social Care system and an increasing difficulty in meeting the future needs of our citizens.

We need to prepare our services for the future, and this will mean making choices about how we want our health and social care services to be delivered, based on the best evidence.

In this document we set out a proposed strategic way forward. We want to hear your views about what we say and encourage a debate about what the future looks like.

1.2 *What is this document?*

This document provides information to help all citizens of Northern Ireland to contribute to the debate on the future of our Health and Social Care.

It is based on the draft Population Plans which have been developed by Local Commissioning Groups with input from Health and Social Care Trusts, to reflect local needs, and a draft Strategic Implementation Plan which gives a wider Northern Ireland overview. All of these documents were originally published in July 2012 but have since been revised following a period of quality assurance. The revised draft Plans are available on www.tyconsultation.hscni.net or by contacting us via the contact details in Part 3.

Such a major programme of change to a system which covers 1.8 million citizens, spends over £10 million per day, and employs over 70,000 people will inevitably be complex and complicated. Naturally, however, most people simply want to be able to understand the individual and personal impact of the changes on them and their family and friends. This is what this document aims to do.

Change is happening all around us on a daily basis and our Health and Social Care system is no different. It is changing all the time. We are continually able to introduce new treatments and support. TYC expressly recognises this, and seeks to provide an overarching framework within which changes can be made.

The proposals in TYC are not about pausing or stopping changes that are underway and already delivering better outcomes or experiences for patients, staff, users and carers, rather TYC seeks to draw these together into a clear and coherent picture. It brings all the changes into a managed programme of transformation to avoid haphazard changes which could potentially have unintended consequences for patients, staff, users and carers.

Therefore, some of the things you read in this document are not new, and may simply relate to the implementation of a strategy or policy which has already been agreed and is underway. Others will be new. We believe it is important to be clear and transparent about these new developments, and therefore this document focuses on them.

We want to encourage open and honest debate on this transformation. These draft plans contain our proposals and aspirations for how we would like to implement the changes proposed under TYC. We want to hear your views on these proposals so that they can inform the decisions for the future provision of services.

Even after this process, all significant service changes, such as the change of use for a facility or a change to the way services are delivered in your local area would be subject to separate public consultation focussed specifically on that change – just as we would for any change in service, in line with our consultation and equality schemes and duties.

Indeed, some of the changes which were already in the pipeline have been issued for public consultation in recent months, or are due to be issued soon. For example, in this document we mention our proposals for Emergency Departments in the Belfast area, and we will soon be consulting on the options for reconfigured services across the acute hospitals in greater Belfast.

1.3 Who is this consultation aimed at?

This consultation is aimed at everyone. We all either use health and social care services, or are highly likely to do so in future; or indeed you may be involved in providing health and social care services. Therefore we are keen to hear from anyone, or any group, who has a view on the proposals in this document.

1.4 Why are we doing this consultation?

We want to be clear and transparent about what we are doing, and are committed to doing so in a co-ordinated manner rather than introducing piecemeal changes which people cannot see or fully understand . We also recognise that the health and social care system is complex and it has different impacts on different people at different times.

Therefore, we are consulting on our overarching strategic direction, and how we are responding to the proposals set out in TYC. But more importantly, we are continuing the debate started with the Review of Health and Social Care, and described in TYC, and want this to be informed and meaningful.

1.5 What is the scope of this consultation?

This consultation is on the Minister's proposals for changes in the delivery of Health and Social Care in Northern Ireland following consideration of the proposals set out in the TYC report published in December 2011.

We want your comments and views on the proposed changes explained in this document, and in the draft plans. It is these major areas of proposed change we want to focus on in this consultation.

There are difficult choices ahead about how we organise ourselves to provide the best possible care to everyone in Northern Ireland, and we need your views on how to make these choices and changes.

This does not always mean it is a simple “either/or” choice between two types of service – rather it may be a choice about “how” we deliver care. For example, it is not a choice about **whether** our frail elderly should receive care and support, but **how** this should happen to ensure the best possible services using the resources available.

It is also important to note that there are a number of other major consultations happening at the moment – notably:

- “*Fit And Well – Changing Lives – A Ten Year Public Health Strategic Framework For Northern Ireland*”; and ¹
- “*Who Cares? - the Reform of Adult Care and Support*”.²

These consider the longer term challenges facing our health and social care system and how best to prepare for those challenges. This consultation complements the proposals in both “Fit and Well” and “Who Cares?” and all three form essential elements of the Minister’s strategic approach to the transformation of Health and Social Care for the future.

We recognise that the draft Population Plans are complex and detailed documents that contain a range of proposals arising from TYC.

Therefore, in this document we want to:-

- Focus on the areas which would see the most significant change in the future.
- Be as specific and explicit as possible about what this might mean for patients, staff, users and carers, whilst recognising the uniqueness of each and every individual’s circumstances.

1 DHSSPS (2012) “Fit And Well – Changing Lives – A Ten Year Public Health Strategic Framework For Northern Ireland”

2 DHSSPS (2012) “Who Cares? Reform of Adult Care and Support”

1.6 How is this document structured?

This document focuses on those proposals which we anticipate would have the greatest impact as we look ahead to changing the shape of our health and social care services, and be as clear and specific as possible about what this means for citizens.

The TYC Report itself, and the draft plans, are structured around the concept of 'Programmes of Care'. We will use the same structure here, having regard also to four themes set out in the TYC model: individual, local services; acute services; and very specialist (or supra specialist) services.

In **Part 2**, we provide more detail on why there is a compelling need for change, and the future model of care proposed by TYC and what it seeks to achieve.

In **Part 3**, we set out how you can get involved.

In each section of **Part 4**, we highlight the key proposals and what these mean. Where there are likely to be significant local implications arising from the proposals these are also explained. Each section sets out question(s) we would particularly seek your views on, although we welcome your views on any aspect of the proposals.

In **Part 5** of this document, we discuss how we need to make changes to support how we turn these proposals into reality, and discuss the possible implications for our workforce and organisation, for our finance, for technology advances, and for how we procure services from organisations outside the HSC family.

The remainder of the document sets out what happens next.

Part 2.

The need for change and the Transforming Your Care model of care

In this section we set out:

- *Why do we need change*
- *The Transforming Your Care (TYC) vision and objectives*

2.1 Why do we need change?

The need for change is first and foremost about using evidence to create a better outcome or experience for the citizen. We can and should do better. Remaining 'as it is' will result in unplanned, and, at times, difficult decisions.

TYC sets out compelling reasons why we need to change. This is not a criticism of what we have now, but recognises that with the challenges ahead, the way we do things now is not going to work well in the future. The system is already under pressure and this is likely to increase dramatically over the next few years.

In looking to the future, there are no neutral decisions. We have to make choices, and these choices need be centred around what is best for the patient or user, not what is best for a building or institution. If we do nothing, the system simply will not be able to provide the high quality and safe services necessary to meet the needs of people in Northern Ireland.

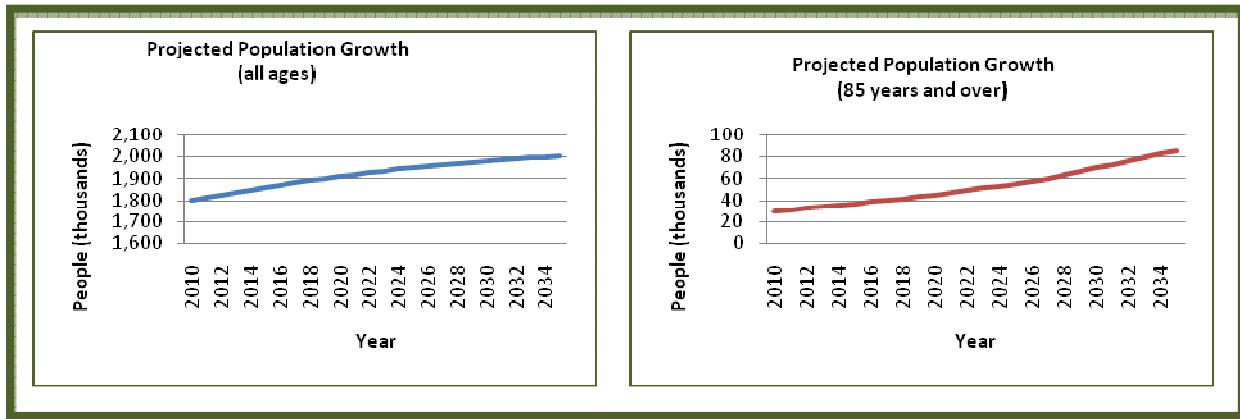
The key factors driving why we need to change are:

- 1. A growing and ageing population:** In Northern Ireland we have one of the fastest growing populations within the UK. The Northern Ireland Statistics and Research Agency (NISRA) has projected the NI population to rise from 1.8 million in 2010 to nearly 2 million in 2025 (this is an increase of nearly 8%)³.

They also project that over the same 15 year period, the numbers of people aged 65 and over will increase by 42% from 260,000 to 370,000. In contrast,

the number of people of working age is projected to increase by only 1.4% from 1,109,000 to 1,124,000 in 2025⁴.

Looking at the projected figures for the over-85 population, the increase is much more dramatic: by 2025 the number of people aged 85 and over will increase by 25,000 to 55,000 (83%). The over-85 population will double by 2027 compared to 2010¹.



Source: NISRA 2010-based National Population Projections

2. **Increased prevalence of long term (chronic) conditions:** There are increasing numbers of people with chronic conditions such as diabetes, respiratory problems, stroke and obesity. Also, individuals often have multiple conditions and sometimes our system could be better co-ordinated in how we deal with this.
3. **Increased demand and over reliance on hospital beds:** it is estimated that the demand for services could grow by 4% per year until 2015⁵. If services continue to be delivered as they are currently this could mean 23,000 extra hospital admissions, 48,000 extra outpatient appointments, 8,000 extra nursing home weeks, and 40,000 extra 999 responses. Simply providing more beds will not address these challenges and will not lead to improving the quality of our services.
4. It is getting more and more difficult to **ensure clinical workforce supply** which can put pressure on service resilience. We have a dedicated and highly skilled workforce but we need to ensure we have a health and social care system that is fit for purpose for them to work in. At the moment, they

4 NISRA (2010) National Population Projections

5 McKinsey (2010) Reshaping the System

want to deliver a better service but can sometimes be constrained from doing so.

5. We need to have **better productivity and value for money**: the TYC Review and Report was not about saving money, it was about making best use of what we have. We can always be more efficient and get more for less by doing things differently. This means ensuring the HSC is configured on the ground in a way which most effectively supports the delivery of first-rate care.

2.2 The Transforming Your Care Vision and Objectives

We all need to think differently about health and social care, and how we use and deliver services. The TYC report sets out proposals for a future model of care which is different to what we are used to. In the past our services have been too often designed around a building. We need to get better at building our services around the needs of the individual, patient and service user.

What has not changed is a belief in the principles of the NHS and the core objectives of what our Health and Social Care system is there to do. These principles are that health services:

- are generally free at the point of delivery, based on individual need not ability to pay;
- are funded by taxation; and
- are available without prior restriction on which cost-effective treatments or therapies individuals should receive – thus the best available cost effective services will be provided for all citizens.

The 12 key principles underpinning the approach in TYC are set out on the next page.

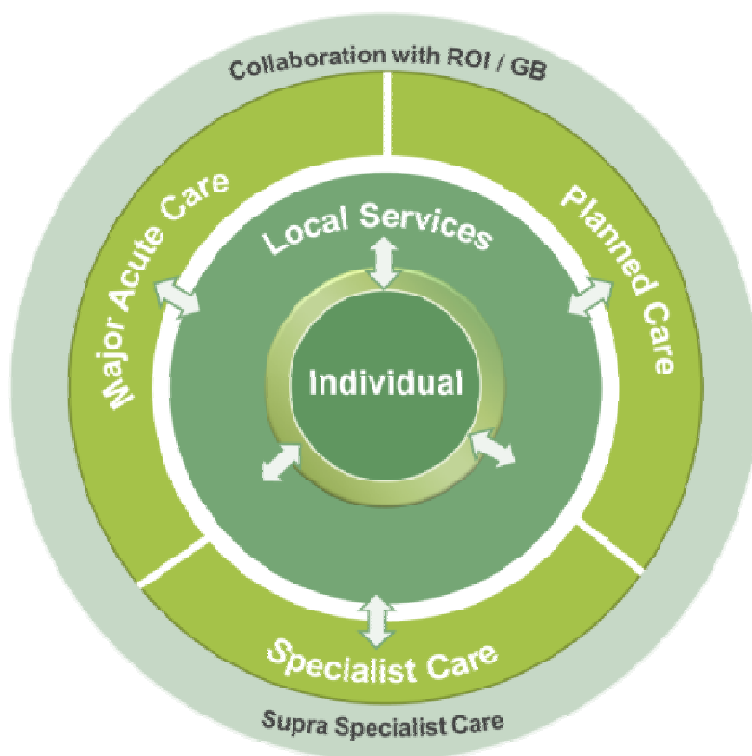
1. Placing the individual at the centre of any model by promoting a better outcome for the user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.
5. A focus on prevention and tackling inequalities.
6. Integrated care – working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.

These principles reflect the key desired outcomes for TYC:

- People will get support to stay healthy, make good health decisions or manage their own conditions.
- More services will be provided locally with opportunities to access specialist hospitals where needed.
- More people will be cared for at home, where it's safe and appropriate to do so.
- People will have more choice and greater control over the types of services they are able to access.
- Investment in new technology will help people stay at home or receive care locally rather than in hospitals.
- Doctors, nurses, social workers and everyone providing care will work together in partnerships to help keep people healthy and prevent them going to hospital when that's not necessary.
- Any decisions about how we do things should be driven by evidence that it will be better for patients and users, and be better quality.
- Everyone working in health and social care services will be supported in helping to make the changes set out in TYC.

In organising care around the individual at the heart of the model, rather than the institution or the hospital, this broadly translates into four key themes which will be covered in this document:

1. **Individual** – Health and social care services start with a healthy person – so how can we help you to improve your own health and wellbeing, prevent illness, and have more independence and manage your own care when you need it?
2. **Delivering health and social care services as locally as possible** – often called ‘primary and community care’ settings – how you can access and receive services in the most appropriate place for you. By viewing the home or the community as the hub of care, we reduce the need for avoidable visits to hospital.



Care should be based on the specific needs of each individual (‘personalisation’) and more of the decisions should be taken by the individual patient or client. This could take the form of Direct Payments where a person receives a cash payment to arrange their own support. Or it could involve the individual deciding how the budget for their care will be spent. The aim is to ensure that care is built around the needs of the individual and that each person should have more control over how their needs are met and what services are provided.

3. **Safety and Quality of acute care in hospital settings.** Emergency care and planned specialist care will still need to be provided in hospitals as the most appropriate place to receive such services. The key principle is that we need to ensure that these services are safe and sustainable, and meet the best quality standards.
4. How we **can collaborate better with our neighbouring jurisdictions** – in some cases, the very best care may not be in Northern Ireland, where there is low volume or the treatment is highly specialised. In other cases we will be able to provide care for those living outside our borders.

TYC sets out a future model of care and these themes run through the proposals set out in each area of care outlined in Part 4 of this consultation document. We would like your views on these themes and the proposed model of care, and have set out some general questions below.

Question 1.

Do you agree that our health and social care services need to change in order to meet the needs of the community and promote health and well-being through prevention and early intervention so that as much acute illness as possible is avoided?

Question 2.

Do you agree that people who need care and support should have control over how their assessed care and support needs should be met?

One of the key themes of TYC is the increased use of individualised budgets and self-directed support. This could take the form of Direct Payments where a person receives a cash payment to arrange their own support, or it could involve the individual deciding how the budget for their care will be spent. In all cases it should ensure the individual has maximum choice and control in planning the services they receive.

Question 3.

Do you feel the provision of individualised budgets and self-directed support should be more widely promoted?

The following questions are relevant to these sections:

- a. Older People (section 4.3)
- b. Long Term Conditions (section 4.4)
- c. Mental Health (section 4.6)
- d. Learning Disability (section 4.7)
- e. Physical Disability and Sensory Impairment (section 4.8)

Please refer to these sections when you are considering your response to the questions below.

Question 4.

Do you agree we should organise our services to enable people to stay at home for as long as possible and / or be cared for at home?

Question 5.

Given the choice, who would you like to provide your care and support in your home?

1. *Statutory bodies*
2. *Voluntary and community groups*
3. *Independent sector*
4. *A mixture of the above*
5. *You would prefer to receive the money yourself to choose*

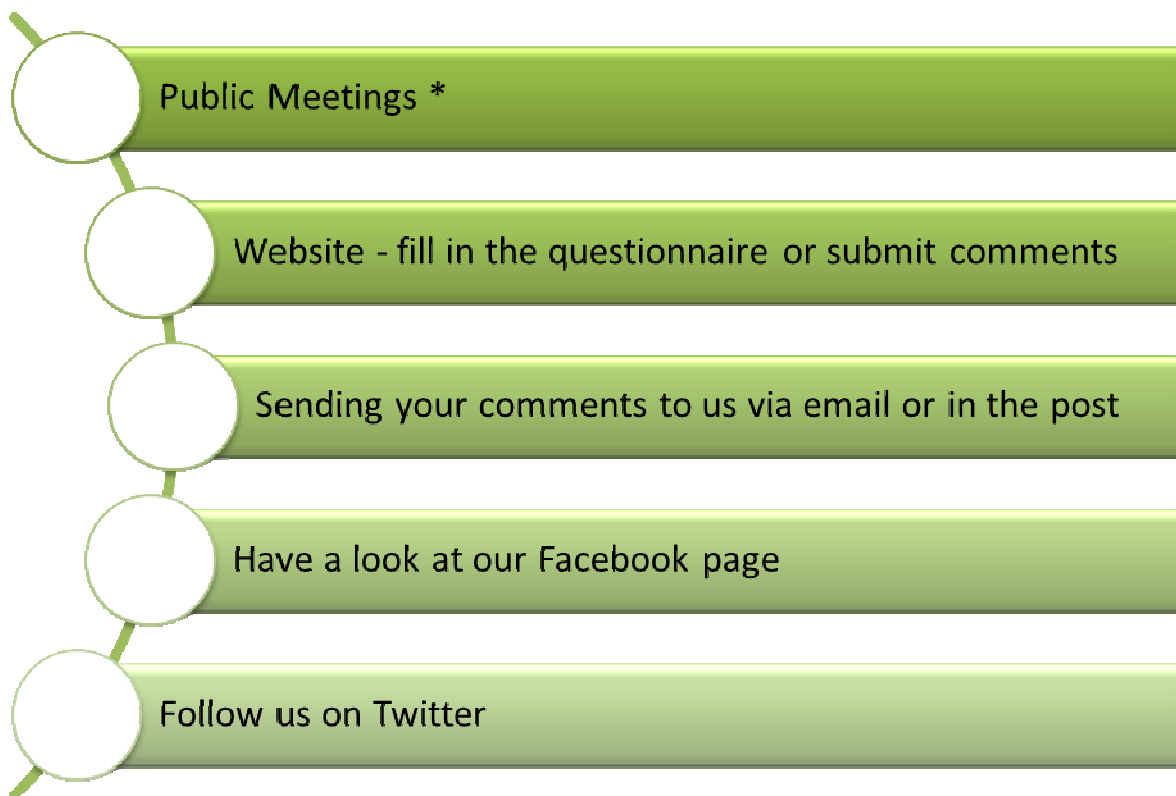
Part 3.

How you can get involved and respond to this consultation

Transforming Your Care (TYC) sets out important changes to our health and social care system. Whilst it is a long term vision, and the plans we describe would take place over a number of years, it is important to understand what this might mean for you, and get involved.

We want to hear your views and include them in shaping the service for all the citizens in Northern Ireland, to promote the best outcomes for everyone.

You can get involved in lots of different ways:



* There are a number of meetings taking place across the region being organised by the HSCB. Keep an eye on the website or in local press for details.

Copies of this document, the draft Population Plans and the draft Strategic Implementation Plan are available from:-

- Our website: www.tycconsultation@hscni.net
- Contacting TYC Programme by phone, email or by post

A separate questionnaire is also available to help you to record your comments and this can be filled in online, or downloaded and sent into us. You can send us your answers or comments, by post or email to:

TYC Programme Team
Health and Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

Website: www.tycconsultation.hscni.net
Email: tycconsultation@hscni.net
Telephone: 02890 553790
Textphone: 18001 02890 553790
Fax: 02890 553625

You can also find us on facebook and twitter.

**However you choose to give us your views, we want to hear from you.
Please send us your comments by 15 January 2013.**

Alternative formats of this document including EasyRead, Braille, audio formats, large print or minority languages (for those not fluent in English) are available on request. Please contact us as above with your request.

Part 4.

Our proposals in response to Transforming Your Care

In this part of the consultation document, we outline our proposals for change in health and social care services, in response to many of the proposals set out in *Transforming Your Care*.

This part is structured as follows:

1. Population Health and Wellbeing
2. Delivering services at home and in the community: Integrated Care Partnerships
3. Older People
4. Long Term Conditions
5. Palliative and End of Life Care
6. Mental Health
7. Learning Disability
8. Physical Disability and Sensory Impairment
9. Family and Child Care
10. Maternity and Child Health
11. Acute Care in Hospitals
12. Increasing our links with the Republic of Ireland and Great Britain

In each of the sections we set out:

- *background*
- *key proposals*
- *questions we would particularly like to hear your views on*

4.1 Population Health and Wellbeing

Health promotion and prevention of illness are integral to the delivery of sustainable health and social care. This enables individuals to make better health and wellbeing decisions, and is an important factor in getting better health outcomes for the citizen. A period of public consultation on “*Fit and Well – Changing Lives – A Ten Year Public Health Strategic Framework for Northern Ireland*” began on 19 July 2012 and concludes on 31 October 2012.⁶

Investment in prevention of ill health and promoting population health and well-being makes economic sense, as well as delivering better outcomes for individuals. For example:

- There are 4,000 premature deaths per year in NI and 61,000 potential years of life lost through preventable illnesses⁷.
- Total annual inpatient costs to health and social care services in Northern Ireland as a result of smoking were estimated at £119 million in 2008/09⁸.
- Loss to the local economy as a result of obesity is estimated at £500 million, with 59% of the population being either overweight or obese⁹. This includes, for example, some £24.5 million spent on prescribed anti-diabetic medication alone¹⁰.
- The impact of the misuse of alcohol on the health and social care system is estimated at some £250 million. The total social costs are estimated at almost £900 million. Furthermore, it is estimated that alcohol is a significant factor in 40% of all hospital admissions, rising to 70% of Accident and Emergency attendances at weekends¹¹.

Given the significant impact of these issues on the health of the population and the costs of care, strategic and bold action is required. No system can withstand the pressure of doing nothing, and health and social care services have a duty to improve health and well-being, and reduce health inequalities in our population.

6 DHSSPS (2012) “Fit And Well – Changing Lives – A Ten Year Public Health Strategic Framework For Northern Ireland”

7 Public Health Agency (2009) Annual Report

8 RCP (2000) Nicotine Addiction in Britain: A report of the tobacco advisory group of the RCP applied to 2008/9 HRG costs. In: Ten Year Tobacco Control Strategy for Northern Ireland Consultation Document.

9 Health Survey Northern Ireland (2010/2011)

10 N Gallagher, Presentation QUB Centre of Excellence 2011, Source BSO.

11 DHSSPS (2008/09) Social Costs of Alcohol Misuse in Northern Ireland

We need to make better use of the resources that we have. Evidence shows that greater investment in preventative care and improving health and well-being is not just good for patients, service users and the public, but is highly cost-effective.

Examples of highly effective public health programmes already in place which prevent ill health or allow earlier diagnosis, more effective treatment and better outcomes for patients are:

- Stop smoking services;
- Public information campaigns on obesity prevention;
- Advice on alcohol and drug misuse;
- Early recognition of and support for mental health problems;
- Early access to GUM (genitourinary medicine) services; and
- Infection control, screening and immunisation programmes.

Greater reductions in the need for health and social care would come through more support for parents in the early years of a child's life, from enhanced services for all parents to intensive support for those in the most difficult circumstances. Some parenting programmes reduce the likelihood of alcohol and drug misuse, mental health problems, and smoking later in life and have been shown to pay for themselves within 4 years.

To enable that greater investment in prevention and promotion of health and wellbeing to happen, current services need to change at a scale that enables funding to be released from inpatient hospital services for reinvestment in the types of public health, primary and community services outlined above.

Simply re-providing acute care elsewhere however is not sufficient as it would not fundamentally improve the health and wellbeing of people in Northern Ireland. Instead, this should be a transformation in the health and wellbeing of people by **promoting** good health decisions, **preventing** ill health, **minimising** the impact of ill health when it does occur and **enabling** people to live healthily and independently for as long as possible.

The proposals for the future approach to population health and well-being are set out in "Fit and Well: Changing Lives" and these complement the proposals in this document and form an essential foundation for the changes proposed here. Everyone with an interest in these issues should respond to the consultation on "Fit and Well: Changing Lives" which is due to end on 31 October 2012.

4.2 Delivering services at home and in the community – Integrated Care Partnerships

Primary and community care are at the core of the delivery of health and social care and considered to be the appropriate setting to meet the vast majority of all health and social care needs. The services and resources available within primary and community care support people to manage and maintain their health and well-being, and have the potential to prevent the development of conditions which might later require hospitalisation. They can also facilitate earlier discharge from hospital.

One of the major proposals in TYC, and in our draft plans, is the introduction of Integrated Care Partnerships (ICPs) to support and enable our primary, secondary (i.e. hospitals) and community care to work differently and more effectively to fulfil the key principles set out above in Section 2.2 “The Transforming Your Care Vision and Objectives”.

ICPs would provide a collaborative network for local health and social care professionals, working as part of a multi-disciplinary team to come together and work in a more integrated way to provide care and support on a more complete range of services, in response to identified need and commissioner requirements. This would involve discussing, agreeing and taking action to improve how patients and service users are treated and dealt with throughout their interactions with Health and Social Care services. Evidence has shown that by all parts of the system working closer together, we can prevent unnecessary hospital visits and admissions.

For example, instead of visiting your GP, who decides you need a test, which would normally require a hospital outpatient appointment, this could be completed in a local surgery or at a local Health and Care Centre that is able to provide diagnostic services. Or again, in diagnosing a condition which would normally require a visit to a specialist consultant, this might be done through patient testing near you or by seeing the consultant who works in a local setting or in the hospital.

Across our system, we can see examples of where small-scale projects are evolving which show how the principles behind ICPs are having real impact, and we would like to provide the right environment to give impetus to this through investing in local services.

Critically this would:

- make it easier for people to access the health and social care system;
- provide an environment for new ideas and innovations with a stronger emphasis on prevention and early intervention;
- support quicker decision making, and therefore start the most appropriate treatment faster; and
- ultimately reduce the need to visit hospital for services which could more easily be delivered locally.

For ICPs, our key proposals are:

1. There would be initially 17 Integrated Care Partnerships across NI, including all GP surgeries and therefore providing services for all of the population.
2. It is anticipated that much of the **initial focus** of ICPs would be on improving some key aspects of the way services are organised for frail older people, and of services for people with specific long term conditions such as Chronic Obstructive Pulmonary Disease and diabetes. Building on this experience there would be scope for ICPs to evolve and develop into other areas in future. An objective would be to reduce measurably hospital admissions.
3. ICPs would proactively develop and put in place strategies to **identify patients at most risk** of having to go into hospital unexpectedly and put in place plans and actions to prevent this, drawing on the whole range of health and social care disciplines.
4. ICPs would include **strong collaboration** with independent health care providers, and the voluntary and community sectors.
5. **Patient and client representatives** would have a role to play in the oversight of the ICP.
6. ICPs should be clinically led and be based on **multi-disciplinary working**. It is envisaged that GPs would have a key leadership role to play: however, clinical leadership should not be seen as exclusive to General Practitioners and opportunities for leadership development will be inclusive and available to other health and social care professionals. ICPs would be **judged and measured** by how well they improve patient experience and outcomes.

The proposals for ICPs would be supported by a capital investment in Health and Care Centres.

It is not the intention that ICPs would be formal organisations to build a 'layer' of bureaucracy into the Health and Social Care system. Rather they would be networks of clinical professionals and provider organisations working together through agreements on how they could better deliver all relevant aspects of care (e.g. HSC Trust, GP, pharmacy, voluntary and community or independent providers).

Implications

- In many instances, you would have improved access to diagnostic tests, treatment and specialist support quicker, easier and without the need to visit hospital.
- We would move significant resources and money out from hospitals into this type of care – as set out in the TYC Report, it is expected that 5% of the current budget would be moved by 2014/15 from hospital services into primary and community care.
- Information about your circumstances would be shared electronically across health organisations and between health professionals more quickly and easily so that diagnosis and clinical decisions about treatment would be made sooner.
- Fewer emergency hospital admissions, either because the occurrence which would cause the need for hospital admission in our current process can be dealt with and treated locally, or because through working in a more integrated way we have prevented it happening altogether.
- Reduced admissions, and length of stay for those who do need to receive acute care in hospital would mean we would need fewer beds in hospitals than would otherwise be the case and hence have more money to spend in other areas, that can deliver better outcomes, such as prevention programmes, self-care education and management programmes, and delivering services and care closer to people's homes in your local community.
- We will explore, within existing arrangements, options to reduce the reliance on temporary and locum staff, and increase the number of substantively employed GPs.

We anticipate that the introduction of Integrated Care Partnerships, together with other initiatives to reduce emergency admissions to hospitals set out in this document would result in the **reduction of 180 acute adult hospital beds across Northern Ireland over the next 3 to 5 years**. We currently have approximately 3,600 acute adult hospital beds.

Question 6.

Do you agree that Integrated Care Partnerships could make a positive contribution to the delivery of care closer to home rather than in hospitals?

If your response is 'disagree' or 'strongly disagree', do you think there are any alternative ways to deliver care closer to home?

Health and Care Centres

To support ICPs, there is a need to invest in the development of the primary and community care infrastructure – that means the buildings and facilities we have.

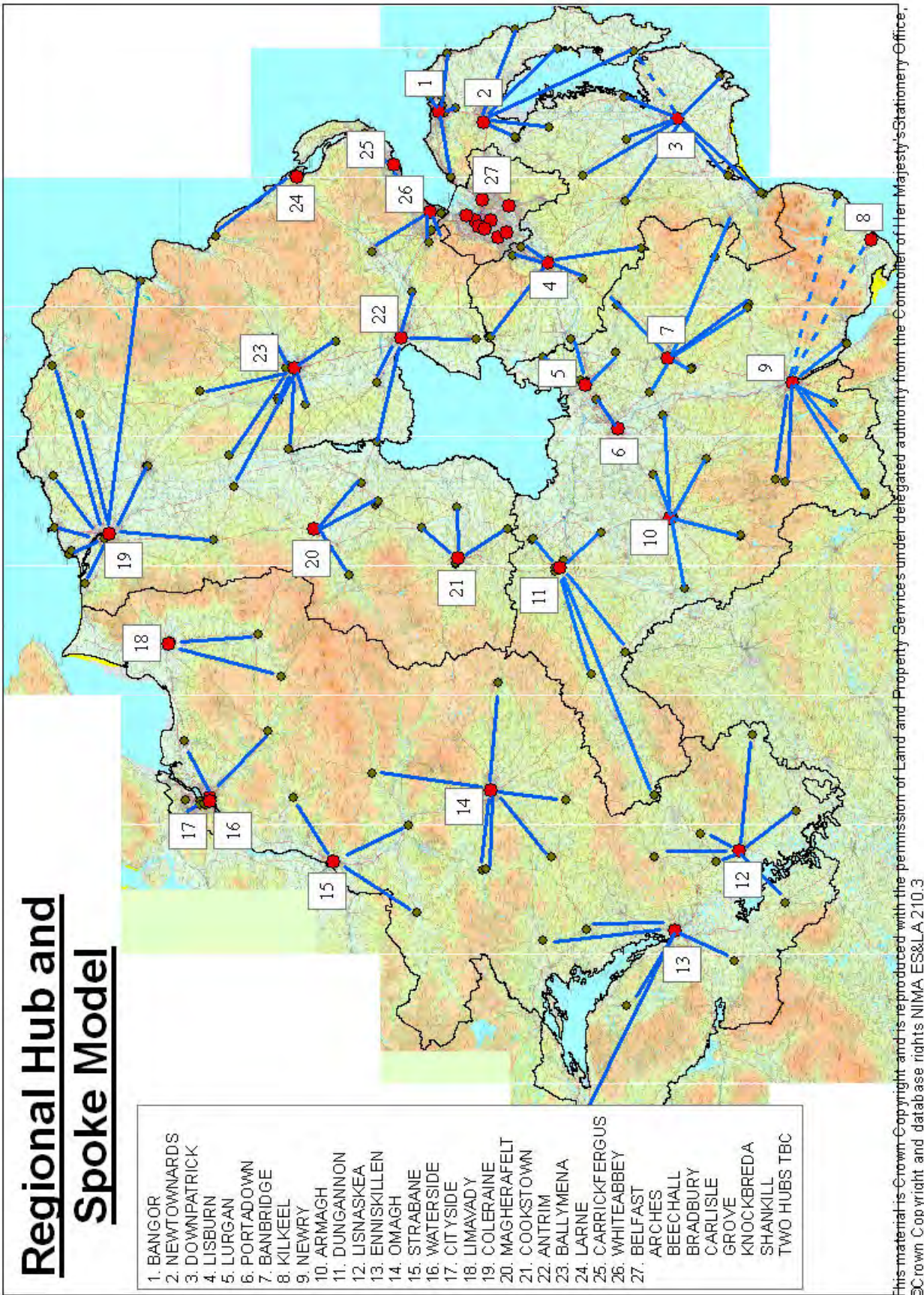
We propose to build and develop these facilities on a 'hub and spoke' approach. 'Hubs' are centres which would provide services for the local population, and for its range of spokes – which are the GP surgeries.

This means that you would be able to get a wide range of services all under one roof. Some of the detailed arrangements would vary in different areas and might include:

- General Practice (GP) services
- Physiotherapy
- Podiatry
- Social care
- Some x-ray and ultrasound investigations

The attached map shows an illustrative 'hub and spoke' configuration. A number of hubs already exist in Portadown, Belfast, L/Derry and Downpatrick, and building work will begin shortly on two new schemes in Banbridge and Ballymena. The locations for the other hubs and spokes, and the range of services to be included in each centre will be discussed and finalised as further plans develop. All future developments will conform to the usual business case processes and consultation.

The map below provides an illustrative view of how the Health and Care Centre hub and spoke arrangement may be laid out.



Community Pharmacy services

Community pharmacy services have been recognised as being the first port of call for many people, particularly in the management of self-limiting conditions. Further, the focus on safety and effectiveness of medicines will continue to be critically important to deliver better outcomes, minimise adverse events, reduce unnecessary admissions to hospitals and, by virtue of more appropriate use and management, generate financial savings.

Given that approximately 10% of the population visit a pharmacy each day and that those suffering from long term chronic illness are supported by pharmacies through dispensing of medicines, there are great opportunities for the development of community pharmacy services in the future within the areas of medicines management and health improvement.

Northern Ireland has a larger number of pharmacies than elsewhere, with one pharmacy per 3400 head of population (Wales is 1:4250; Scotland 1:4200; England 1:4950)¹². Against the context of need and current provision, work will be undertaken to best utilise pharmaceutical services in line with the DHSSPS' strategic review of pharmacy services, and the HSCB and DHSSPS' needs assessment work.

Dental Services

The development of a new general dental services contract for High Street dentists will offer the potential for more disease prevention and increased quality of care. The new contract will also give HSCB the ability to ensure that services are commissioned in areas of Northern Ireland where there is greatest need. Dental practice owners will have the opportunity to approach developers of new health care facilities, allowing them to avail of modern premises and co-locate with other primary care providers.

The HSC Board is piloting a new oral surgery contract, due to begin in early 2013, which will test new remuneration arrangements for 'High Street' oral surgeons. The new contract will lead to high street

12 Business Services Organisation, NHS Information Centre for Health and Social Care, Welsh Assembly Government Statistical Directorate and Information Services Division NHS Scotland.

specialists seeing a greater proportion of oral surgery cases and allow hospital specialists to concentrate on the most complex cases. A referral management centre would determine which cases are appropriate for primary care oral surgery specialists and which need to be seen in the hospital setting.

This new approach is in line with TYC's strategy to develop a mixed economy of providers including dental practitioners who work independently.

Developing Eyecare Partnerships and Improving Eyecare

For most of us, good eyesight is taken largely for granted. However, when eyesight fails, the effects can be devastating; falls increase, the ability to look after oneself reduces, and work prospects decrease.

The regional strategy, *“Developing Eyecare Partnerships - Improving the commissioning and provision of Eyecare Services in Northern Ireland”*¹³ sets out a number of objectives aimed at achieving the best possible care, delivered in a timely manner, with the best possible outcomes and using all of the available clinical skills mix. These objectives are very much in line with the principles of *Transforming Your Care*.

In the context of policies such as *“Fit and Well – Changing Lives”*¹⁴ and the *Service Framework for Older People*¹⁵, by working to the commissioning plan, and by using legislative change where appropriate, partnerships will be developed to reflect clinical leadership, improved outcomes, and value for money, with a focus on prevention, accessible to all.

The improved use of resources will require a resource shift to achieve a regional approach to the development of integrated care pathways, encourage workforce development, and use emerging technologies to enhance and improve referrals, communications and telemedicine.

13 DHSSPS(2011) Developing Eyecare Partnerships- Improving the commissioning and provision of Eyecare Services in Northern Ireland

14 DHSSPS (2012) “Fit And Well – Changing Lives – A Ten Year Public Health Strategic Framework For Northern Ireland”

15 DHSSPS (2011) “Service Framework for Older Peoples Health and Wellbeing”

4.3 Older People

Northern Ireland has the fastest growing population in the UK and it is an ageing population. Between 2010 and 2025, the number of people over 65 years is expected to increase by 42%, and the number of people aged over 85 is expected to almost double¹⁶.

Longer life expectancy is something to celebrate and many older people enjoy good health. We want to continue this trend and focus on keeping older people well through prevention of ill health and the promotion of health and well-being. However, among those over the age of 70, rates of ill health and disability increase dramatically. For example, dementia mostly affects people over the age of 70¹⁷, and the rate of disability among those aged over 85 is 67% compared with only 5% among those of working age¹⁸. Older people are significant users of our services, and almost a fifth of the health and social care budget (17% or £721million) is allocated to meeting the needs of this population.

- In 2011/12 patients aged 65+ accounted for approximately 55% of hospital bed days¹⁹. Many arrive at hospital because there is no viable alternative in the community.
- Approximately 23,522 people receive domiciliary care, equating to some 224,473 hours of care each week²⁰.

Many excellent health and social care services are provided for older people by dedicated staff, volunteers and unpaid carers, but there is a high level of dependence on institutional and hospital care and inconsistencies in the quality and range of services provided across Northern Ireland. Too often the focus is responding to acute events and crises rather than putting the emphasis on providing a range of proactive and preventative support that can maintain the health and wellbeing of older people.

16 NISRA (2010) National Population Projections
17 DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.
18 DHSSPS (2012) Physical and Sensory Disability Strategy and Action Plan for Northern Ireland
19 DHSSPS (2012) Hospital Inpatient System
20 DHSSPS (2011) Domiciliary Care Services for Adults in Northern Ireland

One of the major themes in TYC is making the home into the 'hub' of care for older people. Overwhelmingly, people tell us that they would rather stay in their own homes with the right support, so that they can be as independent as possible, for as long as possible. They also want more say in how care is organised. The social needs of people living at home also need to be addressed to avoid isolation within their communities. This requires innovative partnerships with the voluntary and community sectors to provide appropriate support.

The increased emphasis on promoting independence, more support for carers and better intermediate care facilities is likely to result in a further fall in the demand for residential care for older people. Currently, in a quarter of statutory residential care homes, more than half the beds are unoccupied, and it is expected that demand will continue to fall, despite an increasing elderly population.

Residential Care refers to the delivery of residential accommodation with both board and personal care, for people who need help with personal care due to old age, illness and/or infirmity, disablement, dependence on drugs or mental illness. Some facilities are run by the statutory sector; others are operated by the independent sector. This is different to a nursing home which is a home registered to provide nursing care and will have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse.

Many of the current statutory homes are over 50 years old and in need of significant investment which would be more appropriately directed to non-institutional, community based services as this is what many people would prefer.

The key message is that the model of care is changing with more people receiving care at home and the implications for how we provide this type of care are clear. During the next 3 to 5 years the current number of statutory residential homes, is likely to be reduced by at least 50% across Northern Ireland. The pattern will vary across areas.

We are committed to ensuring suitable, safe alternatives are provided before any closures take place. Where closures are proposed this will be implemented in a planned and phased basis with residents, families and local communities involved in the local consultation processes.

The statutory sector currently provides about a quarter of all residential care homes in Northern Ireland. There are currently 56 statutory homes

and this would mean that at least 28 homes could close. This equates to around 750 places. Many of the homes which may be considered for closure are already running with only a small proportion of residents. Looking beyond this timescale, there would need to be clear and specific reasons for the statutory sector to remain in this field.

This targeted reduction does not include those homes providing services for older people who are mentally infirm, including those suffering from dementia, or those in nursing homes. It also excludes homes providing care for those with physical or learning disabilities, and mental ill-health. Also, this does not necessarily mean a reduction in residential homes provided by the independent sector – where there continues to be a demand for these services, these would continue to be provided.

Our key proposals are:

1. **Integrated Care Partnerships** would focus on how care is provided to frail older people, particularly by the GP, community nurse and care manager, with much closer working one with the other.
2. **A Falls Prevention Programme** to raise awareness of risk factors and identify those at risk of falls and fractures with the objective of reducing those needing hospital services.
3. Improvements in access times to **cataract surgery and audiology services** to support living at home.
4. **Reablement programmes** in order to promote rehabilitation and independence rather than unnecessary or premature reliance on services, often after an unexpected incident or illness. The HSCB is working closely with HSC Trusts and voluntary and community sector partners to promote and rollout this new service model. As a result evidence suggests it is possible to reduce the number of newly referred older people who need long term domiciliary care service by up to 45%.
5. Promote the **wider use of technology** in the form of telehealth and telecare for remote health monitoring and support with activities of daily living. Providing individuals and families with security and communication options to support people in their own homes. This will help to identify potential problems or the deterioration of a condition much more effectively and allow action to be taken sooner.
6. Further develop and review **intermediate care provision** (including sub-acute and non-acute hospitals), for example when support with

rehabilitation is required after an operation or illness. There is a range of such facilities in Northern Ireland. As the new care model develops and alternatives are in place, some of these will expand whilst others will close. It will be for local commissioners to determine the specific changes in individual units to ensure that remaining sites are large enough to provide safe, high-quality care and maintain a safe and efficient level of staffing. Some services will be provided by the statutory sector with some by the independent sector.

7. Increase the opportunity for people to have **self-directed support and individual budgets**; this means that individuals or their carers would be able to have more choice and control about the services they receive.
8. The role played by **carers** is central to supporting the care and wellbeing of older people in the community; consequently, there will be a commitment to improve the quality of life and support for carers through **increased provision of respite and short breaks**.
9. **Implementation of the NI Dementia Strategy**, using in particular the Integrated Care Partnerships to support this process.
10. Enabling individuals to live at home requires a **mixed economy** of service providers to include community and voluntary, private and statutory sectors. Services would be procured to deliver this outcome. This signals a larger role for both the voluntary and private sectors in future. Looking towards this, we will undertake a review to accurately cost such services to ensure value for money and high quality services.
11. Due to improved availability of community-based alternatives, it is expected that demand for our statutory residential homes will further decline. We are proposing therefore **to close at least 50% of our current statutory residential homes over the next 3 to 5 years**. As part of the transitional process towards this, we will consider whether to restrict future admissions in some instances.

Question 7.

Do you agree with the proposals set out in respect of older people's services?

Do you believe there are better alternatives?

4.4 Long Term Conditions

Long term conditions (LTCs) are conditions which, at present, cannot be cured but can be controlled by medications and / or therapy. Examples include diabetes, asthma, hypertension, stroke or respiratory disease.

International studies have found that the cost of care for only 5% of the population makes up nearly 50% of the healthcare budget²¹. The majority of this 5% are made up of the elderly and people with LTCs. Incidence of long term conditions are on the rise, and it is clear that those with long term conditions may sometimes need high levels of care.

The health and social care system needs to focus our efforts on how to deliver high quality care and ensure better outcomes for people living with LTCs. At the moment, on many occasions, individuals with a LTC are admitted to a hospital after a long and complicated journey through A&E because there is no alternative.

The proposals in our plans are aimed at ensuring there is a viable alternative for those with LTCs who are at risk of needing emergency care. We wish to focus on prevention, enhancing the role of primary and community based care in the treatment and management of LTCs, and increasing the level of personalisation and self-management of conditions, where it is appropriate. A key vehicle for these changes would be through the Integrated Care Partnerships which we have described in section 4.2 above.

Our key proposals are:

1. To develop **new LTC 'Care Pathways'** – this means that all those responsible for or involved in providing you with health care services at the moment would develop simpler ways for you to access services, often through your GP or specialist nurse at home. At times this may mean that you may be admitted directly to hospital if you need to be, rather than having to go through A&E.

2. Using the latest clinical evidence we would develop '**risk profiling**' which would help those providing care to target specific support for those most at risk of an acute episode who may need a hospital admission to help to prevent them needing to go to hospital at all.
3. You would be supported and receive education on how to **manage your condition yourself** so that you would more easily identify when you are getting worse or your medication may need to change.
4. **Appropriate follow-up and regular review** of your condition by your GP or practice nurse. This would mean a change in the way hospital specialists work and mean that you get more follow up care.
5. Your pharmacist would play a key role in helping you understand your condition and how to **manage your medication** effectively.
6. Investment in new technology called '**telemonitoring**' where this is appropriate to your situation. This means that you may have new technology in your own home to monitor and test your condition, enabling your clinicians to receive information about your condition in a realtime or regular basis. This can mean that issues are quickly identified and dealt with.
7. Putting the range of initiatives set out in the plans in place would mean there are **fewer emergency visits to hospital** and a reduction in the amount of time you need to spend in hospital when you have an acute episode.

Question 8.

With regard to Long Term Conditions, would it be helpful to

- a) make more information and education available to help those with a long term condition to monitor and manage their own condition?*
- b) enable those with long term conditions to make more use of technology in their home to help problems be identified earlier, and reduce the need for avoidable visits to hospital or the doctor?*

4.5 Palliative and End of Life Care

Palliative and end of life care is an important service in our system, and is defined as: “*the active, holistic care of patients with advanced progressive illness*”. End of life care generally refers to the care people require in the last year of life but this may be longer depending on the progression of the illness.

The Palliative and End of Life Care Strategy for Adults in Northern Ireland ‘*Living Matters, Dying Matters*’²², outlines an approach to improve the quality of palliative and end of life care for adults across all care settings and for all conditions. Approximately 15,000 people die in Northern Ireland each year, and over two thirds of deaths occur in hospitals and nursing homes. As our population grows older and the profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses, demand for palliative and end of life care services is likely to increase significantly.

TYC estimated that two thirds of deaths in Northern Ireland would benefit from a palliative care approach in the last year of life. In 2011/12, there were 16,795 bed days for admissions where the patient died in hospital with a primary cancer diagnosis²³. The Review team concluded that with greater co-ordination, education and training, the quality of care could be improved to ensure that people die with dignity, and so far as is possible, in the place of their choice. We need to shift palliative care into the community and into the home, as this is where most people have told us they would prefer to die. We need to work closely with the voluntary and community sector to support their key role in delivering palliative care services.

There is already a significant amount of work on-going and a range of specific initiatives are being taken forward through the Regional Implementation Group for Living Matters: Dying Matters, working closely with the voluntary and community, and the independent sectors to transform palliative and end of life care.

22 DHSSPS (March 2010) Living Matters Dying Matters – A Palliative and End of Life Strategy for Adults in Northern Ireland

23 DHSSPS (2012) Hospital Inpatient System

In addition, proposals in section 4.10 include a review of acute paediatric services. A review of paediatric and end of life care services for children will follow.

Our key proposals are:

1. To greatly increase the number of people who are **supported to die in their preferred location**, where they have expressed a preference.
2. **More 24 hour community support** for people in the last year of life, in accordance with their assessed needs.
3. Implementation of the **End of Life Care Operational System (EOLCOS)**. This is a system to identify people who may be in the last year of life .It allows for the beginning of a discussion which will support people to express their needs and preferences of how and where they would wish to die.
4. Increased access to **specialist palliative support** out of hours, including specialist 'in-reach' into nursing homes and people's homes when they need it.
5. Working more closely with the **voluntary and community** sector in the provision of palliative care.
6. Better links and **integrated working** between specialist and generalist services, especially through the Integrated Care Partnerships.
7. **Increase the education and training** (and therefore the number) of staff confident and competent in the core principles of palliative and end of life care in all sectors.

Implications

Coping with chronic conditions and moving into the end stages of life is a difficult time, and over the next few years you should see the following changes:

- Should you have an advanced progressive incurable illness we would work with you and your family / carer at an early stage and offer you the opportunity to express your needs and wishes, and develop an advance care plan about how and where you would prefer to be cared for.

- You would have services available in the community to support you to be cared for in your own home or nursing home, rather than in hospital (including Out of Hours during the week and at weekends).
- If you are in a Nursing Home, you would be cared for by staff who, because they have received appropriate education and training, have greater confidence to deliver care there. This would enable you to be able to stay in the Nursing Home, rather than having to be admitted to hospital, particularly at the very end of your life.

The Living Matters: Dying Matters strategy, available from the DHSSPS website provides a useful set of case studies and examples helping to illustrate this.

Question 9.

Do you agree that the proposals set out in respect of palliative and end of life care would support you to be cared for in a place of your choice?

Do you believe there are better alternatives?

4.6 Mental Health

One in five respondents aged over 16 in the Health Survey Northern Ireland in 2010/11 showed signs of a possible mental health problem.²⁴

There are a number of factors contributing to this prevalence including persistent levels of deprivation and the legacy of Northern Ireland's troubled history. The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review)²⁵ set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review, which completed its work in 2007, has set the agenda for the transformation of these services.

The proposals set out in the Strategic Implementation Plan focus on the continued implementation of the Bamford Action Plan, with the aim of accelerating and giving impetus to this.

Many of the policies and strategies underpinning the proposals in this section have been underway for a while – we wish to continue to move on with these initiatives and do so in a consistent and co-ordinated manner. In particular TYC promotes:-

- raising awareness of mental health issues and reducing the stigma associated with mental ill-health.
- mental health and wellbeing generally with a particular focus on suicide rates among men.
- consistent care pathways with early intervention.
- continuing to extend the care provided in the community rather than in hospitals, with a consistent outcome across Northern Ireland so that everyone can expect the same.
- the need to promote a recovery model of care and independence, looking in particular at how the voluntary and community sector is involved in planning services, Direct Payments, and access to information on services.
- ending long term residency in institutional care, and resettling these residents into the community.

24 Health Survey (2010/11) Northern Ireland
25 DHSSPS (2007) Bamford Review of Mental Health and Learning Disability.

In the delivery of changes to mental health services it will be critical to work with patients, service users, carers and their families, and to recognise the complex dynamics in this area, and impact on individuals. We are committed to delivering the best outcomes for people with mental health needs, and increasing their independence and choice.

Resettlement is a process of moving people out of long stay institutions to support them to live independent lives in the community, and this is already well underway. The HSCB proposals in the draft plans provide a framework to complete this implementation alongside other major changes, with close links into the Integrated Care Partnerships which would support how we provide specialist care in the community rather than in hospitals.

Our key proposals are:

1. Be **more joined up** in how we provide services, in particular, how mental health services work with GPs (and other primary care providers) and hospitals – this is critical to getting better at earlier intervention.
2. In line with the Bamford Review recommendations, **reduce the number of people in institutional care and inpatient beds** by existing residents moving to live in the community through intensive home support, alternative supported living arrangements based in the community, and individual budgets. This will take full account of the complex family dynamics in this area.

It is our intention to continue with the Northern Ireland Executive's resettlement programme. At the point of writing, this means that the remaining 116 people from the original targeted group identified in 2007 would move to alternative community based living arrangements, by March 2015. We would also work towards resettling those people who have become long stay residents since 2007, due to delay in their discharge for longer than a year.

3. **Develop 6 in-patient acute mental health units** for those aged 18+. There would be one site in the Northern, Southern, South Eastern and Belfast areas, with two in the Western area. In order to reduce stigma and ensure there is good access to acute care, it is necessary to locate

mental health hospitals close to acute hospital provision, recognising that this may not be possible in all circumstances. These principles would imply that the second location in the Western LCG area would be in the proximity of the new South West Acute Hospital rather than Omagh as previously planned and this consultation seeks views on that issue of principle.

4. **Enhancing the support for carers**, to ensure they have access to services in their community which enhance their quality of life.
5. **Promote the uptake of self-directed support and other programmes** which would mean that people have more choice and control over the type of care they receive.

It is also important to recognise that changing the way we support and care for people with mental ill-health would inevitably lead to changes to the long stay units in institutions such as St Lukes, Tyrone and Fermanagh, Downshire and Holywell. This may see some of these institutions close or have a change in use to provide more intermediate or short term care rather than people staying there for long periods. Some of these units already require significant upgrading and investment to ensure that they are able to provide safe, modern, high quality care in future. Any significant service change would be subject to specific consultation.

Question 10.

Do you agree with the proposals set out in respect of mental health services?

Do you believe there are better alternatives?

4.7 Learning Disability

A learning disability is a lifelong condition and requires long-term support. It includes the presence of a significantly reduced ability to understand new or complex information to learn new skills with a reduced ability to cope independently, which started before adulthood, with a lasting effect on adulthood. People with disabilities have the right to remain within their local community. They should receive the support they need within the ordinary structures of education, health, employment and social services.

Provision of services for people with a learning disability requires a multi-agency and integrated approach – it is not solely a health issue. The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review²⁶) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland and the “Equal Lives” Report provided recommendations for learning disability as a central part of the Review. The demands for learning disability services continue to increase in line with demographic changes.

The proposals set out in the Strategic Implementation Plan focus on the continued implementation of the Bamford Action Plan, with the aim of accelerating and giving impetus to this having due regard to the complex nature of care provision in this area.

Many of the policies and strategies underpinning the proposals in this section have been underway for a while – we wish to continue to move on with these initiatives and do so in a consistent and co-ordinated manner. In particular, TYC promotes:-

- the importance of early years intervention and support.
- the need to promote independence, looking in particular at day opportunities, respite and short break services, self-directed support, access to information on services and advocacy.
- diversity of choice of services for people.
- the critical role of the voluntary and community sector in supporting people with a learning disability.

- ending long term residency in institutional care, and resettling these residents into the community .
- the need to address challenges for those with learning disability in accessing healthcare services, for example dentistry, occupational therapy, physiotherapy.

To take forward the proposals set out in TYC in relation to people with learning disabilities, a range of initiatives is proposed in each local area. In the delivery of any of these changes it will be critical to work with parents, families and carers to recognise the complex dynamics in this area, and impact on individuals. We are committed to delivering the best outcomes for people with learning disability and increasing their independence and choice.

Our key proposals are:

1. In line with the Bamford Review recommendations, **reduce the number of people in long stay institutional care** by existing residents moving to community based options and reducing new admissions through the continued development of self-directed support, supported living arrangements and individual budgets. This will take full account of the complex family dynamics in this area.

It is our intention to continue with the Northern Ireland Executive's resettlement programme. At the point of writing, this means that the remaining 175 people from the original targeted group identified in 2007 would move to alternative community based living arrangements, by March 2015. We would also work towards resettling those people who have become long stay residents since 2007, due to delay in their discharge for longer than a year.

2. **Improve access to respite** and provide a wider range of non-facility based respite for both service users and carers. This will reduce the number of people being admitted to acute beds.
3. Increase the number of people with **self-directed support and individual budgets**; this means that people have more choice about what services they receive.

4. Continue to develop creative and **age-appropriate day opportunities** to promote independence and choice, such as access to employment, leisure and educational activities. This will include more opportunities being provided in partnership with other sectors (including voluntary & community, education and employers). Our statutory facilities may be re-configured as a result.
5. Enhance the **involvement of carers** in care planning and service planning to bring their experience to bear on these functions.
6. Be **more joined up** in how we provide services for people with learning disability so that they have a seamless service when accessing specialist services and health screening.

It is also important to recognise that changing the way we support and care for people with learning disabilities will inevitably lead to changes to the long stay units in facilities such as Muckamore, Abbey Hospital and Longstone Hospital. This may see some of these institutions close or have a change in use to provide more intermediate or short term care rather than long term residency. Some of these changes have already been subject to local public consultation, and any further significant service change will be subject to local consultation as appropriate.

Question 11.

Do you agree with the proposals set out in respect of learning disability services?

Do you believe there are better alternatives?

4.8 Physical Disability and Sensory Impairment

Between 17-21% of the Northern Ireland population have a physical disability and around 37% of households include at least one person with a disability.²⁷ While many disabled people have no greater need for health and social care support than the rest of the adult population, some draw on specific support services provided by the statutory and voluntary and community sectors.

The proposals set out in the Strategic Implementation Plan reflect plans for the implementation of the *Physical and Sensory Disability Strategy and Action Plan for Northern Ireland*, published by the DHSSPS in February 2012²⁸.

Many of the initiatives and policies underpinning the proposals in this section are already well established – we wish to continue to build on these initiatives in a consistent and co-ordinated manner. In particular TYC promotes

- a more person centred approach with health and social care services working in partnership with the individual to promote independence and control over the types of services they want.
- developing more appropriate living options for people with disabilities with community support and through maximising the use of technology to assist people in their day-to-day lives.
- continued development of a wider range of respite, short break and day opportunities for disabled people and their carers and families.
- promoting the uptake of Direct Payments and other self-directed support approaches.
- joint working across government agencies to ensure access to adequate housing, education and assistive technologies, to ensure people with disabilities enjoy full rights and are treated as equal citizens.

27 NISRA 2007, as quoted in DHSSPS (2012) Physical and Sensory Disability Strategy and Action Plan for Northern Ireland

28 DHSSPS (2012) Physical and Sensory Disability Strategy and Action Plan for Northern Ireland

Our key proposals are:

1. Undertake reviews of the current provision of day-care services with the aim of developing **alternative ways to provide day activities**.
2. Put in place more, and a **wider range of, respite** options for carers.
3. Increase the number of people with **self-directed support and individual budgets** to allow them to have more choice about what services they receive.
4. Examine the potential for the development of **specialist supported living options**, for example for those people with acquired brain injury.
5. Enabling individuals to live at home requires a **mixed economy** of service providers to include community and voluntary, private and statutory sectors. Services will be procured to deliver this outcome. This signals a larger role for both the voluntary and private sectors in future. Looking towards this, we will undertake a review to accurately cost such services to ensure value for money and high quality services.

Question 12.

Do you agree with the proposals set out in respect of physical disability and sensory impairment services?

Do you believe there are better alternatives?

4.9 Family and Child Care

Approximately 24% of the Northern Ireland population is aged between 0 and 17 years. Population projections indicate this sector of the Northern Ireland population is set to increase by 3% by 2020.²⁹

Between 2005 and 2010 the number of Looked After Children per 1,000 children increased in Northern Ireland, England and Wales. The number of children on the child protection register per 10,000 children aged 0-18 is higher in Northern Ireland than in England, Scotland or Wales.³⁰

At 31st March 2011, there were 2,511 Looked After Children (LAC) in Northern Ireland, and by March 2012, this had increased by 5% to 2,644. Within this group, 74% were in Foster Care, 11% were placed with family, 8.7% were living in residential care and 6.5% were living in specialist placements².

The total number of children on the child protection register has increased by almost 48% from 1,593 in 2005 to 2,357 in 2010², although recently it has declined to 2,127 in March 2012.

It has been recognised by a number of independent reviews that there is a significant under investment in children's services within Northern Ireland, compared to other parts of the UK. Society will benefit from a coordinated effort to support and promote positive development of the intellectual, emotional and social skills of young children. There is a major incentive in getting this right.

Key to this is promoting and supporting positive, engaged parenting particularly in those families where parenting skills are limited.

The strategic direction over the past few years has recognised the importance of early intervention. The focus has been heightened through the publication of *Families Matter*³¹ and *Healthy Child-Healthy Future*³².

29 NISRA (2011) Population projections

30 HSCB (2012) Delegated Statutory Functions Report

31 DHSSPS (2009) "Families Matter: Supporting Families in Northern Ireland. Regional Family and Parenting Strategy"

32 DHSSPS (2010) "Healthy Child, Healthy Future strategy: A framework for the Universal child health Promotion Programme in Northern Ireland "

The concept of Family Support Hubs is developing and the Family Support NI database provides an information and signposting resource for families, communities and professionals.

Some children and young people will continue to present with poor mental health and / or emotional difficulties. The overall direction in this area will continue to be shaped by the Bamford Review of Mental Health and Learning Disability³³. Our focus will be on the implementation of the recommendations of the **Review of Child and Adolescent Mental Health Services** (CAMHS)³⁴ published in 2011 by the Regulation and Quality Improvement Authority (RQIA).

Our key proposals are:

1. Promotion of a **multi-agency / partnership approach** to prevent children having to be separated from their families and enable some children to remain safely with their families. Where children cannot remain with their family, alternative arrangements to bring permanency in the best interests of the child will be made.
2. Embed **Family Support Hubs** across Northern Ireland to focus on early intervention. An emphasis should be placed on two key areas: the promotion of positive parenting and positive speech and language communication skills for all our children.
3. **Increase the number of foster carers**, and in particular specialist foster carers for those children and young people who are deemed hardest to place, and present significant challenges.
4. Engage with **Strategic Regional Review of Residential Care Services for Children and Young People** to take forward recommendations of local review in line with regional recommendations. Reduce the reliance on **residential care homes**.

33 DHSSPS (2007) Bamford Review of Mental Health and Learning Disability.
34 RQIA (2011) Review of Child and Adolescent Mental Health Services

5. Continue to improve the **Child and Adolescent Mental Health Services (CAMHS)**, to reduce the number of children waiting for service and a reduction in waiting times.
6. Increase availability of **emergency CAMHS** cover to avoid acute admissions.

Question 13.

Do you agree with the proposals set out in respect of Family and Child Care?

Do you believe there are better alternatives?

4.10 *Maternity and Child Health*

Maternity

In 2011 there were over 25,000 live births registered in Northern Ireland. During the last decade the birth rate in Northern Ireland has increased by over 15%, although this increase varies across different local areas.

There are currently nine consultant-led obstetric units and six midwife-led units, three of which are alongside consultant units and two are freestanding. The current configuration presents challenges in providing the recommended staffing across all existing sites particularly for smaller units. Access to a midwife-led unit is not available in all areas.

Other challenges for maternal and child health services include:

- Promoting public health messages and preconception care to ensure women are as healthy as possible before becoming pregnant.
- Providing more antenatal care closer to home in the community.
- A greater emphasis on continuity of care and keeping pregnancy and birth normal through midwives caring for women with straightforward pregnancies.
- Freeing up consultant obstetric time to care for the growing number of women with complex pregnancies.
- Supporting the expectant mother in her ante-natal and post-natal care and connecting that support to the early years of parenthood.
- Giving a realistic choice of birth location for women.

The DHSSPS has recently published its *Maternity Strategy* in July 2012³⁵, and the proposals set out in the draft Strategic Implementation Plan reflect a commitment to the implementation of the objectives in this strategy.

35 DHSSPS (2012), "A Strategy for Maternity Care in Northern Ireland 2012 - 2018"

Our key proposals are:

1. Promote **normalisation of birth** - bringing ante-natal and post-natal visits into line with best practice and NICE guidance, and improving access to midwives as initial point of access.
2. Reduce the length of time mothers **stay in hospital**, where appropriate.
3. **Increase the number of women** having their ante-natal care in the community, rather than attending hospitals.
4. Improve **ante-natal education** and **early parenting** to promote good parent/child relationships in the early years.

In terms of the configuration of maternity units, **we propose the following:**

1. In the **Belfast** area, a freestanding midwife-led unit would be developed in the Mater Hospital, with one consultant-led obstetric unit in the Royal Jubilee Maternity Hospital. We also plan to provide an 'alongside' midwife-led unit in the new regional maternity hospital.
2. In the **Northern** area, initially the current services will remain at both Causeway and Antrim Hospitals. The volume of activity in the consultant obstetric unit in the Causeway Hospital will be reviewed to ensure it meets the required standard. Given the likely number of births at the Causeway Hospital it is probable that there would be change in obstetric services at the Causeway Hospital over the next 3 to 5 years as it is not likely to be possible to maintain a safe and sustainable consultant-led service there.
3. In the **South Eastern** area, there would continue to be a consultant-led obstetric unit and an 'alongside' midwife-led unit at the Ulster Hospital, with freestanding midwife led units in Downe and Lagan Valley Hospitals. These units are to be reviewed over the next 3 to 5 years to ensure their continuance is demonstrably supported by mothers choosing to use them.
4. In the **Southern** area, there would continue to be a consultant-led obstetric unit and an 'alongside' midwife unit at Craigavon Hospital, and a consultant-led obstetric unit in Daisy Hill hospital. The level of medical

cover for the consultant-led obstetric unit in Daisy Hill Hospital would continue to be reviewed to ensure it meets the required standard. An 'alongside' midwife-led unit would also be developed at Daisy Hill Hospital.

5. In the **Western** area, there would continue to be consultant-led and midwife-led units in both Altnagelvin Hospital and the South West Acute Hospital. The level of medical cover for the consultant-led obstetric unit in the South West Acute Hospital would be reviewed to ensure it meets the required standard. It is likely there will be additional activity from the Republic of Ireland.

In relation to midwife-led units, the TYC review proposed a move towards this model of care where appropriate. However, the ability to deliver this will be limited to on-going qualitative review and can only be provided where mothers in reasonable numbers choose to use the service.

Child Health

The Review looked at the issues faced in the area of child health, recognising that child health problems are often diverse in nature, severity and duration. There are often multiple factors in how problems occur, and the causes are poorly understood. The organisation of child health service differs significantly from adult health services.

Giving children the best start in life, through prevention of ill-health and promoting their health and wellbeing are integral to TYC. The "*Healthy Child, Healthy Future*" (HCHF) programme aims to ensure that every family with children has universal access to the HCHF programme, which includes immunisations, developmental reviews, screening, surveillance, and information and guidance to support parenting and healthy choices.

Our key proposals are:

1. Establish **Family Nurse Partnership Programme** pilots; in the first instance these will be in 3 specified areas (Western, Southern and Belfast), to improve the health and wellbeing of our most disadvantaged children and families, thus preventing social exclusion.

2. When children require **hospital care** they need prompt access to skilled staff. It is not possible to provide a full range of paediatric sub specialities for a population the size of Northern Ireland and therefore we will continue to ensure there are arrangements in place when families have to access services in other parts of the UK or when services are not available locally.
3. There is a need to move towards admitting all children under the age of 16 to age appropriate paediatric settings. The DHSSPS will be starting a **review of acute paediatric services**. A review of paediatric palliative and end of life care services will follow. This will facilitate a regional approach to how services should be organised in future, including agreement on the age of transfer from paediatric to adult services.

Question 14.

Do you agree with the proposals we have set out in respect of maternity and child health services?

Do you believe there are better alternatives? Please provide details

4.11 Acute Care in Hospitals

As we secure the major benefits of successful prevention, early intervention and better primary and community care, the nature of hospital based services will continue to evolve.

TYC proposed that there should be 5-7 acute hospital networks and essentially this is developed in the proposals in this document. This means that no hospital operates on its own. Hospitals of different sizes will work with each other to deliver the fullest range of specialist and acute services we all expect. For the majority, this means that each acute hospital network would serve a resident population of 400,000 but in the case of very specialist services this could be for the whole of Northern Ireland.

Advances in treatments and care, and increasing safety and quality standards mean that services are becoming increasingly specialised – and the reality is that this means that we can't have all services at every hospital. Mortality rates and increased life expectancy after treatment are critical determining factors.

There is very strong evidence that where the volumes of activity for a speciality is relatively low compared to the norm for the speciality, the service has a greater potential to have a higher mortality rate, simply because the specialist staff are not able to see enough cases on a regular basis to keep their skills up to date and hence provide the best quality of care. Specialist posts in hospitals which have relatively low volumes of activity in turn become unattractive to potential applicants and as a result can become overly dependent on locum staff.

This is a recurrent root cause of fragility of some specialist services in smaller hospitals and has to be addressed if we are to secure the best possible services to the community. The evidence shows clearly that bringing some such services together at fewer sites and/or through stronger networking, thereby increasing the volumes treated by the relevant teams of specialists has a marked positive impact on survival and recovery rates, along with service resilience.

The approach that has been taken across Northern Ireland for many years, and which is at the heart of these proposals, is to seek the best available combination of safety, sustainability and access for each speciality and each location.

We need to work together and see Northern Ireland hospital services as a whole. We need to focus on what the evidence is telling us about what is best for the patient, rather than try to preserve the institution or building.

The evolution of specialist services towards sites or networks which can deal with higher, optimum volumes of activity has been a process of change for some time, and we want to be specific, open and honest about our proposals for the future of the HSC. In this context, all significant service proposals emerging from this process will each be subject to separate local consultation processes in its own right.

Regionally, our key proposals are:

1. Making sure everyone has 24-hour access to safe, sustainable cardiac **catheterisation laboratory services** – including the introduction of an (emergency) primary Percutaneous Coronary Intervention service, which is a milestone of the Northern Ireland Executive’s Programme for Government – with an associated investment of up to £8m over the next three years. Two sites would be developed: one in Altnagelvin Hospital and the other in Royal Victoria Hospital.
2. Expansion of **orthopaedic** services in Southern, Western and Belfast Trusts with an investment of up to £7m revenue over the next 3 years, to significantly reduce waiting times for fracture and other orthopaedic services for patients.
3. To ensure safe, sustainable arrangements are in place for the provision of **Paediatric Congenital Cardiac Surgery** and **Paediatric Interventional Cardiology** for the population of Northern Ireland.
4. The DHSSPS will be carrying out a **review of paediatric services**, with a view to beginning consultation within 6 months. A review of palliative and end of life paediatric services will follow.
5. Our **Ambulance** services will continue to develop new protocols which support “right care, right place, right time, right outcome”. Protocols will be outcome-driven and reflect best practice. They will provide alternatives to going to hospital, support people to safely manage their health at home (where appropriate), and take patients without delay to the most clinically appropriate destination.

This means that sometimes a patient may not be taken to the closest Emergency Department but be taken directly to a facility they have been to before, or be taken to a hospital which is not the one closest one but specialises in treating their condition.

Key initiatives include looking at the feasibility of:

- A “111” urgent care service sitting alongside “999” – simplified access to urgent care 24/7 with real-time clinical advice and direction/support in accessing healthcare.

- Hospital-at-home protocols with suitably trained and equipped ambulance, hospital and community based clinicians organising and providing clinical assessment and treatment in settings other than hospital.

6. Enhance the **dedicated paediatric and neonatal transport** services throughout Northern Ireland.

In conjunction with the DHSSPS, criteria have been provided to inform the development of the Population Plans with regard to acute hospitals and the expected standards. These criteria seek to provide a consistent basis against which each service is reviewed on an on-going basis, looking at safety and quality, deliverability and sustainability, effective use of resources, local access and stakeholder support. They are for consideration by the HSC Board, its Local Commissioning Groups and the HSC Trusts when configuring and designing acute hospital services.

The criteria used to inform the development of our proposals are set out in Appendix 1 of this document.

In relation to each area, our key proposals are:

1. In **Belfast** the hospitals, comprising Royal Victoria Hospital, Belfast City Hospital, the Mater Hospital and Musgrave Park Hospital, would operate as one network with clinical services dispersed across the sites in the best configuration available. Specifically recent consultation recommends one emergency surgery centre at the Royal Victoria Hospital. Emergency department configuration across the network will be consulted on in 2012.

2. The principal hospital in the current **Northern** network is Antrim. It would continue to deliver all core general hospital services – surgery, medical, emergency department, maternity, renal etc. – responding to its natural population area. A large number of people using Antrim Area Hospital live in the greater Belfast area. Network arrangements need to reflect this and ensure appropriate links with Belfast Hospitals. The need to ensure that acute hospitals are providing safe and high quality services and the natural population flows in the area means that change will occur on the Causeway site in terms of its core in-patient services. There would be access to 24/7 emergency/urgent care on both Antrim and Causeway sites, which would be doctor led. We need to responsibly manage this change over the next 3-5 years.

In that context, any decisions about the networking and future services in Causeway Hospital reflect a strong commitment to the continuing local role for the hospital, but also enable it to benefit fully from being networked with other hospitals.

There will always be some degree of networking between Causeway and both Antrim Area and Altnagelvin Hospitals across the wide range of services, as there is at the moment. However, in planning the organisation of our services, we should consider which formal networking arrangement would have greatest benefit to the population served by the Causeway Hospital and to ensure effective delivery of safe, sustainable and resilient services for patients and clients.

One option is to focus on developing existing networking arrangements

with Antrim Area Hospital. However, given the future changes which are likely to occur in services at Altnagelvin, such as increased radiotherapy, cardiology and orthopaedics, and consequently the likely natural flow towards Altnagelvin, it may be better to develop a more formal network between Causeway and Altnagelvin.

There would in effect be three options:

- (a) An enhanced network with more formalised integrated working between Causeway and Antrim Area Hospitals, with the Causeway Hospital remaining the responsibility of the Northern Trust.
- (b) An enhanced network with more formalised integrated working between Causeway and Altnagelvin Hospitals with the Causeway Hospital remaining the responsibility of the Northern Trust.
- (c) An enhanced network with more formalised integrated working, between Causeway and Altnagelvin hospitals with the Causeway Hospital becoming the responsibility of the Western Trust. Consideration could also be given to the transfer of community services for the population served by Causeway Hospital to the Western Trust.

Looking to the future an appraisal of the implications of each of the above options should be undertaken. It is envisaged that a final decision would be made within 6 months of the close of consultation.

3. In the **Southern** area, there is already strong evidence to suggest that changes have occurred across Craigavon Area Hospital and Daisy Hill Hospital which demonstrate robust networking. This includes a network of medical staff which supports the provision of safe, quality care for more acutely ill patients in the High Dependency Unit in Daisy Hill Hospital, through 'virtual wards rounds' with specialist medical staff based in the Intensive Care Unit in Craigavon Area Hospital. They use new technology which means that the specialist is involved in clinical decision making and can talk to patients and families, as if they were physically present. There is also a networked approach to Emergency Departments to ensure that service is safe and sustainable on both sites

at all times through shared protocols and management. This model is to be supported and encouraged, and it is expected that further sensible changes will occur to maximise the effectiveness of this network in line with the criteria for acute care.

4. In the **South Eastern area** there is a principal hospital network encompassing the three hospitals – Ulster Hospital, Downe Hospital and Lagan Valley Hospital with clinical activity dispersed across the 3 sites. The Ulster Hospital will have 24/7 Emergency department and the full range of normal acute hospital services. The urgent care model operating at Downe Hospital covered by GP out of hours would continue and it is proposed that this would be extended to Lagan Valley Hospital.

Of equal importance is the network between the South East and Belfast. This is most obvious in a flow from Lisburn to Belfast and from east Belfast to the Ulster Hospital. This networking is to be supported and encouraged. Looking to the future the evolving network will continue to use the criteria to shape service provision.

5. The **Western area** has two acute hospitals – the new South West Acute Hospital in Enniskillen and Altnagelvin in Londonderry. The South West Acute Hospital will reflect the needs of its population areas including the dispersed rural population and provide all general hospital services. Altnagelvin Hospital will in future provide a wider range of specialist regional services, including future investment in orthopaedics and cardiology, and cancer services from 2016. Altnagelvin will continue to network with Causeway Hospital and Antrim Area Hospital as appropriate.

The South West Acute Hospital would network strongly with both Altnagelvin and with Craigavon Area Hospital in the Southern area. This reflects natural population flows and takes account of planned specialist service developments.

Question 15.

Do you agree with our proposals in respect of acute hospital services?

Do you believe there are better alternatives?

Question 16.

Do you agree that the criteria set out in Appendix 1 against which acute services have been assessed remain the most appropriate criteria?

If you disagree or strongly disagree, please provide specific details on what you see are more appropriate criteria. Please give reasons for your comments.

4.12 Increasing our links with the Republic of Ireland and Great Britain

The Northern Ireland population, with 1.8 million people will need to have formal arrangements with other jurisdictions, notably the Republic of Ireland. In some instances, this will mean service specific arrangements such as cancer services in the North West; on other occasions it will be a population focus determined by natural flows adjacent to the border.

Such a relationship would mean on occasion those resident in Northern Ireland would travel for treatment in the Republic of Ireland or vice versa.

We propose to:

1. Create more formal contractual arrangements with the Republic of Ireland to reflect this pattern of care.
2. Establish closer planning links to enable the achievement of best outcomes for citizens

Formal contracts will continue to be negotiated with Great Britain covering very specialist services, for example heart transplants.

The overall objective is to ensure the people of Northern Ireland have access to responsive services.

Question 17.

To what extent do you agree we should develop closer working relationships with the Republic of Ireland and Great Britain?

Part 5.

Supporting these changes to happen

The ability to, and the pace at which we can, take forward the proposals set out in this consultation document are reliant on changes across the system. These will be determined by our workforce, its capacity and capability to make the changes and the need for support from our people to make TYC a reality. It will also be dependent on how we go about procuring services and building partnerships with organisations outside the statutory sector, and the financial resources we have. The greater use of technology is another major opportunity which will support and enable the changes to happen.

In this part of the document, we discuss some of the implications for the following:

- Workforce
- Procurement
- Technology
- Finance

5.1 Workforce

As with any change in how we deliver services, there will inevitably be impacts on our workforce. Indeed, one of the main reasons we need to change how we deliver services is to ensure the best possible deployment of skilled staff and better networking between sites, to ensure support for the workforce in delivering services to patients and users.

Problems being experienced by staff trying to deliver services within the HSC were highlighted in the HSC Staff Survey carried out in 2009. Over 2 in 5 staff (43%) felt that they could not meet all the conflicting demands on their time at work, and only 34% agreed that there are enough staff at their organisation to do their job properly³⁶. The most common reason

stated for staff having been injured or feeling unwell in the last 12 months was work-related stress (31%).

During the Review, there was not a single staff voice which argued for the preservation of the existing model of service, and there was a strong willingness to make change happen. We recognise that without support from staff across the system, we would not be able to effect the changes arising from the proposals in TYC.

To enable us to deliver care closer to home and ensure we deliver safe, resilient and high quality services, we will invest in the capacity and capability of staff working across the HSC organisations (for example GPs, nurses, allied health professionals, social workers). Making the best use of the resources we have means having the right people with the right skills working in the right places.

Subject to the outcomes of this consultation process, we hope to move into the 3 to 5 year implementation period. During this time more understanding and detailed plans would be developed about how relevant proposals would be effected in practice. This means we do not know the exact impact on our staff at this present time.

We are committed to a sensible process of staff transition over the period and engaging with staff, and their representative bodies, throughout.

We would anticipate that:

- Some staff who currently work in a hospital, may find that they will be fulfilling an unchanged or very similar role to their present one but more often in a primary or community care setting.
- Some staff will be asked to adapt to a change in role, for example to work in some of the new areas we are developing, and where this is the case they will receive appropriate training and support.
- It is our working assumption that there would be a reduction in our overall workforce of around 3% over the next 3 to 5 years. As we currently employ around 54,000 whole time equivalents, this would equate to 1,620 whole time equivalents. As part of enabling this, it is likely we will provide support for voluntary early retirement / voluntary redundancy and /or re-training support.
- There is likely to be growth of employment in the non-statutory sector.

- If any proposal adopted following consultation involves transferring any staff between organisations within HSC, their terms and conditions would not be affected. There are no specific proposals in this consultation which would involve transfer of staff to an employer outside HSC.

It is vital that our staff are involved in, and take the lead in, the implementation of the changes that will be decided in light of the response to this consultation document. We are committed to supporting all our staff in terms of capacity (having the right number of people) and capability (having the right skills in the right places). Significant training and skills development will be put in place to support staff impacted by TYC.

5.2 Procurement

Procurement is about how we buy services from organisations outside HSC, including independent healthcare providers and the voluntary and community organisations. They already have an extremely important role in delivering our health and social care, and they will be critical in successfully achieving the TYC vision. Procurement has the objective of ensuring a proper mix between statutory, voluntary and community and private sectors.

At the heart of the TYC model is a greater level of personalisation of care and diversity of choice in respect of the services we receive. This means people should be involved in making decisions about how their care needs are assessed, defined and met. What is important and a preference for one person might be very different for another. This has implications for the involvement of organisations outside HSC in providing a greater range of services than we have at the moment.

We need to support the education and training of people working in independent healthcare providers and the voluntary and community sectors to support these organisations to build their capacity and capability. We would also explore ways to support emerging models of social enterprise.

More specifically, we will seek to standardise the procurement of domiciliary services and nursing home places across Northern Ireland.

The implementation of TYC will have implications for how we procure and measure the performance of our partners in the independent and voluntary and community sectors. For example, in future it is likely that there will a greater proportion of residential homes provided through the non-statutory sector as demand for places in the statutory residential homes decline.

5.3 Technology

Technology is a major part of all our lives nowadays, and healthcare is no different. We need to embrace opportunities for new technology to support the way we deliver our services. Many of the proposals in our draft plans will be supported and enabled by new investment in ICT and connected health but some of the specific areas where you may see changes are:

- Increased sharing of your information across HSC organisations where this supports clinical decision making about your diagnosis or treatment. For example, a GP in the community should be able to send information about your condition directly to a consultant based in an acute hospital to enable a decision to be taken without the need to visit hospital.
- Everyone will have an Electronic Care Record. This means that rather than relying on slow paper systems that are not always available to staff looking after patients, it will provide doctors, nurses and other staff with the information they need to provide the right treatment wherever the patient is.
- Connected Health is a term used to describe a new model for healthcare delivery that uses technology to provide healthcare remotely. It aims to maximise healthcare resources and provide increased, flexible opportunities for patients (and often families/care-givers) to engage with clinicians and better self-manage their care. Connected Health encompasses telehealth, remote care (such as home care), disease, and lifestyle management. While it is not limited to managing chronic diseases it can contribute to management of these, and should lead to reduced unplanned admissions to hospital (along with associated cost savings), and improved outcomes for individuals and their families.
- You may have technology in your own home to allow you, and those responsible for your care, to monitor your oxygen or blood pressure levels or alert someone when something has happened, and this will

mean that deterioration of your condition is detected earlier and medication or treatment can be adapted more quickly.

- The introduction of a web based portal - this will be equivalent to the NHS Choices website but for the HSC. It would include information on prevention, self-management of illness, signs and symptoms, investigation and treatment of a range of conditions. It would also include a directory of local GP, community and hospital services.

5.4 Finance

TYC is not about reducing our investment and spending in health and social care services, it is about working within our budget and making the best use of the resources we have. We know our budget for the next few years. But we also know that demand will increase and that our current model will become unaffordable in the medium to long term. We therefore need to think about how we can do things differently whilst improving quality and safety for our patients and users.

We are committed to having a structured and sensible implementation of the TYC proposals set out in this document. The new or different services must, and will, be developed and be working well before we step down other parts of the service. For example, through demonstrating that more older people can be cared for in their own home, through the support of community nursing and support staff before making possible changes to the level of hospital services. This is critical.

TYC indicated that a 5% shift (which is approximately £83 million in the current budgets) from hospital services would need to be re-invested into primary and community and social care services by 2014/15. The pace of change will be influenced by our financial circumstances. Ideally, this would be a 3 to 5 year horizon for the implementation; however, implementation may be achieved slightly quicker, or indeed we may need to go at a slightly slower pace, depending on the level of resources available. We will need to be supported by Transitional Funding over a three year period to make this happen.

In addition, we recognise the need for capital investment in our infrastructure. At the moment our current capital budget between 2011/12 and 2014/15 is £962million which is used to cover a range of projects.

Looking ahead, the draft Investment Strategy for Northern Ireland provides for an indicative allocation of £1.47bn from 2015/16 - 2020/21 against an estimated need of £2.3bn, leaving a projected shortfall of over £800m some of which may be addressed by revenue financing solutions such as Public Private Partnership (PPP).

In this context, it is increasingly likely that without additional sources of capital funding, the scope to take forward major modernisation projects will need to be phased to take account of budgetary availability.

The estimated need for backlog maintenance is well over £1bn. This is additional to the figures stated above although new developments when delivered will reduce the need for backlog maintenance.

The Health Infrastructure Board, set up by the Minister in November 2011, is investigating alternative private funding methods for primary and community care infrastructural development. Business cases for two pilot projects are being developed - Newry and Lisburn Health and Care Centres.

5.5 Organisational Implications

This consultation proposes many changes to the current model of care and treatment provided by the HSC system. Given the scale of change and, looking to the future, it will be necessary to consider whether the organisational structures of the HSC are fully fit for purpose. It will be important that the structures can enable the transformation, are able to deliver better outcomes in terms of individuals' experience of health and social care services, and are as supportive as possible to the strategic aims and objectives set by the Executive and the Minister.

A major review of health and social care structures was completed in 2009. The organisational arrangements remain under continuous review to ensure that they continue to provide best value for money, whilst supporting the planning and delivery of quality services. The implications of the proposed service changes set out in this document would be far reaching and may raise legitimate questions about the best structures to secure implementation of the agreed way forward. Such questions would be for the Minister to consider in the context of the Executive's Review of Arms' Length Bodies.

Part 6.

Equality and Human Rights

The Health and Social Care Board is required to consider the likely equality implications of any policies or decisions. In particular it is asked to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependents and persons without.

We also have due regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group, and have a statutory duty to ensure that our decisions and actions are compatible with the European Convention on Human Rights and to act in accordance with these rights.

The HSCB has undertaken an Equality and Human Rights Screening on the TYC proposals set out in this document. This is available on our website (www.tyconsultation.hscni.net), or by contacting us via the contact points in Part 3 of this document.

One of the stated objectives of TYC and the draft plans is the reduction in health inequalities and the promotion of equality of opportunity. The proposals are not about pausing or stopping changes that are already underway and delivering better outcomes or experiences for patients, staff, users and carers, but rather TYC seeks to draw these together into a clear and coherent picture.

Therefore some of the things you read in this document are not new, and may simply relate to the implementation of a strategy or policy which has already been agreed and is underway. This means they have already been subject to robust screening and impact assessment as appropriate. Others will be new. For those service changes which would be new or represent a significantly different way to provide health and social care services, they would be subject to all appropriate equality screening and impact assessment.

Given the strategic nature of the draft plans, the detail of the approach to implementation has yet to be worked out following the conclusion of this consultation period. Ideally this would be over a 3 – 5 year horizon;

however this timescale is dependent on the level of resources available. As these become known, and further evidence on the nature of the impact on each group becomes clearer, all such changes would be subject to robust screening, Equality Impact Assessment (EQIA), where applicable, and public consultation.

The equality issues as identified in response to this consultation exercise will inform these future screening and impact assessment exercises.

Question 18.

Are the proposals set out in this consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals.

Question 19.

Are you aware of any indication or evidence – qualitative or quantitative – that the proposals set out in this consultation document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

Question 20.

Is there an opportunity to better promote equality of opportunity or good relations? If yes, please give details as to how.

Question 21.

Are there any aspects of the proposals where potential human rights breaches may occur?

Part 7.

What happens next and what we want from you

We recognise that change can be difficult. It can feel threatening and uncertainty over the future can create anxiety.

Our overriding objective and commitment to you is to create safe, high quality, accessible and sustainable health and social care services for the 1.8 million people living in Northern Ireland.

The proposed changes we describe in this document, and in the draft plans, would take time to be agreed and be implemented. We anticipate that the transitional period would be the next 3 to 5 years, maybe longer.

Throughout this period we want to have open and honest debate about the choices ahead, and involve as many people as possible in making those choices.

Following this consultation, scheduled to complete in January 2013, and following analysis of your views the draft plans would be revised and finalised to inform implementation and we would share those with you. Specific components of that implementation would go through the normal change processes, including further and more specific public consultation as appropriate.

We are seeking your views on the proposals and questions set out in this document.

A separate questionnaire is available to help you to record your comments and this can be filled in online via our website, or downloaded and sent into us. You can send us your answers or comments, by post or email to:

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However you choose to give us your views, we want to hear from you. Please send us your comments by 15 January 2013

Appendix 1: Criteria for Acute Reconfiguration

Criterion	Weight
<p>Safety & Quality – the option:</p> <ul style="list-style-type: none"> • Comfortably meets any professional standards for minimum volumes of activity • Meets quality standards endorsed by DHSSPS or accepted by commissioners • Supports rapid and senior clinical decision making • Meets the requirements in the Commissioner Specifications • Facilitates research to further drive improvements in care 	30
<p>Deliverability and sustainability – the option:</p> <ul style="list-style-type: none"> • Requires realistically deliverable numbers of multidisciplinary teams • Realistically can recruit and retain the number and range of staff required, taking account of recent experience • Is deliverable and sustainable in the context of reliance on relevant interdependent clinical services • Supports recognised accredited training for junior medical staff • Enables European Working Time Directive requirements to be met • Can accommodate future new technologies • Can be organised to deliver reliably and consistently in accordance with agreed standards 	25
<p>Effective use of resources – the option:</p> <ul style="list-style-type: none"> • Supports a staffing model to deliver 7-day a week working • Maximises use of built infrastructure by minimizing downtime & enables productivity improvements • Maximises available opportunities for cross-boundary and cross-border working • Minimises delays for inpatients and delivers against waiting time targets 	15
<p>Local access – the option:</p> <ul style="list-style-type: none"> • Delivers timely access to quality services according to a patient’s clinical acuity/needs • Provides services as locally as possible, where this can be done safely, sustainably and cost-effectively 	15
<p>Stakeholder support – the option:</p> <ul style="list-style-type: none"> • Has public and patient support • Has clinical & other professional support • Has the support of professional standard-setting organisations • Has staff representative support 	15
Total	100

Appendix 2:

Freedom of Information & confidentiality

Freedom of Information Act (2000) – Confidentiality of Consultations

The Board will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Board can only refuse to disclose information in exceptional circumstances. Before you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Board in this case. This right of access to information includes information provided in response to a consultation. The Board cannot automatically consider as confidential information supplied to it in response to a consultation.

However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

- The Board should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Board's functions and it would not otherwise be provided.
- The Board should not agree to hold information received from third parties "in confidence" which is not confidential in nature.
- Acceptance by the Board of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact the Information Commissioner's Office (or see web site at:

<http://www.informationcommissioner.gov.uk>)

Appendix 3: Glossary of Key Terms and Abbreviations

<i>Term</i>	<i>Meaning</i>
A & E	Accident and Emergency.
Bamford Review	Review of Mental Health and Learning Disability, making recommendations for the improvement of Mental Health and Learning Disability services.
CAMHS	Child and Adolescent Mental Health Services.
Care Pathways	Tool based on evidence based practice for groups of patients with predictable clinical course to promote organised, safe and efficient care through standardised models of care.
CATH Lab	Catheterisation Laboratory for diagnostic and interventional procedures for patients with Coronary Heart Disease.
Connected Health	Use of the latest technology in health care to give patients more freedom to lead a more independent life.
COPD	Chronic obstructive pulmonary disease.
DHSSPS	Department of Health Social Services and Public Safety.
Direct Payments	Cash payments by HSC Trusts to the value of services they would otherwise provide, that allow individuals to arrange for themselves the social care services required to meet their needs as assessed.
ED	Emergency Department.
Family Nurse Partnership Programme (FNP)	Intensive home visiting from early pregnancy until the child is 2, designed to support young mothers.
Home as Hub	A model identifying home as the central focus for the care of each individual rather than an acute setting.
HSC	Health and Social Care.
HSCB	Health and Social Care Board (Commissioner for health and social services in Northern Ireland).
Hub and Spoke model	Primary Care model, whereby hubs are centres which provide services for the local population and a range of spokes, these are surrounding GP surgeries.
Integrated Care Partnerships (ICP)	Collaborative network for local health and social care professionals, working as part of a multi-disciplinary team to come together and work in a more integrated way to provide care and support on a more complete range of services.
ICT	Information Communication Technology.
Intermediate Care	The primary function of intermediate care is to build up people's confidence to cope once more with day to day activities. It services as an extension to specialist clinical care and rehabilitation, but not as a substitute for it.
Local Commissioning Group (LCG)	Responsible for the commissioning of health and social care by addressing the care needs of their local population.

Term	Meaning
Long Term Condition (LTC)	Chronic ailment from which there is no cure but will require long term treatment or monitoring.
NICE	National Institute for Health and Clinical Excellence. NICE guidance supports healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for money.
Nursing home	A Nursing home is a home registered for nursing that will provide personal care and will also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse.
Personalisation	Care is tailored for each individual shaping support to meet individual needs. Individuals are empowered to shape their own lives and services they receive. They have the preferences to choose how, when, and what treatments or other services they receive, organised around their lifestyles.
PHA	Public Health Agency.
Population Plans	Document outlining key proposals for how TYC would be implemented developed by each LCG in conjunction with respective providers.
Reablement	Programme of support to assist people in getting back to independent living.
Resettlement	Shift from long term institutional care to living in the community.
Residential Care	Refers to the provision of residential accommodation with both board and personal care, usually long-term, for people who need help with personal care due to old age, illness and/or infirmity, disablement, dependence on drugs or mental illness. This service is means tested.
RQIA	Regulation and Quality Improvement Authority.
Self-directed support	Individuals will have as much on-going control as they want over the individual budget spent on their support.
Shift Left	Change in service delivery from an acute setting to community-based delivery; also a shift to greater emphasis on prevention of illness rather than response to exacerbations.
Strategic Implementation Plan (SIP)	Describes a planned approach for the delivery of the TYC proposals over the next 3-5 years reflecting the shared ambitions and commitments of the TYC programme.
Telehealth, Telecare, Telemedicine	Use of telecommunications to facilitate an independent lifestyle, includes alarm systems and monitoring systems, particularly in Long Term Conditions.
Transforming Your Care (TYC)	Report on the Review of Health and Social Care in Northern Ireland 2011.
Trust	Provider of Health and Social Care Services to a particular population.