Transforming Your Care

Strategic Implementation Plan

October 2013

Final Version
Preface:

This document was initially published in July 2012, and a revised version was published in October 2012 as part of the ‘Transforming Your Care: Vision to Action’ public consultation which took place between October 2012 and January 2013. It has subsequently been revised in light of the outcome of that consultation, as outlined in the Post Consultation Report published by the Health and Social Care Board in March 2013. This Strategic Implementation Plan provides an overarching plan for the service changes to be made in support of Transforming Your Care, and will help to inform the development of the comprehensive plans incorporating commissioning, finance and Transforming Your Care for the period ahead.
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1 Executive summary

‘Transforming Your Care: A Review of Health and Social Care’ (TYC) was published by the Minister on 13 December 2011 and sets out 99 proposals for the future health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform. The review proposed a model of health and social care which would drive the future shape and direction of the service and puts the **individual at the centre** with services becoming increasingly accessible in local areas. This transformation will result in a significant shift in the way services are provided across hospitals and the community, with some provision moving from hospitals to the community, where it is safe and effective to do this.

This Strategic Implementation Plan (SIP):

- Describes a planned approach for the delivery of the TYC proposals over the next 3 to 5 years (starting from 2011/12 baseline).

- Reflects the shared ambitions and commitments of the TYC programme leadership and is intended for everyone involved in leading and managing delivery of any part of the TYC transformation programme across the health and social care system in Northern Ireland.

- Sets out the key commitments and the major changes which will drive service transformation in Section 4.2.

- Presents the big themes for each of the Programmes of Care over the next 3 to 5 years across the 5 Local Commissioning Group (LCG) areas (Section 4.4). At the heart of this are the 5 local Population Plans, which provide the building blocks for this SIP. These
set out in detail the service transformation initiatives for delivery of the TYC proposals for each of the 5 local areas.

- Reflects the outcomes of the public consultation process on the Vision to Action document which took place October 2012 to January 2013.

How the HSCB will collaborate to deliver

The SIP provides a coherent, controlled and managed framework which brings existing programmes together and adds new ones, in a well-integrated way, to deliver these proposals. The HSCB have developed an integrated planning approach which aligns whole system planning, regional workstream planning and LCG area planning. In bringing together our plans, reducing health inequality will be built into the heart of our design and implementation of the programme.

Alongside our aligned delivery strategy will be a robust collective monitoring and learning framework. This will include: integrated monitoring of delivery; assessing impact; spreading innovation and developing capabilities and supporting delivery and recognising system drivers.

The overall objective is to enable managed change from the existing service delivery model to one which encapsulates Transforming Your Care.

Recognising the importance of the transformation and its challenges, the Minister has stated his full support for TYC, particularly given the exciting opportunities its implementation presents.
The major initiatives and drivers of the transformation are summarised below (presented in greater detail in Section 4 of this Strategic Implementation Plan):

**Population health & well-being**

- Implement the new Public Health Strategic Framework.
- Expand / introduce evidence-based programmes to support parents and families.
- Extend the Roots of Empathy programme in primary schools.
- Implement Fitter Futures for All to reduce obesity, and the new tobacco control strategy to reduce smoking rates.
- Tackle alcohol and drug misuse.

**Local Services - At home and in the community**

- **17 Integrated Care Partnerships** – bringing together health and social care providers, to work as collaborative networks, improving care pathways focusing initially on Older People and aspects of Long term Conditions; namely Diabetes; Stroke Services and Respiratory disease. Benefits include:
  - Supporting a more co-ordinated, person-centred approach to how treatment and care are planned and delivered for specified Long Term Conditions.
  - Reducing ED attendances and admissions for Older People.

- **Reablement** – promoting greater independence for older people at home using planned short-term support services following a hospital admission or health or social care crisis at home.

- **Falls prevention** programme to identify those at risk of falls and fragility fractures and provide targeted interventions.

- **Personalised care**, with individual budgets to promote patient/client control over care and services.

- Reduction in **statutory residential care** homes for older people.

- Increase support for carers and improved access to respite care.
Transforming Your Care – Strategic Implementation Plan

- Fostering schemes for children hardest to place.
- Embed family support hubs to focus on early intervention.
- Reduce reliance on residential care homes.
- Develop Child and Adolescent Mental Health Services.

- 6 Admissions units – one in each of the 5 local areas plus one more unit in the Western area.
- Significant reduction in institutional care and the number of inpatient beds across the region by 2015.
- Improved focus on community-based treatment.

- Care closer to home, keeping as many people with a physical disability out of hospital where possible, improve rehabilitation.
- Enhance links between community and voluntary services, create broader range of respite.

- Move clients into community based options such as supported housing, and as a consequence reduce the number of people in institutional care.
- The service will resettle all people with a learning disability living in hospital by March 2015 to community living options with appropriate support.
- Provide support for families and carers including short breaks/respite and day opportunities to enable people with a learning disability to remain at home with appropriate support.

- All children to be offered universal child health programmes as a means of supporting them and their families to have the best start in life.
- Safe and sustainable maternity services.
- Development of MLUs with effective links to consultant led care.
- Provide women with choice and promote normalisation of births.
- Implement Family Nurse Partnerships to improve the health and well-being of children and families.

- Public and staff involvement and awareness of Palliative and End of Life care (End of life care refers to the last year).
- Identification, assessment and advance care planning.
- Co-ordination of care across organisational boundaries.
- Improving the availability of services.
- Increase the number of staff confident and competent in core principles of palliative and end of life care.
- **5 – 7 networks of hospitals** to guarantee safe and sustainable services – Address fragility of services in terms of throughput and staffing levels. Changes to services provided at hospitals, localising services where possible, centralising services where necessary, creating centres for major acute services and elective services for local populations.

- **1 regional trauma centre** for Northern Ireland.

- **24/7 access to safe sustainable cardiac catheterisation labs**, with an investment of £8m.

- A **review of paediatric services** is on-going and is taking account of the recommendations as outlined in the Maternity and Child health section of TYC. This review is focused on the commissioning and provision of effective and sustainable hospital and community services, and also incorporates paediatric palliative and end of life care.

- 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.

- **Modernisation of pathology**.

- Expansion of **orthopaedic services** in Southern, Western and Belfast Trusts with an investment of up to £7m revenue over the next 3 to 5 years.

- Enhanced **ambulance services** bringing patients to destination with best outcomes - Introduction of “111” urgent care number; neo-natal retrieval service for babies below 1500g.

- Where there isn’t sufficient volumes to support specialist services there will be access to quality services in neighbouring health services.

- Further details are set out in Section 4.2.11.
Delivering the service model - Detailed workforce and financial planning

The initiatives contained in the SIP and the Population Plans are focused on describing the service model. Further detailed planning concerning the workforce, the financial and capital implications of the service model is required and will be completed over the coming months. This localised costing and planning of all the initiatives will aim to identify in a detailed way the reinvestment in each Local Commissioning Group (LCG) area and affirm the affordability of the new model of care. This exercise will provide the evidence base to support the implementation of the initiatives.

Supporting our workforce and engaging others in the transformation

With such significant transformation in how health and social care services are delivered, the HSC system needs to create an environment which is receptive to and supports the transformation required to deliver TYC. There is a strong commitment to supporting those impacted upon by the changes and enabling HSC staff to take forward and deliver the change. Citizens and the wider HSC workforce are the key to making change happen. The chosen model is based on evidence of what makes transformation successful. The challenge ahead cannot be underestimated and the HSCB is committed to investing in our capability and engagement approach.

- Evidence based workforce modelling to ensure that we know what skills will be required to deliver services.
- Investment in the workforce to ensure they have the right skills to support our journey. Our health and social care service will attract the best people offering opportunities to play a key part in its transformation.
- Leadership and capability development - For this unprecedented change, leaders at all levels need enhanced skills and capability. There will be investment in the people with the skills to deliver change, and establish a programme of training to support their development.
- Continuous and tailored engagement and communication with everyone impacted by TYC, to listen and act upon their views, and ensure that everyone has a voice in the way forward.

Next Steps: Detailed operational planning and implementation, with further local consultation as appropriate

The draft Strategic Implementation Plan, and the Population Plans which support it, were initially submitted to the Minister at the end of June 2012, after which a period of consideration and quality assurance took place, followed by a 14 week period of public consultation. The Post Consultation Report sets out the views received during that consultation, together with the Health and Social Care response. It was agreed that the draft SIP would be updated to reflect the material and significant changes to the strategic direction as a result of the public consultation.

In parallel, further detailed operational planning is underway to cover all the TYC recommendations for which the HSCB has responsibility and the service change proposals set out in the Vision to Action document and endorsed by public consultation. Further local consultation and on-going monitoring and planning will be a feature of the implementation of
the TYC Programme, as set out in Section 3, and therefore these operational plans are subject to change. It is therefore not intended that this detailed operational planning is reflected in this document.
2 Context and background

2.1 Purpose of this document

This document describes the Strategic Implementation Plan (SIP) for the delivery of the TYC proposals over the next 3 to 5 years. It contains our shared commitments across the HSC for what the programme will deliver together with the delivery strategy for how the HSCB, Trusts and PHA, and other providers will work together to achieve these.

It also describes the strategic components of the TYC transformation programme and associated responsibilities.

This document:

- Reflects the shared ambitions and commitments of the TYC programme leadership and is intended for everyone involved in leading and managing delivery of any part of the TYC transformation programme across the health and social care system in Northern Ireland.

- Reflects the outcomes of the Public Consultation which took place on the Vision to Action document between October 2012 and January 2013. Further details on the service change proposals, the views expressed by those responding and the outcomes of the consultation can be found in the Post Consultation Report published by the HSCB and launched by the Minister in the NI Assembly on 19 March 2013.

- Sets out our Key Commitments - the major changes which will drive service transformation and acute service reconfiguration (Section 4.2).

- Presents how each of the Programmes of Care will evolve over the next 3 to 5 years across the 5 LCG areas (Section 4.4) along with an overview of the Regional Programmes.

2.2 Background to the TYC transformation programme

In June 2011, the Minister for Health, Social Services and Public Safety, announced the need for a review of HSC services. The key objectives of the Review were to:

- Undertake a strategic assessment across all aspects of health and social care services.
- Undertake appropriate consultation and engagement on the way ahead.
- Make recommendations to the Minister on the future configuration and delivery of services.
- Set out a specific implementation plan for the changes that need to be made in health and social care.

The Minister’s vision for the HSC Review was to drive up the quality of care for clients and patients, improving outcomes and enhancing the patient and client experience. In addition there is a need to improve productivity and make sure that every penny is spent effectively. The Minister emphasised the importance of promoting greater involvement of frontline
professionals in decision making and service development and the crucial role which more powerful local commissioning and community and voluntary sector providing services could play in driving change and innovation.

‘Transforming Your Care: A Review of Health and Social Care’ was published by the Minister on 13 December 2011 and sets out proposals for the future health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform. The figure below across outlines the core challenges and pressures for transformational change.

Figure 1: Summary of Pressures & Consequences for Health & Social Care Change

Responding to these pressures, the Review identified 11 key reasons for change.

<table>
<thead>
<tr>
<th>Reason 1:</th>
<th>The need to be better at preventing ill health</th>
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<tr>
<td>Reason 2:</td>
<td>The importance of patient centred care</td>
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<td>Reason 3:</td>
<td>Increasing demand in all programmes of care</td>
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<td>Reason 4:</td>
<td>Current inequalities in the health of the population</td>
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<td>Reason 5:</td>
<td>Giving our children the best start in life</td>
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<td>Reason 6:</td>
<td>Sustainability and quality of hospital services</td>
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<td>Reason 7:</td>
<td>The need to deliver a high quality service based on evidence</td>
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<td>Reason 8:</td>
<td>The need to meet the expectations of the people of NI</td>
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<td>Reason 9:</td>
<td>Making best use of resources available</td>
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<td>Reason 10:</td>
<td>Maximising the potential of technology</td>
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<tr>
<td>Reason 11:</td>
<td>Supporting our workforce</td>
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</table>

‘Transforming Your Care’ also proposes a model of health and social care which would drive the future shape and direction of the service and puts the individual at the centre with services becoming increasingly accessible in local areas. This transformation will result in a significant shift in the way services are provided across hospitals and the community, with
some provision moving from hospitals to the community, where it is safe and effective to do this – this service transformation is generally known as the “Shift Left”.

Briefly described the model means:

- Every individual will have the opportunity to make decisions that help maintain good health and wellbeing. Health and social care will provide the tools and support people to do this.

- Most services will be provided locally, for example diagnostics, (where volumes/throughput and skill mix make it safe and sustainable to do so), outpatients and urgent care, and local services will be better joined up with specialist hospital services.

- Services will regard home as the hub and be enabled to ensure people can be cared for at home, including at the end of life.

- The professionals providing health and social care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care for patients.

- Where specialist hospital care is required it will be available, discharging patients into the care of local services as soon as their health and care needs permit.

- Some very specialist services needed by a small number of people will be provided on a planned basis in the ROI or further afield.

“Shift left” in health care will require a combination of a greater focus on a preventative approach, including high quality management of Long Term Conditions, like COPD and heart failure, to reduce the frequency of acute exacerbations and need for hospital care, 7-day acute-care-at-home services to enable people to be looked after at home and thereby reduce admission numbers and the length of time people spend in hospital, and finally,
intensive treatment of people who do need hospital care, including more services available 7-days a week.

The Review considered and presented the methodology to make the change over a 5 year period. It initially describes a financial remodelling of how money is to be spent indicating 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 it may need to go at a slightly slower pace, depending on the level of resources available. The transformation will need to be supported by Transitional Funding over a 3 year period to enable the new model of service to be implemented. This is a fundamental enabler in the change process. The Review re-affirmed there are no neutral decisions and there is a compelling need to make change. The choice is stark: managed change or unplanned, haphazard change.

There are a total of 99 proposals resulting from comprehensive engagement with a wide range of stakeholders, and analysis of the current provision of care. Together these represent a fundamental change in how deliver services are delivered with overarching focus being on quality of care and care provided as close to home as practical. The key proposals are summarised below.

| Quality and outcomes to be the determining factors in shaping services. |
| Prevention and enabling individual responsibility for health and wellbeing. |
| Care to be provided as close to home as practical. |
| Personalisation of care and more direct control, including financial control, over care for patients and carers. |
| Greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector. |
| New approach to pricing and regulation in the nursing home sector. |
| Development of a coherent regional programme for 0-5 year old children, to include early years support for children with a disability. |
| A major review of inpatient paediatrics. |
| In GB a population of 1.8million might commonly have 4 acute hospitals. In NI there are 10. Following the Review, and over time, there are likely to be 5-7 major hospital networks. |
| A changing role for general practice working in 17 Integrated Care Partnerships across Northern Ireland. |
| Recognising the valuable role the workforce will play in delivering the outcomes. |
| Confirming the closure of long stay institutions in learning disability and mental health with more impetus into developing community services for these groups. |
| Population Planning and local commissioning to be the central approach for organising services and delivering change. |
| Shifting resource from hospitals to enable investment in community health and social care services. |
| Modernising technological infrastructure and support for the system. |
As part of the “Roadmap for the Future” set out in the Transforming Your Care report, a strategic approach to the implementation of the 99 proposals is set out. It is aimed that this will primarily be delivered through the commissioning process and the development and implementation of Population Plans. These 99 proposals have been formally reviewed and accepted by the Minister and DHSSPS.

Alongside this, Health and Social Care in NI faces a considerable financial challenge over the next 3 to 5 years. The NI Budget settlement for the 4 year period 2011 to 2015 will result in £4.65bn by 2014/15 being available for Health and Social Care deployment. Managing resources in Health and Social Care is always contentious but it is clear that a significant funding gap will emerge in the years ahead if no change to and transformation of services is made.

To address this challenge, a number of opportunities have been identified to reduce cost whilst improving quality – the Quality Improvement and Cost Reduction Programme (QICR). Critical to this is the planning and delivery of the necessary reforms in an integrated fashion. It is intended that TYC’s regional and local projects will be brought together with QICR, working in an effective consistent manner to support the financial challenge.

Significant investment is required in public health programmes to prevent ill health in the first place. There are 4,000 premature deaths per year in NI and 61,000 potential years of life lost through preventable illnesses. Stop smoking services, public information campaigns on obesity prevention, brief advice on alcohol and drug misuse, early recognition of and support for mental health problems, early access to GUM (genitourinary medicine) services, infection control, screening and immunisation are just some examples of highly cost-effective public health programmes which would prevent ill health or allow earlier diagnosis, more simple treatment and better outcomes for patients. Service Frameworks and a range of other documents, for example, on nutrition, patient experience, and perinatal mental health, set the standards that need to be met.

Even 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.

Furthermore, to ensure that people in Northern Ireland continue to have access to new drugs and new technologies, significant resources are required to fund NICE-approved drugs and guidelines and meet good practice standards for care as set by DHSSPS. Greater investment in high quality care, and preventive care, is not just good for patients, clients and the public, it is cost-effective. However, to enable that greater investment to happen, current services need to change at a scale that enables funding to be released from inpatient services for reinvestment in the types of public health, primary and community services outlined above. Simply re-providing acute care elsewhere is not sufficient as it will not fundamentally improve the health and wellbeing of people in Northern Ireland.
2.3 Regional assessment of strategic need

Population plans have all detailed the projected changes in the demographic profile in Northern Ireland and also the projected increases in incidence of Long Term Conditions, as detailed in the diagrams below.

By 2014 there will be approximately 50,000 more people in N.Ireland than there are today and more than half of these will be over 65 years old.

Figure 2 Population Projections
Source: 2008 Based Population Projections, NISRA

Figure 3 Projected Growth of 85+
Source: 2008 Based Population Projections, NISRA

Figure 4: Estimated growth of the incidence rates for Coronary Heart Disease (CHD), Diabetes and Hypertension for males aged 40 to 60.
Advancements in modern treatments should be celebrated, but the implications on health and social care provision need to be recognised and planned for accordingly. In addition to an ever increasing older population, health and social care is also required to respond effectively to the growing incidence rate of chronic conditions such as hypertension, diabetes, asthma and obesity. A study in Northern Ireland predicted a 10% increase in adults with hypertension between 2007 and 2020, and a 40% increase in adults with diabetes over the same period\(^1\). The Quality and Outcomes Framework (QOF) information published by the DHSSPSNI also demonstrates that these conditions have all shown an increase between 2007 and 2012\(^2\).

The incidence rate (new cases) is influenced in part by lifestyle choices and government and personal action is required to make healthy choices easier. The 2010/11 Health Survey of Northern Ireland demonstrated, although through a relatively small sample of 4000, 72% of respondents felt that they could do something to make their own life healthier, with males (74%) more likely to indicate this than females (71%)\(^3\). In addition, the prevalence rate (total number of cases) is influenced by survival rates. Early diagnosis and modern treatments reduce mortality and increase the need for services to manage chronic conditions in the long term; increasingly, this includes people with cancer.

The preference for the location of services differs depending on the type of care required. An Omnibus survey (2011), found that over 80% of those surveyed would prefer long term care to be closer to home. Alternatively for short term episodes of care, the Patient Client Council found that people are prepared to travel to get the right treatment quickly. Health and social care services will be required to adapt to new ways of working in order to provide services of the highest quality consistent with the needs and expectations of patients and clients.

It is estimated that the demand for services could grow by around 4% per year by 2015\(^1\). Examples of the potential consequences without change are listed below:\(^2\)

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 8,000 extra nursing home weeks; and
- 40,000 extra 999 ambulance responses.

In addition, there is clear evidence of health inequalities in Northern Ireland, the consequences being poorer health outcomes observed in the most deprived areas than in the region generally such as:

- lower life expectancy;
- 33% higher rates of emergency admission to hospital;
- 72% higher rates of respiratory mortality;

\(^1\) Reshaping the System (2010) McKinsey  
\(^2\) NI Confederation for Health and Social Care: Areas for Action for Health and Social Care in Northern Ireland 2011-2015
• 59% higher incidence rates of lung cancer;
• 82% higher rates of suicide;
• self-harm admissions at more than twice the Northern Ireland average;
• 55% higher rates of smoking related deaths; and
• 124% higher rates of alcohol related deaths.

2.4 Transformation programme brief

The Minister and the DHSSPS have established a Whole System Planning approach to the planning and reform of health and social care. This encompasses the following:

• The Programme for Government, Investment Strategy for Northern Ireland and the Northern Ireland Economic Strategy;
• The new Public Health Strategic Framework;
• The Quality 2020 Implementation Plan;
• The TYC Transformation Programme;
• Commissioning Plan(s) (including LCG Plans);
• Quality Improvements and Cost Reduction Plans;
• Trust Delivery Plans; and
• Infrastructure Development (Capital) Plans.

The Minister for Health Social Services and Public Safety sets out the priorities for health and social care in an annual Commissioning Plan Direction to the Health and Social Care Board (HSCB). The Minister’s priorities are set in the context of wider policies and strategies embracing the full range of health and social care services in Northern Ireland. The HSCB responds to the Direction by working with the Public Health Agency (PHA) to develop an agreed Commissioning Plan for Northern Ireland. Local Commissioning Groups, play an important role in assessing the particular needs of local populations in the context of the Minister’s priorities and ensuring that they are properly represented in the Commissioning Plan. These arrangements are set out statute.

The proposals in Transforming Your Care impact on a wide range of health and social care services and will require a great deal of work to plan and deliver. In recognition of the size and importance of this service modernisation agenda, the Minister asked the HSCB, working with the PHA and service providers, to draw up local population plans and an overall strategic implementation plan to ensure that all stakeholders have a clear understanding of what TYC proposes and how it will be delivered. These strategic proposals were the subject of public consultation, as will the individual service changes that flow from them.

Ministerial decisions will be reflected in future Commissioning Plan Directions along with other priorities not directly connected to Transforming Your Care. This will ensure that the
important changes are taken forward within the existing legislative framework and fully in concert with all relevant policies and strategies for health and social care in Northern Ireland.

As part of this, the Minister and DHSSPS have devolved responsibility for many of the TYC outcomes to the HSC Board who will take the lead, working alongside the 5 local commissioning areas in delivery.

The 99 proposals contained in the TYC Report are wide-ranging and the Strategic Implementation Plan and Population Plans are not intended to cover all aspects of the Proposals. A number of proposals in the TYC report are not addressed through the Plans. This includes, for example, policy development work to be determined by the Department for Health, Social Services and Public Safety. The scope of these documents is purely to provide summary details of the intended response to proposals that the HSCB and PHA have responsibility for.

The TYC programme defines transformational changes and service reform across the whole health and social care system and is designed to ensure that both service delivery and reform are managed and delivered in a coherent and co-ordinated way. The TYC Programme Initiation Document describes how the transformation programme has been established and is organised, managed and governed.

### 2.5 TYC Transformation Programme objectives

The objectives of the TYC transformation programme are the following:

- Implement the Transforming Your Care proposals for which the Health and Social Care Board has responsibility, within 3 to 5 years following the completion of public consultation of the strategic service change proposals.
- In doing so, contribute to the outcomes set out in the Transforming Your Care Review Report, inter alia.
  - Shift of 5% (circa £83m) from current hospital spend and its reinvestment into primary, community and social care services by 2014/15.
  - Improvements of the quality of service.
  - Build resilience of service, against a backdrop of increasing demand and clinical workforce supplies difficulties.
  - Greater levels of productivity and value for money.

### 2.6 Desired outcomes from the TYC transformation programme

The desired outcomes from the TYC transformation programme are the following:

- 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 things are done 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.

The new model of care will build on evidence of what produces good outcomes, and supports the resilience and flexibility of the health and social care system for the future. The draft Population Plans and SIP were supporting documents in the consultation process. Implementation Plans will be developed, which will include Key Performance Indicators and accountability arrangements to secure the desired outcomes.

### 2.7 Next steps: Detailed operational planning and implementation, with further local consultation as appropriate

The draft Strategic Implementation Plan and the Population Plans which support it were initially submitted to the Minister at the end of June 2012, after which a period of consideration and quality assurance took place, followed by a 14 week period of public consultation. The Post Consultation Report sets out the views received during that consultation, together with the Health and Social Care response. It was agreed that the draft SIP would be updated to reflect the material and significant changes to the strategic direction as a result of the public consultation.

In parallel, further detailed operational planning is underway to cover all the TYC recommendations for which the HSCB has responsibility and the service change proposals set out in the Vision to Action document and endorsed by Public consultation. Further local consultation and on-going monitoring and planning will be a feature of the implementation of the TYC Programme, as set out in Section 3, and therefore these operational plans are subject to change. It is therefore not intended that this detailing operational planning is reflected in this document.
3 Delivery strategy

3.1 Purpose of this section

This section describes the strategic approach to implementation of the Transforming Your Care proposals. It also describes the strategic components of the TYC transformation programme, associated responsibilities and the key ways in which the HSC organisations will work together to deliver the benefits of the TYC proposals.

3.2 Strategic principles

The following strategic principles guide the strategy for delivery of the transformation programme objectives.

- **Patient/user focus**

  An unrelenting focus on the outcomes and benefits set alongside the experience for patients/users will be at the centre of all that we do. This will be reflected in the individual being at the heart of re-designed services; planning for improvements as close to the point of delivery as possible; a clear ‘line of sight’ of how all programme activities are evidence-based; improve outcomes and services for patients/users; address inequalities; and finally, patients, users and staff engagement plans being the foremost consideration in securing commitments to change.

- **Clinical leadership and commitment**

  The uniquely challenging context of implementing a radical change programme, together with the financial context faced by HSC organisations, places a particular demand for leaders to create the conditions for change, role modelling the shared purpose, vision and values and engaging others to act. The programme will require collaborative system-wide leadership across all parts and at all levels with the health and social care system. This will be evident through a collaborative approach to planning and delivery, recognition of system drivers of change, and supported by effective capability and engagement plans.

- **Rigorous delivery**

  A programme as large and complex as this will not achieve rigorous and effective delivery of the scale and pace of improvements without genuinely shared commitments, a coherent overall plan and well managed delivery.

  This SIP is intended to provide high level planning coherence: combining and coordinating a portfolio of regional and local commitments, plans and processes with a shared timetable. The emphasis on localisation and ownership allows local service areas and their populations to shape change and realise benefits, with local leadership being supported at a regional level. In order for this to be successful, the plans will be underpinned by appropriate local and regional delivery capability and support.
### 3.3 Delivery strategy overview

TYC provides a coherent, controlled and managed framework which brings existing programmes together and adds new ones, in a well-integrated way, to deliver TYC proposals.

The SIP was developed as a response to local Population Plan requirements and lessons, which are in turn based on the TYC proposals. In this way, the SIP provides a cohesive strategic response to TYC based on a collaborative local and regional dialogue and clear mutual expectations.

This collaborative approach to integrated planning provides a basis for strong aligned delivery and collective monitoring and learning, as shown in the diagram below:

![Delivery Strategy Framework](image)

**Figure 3: Transforming Your Care Delivery Strategy Framework**

### 3.4 Integrated planning

This section describes the planning framework within which the TYC transformation programme workstreams (a workstream is defined as an area of focus, such as acute care) will be specified, collective commitments agreed and interdependencies managed across whole system plans, regional plans and local plans.
3.4.1 Whole system planning approach

Transforming Your Care, which focuses on reshaping how services are to be structured and delivered in the future so as to make best use of resources, is not being taken forward in a policy vacuum. It is set within a very robust policy context. For example, the Quality 2020 strategy, published in 2011, preceded TYC and was designed to ensure that the HSC can effectively protect and improve quality of services going forward. The key principles underpinning the approach in Transforming Your Care are all reflected in Quality 2020. Other key Departmental strategies and policies, such as the Public Health Strategic Framework, also have important links and help shape and influence the implementation of Transforming Your Care and ultimately positive health outcomes for all.

The Transformation Programme will look to the DHSSPS to ensure any policy and legislative changes are in place to support TYC.

The Transformation Programme will work closely with and report to the DHSSPS Strategic Planning Group (SPG).

3.4.2 Regional workstream planning approach

The HSCB will lead on the TYC transformation programme. In this regard, the Strategic Implementation Plan, along with the Population Plans will be incorporated into the commissioning process. In developing their Population Plans, Local Commissioning teams were required to having cognisance of all commissioning specifications and all major change initiatives which will deliver the shift left. The Programme Initiation Document will also be refreshed to reflect any changes to how the TYC transformation programme is organised, managed and governed.

The regional workstreams are defined in Sections 4.3 and 4.4 and have been identified or developed based upon:

- An understanding of the portfolio of existing or planned regional programmes that are either underway or committed, that are expected to have a direct impact on achievement of TYC proposals.
- Alignment with existing commissioning groups and structures.
- A response to common demands across programmes of care identified through the Population Planning process.
- Analysis of coverage of TYC proposals of the local Population Plans combined with existing or planned regional programmes. There is an expectation that there might be a small number of cases where TYC proposals are not, or not adequately, covered by current plans – resulting in a small number of potential additional new regional programmes.

The scope and accountability of regional programmes will change over time as they mature to reflect transformation decisions and responsibilities for delivery.
Equality

One of the key objectives of the Transforming Your Care future service model is the reduction of health inequality, and the transformation programme is committed to building this aim into the heart of our design and implementation of the programme and the specific projects and initiatives which will be taken forward as part of this. The HSCB believes that undergoing screening exercises and impact assessments will help to inform what we do, to ensure that we are improving services for our users, staff and the public.

In addition, Section 75 of the Northern Ireland Act 1998 requires the HSCB 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 dependants and persons without. The HSCB is also required to “have regard” to the desirability of promoting good relations between persons of a different religious belief, political opinion or racial group.

In keeping with the overall aim to reduce health inequality and improve access to health and social care services, the above statutory obligations, and the guidance produced by the Equality Commission for Northern Ireland, equality and human rights issues will be specifically addressed through a number of activities led by the HSCB:

- A preliminary equality screening exercise on the draft Strategic Implementation Plan, in line with the HSCB’s standard screening template, was completed in advance of public consultation. The screening was included in the consultation and questions were asked in relation to equality and human rights. In parallel, there were improvements to available data (for example due to the release of additional census information). Therefore the screening exercise has been updated and will be published in due course.

- Whilst we acknowledge the calls for an EQIA at this point, we remain of the view that it would not be meaningful to conduct an assessment on an overarching strategic vision, rather it would be more meaningful for specific service changes to be subject to full impact assessment as the specific impact on s75 groups can be fully assessed once detailed plans are known. This view also recognises that some of the proposals have already been subject to screening and EQIA when they were developed as policy. We are therefore not proposing to conduct a full EQIA at this point, but will continue to keep this under review.

- As we move into later years of the TYC transformation programme, the Population Plans and Strategic Implementation Plan will be integrated with Local Commissioning Plans, Trust Delivery Plans and Quality Improvement and Cost Reduction Plans (QICR). This will include service modelling and planning at increasing levels of detail based on data analysis of projected user demand. Enhanced data gathering on Section 75 categories will be built into this process to augment the quantitative data already available to assess who is affected and therefore inform the screening of later plans.

- As individual service changes and projects are initiated and embark on their implementation processes, they will be subject to their own equality screening, and if appropriate a full Equality Impact Assessment to address equality and human rights issues of the specific change due to take place.
• We commit to having on-going dialogue with both the Equality and Human Rights Commissions on how best to integrate and equality and human rights approach into how we design services in future.

**Transitional Funding**

The Transforming Your Care Report identified the need for transitional funding to enable the new model of service to be implemented and underpin the changes required. This transitional funding will be particularly focused on the following areas:

- Integrated Care Partnerships
- Service Change
- Implementation Funding
- Voluntary Redundancy / Voluntary Early Retirement Schemes

**3.4.3 Local Population Planning approach**

The local Population Plans will feed into and be integrated with Local Commissioning Plans, Trust Delivery Plans and Quality Improvement and Cost Reduction Plans (QICR). This has been completed for the 2013/14 year.

The Population Plans were developed during May and June 2012 by the Local Commissioning Groups working closely with their Trust and other stakeholder colleagues. Given the need to develop a comprehensive understanding of TYC at a local level, the focus of this process was to identify the key initiatives which would support the delivery of the TYC proposals. In particular the local teams focused on articulating how their services would be transformed to reflect the “Shift Left” and that greater prevention in how Health and Social Care is delivered.

It is recognised that further detailed analysis of the service initiatives in the Population Plans, in terms of workforce and financial implications, is still to be completed to inform the implementation.

The key features of the 2012/13 Population Planning process were as follows:

- Describing the Vision and Context for the Population Plan, including:
  - Current services provided and financial status
  - Challenges – why the local services needs to change
- Assessing the strategic needs of the local population based on demographics and population health trends analysis.
- Articulating how the local area will respond to the TYC proposals under each of the Programmes of Care:
  - Identifying prioritised initiatives at a local level for each Programme of Care
  - Describing the impacts of the initiatives on quality and productivity
  - Presenting key success factors for each Programme of Care
• Setting out the Enablers for Implementation, including: Outcomes and Quality Measures; the Implementation structure; plans for building capacity and capability; engagement with stakeholders; and key considerations.

Plans were drafted to reflect and respond to TYC proposals, and also complement current strategic documents such as the Public Health Strategic Framework. They were also cognisant of Commissioning Specifications for each of the service areas mentioned in the following sections. Where there are variations in numbers, for example where an LCG indicated that their plans will achieve a different percentage change in a particular service area compared to another LCG area, it should be noted that each underwent due scrutiny to ensure that each individual LCG’s figures are as robust as possible. Whilst population needs for each area will all feature the same high level themes, such as prevalence of Long Term Conditions, each LCG area will have emphasised what they believe will do most to improve their particular baseline position.

When considering the implications of the initiatives in the Population Plans, it is critical that they take into account unfunded residual demand. Together with the service model changes which are articulated in the Population Plans, it is anticipated that medical advances, changes in clinical practice, and the development of new technologies and medicines will contribute significantly to the cost associated with providing modern health and social care services in Northern Ireland.

The Population Plans focus primarily on the nature of the services changes. The implications for the workforce in terms of skill mix would be developed following detailed operational planning in the workstreams, and as part of an overall strategic service planning exercise. Detailed discussions on nursing, midwifery, allied health professionals and doctors requirements to support the initiatives will be required over the coming months.

In terms of the changes in capital infrastructure needed to fully implement TYC, the Population Plans will require a detailed working up of the capital implications and requirements over the 3 year planning period.

The approach to the ‘Shift Left’ included in Population Planning and plans for implementation

Section 3 of the Population Plans details the new service models across 10 Programmes of Care. Across the 5 local Population Plans, the transformation in how care is delivered focuses on:

• Care delivered closer to or in the home.
• Reconfiguration of acute services across 5-7 networks of hospitals, in line with best practice and professional guidelines, including access to specialist services.
• Contracts with users and personalised care/budgets.
• Reduction in residential and institutional care.
• An enhanced role for primary care, pharmacy and medicines management.
• Strong emphasis on prevention.
• Increased use of community and social care services to meet people’s needs.
• Outreach of acute services into the community.

Over the next 3 to 5 years, the transformation of services is expected to result in funding shifting from the current hospital services budget and reinvested into the primary, community and social care services. TYC identifies a 5% reduction in the hospital services budget by 2014/15 equating to a recurrent shift of resources of circa £83m pa. This reduction is to be accompanied by a corresponding increase in spending broadly in the following areas:

• £21m increase in spending on Personal Social Services (2% increase in that budget by 2014/15).
• £21m increase in spending on Primary Care / Family Health Services (3% increase in that budget by 2014/15).
• £41m increase in spending on community services, namely health and social care services that are provided in a community setting, (9% increase in that budget by 2014/15).

Initial estimates of the share of the TYC 5% reduction in hospital spend that each LCG is likely to be required to deliver, is currently under development.

Guidance will be issued to LCGs in order to appropriately monitor and report on the shift of resources from hospital spend into personal social services, primary care, Family Health Services and community services.

Following quality assurance activities of proposed changes in services, the HSCB will build on the analysis done to date and complete a detailed localised costing and planning of all the service initiatives to identify: the reinvestment in each LCG area; the affordability of the new model of care; and to start the process of service and workforce planning.

Detailed bottom up costing of the service models would form part of the consideration of a long term financial planning model for each LCG area. This approach allows the LCG area to assess how the initiatives they have developed for both QICR and TYC work together to result in financial balance for the LCG area.

The key initiatives by Programme of Care for each of the Population Plans are summarised in Section 4.5.

3.5 Aligned delivery

TYC provides a coherent, controlled and managed framework which brings existing programmes together and adds new ones, in a well-integrated way, to deliver TYC proposals.

This section describes the delivery workstreams and how they will be aligned to maximise delivery of programme benefits.
3.5.1 The regional workstreams

The regional workstreams comprise a series of regional programmes and regional enabler workstreams. The regional workstreams are further described in this document in Section 4.3.

1. Regional programmes:

These are a portfolio of either existing/planned or new programmes which require integration of existing regional accountabilities and processes - to align with and maximise delivery of TYC proposals, details are provided in Section 4.3. These programmes will be focussed on the regional reforms necessary to achieve transformation, which will have local dimensions and require local integration with delivery of Population Plans. As these programmes mature, responsibilities for delivery may change and will be agreed across regional projects and local Population Plans either through the annual planning processes or as regional programmes reach key milestones. Initiatives detailed below are HSCB/PHA programmes and workstreams, to progress the objectives of TYC.

2. Regional enabler workstreams:

These enable other regional programmes or local Population Plans to be delivered and are a strategic response to the collective requirements across these local and regional programmes. The regional enabler workstreams include Finance and workforce planning; Capital/Estates; Capability and Engagement; ICT; and Programme Management Office (PMO).

3.5.2 The local workstreams

The local workstreams comprise the initiatives contained in the Population Plans for each of the 5 local areas; further details are provided in Section 4.4.

The Population Plans described the local plans for delivery of those TYC proposals that were locally developed through the planning process. Each plan has been drafted according to a consistent approach described earlier, access to insight, sharing of plans and ideas across local areas and external challenge.

Summaries of the 5 Population Plans across the Programmes of Care are presented in Section 4.4.

3.6 Collective monitoring and learning

TYC provides a coherent, controlled and managed framework which is not only enabled by integrated planning and joined-up delivery, but also supported by collective monitoring and learning.
This section describes the collective monitoring and learning arrangements that will needed to support a transparent collaborative approach to managing delivery across the portfolio of programmes and relentlessly focusing on benefits for patients.

### 3.6.1 Integrated monitoring of delivery

A programme as large and complex as this will not achieve rigorous and effective delivery of the scale and pace of improvements required without well managed collaborative delivery of coherent regional and local plans. The emphasis on localisation and ownership allows local teams and their populations to shape change and realise benefits, with local leadership being supported at a regional level in an environment of trust, mutual challenge and support. A successful collaborative approach to integrated monitoring of delivery will depend on:

- The identification and development of a small TYC PMO team with clear responsibilities for managing and monitoring delivery across local areas, regional workstreams and the TYC programme management office. This will be a close-knit mechanism for information sharing, transparent monitoring and reporting of delivery performance to plan, and applying and refining the best common standards and approaches to programme delivery.

- The establishment of common TYC good practice standards in programme management.

- Clear and aligned use of existing governance arrangements with aligned transparent programme reporting and support requirements.

### 3.6.2 Assessing impact

An unrelenting focus on the outcomes and benefits for patients and users will be at the centre of all that we do. This will be reflected in a clear ‘line of sight’ of how all TYC transformation programme activities are evidence-based, improve outcomes and services for patients and address inequalities. A robust approach to assessing impact through the identification and monitoring of transformation programme benefits (quality and productivity) will be developed as part of the TYC Programme.

- This will be based on a coherent framework of transformation programme benefits across the portfolio - that enables a common approach to mapping of activities by programme of care (programme workstreams or local initiatives) to associated benefits and to TYC proposals.

- Integrated transparent monitoring arrangements will be established using existing mechanisms wherever possible, either regionally or locally, and co-ordinated in a regular systematic way across the programme management community. For each benefit, a means of measurement (indicator) will need to be confirmed together with a baseline measure and its means of application.
3.6.3 **Spreading innovation**

The TYC case for change, combined with the challenging financial context faced by HSC organisations, places a particular demand for leaders to create the conditions for change and innovation. In order for the TYC transformation programme to be able to rapidly identify and spread ideas that work it will be important to enable teams to access new ideas. The TYC Programme will do this by:

- Actively managing a process of identifying programme ideas that work - and sharing, disseminating and scaling these rapidly across local teams.
- Establishing practical enablers of innovation across regional and local programme team activities. These can include events/forums to share know-how and approaches, improving access to external best practice expertise and insight, targeted use of management information (insights through benefits management), connectedness across teams, and the use of rewards/prizes.
- Supporting leadership development to create the conditions for innovation, such as supporting the vision and spirit of innovation, attitudes to risk taking and learning, engagement of patients and front-line staff, and the willingness to collaborate across organisational boundaries.
- Establishing a Skills Transfer Programme, whereby staff who have been involved in design and delivering a change initiative or project in one locality or organisation is offered the opportunity to transfer to another project to share what they have learnt through a structured programme of activities.
- Developing an 'intelligence hub' to provide access to the latest thinking and space to discuss and explore innovation with others from across the HSC system and beyond.

3.6.4 **Developing capabilities and supporting delivery**

The skills required implementing a radical change programme, together with the nature, scale and imperative of the TYC case for change, means a dedicated Programme Team will be required to support the core business in delivering against this challenge. A dedicated team has been set up to:

- Provide support for LCG / Trust teams to develop and deliver Population Plans and undertake service modelling and planning.
- Instigate and deliver sustained, co-ordinated and focused engagement, communication and involvement with all key stakeholders, to secure the support of the public and their political representatives, clinicians and other partners for the required changes.
- Inject pace and momentum into the TYC transformation programme, and facilitate the acceleration and deliverability of timescales.
- Minimise the risk of disruption to the service; it is critically important that frontline services are not adversely impacted by reforms.
- Reduce the risk of overstretch of one team in terms of concurrently spreading their resource and expertise across numerous work strands / localities / clients.
• Provide a mixed economy of experience, expertise and support to the overall planning and implementation process.

• Maintain effective control throughout the implementation process via clarity of policies, processes and procedures, and transparency of roles, responsibilities and accountability for the delivery of outcomes.

3.6.5 Recognising system drivers

The TYC transformation programme will require collaborative system-wide leadership across all parts and at all levels with the health and social care system, with particular demands for clinical leaders to create the conditions for change and role model the shared purpose, vision and values, thus engaging others to act. This will translate not only through fostering a collaborative approach to planning and delivery, but also through recognition of system drivers of change. The programme will support development of this understanding in particular through leadership capability development.

Also, the annual planning process will explicitly provide the opportunity to challenge the delivery strategy through collective review and involvement of external expertise, in particular to address any problems in delivery and challenge:

• The essential mechanisms by which the transformation programme will deliver change and benefit citizens across the programme portfolio.

• Current assumptions regarding the levers of change, the importance of clinical leadership and whether important levers are being ignored or mis-used.

• Options for alternative delivery strategies across programmes of care.

• The desired impacts on citizens and their role in shaping change and realising benefits.

• Whether the roles across regional workstreams and local teams are optimised.

3.6.6 Workforce

One of the main reasons why the way services are delivered needs to change is to ensure the best possible deployment of skills and staff, and better networking between sites, to ensure the workforce are supported in the delivery of services for patients and users.

It is recognised that for this to happen there is a need to improve detailed service and workforce modelling around the new service models, enabling clarity on the impact of TYC and so that the detailed information about capacity, skills levels, gaps, etc. are fed into the implementation processes in the short, medium and longer term.

It is expected that there will be some transition of staff to different roles, and it is recognised that for some staff this may not be appropriate and as part of the transitional funding we have allowed for Voluntary Early Retirement and Redundancy.

There will also be training and development needs that will impact across the different staff groups and professions within HSC. In particular, achieving a shift in services from hospital to community settings, including making use of new technology, will require workforce planning to ensure that the requisite skills to sustain the future model of care are in place at
the right time. As part of this process, the HSCB, together with BSO, DHSSPS and the Trusts will procure the use of a workforce / service planning tool to inform and support future planning.

Recognising that the responsibility for workforce planning rests with the DHSSPS, the TYC transformation programme will work closely with the Regional Workforce Planning Group to support the development of detailed workforce plans, based on the service modelling which will be part of the implementation of TYC. Throughout this process, there will be a strong commitment to continuing engagement with staff, professional bodies and staff side organisations. A Joint Forum has been set up with the staff side organisations for the purposes of Transforming Your Care.

Each workstream area that is set out in the following chapter should have a workforce planning component that specifically examines the skill set associated with the current service, and sets out what needs to change to position the service to deliver care in a new way in future. Developing the necessary skills will be a key part of the action plan for each work area.
4 Implementation commitments and Timelines

4.1 Introduction

This section provides a summary description of the regional and local TYC workstreams to deliver the TYC proposals. It also provides a current statement of declared commitments for achievement of each workstream over the 3 to 5 year timeframe of the TYC transformation programme. The HSCB will ensure that robust programme governance workstreams exist to further develop plans and monitor the progress against them. It is possible that the responsibility for these workstreams may change as plans move ahead. Where this is the case, this will be clearly detailed in all plans and governance arrangements.

At concept stage, detail on proposed initiatives is not always available but further detail will be developed at Implementation stage and will form part of the Project Initiation Documentation for each initiative.

This section is structured as follows:

- Section 4.3 describes overarching TYC key commitments.
- Section 4.4 describes the regional workstreams that contribute to the achievement of TYC proposals. These are a combination of existing and new programmes as well as a number of TYC enabler programmes.
- Section 4.5 describes how each of the Programmes of Care will evolve over the next 3 to 5 years across the 5 LCG areas.

4.2 Implementation Timelines

The journey over the next 3 to 5 years of how each of the Regional and Local service changes will be designed and implemented, is aligned to the strategic direction set out in this Strategic Implementation Plan which has been endorsed though the public consultation on the proposals described in Vision to Action. However it is recognised that this will evolve and change. The Population Plans, and this Strategic Implementation Plan, as well as the views expressed during the consultation are being fed into detailed operational planning processes across each of the workstreams and projects within the Programme. This detailed operational planning, and further local consultation as appropriate on proposed service changes, may impact on the nature and timing of the outcomes set out in this section. In addition the plans and anticipated timescales will continue to be reviewed over the 3 to 5 years to consider the affordability. This could speed up the pace of implementation or indeed it may need to go at a slightly slower pace, depending on resources available.

It will be critical to ensure there is a structured and sensible implementation of the TYC proposals as set out in Vision to Action. This includes ensuring that new or different services must, and will, be developed and working well before stepping down other parts of the service.

This section is therefore intended to provide a strategic picture of the possible changes at a point of time, and further information about the detailing timelines for delivery of interim and final milestones will be contained, maintained, monitored and updated through the operational plans and processes in the TYC Programme.
Also, in defining implementation timelines it is acknowledged, that for significant investments, appropriate approvals will need to be sought through the existing business case process. Greater detail and clarity will be required to allow any initiatives proposed to proceed and this detail will be provided before any plans can move ahead to implementation stage. This detail is important and largely operational therefore not necessarily appropriate for the SIP.

It should be noted that access to transitional funding will be to enable duplication of service to guarantee no detriment to patient safety and to provide confidence that the alternative services are in place before reconfiguration of existing services. All change plans will demonstrate a clear sequence to deliver each of the recommendations in an integrated and cohesive fashion, rather than in isolation from other initiatives.

4.3 TYC’s key commitments

TYC presents Northern Ireland with an unprecedented opportunity to transform our health and social care service. With transformation of such scale there will be difficult times ahead and challenging decisions to be made – it is important to remind ourselves this transformation is about people and services, rather than buildings. Some projected gradual changes in the use of resources are indicated in this section and these are picked up in some of the Population Plan details summarised in Section 4.4. Some LCG areas have detailed a percentage change anticipated and where this is so, this has been as a result of in-depth engagement between Trust and LCG teams, focusing on current and best practice, and informed by information on practice elsewhere as provided by the external consultants who were engaged to support the production of the draft Population Plans. Recognising the importance of the transformation, the Minister has stated his full support for TYC, particularly given the exciting opportunities it presents.

The key commitments across the Programmes of Care are summarised below:

4.3.1 Integrated Care Partnerships – a new way of providing primary and community care

Key to the delivery of the new model of care proposed in Transforming Your Care is a more integrated approach to service planning and delivery. The TYC report recommends the establishment of 17 Integrated Care Partnerships which would join together the full range of health and social care services in each area, including GPs, health and social care providers, hospital specialists and representatives from the independent, voluntary and community sector.

ICPs would be developed as collaborative networks of service providers. Their aim would be to focus on the ‘Shift Left’, ensuring that services are delivered as close to patients’/service users’ homes as possible, are personalised and seamless; empower patients and promote health and prevent illness where possible.

Improving how providers work together to the benefit of patients and service users would mean challenging existing systems and processes that impede effective health and social care in order to ensure:

- A multi-disciplinary approach to the planning and provision of treatment and
care, co-ordinating how care would be planned and delivered.

- The individual would be placed at the centre of care and promoting partnership working, both with individual service users and within and across the statutory, independent, voluntary and community sectors.
- Better communication, including detailed, accurate and timely information flow.
- Safe, high quality treatment and care through taking a holistic approach to improving services.
- Improved speed of operational decision making.
- The effective deployment of resources.

The development of ICPs would be based on a number of key principles, including:

(i) ICPs would be a collaborative alliance with membership that would include statutory, independent and voluntary and community practitioners and organisations. A key consideration would be the inclusion of the voluntary and community sector in the work of ICPs.

(ii) ICPs would not be established as separate legal entities but would be a networked group of service providers within the existing HSC structures.

(iii) The aim of ICPs would be to focus on identifying how the blockages and barriers to the integration of services might be overcome through re-designing care pathways and improving how services are planned and delivered to the benefit of patients and clients.

(iv) ICPs would not have a commissioning role. Responsibility for commissioning and funding services would continue to lie with the HSCB and its LCG committees.

(v) ICPs would be established around natural communities (approximately 100,000 people) and would evolve from and replace the 17 Primary Care Partnerships.

(vi) ICPs should be clinically led and be based on multi-disciplinary working. It is envisaged that General Practitioners 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.

(vii) ICPs should be operated and regulated in a way that ensures equity of service across all regions.

ICPs will focus initially on frail elderly and aspects of long term conditions for all ages namely diabetes, stroke services and respiratory conditions to include end of life and palliative care in respect of these priority areas. However, subject to these initial work areas being effectively addressed, additional areas of focus may be proposed by the Department, the Health and Social Care Board, the Local Commissioning Group, and/or the ICPs.
ICPs would operate in line with guidelines developed by the Health and Social Care Board and agreed by the Department of Health, Social Services and Public Safety.

ICPs would be a key vehicle in working towards achieving improvements in 3 areas:

- 20% reduction in ED admissions for Older People.
- Reduction in ED attendances of 20% for Older People.
- Reduction in unscheduled admissions of 10% for people with Long term Conditions and a reduction of 18% in LOS.

ICPs would play a key role in supporting people to manage their Long Term Conditions, for example in medicines management and community pharmacy. ICPs would also expand the role for community pharmacy in terms of health promotion and medicines management. Effective clinical pharmaceutical practice will significantly improve quality and safety leading to improved health outcomes as well as generating efficiencies.

ICPs will seek and maximise engagement and involvement of voluntary and community sector, carers and patients / users.

4.3.2 Older people

- Support Older People and those with Long Term Conditions to maintain their own independence and manage the functions of daily living in their own home or assisted housing, as opposed to in an acute setting or long term care.

- Significant change and benefits of TYC will be realised over the next 3 to 5 years, including:
  - Provide 24/7 district nursing services and social inclusion programmes to help older people remain active. Work to improve engagement with other agencies, such as local councils, transport services and the voluntary and community sector to create better opportunities for older people to keep active and to have social contact.
  - Community-based alternatives to residential care are increasing all the time, and there is a need to ensure that the availability and functioning of these is more widely known so that people can see the different styles of independent living that it is now possible to offer to older people, where the traditional response would have been to offer a residential placement. Due to improved availability of these types of community-based alternatives, it is expected that demand for statutory residential homes will further decline. The proposal was to close at least 50% of current statutory residential homes over the next 3 to 5 years. The proposals for older people were endorsed through public consultation, although there was concern expressed about how changes to statutory residential homes would take place. The HSCB and the Trusts are committed to ensuring the development of a clear framework within which any closures would happen so that people affected by the closure are engaged and consulted and their needs carefully considered to minimise disruption as far as possible. All such changes would be subject to local consultation. As part of the transitional process towards this, it is expected that future
admissions will be restricted in some instances. The changes proposed relate only to facilities for older people, not beds for Elderly Mentally Infirm (EMI) residents, or residential beds for people with learning disabilities.

- Reduction in admissions resulting from falls of 5%. A falls prevention programme will be rolled out to identify those at risk of falls and fragility fractures, to educate and raise awareness and provide targeted interventions, including raising awareness of the need to ensure good vision health to reduce the risk of falls. Closer working with organisations such as local councils and Housing will help with this goal as it should be possible to encourage increased uptake of leisure and activity opportunities, and supported living options.

- A reduction in acute hospital bed days and emergency department attendances of 20% for Older People.

- Reduction of 10% on unplanned admissions by implementing telehealth, telecare and telemedicine solutions which increase the variety of ways in which services can be provided, in particular for people with Long Term Conditions.

- Ensure the risk of social isolation is carefully considered when developing any proposals that promote more independent living.

- Reablement - provide a wider range of focused programmes of therapeutic care and support interventions to individuals referred from the community or from hospital, and support them to become as independent as possible.
  - In line with our reablement strategy, develop effective Rehabilitation Services and reduce readmissions.
  - Provide planned, short-term, intensive care and support services to people in their own home, following a hospital admission or when they have experienced a health or social care crisis at home.
  - As a result of reablement, it is expected there will be a reduction in the number of newly referred older people who need a long term domiciliary care service by up to 45%.
  - Further develop intermediate care, which will include the use of bed based facilities focused in fewer settings.

- Carers play a well-established and critical part in the overall care and wellbeing of older people in the community. There will be continued commitment to improve the quality of life of and support for carers including new models of respite and short breaks. See section 4.2.17 for an elaboration of this, which covers our intentions with regard to carers for all different types of service user, including older people.

- Improvements in access times to cataract surgery and audiology services to support living at home.

- The NISAT assessment process allows community services to identify more carers who can then be offered the opportunity to have individual assessment using NISAT carers’ assessment documentation. Carers are pivotal to the delivery of the ‘shift left’. There is
a need to develop and improve how carer’s are supported, including better information, new forms of respite care and technology to help to sustain arrangements where people live as independently as possible at home.

- Implementation of the NI Dementia Strategy. Working closely with the community/voluntary/independent sectors people with dementia admitted to hospital with medical needs will be supported by staff well equipped to meet their needs in acute and non-acute hospitals settings.

- Services will also develop their safeguarding aligned with the regional policies and procedures and associated operational changes.

### 4.3.3 Long Term Conditions.

- Develop new LTC ‘Care Pathways’ – those responsible for or involved in providing health care services would develop simpler ways to access services, often through a GP or specialist nurses at home. This will sometimes mean easier direct admission to hospital rather than going through the Emergency Department first.

- Develop ‘risk profiling’ using the latest clinical evidence, which will 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.

- Supported delivery of education for patients on how to manage their condition so that they can more easily identify when they are getting worse, if their medication may need to change and when the right time to seek help is.

- Appropriate follow-up and regular review of patient’s condition by the GP or practice nurse. This would mean a change in the way hospital specialists work and mean that patients get more follow up care.

- The pharmacist would play a key role in helping patients understand their condition and how to manage their medication effectively.

- Investment in ‘telemonitoring’ where this is appropriate to the patient’s situation. It is accepted that this method of monitoring may not be suitable for all patients, and that factors such as social isolation must be borne in mind when considering whether it would be a good option for a patient. The views of carers must also be reflected in the process.

- Share and communicate practical examples and details of the new ways long term conditions can be managed to enable patients and users to consider what impact the different approaches could make, and which ones might be of benefit to them. This would also allow consideration of how the current working relationships between patients and clinical staff would develop and change over time.

- 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 average length of stay associated with an acute episode.
4.3.4 Ensuring our acute hospital services are safe and sustainable

As acute services are developed over the coming months and years, there are particular service developments which will drive change across how our services are configured:

- Implementation of one regional trauma centre for Northern Ireland based in the Royal Victoria Hospital, as a key responsibility for Belfast Trust. The development of regional protocols and procedures for ambulance services would support this development.

- 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 3 to 5 years. Two sites would be developed: one in Altnagelvin Hospital and the other in Royal Victoria Hospital.

- Expansion of orthopaedic services in Southern, Western and Belfast Trusts with an investment of up to £7m revenue over the next 3 to 5 years, to significantly reduce waiting times for fracture and other orthopaedic services for patients.

- 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.

- A review of paediatric services is on-going and is taking account of the recommendations as outlined in the Maternity and Child health section of TYC. This review is focused on the commissioning and provision of effective and sustainable hospital and community services, and also incorporates paediatric palliative and end of life care. TYC will engage with the DHSSPS regarding the outcomes of this review to ensure that these are incorporated to service planning as appropriate.

- 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 you may not go to A&E but are taken directly to a facility you have been to before, or you may go to a hospital which is not the one closest to you but one that specialises in treating your 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.
• Enhance the dedicated paediatric and neonatal transport services throughout Northern Ireland.

• Modernisation of pathology.

• Workforce development has been referred to elsewhere in this document and will be critical to the establishment of the new network models of care set out below. Increasingly, there is a need for some care services to move to 7 day per week working, and where this will achieve measurable improvements in care, service planning and future investment will aim to secure this.

• In the coming years, TYC will ensure a gradual shift of resources into the community to prepare the way for the shift of some care into community settings. Measures will be developed to model, track and demonstrate this shift in resources from acute settings to primary and community settings, set within the overall financial plan for the health and social care system.

Below we set out the direction of travel planned for acute hospitals:

• Creating hospital networks and reorganising acute services - No hospital will work in an isolated way and the existing infrastructure will form part of a network, contributing to the provision of services to the population in its area, and where appropriate adjacent areas.
  – Guaranteeing the future sustainability of our hospitals by ensuring all acute services adhere to best practice in terms of quality outcomes, infrastructure and staffing.
  – Addressing the fragility in our hospital services by ensuring volumes are sufficient to support best outcomes and staffing levels are in line with best practice, with activity directed to component parts of the network to achieve this outcome.
  – Through the creation of 5-7 hospital networks, the role of some hospitals will change as they become part of a network working together with their partner providers to provide comprehensive services to their local population. Individual hospitals will all be part of a network. It should be noted that this does not mean that there will be a total of only 5-7 hospitals, but rather that each hospital will be in one of 5-7 networks regionally.
  – Work with DHSSPS to consider ways to work across government departments to address issues around access to acute services, including transport in rural areas.
  – In developing our hospital networks and reconfiguring our acute services the following configurations are proposed, subject to public consultation.

• 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 consultation recommends one emergency surgery centre at the Royal Victoria Hospital. Emergency department configuration across the network was consulted on in 2012.
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. There is a need to responsibly manage this change over the next 3 to 5 years.

Further to the public consultation on the proposals relating the management arrangements for Causeway Hospital, the DHSSPS will carry out an option appraisal on the 3 options set out in the Vision to Action consultation document. This will be informed by the work of the Turnaround and Support Team in the Northern Health and Social Care Trust. The options set out in Vision to Action were as follows:

(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.

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.

In the South Eastern area there is a principal hospital network encompassing the 3 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.

- The **Western area** has 2 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 Orthopaedics, Cardiology and Cancer Services from 2016. Altnagelvin will continue to network with Causeway 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. No change in the management arrangements is proposed.

### 4.3.5 Palliative and End of Life care

- Include local and regional raising awareness initiatives across all sectors, for public and staff involved in various stages of the patient journey: Identification, Assessment and Advanced Care Planning.

- Develop trust information systems to quantify and identify those approaching the end of life as per regionally agreed prognostic indicators and placed on GP registers and the trust information system.

- Have care plans developed and continually reviewed for those in the last year of life. (These should include DNAR wishes, place of care and referral for carer’s assessment).

- Ensure that people identified as being in the last year of life have been offered the opportunity to have advance care plans developed. Ensure that all people, on admission to a nursing home, have been offered the opportunity to have an advance care plan developed.

- Ensure that there is a standardised approach, such as an individualised care plan, implemented according to quality standards across all care settings.

- Promote effective co-ordination of care across organisational boundaries - implement the regionally agreed key worker function and the use of multi-disciplinary records in the home and out-of-hours handover.

- Reduce the number of people admitted to hospital inappropriately during their end of life phase and ensure people are given the choice to die at home, with particular focus on those who die within 48 hours of admission. There will be an increase in the number of people who are facilitated to die in their preferred place of care as recorded in their care plan. By year 2014 -2015 there will be a 10% reduction in the number of people who are admitted to hospital during these last hours.

- Right size community nursing and other support staff to ensure people receive palliative care across all community settings. Scope existing arrangements with the nursing home
sector for delivery of palliative care services in terms of value for money and quality of outcomes. Provide support to nursing homes to meet the standards currently being developed in conjunction with RQIA. (End of 2014).

- Increase access to specialist palliative support out of hours and enhanced links between specialist and generalist services.
- Consider the unique contribution of voluntary and community sector groups to palliative/end of life care, examining the procurement processes to ensure effective engagement with this sector where possible.
- Increase the number of staff confident and competent in the core principles of palliative and end of life care.
- Increase generalist palliative care services available in the community including medical services, personal care services, access to pharmacy services, AHP services, supported by specialist palliative care as required across settings.
- End of Life and Palliative Care standards should be met for those with long term conditions, such as cancer, heart failure, renal disease, stroke and respiratory disease by March 2014.
- Significant progress against these standards should be demonstrated for those with other chronic conditions, such as dementia and for the frail elderly who are recognised to be at the end of life.
- Work with NIAS to develop out of hours services to reduce ED attendances; working with nursing homes and NIAS to avoid unnecessary admissions from nursing homes, including for end of life care.
- Implementation of ‘Living Matters: Dying Matters: Palliative and End of Life Care Strategy for Adults in Northern Ireland’.
- Engage with DHSSPS reviews of palliative care for children, ensuring that the outworkings of reviews are built into TYC plans in a timely manner.

4.3.6 Mental health services

- Mental health services will focus on their community teams’ interface with primary and secondary care. The importance of ‘joined up’ working was emphasised repeatedly in consultation responses relating to mental health services and all HSC organisations will continue to promote effective working between community services that are provided to people with mental health problems. The services will also explore the use of technology to aid mobile working and create a stronger network with primary and secondary care, enhancing home treatment models.
- Across the region, there will be a focus on resettling those people in the community who are living in long stay hospitals. This will involve close working with voluntary sector providers.
- Mental health services will ensure that no patient is required to live in a hospital after their treatment has been completed. Therefore mental health services providers will
ensure the resettlement process for all people currently living in mental health hospitals has been completed by March 2015.

- As part of this community work the teams will also seek to form closer working ties with the voluntary sector to integrate where possible, their resources into the transformation initiatives and send service users to the most appropriate care provider.

- In continuing to focus on personalised care of service users, increasing the uptake of self-directed and individual budgets can be achieved with the involvement and support of carers.

- Carers play a well-established and critical part in the overall care and wellbeing of people with mental health needs. There will be continued and committed support for carers ensuring they have access to community-based interventions which enhance their quality of life, for example employability and emotional wellbeing. Intentions around support for carers are set out in further detail in section 4.2.17.

- Regionally there will be a reduction in the number of acute mental health inpatient beds over the next 3 to 5 years to a point on 31st March 2015 where:
  - No patient will be living in a long stay mental health hospital setting.
  - Six in-patient acute mental health units for those aged 18+ are developed. There would be one site in the Northern, Southern, South Eastern and Belfast areas, with 2 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.
  - Following the range of views expressed during the public consultation on the proposals for the location of the in-patient acute mental health units in the Western area, further consideration is to be given to this matter through the completion of a Business Case looking at a range of options. This will be completed before a final decision is made by the Minister on where the second unit will be located.

- Regionally the CAMHS service will focus on developing its service. It will implement the RQIA recommendations in relation to CAMHS. This will involve cross boundary co-operation.

- LCGs will continue to tackle suicide through implementation of the Refreshed Protect Life Strategy 2012.

- The transformation of mental health care will be progressed through the implementation of the stepped care model, the Mental Health Services Framework, Regional Psychological Therapy Strategy and related NICE Guidance. These have been designed to enable the reorganisation of services across the primary, community, and secondary care systems by matching service intervention with a person’s presenting needs. Integral to the model is the emphasis on prevention, early intervention and the development of integrated care pathways which will simplify and promote better access to care across each LCG locality.
• Improving access to psychological therapy is a fundamental component of recovery and is critical to the successful implementation of the Stepped Care Model for people with common mental health problems. It is within this context that each LCG locality will establish a dedicated Primary Care Psychological Therapy Service with the capacity to provide through a single gateway, facilitated self-help, group therapy, and/or one-to-one counselling or Cognitive Behavioural Therapy for common mental health problems.

• Substance misuse services will implement existing Health Improvement strategies which aim to increase population awareness of alcohol/substance misuse related harm in partnership with community and voluntary sector. LCG Localities will support the implementation of the regional Integrated Care Pathway for substance misuse and ensure practice reflects such care across steps 3 and 4. This will also involve working with primary care and other community based services to undertake agreed ‘screening and brief intervention’ programmes.

• Advocacy services’ standards will be improved in line with the 2012 Guidance for Commissioners. Services will be in place to provide support for women with serious psychiatric conditions in pregnancy and the post-partum period.

### 4.3.7 Learning disability services

• The service will aim to reduce the number of people in institutional care by moving them into community-based options through the continued development of self-directed support and individual budgets and the supported living model. This will take full account of the complex family dynamics in this area.

• Learning disability services will continue efforts to be more resettlement focused. It is the intention that this process will be complete by March 2015.

• There will be continuing focus on reducing delayed discharge from hospital with investment in community infrastructure. Challenging behaviour services and alternatives to hospital based assessment and treatment will be further developed in order to shorten lengths of stay and reduce the number of service users being admitted to acute beds unnecessarily.

• The regional services will improve access to respite provision and provide a wider range of non-facility based respite for both service users and carers to help the development of self/carer care and reduce the number of service users being admitted to acute beds. It is vital that carers continue to be involved in service design, care planning and service planning to bring their experience to bear on these functions. It is hoped that greater involvement of service users and carers will help to tailor the service better to the particular needs of the different age groups who use these services.

• A Regional Day Opportunities Model for Learning Disability will be developed and implemented across all localities. This model will include a variety of options to reflect the need for age-appropriate opportunities for people and will be consulted upon in 2013.

• The physical wellbeing and mental health of people with a learning disability will be improved through the Directed Enhanced Service in Primary Care for adults with a learning disability.
• Advocacy Services Standards will be improved in line with the 2012 Guidance for Commissioners.

• In order to facilitate the independence of people with learning disabilities and carers, a special focus needs to be made to simplify services and care pathways.

4.3.8 Physical disability and Sensory Impairment services

• The services will conduct a review of daycare provision with a view to establishing the level of access to such services regionally, with the objective of enabling more care closer to home. Some areas have already moved to public consultation on this reform. Service users with complex needs will remain in the statutory sector where this is most appropriate to their needs, with flexibility of service provision to other service users with a less complex profile of need. The overall aim is to ensure that people with physical disabilities do not have to be admitted to hospital where day case provision is a viable alternative.

• In the design of day care services, ensure there is a focus on provision of more vocational support and rehabilitation for those with a physical disability or sensory impairment.

• Continued and enhanced engagement with service users in the design of services, particularly where these are across programmes of care.

• Multi-agency and multi-disciplinary collaboration will improve the choice of services for people with physical disabilities and as a result improve rehabilitation, create an increased and broader range of respite options across the region and increased the capacity to meet supported housing needs.

• Work with DHSSPS to consider how better collaborative planning of services can be achieved across government departments.

• In line with the personalised care agenda, the proportion of people with self-directed and individual budgets will increase.

• Examine the potential for the development of specialist supported living options, for example for those people with acquired brain injury.

• Services will also develop their safeguarding aligned with the regional policies and procedures and associated operational changes.

4.3.9 Population health & wellbeing

• Ensure that support is in place for pregnant mothers with risk factors such as smoking, obesity, mental health conditions or poor mental wellbeing, alcohol and drug use.

• Implement the ‘Fitter Futures for All’ framework to address obesity, and the Tobacco Control Strategy to reduce smoking rates.

• Expand the Roots of Empathy Programme in primary schools to improve the social and emotional wellbeing of children.
- Expand and/or introduce a range of evidence-based programmes to support parents and families and expand training for professionals and key community workers on infant mental health.
- Expand breast feeding peer support programmes.
- Expand programmes which tackle poverty (including fuel poverty) and maximise access to benefits, grants and a range of services.
- Establish programmes that address employability and the needs of long term unemployed people with a focus on skills development and opportunities for training and employment within the health and social care sector.
- Strengthen workplace health programmes to improve the health and wellbeing of the workforce and ensure that staff provides appropriate information to HSC service users, to their own families and social networks.
- Incrementally expand capacity in providers of contraceptive and sexual health services specifically tailored to the needs of young people, and providers of sexual health services, particularly for groups at high risk of HIV and STIs.
- Expand community capacity to respond to potential suicide clusters.

4.3.10 Family and Child Care

- Northern Ireland has a unique opportunity to position itself as an early intervention region for generational change to support the improvement of life chances for children by achieving better outcomes. This focus on early intervention will require 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.
  - Embed Family Support Hubs across the area to focus on, and investment in early intervention. This will include delivery of Step 1 'Targeted Prevention' services and Infant Mental Health supports. Ensuring effective ‘joined up’ working between different parts of government involved in the care process will be vital also.
  - Support to families and parenting skills, including signposting families with particular needs to the correct pathways of care.
- Children are best cared for within the family of origin, or where that is not possible, within family settings where appropriate. Plans regarding the provision of residential childcare must be made on the basis of the assessed need of children and young people and the availability of suitable alternative placements such as foster care. Key aspects include:
  - Increase in the number of foster carers and in particular specialist foster carers.
  - 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.
The development of a fostering scheme for children hardest to place.

- Develop Child and Adolescent Mental Health Services: reduce the number of children waiting for service and a reduction in waiting times.
- Increase availability of emergency CAMHS cover to avoid acute admissions.
- Child and Adolescent Mental Health services will continue to implement the recommendations outlined in the RQIA CAMHS review (February 2011) and the DHSSPS Policy Guidance 'Child and Adolescent Mental Health Services: A Service Model' (July 2012). This guidance provides a basis for reshaping service provision and will require each LCG locality to establish a Primary Mental Health Team and Crisis Resolution and Intensive Treatment Teams as part of CAMHS service provision. Trusts will also be required to take steps that further integrate CAMHS, Child Development and Behavioural Services into a more coherent system of care.

### 4.3.11 Maternity and Child Health

- Area specific proposals, which will be subject to further discussion and consultation in the localities affected as appropriate, particularly in the case of free-standing midwife led units.
  - 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. There will also be an ‘alongside’ midwife led unit in the new regional maternity hospital.
  - 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.
  - 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.
  - 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.
  - 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.

- Progress regional plan to support mothers with serious psychiatric conditions, referencing the work that HSCB has already commenced to scope out a regional perinatal mother and baby unit, and the views provided during the Vision to Action consultation exercise.

- Keep first pregnancy and labour normal to reduce interventions and promote normalisation of birth - bring antenatal and postnatal visits into line with NICE guidance. Reduce LOS and attendances at outpatients and foetal assessment units.

- Provision of antenatal care in the community: increase the percentage of women having their antenatal care in the community.

- Ensure that there are appropriate numbers of community midwives to meet demand for community-based antenatal care, and increasing normalisation of birth.

- Support Healthy Pregnancy and early parenting to promote good parent/child relationships in the early years.

- Improved facilities for children who need acute in-patient treatment with extended community services involving GPs - care closer to home.

- Establish Family Nurse Partnership Programme pilots in the 3 specified areas (Western, Southern and Belfast), to improve the health and well-being of our most disadvantaged children and families, thus preventing social exclusion. Subject to satisfactory evidence that Trusts can deliver the programme within the fidelity requirements of the license from the 3 pilot areas, the Programme will be rolled out in other areas in the region. The Family Nurse Partnership Programme is offered to all first time teenage mothers within an area.

- It is recognised that as well as Family Nurse Partnership Programmes, a number of policies exist, for example the Child Health Promotion programme, Healthy Child, Healthy Futures, to deliver improvements and give the best start in life. It is acknowledged that there is a need to introduce evidence-based programmes to support parents and families.

- Establish the neonatal managed clinical network.

- Engage with the DHSSPS on the outcomes of the review of acute Paediatric services, and further reviews to be undertaken.

### 4.3.12 Increased collaboration with our colleagues in ROI and GB

- Where there are not sufficient volumes to support specialist services the HSC will access quality services in neighbouring health services. Through these service arrangements, our population will have access to the highest quality specialist services not currently available in Northern Ireland. There will be better quality outcomes as a result.

- To progress this, the HSC Board and the Service Delivery Unit in the Department of Health (Republic of Ireland) have been discussing opportunities for engagement on
major strategic issues. Terms of Reference are currently being finalised. Areas of collaboration suggested to date include the following:

- Patient flows between hospitals on both sides of the border. Initial ideas of Trusts and hospitals involved include:
  - CAWT out of Hours project.
  - South Western Hospital (Enniskillen); Altnagelvin (Derry) and Daisy Hill Newry.
  - Southern Trust (in relation to Dundalk/Drogheda); Western Trust (in relation to Letterkenny)
- The provision of specialist services, for example:
  - ROI patients accessing tertiary services in Belfast Trust.
  - Access for ROI patients to CATH Labs in Northern Ireland.
  - Collaboration on the provision of cancer services.
- Consideration of collaboration around CAMHS, acknowledging that there is much demand for this specialist resource on both sides of the border.

4.3.13 Developing our workforce to support our transformation

- It is essential that there is sufficient staff available to manage the ‘shift left’. Transitional funding will be required to ensure that services are maintained in the acute sector, while staff are undergoing retraining where redeployment may be necessary, and additional skills are being established in the primary and community sectors. We will ensure our TYC transformation programme supports those in transition.

- Critical Workforce changes:
  - Investment in our people to ensure they have the right skills to support our journey. Our health and social care service will attract the best people offering opportunities to play a key part in its transformation.

- Leadership and capability development:
  - For this unprecedented change, our leaders need enhanced skills and capability. We will invest in our people, in particular our leaders, and establish a programme to support their development.

4.3.14 Procurement and opportunities for partnership working with the voluntary and community sector

- TYC seeks to increase choice for people in access to services, which can be particularly important in rural areas where people wish to remain at home. A wider range of potential providers could make it easier for those services to be available.

- A project to quantify current and future social care needs will be undertaken, and it is anticipated that this will generate opportunities for provision of new and flexible services from statutory and non-statutory providers. It is hoped that this will encourage greater levels of input from the community, voluntary, social enterprise and independent
sectors, within existing legal framework for the procurement and involvement of these sectors.

- Standardisation of procurement of domiciliary services and residential and nursing home places.
- Engage with DHSSPS on on-going work across government departments and agencies on the involvement of voluntary and community sector organisations.
- Continue to engage with key voluntary and community sector umbrella groups such as NICVA and CO3 to understand how TYC can support capability and capacity building in this sector.

4.3.15 Technology

Many of the proposals in TYC plans will be supported and enabled by new investment in ICT and Connected Health and some of the specific areas where there may be change are:

- Increased sharing of patient 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 a patient’s condition directly to a consultant based in an acute hospital to enable a decision to be taken without the need for the patient to visit hospital.
- Everyone will have an Electronic Care Record.
- Connected Health uses technology to provide healthcare remotely and 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 patients and their families.
- Community Information Systems should be able to consistently generate minimum data sets that can be shared appropriately to facilitate effective service provision.
- 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.
- It is acknowledged that remote monitoring and telehealth relies on sufficient broadband coverage and reliable internet access to allow data to be transferred. The extent of coverage of suitable levels of service will need to be understood as any roll-out of technology to enable remote monitoring is carried out.
- As mentioned in the earlier section relating to Long Term Conditions, the individual needs of the patient and their carers will be considered in any decisions about using technology in the home to support clinical care. Outcome-based evidence and patient views will also be considered in the any investment decisions around telehealth.
4.3.16 Finance

- Financial remodelling of how money is to be spent indicates a 5% shift from current hospital spend estimated at £83 million and its reinvestment into primary, 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 it may to need to go at a slightly slower pace, depending on the level of resources available. Measures will be developed to model, track and demonstrate this shift in resources from acute settings to primary and community settings, set within the overall financial plan for the health and social care system.

- The initiatives contained in the SIP and Population Plans are focused on describing the service model. It is recognised that further detailed planning around the workforce and financial (including capital) implications of the service model is required to be completed over the coming months. This localised costing and planning of all the initiatives will aim to identify the reinvestment in each LCG area and the affordability of the new model of care. This exercise will provide the evidence base to support the implementation of the initiatives.

- In addition, there is recognition for the need for capital investment in our infrastructure. At the moment our current capital budget between 2011/12 and 2014/15 is £962 million 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.

- Transitional funding is critical to enable the new model of service to be implemented. This transitional funding will be particularly focused on the following areas:
  - Integrated Care Partnerships
  - Service Change
  - Implementation Funding
  - Voluntary Redundancy / Voluntary Early Retirement Schemes

Residual demand will need to be taken into account during the financial modelling of the initiatives. Together with the service model changes which are articulated in the Population Plans, it is anticipated that medical advances, changes in clinical practice, and the development of new technologies and medicines will contribute significantly to the cost associated with providing modern health and social care services in Northern Ireland.
4.3.17 Carers

- Carers fulfil a vital role in supporting vulnerable people in Northern Ireland and without this input, many people would not be able to live in a community setting or enjoy the level of independence that they currently have. The recommendations in TYC will require continued support from carers and given the intention to provide more care closer to people’s homes, it will be vital to provide adequate support to carers to ensure that they are able to continue to play their essential role in partnering with HSC services to provide care for people.

- HSC services have tried to understand and quantify the needs of carers via the Northern Ireland Single Assessment Tool Carer’s Assessment process but it is acknowledged that not all carer’s have had their needs assessed, or perhaps are even aware that assessment is an option. There needs to be an increase in uptake of Carer’s Assessments and HSC bodies need to ensure that data captured on carer’s needs is fed into the commissioning and service design process so that services are configured in a way that makes them better able to meet carer’s assessed needs. HSC senior management teams should also review uptake rates for Carer’s Assessments to ensure that there is an increase in the numbers of people availing of these across the various programmes of care.

- It will be important to recognise that there is no uniform model of support that will work in every circumstance. This includes considerations around the design of flexible respite care, which is often cited as a lifeline for carers. Services need to involve carers in the design of supports intended to help them, to ensure that these are tailored to meet the needs of carers.
  - Review undertaken of operational and terms of reference of the Carer’s Strategy Implementation Strategy group to seek improvements to the engagement of carers in the development of services and mainstreaming of their involvement across all commissioning areas.
  - Actively engage with carers in the design of new care pathways, where appropriate, including through representation on partnership committees for the Integrated Care Partnerships.
  - Take every opportunity to promote Carers’ Assessments and encourage service partners to do likewise. Review will be undertaken on a regular basis of the uptake rates for Carers’ Assessments to track progress.
  - Ensure that the health and social care needs assessment process incorporates findings from Carers’ Assessments where available so that there is a much better regional understanding of the range of services carers need most, including respite, that is then fed into the service redesign and commissioning processes.
4.4 Regional programmes

TYC provides a coherent, controlled and managed framework which brings existing programmes together and adds new ones, in a well-integrated way, to deliver TYC proposals.

The regional programmes described in this SIP are the portfolio existing/planned programmes together with new programmes - which require integration of existing regional accountabilities and processes - to align with and maximise delivery of TYC proposals. These programmes will be focussed on the regional reforms necessary to achieve transformation, which will have local dimensions and require local integration with delivery of Population Plans.

As noted above it is recognised that detailed operational planning, and further local consultation as appropriate on proposed service changes, may impact on the nature and timing of the outcomes set out in this section. In addition the plans and anticipated timescales will continue to be reviewed over the next 3 to 5 years to consider the affordability. This could speed up the pace of implementation or indeed it may need to go at a slightly slower pace, depending on resources available.

This section is therefore intended to provide a strategic picture of the possible changes at a point of time, and further information about the detailing timelines for delivery of interim and final milestones will be contained, maintained, monitored and updated through the operational plans and processes in the TYC Programme.

As these programmes mature, responsibilities for delivery might change and will be agreed across regional projects and local Population Plans either through the annual planning processes or as regional programmes reach key milestones. Also, addition projects and programmes may be added to reflect the implementation of TYC.
### 4.4.1 Existing regional programmes

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<tr>
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<td>1</td>
<td>Implementation of the Bamford Action Plan 2012 – 2015 [52,56,57,58,60,62]</td>
<td>The Review of Mental Health and Learning disability (commonly referred to as the Bamford Review) set out to reform the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review completed its work in 2007, however, a revised action plan has been published and its recommendations need to be implemented.</td>
<td>The programme scope should cover the recommendations of Bamford and be cognisant of the commissioning intentions across Mental Health and Learning Disability.</td>
<td>• Publication of the Bamford Action Plan</td>
<td>• Full implementation of the recommendations of the 2012 Bamford Action Plan</td>
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| 2  | Implementation of the DHSSPS Maternity strategy 2012-2018 [34,36,37,38,39] | This 6 year strategy (published in July 2012) replaces the previous DHSSPS policy on maternity services issued in 1996 and focuses on 6 main outcomes:  
• Giving every baby and family the best start in life.  
• Effective communication and high quality maternity care.  
• Healthier women at the start of pregnancy (preconception care)  
• Effective, locally accessible antenatal care and a positive experience for prospective parents.  
• Safe labour and birth (intrapartum care) with improved experiences for mothers and babies.  
• Appropriate advice and support for parents and babies after birth. | Project infrastructure will need to be put in place to ensure the strategic objectives are implemented. The required elements that are to be addressed in the strategy will be:  
1) Pre-conception care,  
2) Antenatal care,  
3) Intrapartum care  
4) Postnatal care | • Regional Review of Paediatric Services.  
• Forthcoming Public Health Strategic Framework. | Full implementation of the Maternity strategy by March 2018  
A regional action plan to implement the maternity strategy has been drafted by the PHA and the HSCB and it is hoped that implementation will commence later in the year. The action plan will include interim milestones with outputs and outcomes which will improve health outcomes for women and children. |
| 3  | Implementation of the Physical Disability and Sensory Impairment strategy [28,29,30] | One of the key issues identified for urgent action by the NI Executive following devolution was the promotion of social inclusion for all citizens and particularly for those groups or individuals who are, or may feel, marginalised or disadvantaged in society. The goal of the strategy is to increase the empowerment of people with physical disabilities and/or sensory impairment so that their disability does not stop them from participating in society. | Programme scope is delivery of the strategy vision and objectives, namely to ensure:  
• The support of disabled people to become well informed and expert in their own needs.  
• The promotion of health, wellbeing and maximizing the potential of individuals.  
• Encouragement of the social inclusion of disabled people and work to address the stigma associated with disability.  
• Encouragement of the family and person-centred services and the promotion of independent living options, such as using self-directed support and Direct Payments.  
• Ensuring that practical supports such as suitable housing, necessary equipment or access to employment, are tackled. | Development of agreed partnership models with ALL key stakeholders, integrated working across ALL Government departments, effective interfacing with other regional groups developed to take forward Actions contained in the Strategy, e.g., Self-directed support and individual budgets, etc.; meaningful service user engagement. | Full implementation of the Physical Disability and Sensory Impairment strategy. |
<p>| 4  | Modernisation of pathology services | Around 70% of diagnoses in the HSC depend on pathology test results; as learnt from other areas of the UK, any HSC | The core team leading the established federated network is a lead clinician and a  | • Support from the DHSSPS, commissioners and local trusts. | Full implementation of technological transformation to |</p>
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| 5  | Implementation of ‘A Fitter Future for All: Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland, 2012 - 2022 [1] | In the Health Survey Northern Ireland’s (2010-2011), 59% of adults measured were either overweight (36%) or obese (23%). The health impacts of obesity include an increased risk of type 2 diabetes, coronary heart disease, stroke and some cancers and complications in pregnancy. It is also known that obese children are more likely to become obese adults. A significant challenge is faced in reducing the proportion of the population who are overweight or obese. | The scope of the programme is to implement the actions needed to tackle obesity set out in the Fitter Future for All Framework. This involves a wide-ranging, multi-sectorial, long-term and integrated approach through the different stages of life. It includes supporting the individual to develop the knowledge and skills to make healthy lifestyle choices and creating an environment that supports and promotes healthy eating and physical activity. | • Partnership working with the voluntary and community sector.  
• Partnership working across other government departments (e.g. DE, DCAL, DRD)  
• Partnership working at local level with all sectors – e.g. local government, schools.  
• Ensuring that funding that has been identified in the Programme for Government is realised. | Implementation of the 2015 short-term outcomes/outputs outlined in ‘A Fitter Future for All’ |
| 6  | Introduction of a reablement model of care [10,11,14,17,19] | The ageing population of NI will place increasing pressure on health and social care services, with the number of people over 65 set to increase by 16% (including a rise of 29% in the number aged over 85) by 2015 and a 30% in the number of people with dementia 2017. | The programme will introduce a reablement model which promotes greater independence and reduces unnecessary reliance on statutory services. This increases the capacity of the voluntary and community sector and promotes healthy ageing. This model will shift the emphasis from traditional service models to a partnership approach, optimising inter-agency working, enhancing the capacity and role of voluntary and community organisations to support self-management. | • Partnership agreements between Trusts, other statutory agencies and the community and voluntary sectors to maximise the use of existing resources in the community.  
• A regional Performance Management Framework which can continuously monitor Trust activity/performance, production of regional protocols and tools needed to operate a full-scale reablement programme.  
• The establishment of ICPs will be a major enabler for this  
• Require an Action Plan for workforce over next few years, especially AHP  
• Review and re visit policy circulars - Intermediate Care particularly as there are different views on what this means in different areas, and in light of ICPs. | Full implementation of the reablement model of care |
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<td>7</td>
<td>Implementation of the Dementia Strategy [9,19,21,22,54,56,58]</td>
<td>There are an estimated 19,000 people living with dementia in Northern Ireland, 1,000 of whom are under the age of 65 years. Numbers are expected to grow to 23,000 by 2017 and 60,000 by 2051. In recent years there have been numerous publications worldwide that have documented the economic and social cost of dementia to the middle of this century. Likewise, over the past decade, there have been important developments in addressing dementia however, lack of resources and insufficient funding for research have restricted progress.</td>
<td>The programme scope is to implement the 44 recommendations within the Action Plan arising from the dementia strategy (<em>”Improving Dementia Services in NI” launched in Nov 2011</em>) over a period of 3 to 5 years through a regional steering group and a number of multi-agency/disciplinary workstreams with input from people with dementia and their carers/advocates.</td>
<td>• £6m - £8m in funding is required for full implementation of the recommendations. • Dependency on recommendation 59: the further shift of the balance of spend between hospital and community, with re-investment of any hospital savings into community services.</td>
<td>Full implementation of the Dementia Strategy and achievement of its stated objectives of dignity and respect; autonomy; justice and equality; safe, effective; person-centred care; care for carers and skills for staff.</td>
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<td>8</td>
<td>Regional expansion of Radiotherapy Services</td>
<td>Radiotherapy services are currently only provided for Northern Ireland Patients at the Regional Cancer Centre at Belfast City Hospital. Whilst a sub-regional centre at Altnagelvin is necessary to secure sufficient radiotherapy capacity for the region from 2016 onwards, more immediately there is a need for additional capacity in the cancer centre. The number of radiotherapy fractions being given per annum at the Cancer centre is increasing each year by an average of 5% and the current existing linear accelerator capacity will be insufficient to meet the rising demand.</td>
<td>The programme scope is to deliver a solution for the future provision of radiotherapy services for NI which takes full account of service needs, infrastructure, staffing and resources.</td>
<td>• Need to ensure that workforce requirements are properly considered and planned for the region</td>
<td>Expansion of radiotherapy capacity in NI to meet the growing needs of the population</td>
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<td>9</td>
<td>Transforming Cancer Follow Up – Macmillan Survivorship Programme [21,22]</td>
<td>There are increasing numbers of Cancer survivors across the UK, rising by 3.2% per year with 4 million by 2030. NI has 51,000 cancer survivors. As a result of this, and the failings of the current system such as crowded clinics, overly clinical focus, responsiveness of test results etc. services will need to change to accommodate post-cancer support.</td>
<td>The programme scope should focus on the development of a risk stratified model of follow-up in line with the national cancer survivor initiative. This should address both the increasing numbers of cancer patients as well as their health and well-being needs. Partnership working with the voluntary sector is likely to enable this model. Programme objectives are: 1) To improve patient experience of care. 2) Effective resource utilisation. 3) Streamline services.</td>
<td>• Funding to support local bids. • Macmillan cancer support working in partnership with HSCB/PHA. • Collaboration with other cancer charities.</td>
<td>A robust external evaluation of the regional breast cancer pathway will be complete. Mechanisms for sustaining transformational change will be identified.</td>
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<td>10</td>
<td>Implementation of Living Matters Dying Matters Palliative and End of Life Care Strategy [80,81,82,83]</td>
<td>There is a need for raised awareness and understanding of palliative and end of life care including increased knowledge and skills of health care professionals in respect of palliative and end of life care; health and social care professionals enabled to identify individuals who could benefit from palliative or end of life care.</td>
<td>The strategy refers to supports for adults from the point of diagnosis of a life-limiting illness, to death and bereavement.</td>
<td>• Appropriate identification and addressing of education/awareness needs of staff • Effective quantification of service needs and provision of supply to match those • Effective identification of patients who need targeted with support • Practical and flexible supports are available for patients and carers to allow delivery of effective care</td>
<td>See Living Matters Dying Matters Strategy Action Plan</td>
</tr>
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<td>11</td>
<td>Screening and immunisation</td>
<td>Population screening programmes enable the early detection of disease. Screening allows earlier intervention</td>
<td>The programme needs to determine from an evidence based viewpoint where new</td>
<td>• UK National Screening Committee advises on all aspects of screening policy based on</td>
<td>Full implementation of population screening and</td>
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Transforming Your Care – Strategic Implementation Plan
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<td>12</td>
<td>Public Health Strategic Framework [1,2]</td>
<td>In general, the health of the NI public has been improving over time, however not everyone has been able to benefit from this process. Health inequalities persist, with poorer health outcomes disproportionately concentrated amongst particular population groups and amongst those living in deprived areas.</td>
<td>The framework proposes an updated strategic direction for public health bringing together actions at government level to improve health and reduce health inequalities, and which will guide implementation at regional and local level. Improving and strengthening the health system will make a growing contribution to health and wellbeing.</td>
<td>• Public health and wellbeing placed firmly at the centre of the system with greater emphasis on prevention, early intervention and support for vulnerable people, and greater focus on tackling health inequalities. • Partnership working across other government departments (e.g. DOJ, DSD, DE, DOE) • Partnership working with the voluntary and community sectors. • Partnership working at local levels with all sectors, e.g. local government, schools.</td>
<td>• Implementation of outcomes agreed for 2012-15.</td>
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<td>13</td>
<td>Healthy Child, Healthy Futures (HCHF)</td>
<td>The 0 – 17 aged population is set to rise by 3% by 2020 and existing and emerging evidence overwhelmingly supports early intervention to improve health and social outcomes for children and young people. The publication of Healthy Child, Healthy Futures in 2010 provides a strategic direction to ensuring a co-ordinated approach to supporting children and their families and the programme will continue to be developed.</td>
<td>Healthy Child, Healthy Futures is provided to all children and young people aged 0 – 19 years irrespective of need. In addition some children and their families will receive a targeted service dependant on their individual need. The programme offers: • A universal service with a number of set contacts. • Holistic assessment. • Screening and surveillance. • Early and progressive intervention.</td>
<td>• Work streams established as part of implementation process rely on close working between primary/community care and secondary care • Workforce and training issues identified required funding and support • ICT support required enabling monitoring of programme through an electronic record which will include the child health record and work is ongoing to develop a Family Needs Assessment database.</td>
<td>This will be informed by the audit of the outcomes and the compliance with implementation.</td>
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<td>14</td>
<td>Autism Strategy</td>
<td>There is a recognised need to ensure a new approach to the delivery of autism specific services. It recognises the need to improve commissioning and provision of ASD services, training and education so that there is earlier recognition, intervention and support for people with an ASD and their families. A Regional ASD Network has been launched to oversee and ensure the implementation of the action plan developed in response to the strategy.</td>
<td>• Service redesign to improve ASD care. • Performance improvement of ASD services. • Training and raising awareness. • Improving communication and information for individuals and families. • Effective engagement and partnership working.</td>
<td>The Action Plan recognises that important work is being carried out by Health and Social Care organisations and other Government Departments. The DHSSPS Action Plan on ASD acknowledges that effective co-ordination and sharing of information and best practice with other agencies and sectors is essential.</td>
<td>• Consolidation of the Children’s’ Pathway • Implementation of the Adult Care Pathway • Establishment of local cross-sectorial improvement groups.</td>
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<td>15</td>
<td>Implementation of the New Strategic Direction for Alcohol and Drugs Phase 2 [1]</td>
<td>Research has shown that alcohol misuse costs Northern Ireland up to £900 million every year and almost £250 million of these costs are borne by the Health and Social Care Sector. If the costs of drug misuse were to be added in this would be over £1 billion.</td>
<td>The scope of the programme is to implement the actions needed to reduce the harm related to alcohol and drug misuse in Northern Ireland, through the outcomes set out in the New Strategic Direction for Alcohol and Drugs Phase 2.</td>
<td>• Partnership working with the voluntary and community sector • Partnership working across other government departments (e.g. DE, DSD, DoJ, DoE, etc.</td>
<td>• Implementation of the short-term outcomes/outputs outlined in the New Strategic Direction for Alcohol and Drugs Phase 2.</td>
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<td>and Drugs Phase 2 (NSD). This involves a wide-ranging, multi-sectoral, long-term and integrated approach through the different stages of life. The NSD seeks to direct action across 5 pillars: prevention and early intervention; harm reduction; treatment and support; law and criminal justice; and monitoring, evaluation and research</td>
<td>Working across the UK, RoI and Europe</td>
<td>Partnership working at local level with all sectors – e.g. local government, schools</td>
<td>Ensuring that related funding is used to commission effective services.</td>
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### 4.4.2 New regional programmes emanating from TYC

The new regional programmes, described below, are subject to formal programme initiation.

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| 1  | Development of ICPs [5,15,60,65,76,86]           | The creation of ICPs is a key recommendation of Transforming Your Care – A Review of Health and Social Care in Northern Ireland (December 2011). | The ICP workstream comprises 4 main stages; Design, Initiation, ICP maturity and On-going development. The goal is the achievement of a care model in which individuals will have the opportunity to make decisions that maintain their health and wellbeing. Services will potentially be better co-ordinated and provided locally where safe and appropriate (with the home as the hub). | • Stakeholder engagement and buy-in of the ICP Guidance Notes and Implementation Plan, including HSCTs, GPC, DHSSPS, etc.  
• Completion and sign off of Population Plans  
• Securing transition funding Development of ICP policy document by DHSSPS to be implemented by HSCB | • Establishment and effective operation of 17 ICPs. |
| 2  | An assessment of respite requirements by PoC and sourcing of investment required for implementation [13,19,31,33,67,70] | Respite care has been shown to help sustain family/caregiver health and wellbeing, avoid or delay out of home placements and reduce the likelihood of abuse and neglect. The ARCH outcome based evaluation pilot study showed that respite may also reduce the likelihood of divorce and help sustain marriages. | The programme scope should cover clear identification of the capability and capacity investment needed in order to provide increased respite to carers across PoC’s. In addition, the programme should consider ‘local day placement’ opportunities that are age appropriate across PoC’s. | • Carers strategy implementation groups.  
• Reallocation of resources to the community.  
• Dependent on overhauled financial model. | • Greater support to carers by way of full implementation of an increased suite of respite opportunities . |
| 3  | Develop, and create awareness of information resources for people with a learning disability [69] | In general, service users and carers consider it remains difficult to access information on the services available for people with a learning disability. Information on housing options was highlighted as an issue within TYC. Many carers are also unaware of their right to a carers’ assessment and access to support to meet their physical and emotional needs. | This programme scope should focus specifically on resources for those people with a learning disability from both a resource quality and awareness perspective. In addition, the programme should involve a ‘joined up’ approach with the PHA in its overall ‘population health and wellbeing awareness’ campaign. | • Build links with the Department of Education.  
• Bamford Action Plan: Dependency on DHSSPS to work with HSCB to make more use of the DHSSPS website and NI Direct website.  
• Dependency on BSO to provide guidance and policy on the use of social media and apps’. | • Widespread availability and accessibility of information resources for those people with a learning disability. |
| 4  | Implementation of a regional approach to the provision of self-directed support and individual budgets [16,17,22,28,29,60] | The provision of self-directed support and individual budgets is seen as a way in which the TYC agenda of ‘Promoting independence and personalisation’ can be taken forward. TYC has stated that this should be implemented at a regional level. | The programme scope should include provision of self-directed support and individual budgets (if desired) to older people who need support and individuals with physical disabilities, learning disabilities or mental health issues. As a minimum, clear information on the financial package available should be given to those using the service. | • Link to publication of Advocacy Strategy May 2012.  
• Consideration to be given to setting up a self-directed support and individual budgets Steering Group.  
• Links to enablement programme with HSCB. | • Increase uptake among older people, those with LTCs physical and learning disabilities of self-directed support and individual budgets . |
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| 5  | Implementation of a single number (111) for Urgent Care [93] | A single number (111) for Urgent Care will help people to access local health services when they need medical help or advice fast, but it is not an emergency. This will improve both the delivery and future planning of local healthcare. Callers using 111 will be assessed, given advice and directed straightaway to the local health service which best meets their need – such as A&E, out of hours GP, Urgent Care centre, community nurse or pharmacist. 111 will work alongside and be integrated with the 999 emergency services to ensure there is no delay for emergency callers whichever number they use. Calls will be answered by highly-trained call advisers, supported by experienced clinical professionals. This number has already been piloted by the NHS in the North East of England, and is part of the NHS programme to ensure people receive the right care, from the right person, in the right place, at the right time. | The programme scope is to develop and implement a single number (111) for Urgent Care operating on a 24/7 basis alongside and integrated with the 999 system, linked to a common clinical triage system and dynamic electronic directory of local and regional services which makes it easier for people to access the most appropriate service in the most appropriate, consistent and timely manner. | • Seamless linkages to 999 system to ensure safety and confidence.  
• Dynamic electronic directory of local and regional services.  
• Common clinical triage system for both 111 & 999 (such as NHS Pathways or NHS Scotland developments)  
• Social work Out of Hours (OOH) system being developed needs to be inclusive.  
• Regional Strategic Framework for GP OOH's is currently with Minister.  
• Engagement with relevant stakeholders and HSC Trusts to populate and further develop directory of services with local and regional health services (such as crisis response teams for social work, mental health, nursing, etc.; pharmacy; dental; Out of Hours GP) | • Simplified, robust 24/7 access to urgent and emergency care via 111/999 with clinical triage and disposition which is regionally consistent and locally sensitive. |
| 6  | Development of a suite of clear regional patient transfer/bypass protocols throughout the healthcare network [72, 89 also thematic] | The reconfiguration of services brought about by the implementation of TYC will act as a driver for clear protocol definition for patient transference throughout the healthcare system (both for major trauma and non-emergency). Patient transfer/bypass protocols are currently partially defined, but not fully. | Working with the Northern Ireland Ambulance Service, the programme should clearly define and develop patient /bypass protocols throughout the healthcare network. This should include arrangements for adults and children. | The configuration of acute services and clinically agreed protocols. | Clearly defined regional protocols for patient transfer throughout the NI healthcare network. |
| 8  | Implement effective partnership working to maximise outcomes for children and their families in the early years [41,63] | It is widely acknowledged that early intervention produces positive dividends for children and families. The learning and experiences from the Sure Start model which targets ‘children who will benefit most’ and other similar initiatives needs to be understood and extended where benefit can be demonstrated, early intervention to support the development of young children is one of the most cost-effective aspects of social care. | The programme scope will cover integrated working between the HSCB/PHA to maximise outcomes for 0-5 year olds. The programme objectives need to be clearly defined. | • Dependency on DHSSPS to provide clarity on how this should be taken forward.  
• Dependency/ strong links with Department of Education.  
• Dependency on on-going AHP review. | Tangible benefits arising for 0-5 year olds versus 2012 baseline based on the programme objectives. |
| 9  | Set up dedicated long term condition management programme for those people who wish to be enrolled | It is stated within TYC that the review should take account of extant statements of policy approved by the Minister including (as a major theme) the quest for better intervention and chronic condition management. | The scope of the programme that would need to be set up would be to identify and evaluate the current baseline of patient education and self-management support programmes that are currently in place in each LCG area and then implement the necessary condition management to close the | • This may be assisted by the establishment of ICPs  
• Policy Framework on LTCs was published in April 2012, which focused on adults | To be defined during programme initiation. |
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<th>No.</th>
<th>Regional programme [TYC recommendation addressed]</th>
<th>Summary of case for change</th>
<th>Programme Scope</th>
<th>Dependencies</th>
<th>3 – 5 year commitment (baseline = 2011/12)</th>
</tr>
</thead>
</table>
| 10  | Develop a model of non-surgical oncology service which best addresses acute oncology requirements and makes most effective use of the multiprofessional workforce [74, 77, 78] | The development of a radiotherapy service in Altnagelvin changes the current outreach model of oncology and will impact on patient pathways and service provision in other trusts. There is a need to develop robust Acute Oncology Services to enhance patient safety in line with National Chemotherapy Advisory Group recommendations. The NICaN Chemotherapy service review (2010) identified the need for service reform & workforce modernisation. To undertake a review of the current non-surgical oncology outreach model and drawing on work to date, identify which model enables the development of robust acute oncology services. The review would need to ensure maximum use is made of skill mix in the development of new patient pathways which take account of local and regional requirements. | gap to best practice. | rather than children. | Establishment of a sub-regional radiotherapy centre in Altnagelvin.  
Transforming Cancer Follow Up.  
Establishment of Acute Oncology Services.  
Robust workforce identified for staffing the radiotherapy unit. |
### 4.4.3 Regional enabler workstreams

These workstreams enable other regional programmes or local Population Plans to be delivered and are a strategic response to the collective requirements across programmes. They also enable TYC programme plans, supported by effective programme management arrangements, to be aligned with other regional programmes within whole system plans.

<table>
<thead>
<tr>
<th>Enabler workstream</th>
<th>Existing/New</th>
<th>Summary description</th>
<th>Regional programmes enabled by the workstream</th>
<th>3 – 5 year commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance and workforce planning</td>
<td>Existing</td>
<td>The finance programme has been set up to:</td>
<td>• This enabling workstream cuts across all potential new and existing regional programmes.</td>
<td>• Validate that the agreed shift in expenditure out of hospital services and into alternate community and primary care based service provision has taken place recurrently.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enable key programme workstreams by the provision of financial expertise to support the detailed work up of workstream plans.</td>
<td></td>
<td>• Ensure that appropriate funds and resource flows are put in place to put into effect the agreed shift in the provision of care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure that the financial implications of all workstreams are reported through the TYC TPB and that appropriate actions are taken.</td>
<td></td>
<td>• Ensure that the HSC maintains financial stability during 2012/13 -2014/15 by delivering on both TYC and QICR financial objectives.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure financial stability is maintained during the implementation of transformation / TYC plans.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• In addition to the finance aspects, detailed workforce planning will need to be undertaken to ensure the correct skills mix exists in the newly reconfigured healthcare world.</td>
<td></td>
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</tr>
<tr>
<td>Capital/Infrastructure</td>
<td>Existing</td>
<td>The Health Infrastructure Board (HIB) considers the capital investment requirements for HSC.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• The workstream will work closely with projects/initiatives for service change requiring capital investment.</td>
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<tr>
<td></td>
<td></td>
<td>• The workstream will work with the ICT programme to maintain oversight of ICT capital investment.</td>
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<td></td>
<td></td>
<td>• A comprehensive infrastructure investment programme is to be developed that will incorporate investment in the primary and community based infrastructure network and on improving the delivery of integrated GP and Trust-led primary care services. This includes the delivery of a range of Primary and Community Care Centres (PCCCs).</td>
<td></td>
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<tr>
<td></td>
<td>New:</td>
<td>Development of ICPs.</td>
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<td></td>
<td></td>
<td>Development and creation of information resources for people with a learning disability.</td>
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<td></td>
<td></td>
<td>Evidence based population screening and immunisation assessment, and implementation of new programmes.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Service changes requiring capital investment in equipment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Existing:</td>
<td>The full suite of programmes identified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capability and Engagement</td>
<td>Existing</td>
<td>The objective of the Capability and Engagement workstream is to help create an environment which is receptive to and supports the transformation required to deliver the vision set out in ‘Transforming Your Care’ and the benefits set out in this SIP.</td>
<td>• This enabling workstream cuts across all potential new and existing and regional programmes</td>
<td>• Validation of proposals for 4 key capability programmes (Leading Transformation, Building Capability to Deliver, Skills Transfer and Intelligence Hub) by Sept 2013.</td>
</tr>
<tr>
<td>Enabler workstream</td>
<td>Existing/New</td>
<td>Summary description</td>
<td>Regional programmes enabled by the workstream</td>
<td>3 – 5 year commitment (baseline = 2011/12)</td>
</tr>
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<tr>
<td><strong>In order to achieve this it will be critical that key groups are receptive in terms of their willingness to adopt new behaviours and support the delivery projects (‘engagement’), and that they have the ability to do so (‘capability’).</strong>&lt;br&gt;&lt;br&gt;This workstream will both directly manage some programme level engagement and capability activities (Appendix 1 of this document provides more detail on these activities), and will provide tools, templates and support to projects and initiatives taking place throughout the TYC Programme to build consistency of approach and ownership at a local level.</td>
<td></td>
<td>• All capability programmes completion by March 2016 in line with other key Programme milestones (i.e. the completion of the capability programmes will be aligned with Programme milestones to provide support as long as it is needed)&lt;br&gt;• Validation of Engagement approach and plan, and updated Regional Communications Strategy by September 2012.&lt;br&gt;• Delivery of engagement activities as per plan with completion in March 2016 in line with other key Programme milestones (i.e. the completion of engagement activities will be aligned with Programme milestones to provide engagement activities as long as they are needed)&lt;br&gt;• Evaluation Reports and updated capability and engagement plans to ensure alignment with objectives.</td>
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<tr>
<td><strong>HSC ICT Programme</strong>&lt;br&gt;This is a programme of projects that has been running for several years. There are dozens of projects contained within the programme, as far as TYC is concerned the most relevant project is Electronic Care Record. There are also a number of emerging requirements from TYC, e.g. the need to increase the bandwidth for the network that supports GP practices (e.g. to give G.P.’s access to video conferencing and online collaboration tools etc). In addition, there is an understanding that there are additional TYC requirements that need to be addressed, namely ICT support for risk stratification. The HSCB will work collaboratively with Trusts and other stakeholders to meet specific IT challenges arising from emerging business requirements under TYC. There will be further development of NIPACS to enable a more networked approach to service delivery.</td>
<td>Existing</td>
<td>• This enabling workstream cuts across all potential new and existing and regional programmes.&lt;br&gt;• Workshop between ICT and Trusts to further establish requirements (input from TYC programme team required) September 2012.&lt;br&gt;• First phase of ECR available to all trusts by July 2013&lt;br&gt;• To fully integrated community information systems in Belfast and Southern Trusts with project also well underway in the Western trust&lt;br&gt;• Draft DQIP Outline business case to DHSSPS by the end June 2013.</td>
<td></td>
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<tr>
<td><strong>PMO</strong>&lt;br&gt;This workstream will be responsible for the delivery of effective integrated programme management arrangements to support the TYC programme for its duration. It’s key responsibilities will be for: Delivery of the programme management arrangements in an efficient and systematic way to co-ordinate effective overall programme delivery. These will critically cover integrated programme plans, delivery monitoring, risk management and governance support and reporting. Development of a regional programme management community working together in close collaboration to deliver the above.</td>
<td>Existing</td>
<td>All regional and local workstreams will be supported by the PMO activities. Particular activities supported by the PMO are:&lt;br&gt;• Benefits management.&lt;br&gt;• Programme delivery and risk management monitoring / reporting.&lt;br&gt;• Equality Impact Assessment programme.&lt;br&gt;• TYC innovation management.&lt;br&gt;• Commencement of a TYC benefits framework by September 2013.&lt;br&gt;• Equality Impact Assessment planning &amp; awareness – July/December 2013.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enabler workstream</td>
<td>Existing/New</td>
<td>Summary description</td>
<td>Regional programmes enabled by the workstream</td>
<td>3 – 5 year commitment (baseline = 2011/12)</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>Development and deployment of an approach to monitoring benefits of the TYC programme. Development and co-ordination of the Equality Impact Assessment programme.</td>
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<tr>
<td></td>
<td></td>
<td>• Co-ordination and delivery of a plan to actively support the management of innovation during the programme.</td>
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</tr>
</tbody>
</table>
4.5 Population Plans

The Population Plans were the local strategic articulation of Transforming Your Care. They described models of care which are aligned to the TYC proposals. The Population Plans address the health and social services needs of a population over the next 3 to 5 years, and are founded on a number of core principles:

- Commission safe, resilient and sustainable personalised health and social services which meet the needs of a population, achieve greater integration of care between organisations and settings, and brings care closer to home.
- Improved access, quality and choice of health and social services in a LCG locality which achieves efficiency and enhances the patient experience.
- Integrated programmes of care across primary, community and secondary care.
- Improve morbidity, mortality and health inequalities.
- Improved quality of mental health and learning disability services by meeting the resettlement targets for 2015 and encourage independence and self-care.
- Identified acute productivity opportunities in the hospitals services system which seek to reduce the need for admissions and to plan more effectively for discharge and length of stay.
- A transformation in the workforce, in terms of skills development and realignment will enable the delivery of Transforming Your Care in each LCG locality.
- Overall, the Population Plans aim to reduce activity in the acute system by shifting care into the community. This will require growth in community care, and an enhanced primary care system.

The Population Plans were developed in June 2012, and refined through the quality assurance period to October 2012, by each of the Local Commissioning Groups in consultation with their provider colleagues. They described the Local plans for delivery of those TYC proposals that have been locally shaped and developed through the population planning process. The Population Plans were designed to be consistent in terms of how they address the issues that exist for their populations; this was checked through the quality assurance process.

The journey over the next 3 to 5 years of how each of the Programmes of Care will evolve and change as described in the Population Plans is summarised below for each local area. The Population Plans, and this Strategic Implementation Plan, as well as the views expressed during the
consultation are being fed into detailed operational planning processes across each of the workstreams and projects within the Programme. It should be recognised that this detailed operational planning, and further local consultation as appropriate on proposed service changes which will take place during implementation, may impact on the nature and timing of the outcomes set out in this section. In addition the plans and anticipated timescales will continue to be reviewed over the 3 to 5 years to consider the affordability. This could speed up the pace of implementation or indeed it may need to go at a slightly slower pace, depending on resources available. This section is therefore intended to provide a strategic picture of the possible changes at a point of time. The baseline year for the purposes of this plan is 2011/12.

The Programmes of Care set out in Section 4.4 reflect those used in the ‘Transforming Your Care: A Review of Health and Social Care in Northern Ireland’. This may differ in some instances from the official statistical definition of Programmes of Care.
## 4.5.1 Older people

### Regional Strategic Direction – *Reduce residential care beds and establish services to support independent living*

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
</table>
| Northern | • Build on the established in-house reablement service to ensure that 90% of people requiring a new domiciliary care package are admitted to reablement.  
• 90% of new referrals to domiciliary care admitted to reablement.  
• 20% of people going into reablement will leave with no service required. | • Implement reduced number of specialised intermediate care units (to 6 in Phase 1 – beds from 143 to approx. 111) throughout NHSCT to ensure best possible service user outcomes and optimum use of resources.  
• Increase Occupancy rates from 85% to 90% and reduce Length of Stay in the service from 31 days to 28 days across all Intermediate Care beds. | • Develop a range of Housing Support services including Sheltered Accommodation, Supported Living, Floating Support and Peripatetic Housing Support Services.  
• Increase by 250 the number of service users using alternative Housing Support Services. |
| Western | • Re-tender the provision of domiciliary care provision, re-align and reduce statutory homecare to focus on own home reablement.  
• Develop an assessment and liaison model to save excess bed days through rapid access to community based teams.  
• Develop a memory service to increase the length of time from diagnosis to long term care dependency and associated dependency. | • Therapy led goal setting will optimise independence.  
• A range of housing with care models focusing on addressing the growth in dementia related demand.  
• Reconfiguration of bed numbers. | • Reduced residential care placements made and reconfiguration of statutory residential care.  
• Delivery of long term care through other alternative approaches including greater utilisation of the independent sector. |
| Belfast | • Develop a reablement gateway service for people requiring community care which provides intensive assessment and support to maximise independence.  
• 20% of people going into reablement will leave | • Further develop supported housing schemes jointly with NIHE and housing associations and avoid the need for residential care.  
• Support the natural cessation of use of the 2 remaining statutory residential care | • Reduction in nursing home and residential home placements.  
• Increase in home based respite.  
• Removal of excess residential care home provision. |
<table>
<thead>
<tr>
<th>South Eastern</th>
<th>Southern</th>
</tr>
</thead>
</table>
| • Reduce ED attendances by 5%, unplanned admissions by 10% and LoS by 2%.  
• Develop co-ordinated service model and care pathway for falls.  
• Reconfigure statutory residential care capacity by 40 beds. | • Therapy-led reablement services will be rolled out across the southern area - Increase from a baseline of 3 to 7 localities. Demand for mainstream domiciliary care services will be maintained against demographic growth.  
• Work will continue with NI Housing Executive to secure development of supported housing across the area including addressing the growing demand for housing with care opportunities for people with dementia. |
| • Further reduce ED admissions, LoS and statutory residential care capacity for Older People.  
• Expand Mobile Working pilot across the South Eastern locality to deliver a further 2,547 client contacts. | • The number of people able to live independently in their own homes will increase and specifically there will be an increase in the number of people availing of telecare or other technology based solutions and personalised budgets.  
• There will be an increase in the number of referrals accepted to reablement (improve upon the 74% figure of April 2012).  
• Rapid response community services will be in place to safely avoid admission to hospital or reduce length of stay in hospital where admission is required resulting in a reduction in non-acute hospital beds.  
• Programmes to support the physical and emotional wellbeing of older people including promoting social interaction and targeting falls prevention, will be in place. |
| • Excess beds within acute hospitals reduced to plan. | • Access to specialist community-based support and treatment services for people with dementia will be improved including redesign of statutory day care.  
• There will be a diversity of providers of domiciliary care including social enterprises with a reduced percentage of domiciliary care provided by statutory services.  
• As a result of enhanced supported living opportunities, reconfigure statutory residential homes over time. |
### 4.5.2 Population health & wellbeing

<table>
<thead>
<tr>
<th>Population health &amp; wellbeing</th>
<th>Regional Strategic Direction – A renewed focus on health promotion and prevention, with particular emphasis placed on smoking, obesity and alcohol consumption</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
</tr>
<tr>
<td>Northern</td>
<td>• Tobacco Control – services will be targeted at pregnant women and their partners who smoke; those with long term conditions and pre-operative patients- 5% of the smoking population will have accessed services in each year.</td>
</tr>
<tr>
<td></td>
<td>• Obesity – children and young people will be assessed in school and will be referred to obesity management programmes if appropriate.</td>
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<tr>
<td></td>
<td>• KPIs - Year 1/ 8 Obesity &amp; Overweight Levels; Regional Obesity Prevalence; Obesity in pregnancy data.</td>
</tr>
<tr>
<td></td>
<td>• Drugs, Alcohol, Substance Misuse – a range of preventative, early/brief intervention and treatment services will be available across the NLCG area.</td>
</tr>
<tr>
<td></td>
<td>• KPIS - Increased uptake in preventative services; increased range of preventative/early intervention services; Decreased substance misuse prevalence; Decreased admissions to ED with alcohol/drug effects.</td>
</tr>
<tr>
<td>Western</td>
<td>• Under the Public Health Strategic Framework implement joint working and multidisciplinary pilots on lifestyle management programmes aimed at tackling alcohol and drug abuse, smoking in pregnancy, obesity, CHD, falls and diabetes.</td>
</tr>
<tr>
<td></td>
<td>• Reduction in smoking in pregnancy by 30%.</td>
</tr>
<tr>
<td></td>
<td>• Halt in the rise of obesity in families.</td>
</tr>
<tr>
<td></td>
<td>• Reduction in harmful drinking and improved lifestyle behaviour: reduced STIs.</td>
</tr>
<tr>
<td></td>
<td>• Reduced demand for acute services.</td>
</tr>
<tr>
<td></td>
<td>• Reduced residential care placements made and reconfiguration of statutory residential care. Delivery of long term care through other alternative approaches – including greater utilisation of the independent sector.</td>
</tr>
<tr>
<td></td>
<td>• Reduction in hospital attendance and outpatient capacity.</td>
</tr>
<tr>
<td></td>
<td>• Delivery of AHP and community pharmacy led programmes.</td>
</tr>
<tr>
<td></td>
<td>• Reduced numbers of continuing care packages.</td>
</tr>
<tr>
<td>Belfast</td>
<td>• Higher awareness amongst the BME communities.</td>
</tr>
<tr>
<td></td>
<td>• Increased uptake of weight management, smoking cessation and cardiac rehab.</td>
</tr>
<tr>
<td></td>
<td>• Improvement in breast feeding rates and increased dental registrations.</td>
</tr>
</tbody>
</table>
### South Eastern
- Reduce long-term demand for acute, primary and social services by promoting physical and mental wellbeing.
- Establish ‘Roots of Empathy’ programmes in 30 primary schools to encourage better health and social outcomes.
- Provide 12 paid and 12 unpaid apprenticeships for young people leaving care.
- Reduce rates of smoking during pregnancy by 5% through targeted midwife interventions.

### Southern
- Tobacco Control services will be targeted at pregnant women and their partners, who smoke, long term conditions and pre-operative patients.
- Weigh to Health programme for obesity will be promoted in the community.
- Services to promote and support mental wellbeing, including community development and training will be made available across the area.
- The public will have easier access to stop smoking services in a range of settings by 2014.
- A pilot programme of referral to commercial weight management programmes will be undertaken and evaluated.
- There will be increased community engagement and development around mental health issues.

### South Eastern
- Reduced referrals to secondary care.
- Improvement in the cardio vascular health of the population through specific indicators.
- Reduction in incidents of dental decay in children and lower cost of interventions.
- Reduction in ED related admissions.

### Southern
- 5% of the smoking population will have accessed services in each year.
- A range of preventive, early intervention and treatment services for drug, alcohol and substance misuse will be available.
- Enhanced community capacity for mental health services will be in place provided by a range of organisations including the voluntary and community sector.
## 4.5.3 Long term conditions

<table>
<thead>
<tr>
<th>Long term Conditions</th>
<th>Regional Strategic Direction – Focus on primary and secondary prevention and personalisation of care planning, with assistance from technology and pharmacies to reduce hospital admissions.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
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<tr>
<td></td>
<td>Year 2</td>
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<tr>
<td></td>
<td>Year 3</td>
</tr>
<tr>
<td>Northern</td>
<td>• Application of reliable Risk Stratification model and tailoring of interventions accordingly across all care providers.</td>
</tr>
<tr>
<td></td>
<td>• Redesign existing and develop new LTC Care Pathways for all chronic conditions across all settings leading to a reduction of admissions, and overall acute bed days.</td>
</tr>
<tr>
<td></td>
<td>• Establish case management and community based teams to support complex patients and those with multiple LTCs.</td>
</tr>
<tr>
<td></td>
<td>• Establish self-care and preventive programmes across all LTCs.</td>
</tr>
<tr>
<td></td>
<td>• Develop ICPs to provide integrated, accessible healthcare services by clinicians who are accountable for addressing the large majority of personal healthcare needs on a 24/7 basis.</td>
</tr>
<tr>
<td></td>
<td>• Continue the development of new LTC Care Pathways for all chronic conditions across all settings leading to a reduction of admissions, and overall acute bed days.</td>
</tr>
<tr>
<td></td>
<td>• Provide support for self-care, transitional points and proactive case management.</td>
</tr>
<tr>
<td></td>
<td>• Optimise the use of Telehealth.</td>
</tr>
<tr>
<td>Western</td>
<td>• Through ICPs and PC federations develop LTC pathways for all chronic conditions to ensure support for self-care and contact between GPs and consultants.</td>
</tr>
<tr>
<td></td>
<td>• Additional GP nursing and phlebotomy will result in reduced A&amp;E demand, admissions and OP appointments.</td>
</tr>
<tr>
<td></td>
<td>• Prevent 5% of referrals and 10% of emergency admissions.</td>
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<tr>
<td></td>
<td>• Develop the use of Telehealth and NPT for LTCs.</td>
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<tr>
<td></td>
<td>• Establish personalised plans managed by ICPs with escalation protocols.</td>
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<tr>
<td></td>
<td>• Enable the review of acute capacity as productivity of district nursing improves.</td>
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<tr>
<td></td>
<td>• As referrals, admissions reduce and LOS improve medical systemic bed numbers can be reduced.</td>
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<tr>
<td></td>
<td>• Investment in technology and ICP teams will enable robust out of hospital care infrastructure.</td>
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<tr>
<td>Belfast</td>
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<td>-------------------------------</td>
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<tr>
<td>• 8 multi-disciplinary primary care teams (IPACTs) to be established on a 'hub and spoke' model (2 per ICP), inc. GPs, Community Pharmacists, OT, Nursing, S Worker.</td>
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</tr>
<tr>
<td>• Dynamic risk stratification of disease registries – supported by data warehouse and risk stratification tool as basis for deployment of stratified interventions in the IPACTs.</td>
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</tr>
<tr>
<td>• Develop telehealth; community nursing and community-based diagnostics, where volumes/throughput and skill mix make it safe and sustainable to do so and integrated pathway for older people: Target Diabetes; Heart Failure; Atrial Fibrilation; CHD and COPD.</td>
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</tr>
<tr>
<td>Belfast</td>
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<tr>
<td>• Integrated care pathways fully developed and operational.</td>
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<tr>
<td>• Personalised plans and a named worker in place. Reduction in ED attendances. Reduced referral to secondary care. Reduction in beds commences.</td>
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<tr>
<td>• Patients managed within community.</td>
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<tr>
<td>• Reduced admissions for LTCs.</td>
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</tr>
<tr>
<td>• Reduction in beds in acute settings complete.</td>
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<tr>
<td>• Reduce unplanned admissions of adults (18-64) with a Long Term Condition as a primary diagnosis.</td>
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<tr>
<td>• Reduce unplanned admissions of people aged 65 and over with Long Term Conditions as a primary diagnosis.</td>
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<thead>
<tr>
<th>South Eastern</th>
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</thead>
<tbody>
<tr>
<td>• In Year 1 the Trust will work with the SELCG and GP Practises to ensure that practice registers for a COPD, diabetes, stroke and dementia are accurate including patients with a history of multiple hospital admissions and co-morbidities, and that the information is shared. A process of risk stratification will be undertaken to determine those at greatest risk of rehospitalisation requiring case management and those who will benefit from supported self-management.</td>
</tr>
<tr>
<td>• Year 1, 50 patients in Virtual Ward in Down sector (160 admissions saved and 800 bed days). Year 2, 70 patients on Down Ward (192</td>
</tr>
<tr>
<td>• Year 2 and 3 will demonstrate that telehealth contributes to reducing hospital admissions, total bed days, ED visits, ambulance call outs, nurse to home visits and patient visits to GP by 10% per year for all patients on the virtual ward.</td>
</tr>
<tr>
<td>• Increase the number of people on telemonitoring by 50% each year from the baseline of n = 100.</td>
</tr>
<tr>
<td>• After years 2 and 3 to include other LTC's such as Dementia as part of a widening ICP network within Primary Care.</td>
</tr>
<tr>
<td>• Through case managing 10% of GP Register Respiratory patients in year 2 and 20% in year 3, there will be a reduction in GP attendances by 10% each year.</td>
</tr>
<tr>
<td>• Based on 4659 COPD patients, the 10% reduction will be 1864 GP appointments in Year 2 and 3727 appointments in Year 3.</td>
</tr>
</tbody>
</table>
admissions and 960 bed days) and Year 3, 100 patients on Down Ward (320 admissions and 1600 Bed days).

| Southern | • By March 2013, ensure that at least 2,200 patients with long term conditions locally are availing of remote Telemonitoring services through the Telemonitoring NI contract.  
• Integrated care pathways supported by risk profiling will target support at those most at risk of multiple hospital admissions, for example, implementation of the NI COPD Integrated Care Pathway by March 2013.  
• Enhanced training and support will be available within primary and community settings. | • The number of children and adults with type 1 diabetes who have access to insulin pumps that improve their outcomes will increase.  
• The proportion of patients with confirmed ischaemic stroke who receive thrombolysis will have increased. | • Unplanned admissions to hospital for people with long term conditions will have significantly reduced and more people will be confident in managing their condition at home.  
• NICE guidelines for a range of long-term conditions will be implemented. |
### 4.5.4 People with a physical disability and/or sensory impairment

<table>
<thead>
<tr>
<th>People with a Physical Disability</th>
<th>Regional Strategic Direction – <em>A system that focuses on personalisation, independence and control, providing the right care in the right place at the right time</em></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
</table>
| Northern                         | • Continued promotion of the use of self-directed support and individual budgets across the Trust that increases uptake whilst promoting choice and independence.  
• Continued development of creative day opportunities including access to employment, leisure and educational activities that promote independence and choice.  
• Continue to move people as appropriate to need from adult centre day care to independent sector day opportunities provision. |       | • For building based day care, continue to review current provision ensuring needs are met in the most appropriate setting. Consult and Implement changes to provision Sept 14.  
Increased numbers of people receiving day support through a range of day opportunities:  
• In partnership with the Housing Executive and Independent sector maximise adapted housing options as well as the further development of floating support and peripatetic services to maintain people in the community.  
• Increased use of technologies and specialised equipment for people with progressive illnesses to remain at home.  
• 85 clients across the Trust (still at Adult Centres for part of their week), remain to be transferred completely to Day Opportunities.  
• 23 clients in transition from education are currently referred for Day Opportunities. |       |
| Western                          | • Development of step down rehabilitation in Spruce will increase utilisation of capacity.  
• Re-design of traditional day support means that more people with PD will access day opportunities. |       | • Provide different models of person centred respite linked to carer assessed needs promoting increased choice and accessibility. |       |
|                                  |                                                                                                                  |       | • Improved capacity efficiency and savings through retendering of domiciliary care.  
• Increased self-directed support and individual budgets. |       |
### Belfast
- Develop a Joint Plan for services for people with a disability involving:
  - Users and carers; Community & Voluntary sector providers and other agencies which increases.
  - Choice and which provides a signposting, advocacy and support service.
  - Reduced numbers of people with complex conditions living long term in hospital and nursing homes.
- Enable choice through increased personalised budgets.
- Increased number of people with personalised budgets.
- Reduction in number of people with complex conditions living long term in hospitals.
- Reduction in use of intensive services.
- Reduction in hospital and nursing home beds.

### South Eastern
- Increase number of self-directed support and individual budgets to carers to promote care in the home.
- Engage with local communities to prevent dependence and redirect care to more appropriate options.
- Further roll out NISAT to increase the number of assessments by AHP and Nursing staff.
- Enhance multi-disciplinary working to improve rehabilitation.
- Develop a broader range of respite provision across the Health and Social Care sector.
- Increase the level of engagement of people with Physical Disability in programmes focusing on increasing physical activity levels.
- Ensure people with continuing care needs are assessed within 8 weeks and have the main components of their care met within a further 12 weeks.

### Southern
- Review of current day service programme and re-profile existing ‘building based’ provision to community based services and day opportunities on an individual case by case basis.
- Targeted engagement strategy to scope community opportunities with a view to extending current provision and/or adding additional capacity with new providers.
- Review and refocus statutory day care provision to focus on ‘unmet’ need.
- Reconfigure statutory day care centre provision across the Trust in line with the development of the new day opportunities service model.
### 4.5.5 Maternity & child health

**Regional Strategic Direction** – Provide continuity of care and throughout pregnancy, focussing on the reduction of ill health, the normalisation of birth and connecting support from antenatal care into early parenthood

<table>
<thead>
<tr>
<th>Maternity and Child Health</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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</thead>
<tbody>
<tr>
<td>Northern</td>
<td>• Develop optimum service configuration to meet minimum standards and promote choice.</td>
<td>• Develop midwife led community care for postnatal support.</td>
<td>• Intra-partum Care: Introduce quality and service improvement programme within obstetrics services including a focus on reduced interventions and improved productivity and efficiency.</td>
</tr>
<tr>
<td></td>
<td>• Implement midwife led antenatal clinics.</td>
<td>• Reduce caesarean section rate.</td>
<td>• Reduce caesarean section rate from 30% to 28% by April 2014.</td>
</tr>
<tr>
<td></td>
<td>• Increase capacity of midwife led clinics for low risk expectant mothers: 1 additional midwife led clinic per week by Sept 2012.</td>
<td>• Develop improved dedicated in-patient Paeds. facilities.</td>
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<td></td>
<td>• Develop 6-hour discharge for normal delivery: ALoS from 2.3 to 1.9 days by April 2013.</td>
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<tr>
<td>Western</td>
<td>• Normalisation of Child Birth: Bring antenatal and postnatal visits into line with NICE guidance 1) Reduced LOS 2) Reduced attendances at outpatients and foetal assessment units.</td>
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<td></td>
<td>• Development of community based specialist paediatric nurse for long term conditions for example: diabetes, asthma, continence and epilepsy 1) Reduced acute paediatric attendances 2) Reduced admissions 3) Reduced demand on GP’s and decrease in consultant referrals.</td>
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<td></td>
<td>• Family Nurse Partnership Programmes: Expansion of current scheme to support all appropriate pregnant women to support maternal and child health 1) Reduce ED admissions due to accidents 2) Referral to secondary care and tier 2 and 3 social services subject to license and agreement of the PHA.</td>
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<tr>
<td></td>
<td>• Development of paediatric specialist nurses for LTCs will reduce ED attendances and demands on GPs and consultant referrals.</td>
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<tr>
<td></td>
<td>• Improved acute paediatric facilities and extended community services involving GPs and other professionals in providing services locally</td>
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</table>
### Transforming Your Care – Strategic Implementation Plan

<table>
<thead>
<tr>
<th>Belfast</th>
<th>South Eastern</th>
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</thead>
</table>
| • Provision of antenatal care in the community: Increase the percentage of women having their antenatal care in the community by 30%.  
  • Increase in midwife led births.  
  • Sustainability of neonatal services examined.  
  • Provide care closer to home.  
  • Improved dental registration for children.  
  • Specialist paediatric networks developed. | • Reduction in intrapartum interventions.  
  • Reduction in unnecessary interventions.  
  • Reduced length of stay.  
  • Common data set across maternity services established.  
  • Reduced hidden harm.  
  • Reduced referrals at UNOCINI levels 2 and 3.  
  • Implement paediatric networks.  
  • Attendances to paediatric ED reduced.  
  • ICPs to work with Belfast Outcomes Group to support Healthy Child, Healthy Future and establish Family Support Hubs and multi-agency Locality plans. |
| • Normalisation of labour.  
• Sustainable neonatal services.  
• Reduced antenatal clinics in hospitals.  
• Sustainable specialist paediatric services.  
• Improving life chances for children.  
• Disease levels in children reduced.  
• Admissions to paediatric services reduced. | • Transfer of antenatal care from acute hospital site into community setting.  
• Normalising child birth as per Normalising Child Birth Action plan.  
• Development of paediatric diabetic outreach service.  
• Promoting and sustaining free standing MLUs.  
• Deliver 1,270 births in the community.  
• 60% of all births will be normal births.  
• Reduction in LOS to 6-24 hrs. for 60% of mothers with normal deliveries (currently 31 hrs.).  
• 30% of all Trust births in MLUs (currently 23%). |
| • Reduce admissions, waiting times and LoS.  
• Reduction in LOS for disorders in the NNU to 4 days. |
| Southern (including Children's Services) | • There will be a renewed focus on supporting healthy lifestyle choices for women and their families and access to Day Obstetric services will increase.  
• A care bundle to reduce infant mortality by addressing smoking and obesity in pregnancy and promoting breastfeeding will be in place.  
• Early intervention programmes will be in place for children with known health risk factors such as low birth weight and a Family Nurse Programme will be implemented to support young first time parents and their children.  
• Ambulatory services will be further developed to avoid the need for children to be admitted to hospital and plans to provide acute child-only services up to 16 years through a networked approach across our hospitals will be taken forward in the context of the Regional Review of Paediatric services.  
• Effective transfer and communication arrangements will continue to be in place with regional paediatric services. | • The volume of midwife led clinics within the community and the number of births in the Midwife Led Unit will increase.  
• The number of normal deliveries for first pregnancy will increase with a reduced number of interventions including C-sections.  
• Increase from 10 to 14 the number of midwife led clinics within the community per week.  
• Increase the percentage of normal deliveries to 75%.  
• “Wraparound” community integrated teams will be in place to improve care and outcomes for children with specialist health needs and/or disabilities. |
### 4.5.6 Family & child care

<table>
<thead>
<tr>
<th>Family and Child Care</th>
<th>Regional Strategic Direction – Provide a service that focuses on early intervention, family support and foster care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1</strong></td>
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</table>
| Northern              | • Reduce reliance on residential care homes for children and young people and increase the number of foster carers - Transfer 5 children out of independent sector care.  
                        | • Develop intensive family support social services to aid those children on the edge of care for intervention, to escalate efforts at that point aiming to avoid admission to care.  
                        | • Increase foster care capacity.  
                        |                                                                                                          |
| Western               | • Single point of access for children with behavioural and psychological difficulties.  
                        | • Early intervention family therapy service to be initiated and will prevent more intensive resources being necessary.  
                        | • Introduction of skills mix into early years service and self-evaluation to ensure compliance with statutory processes.  
                        |                                                                                                          |
| **Year 2**            |                                                                                                          |
| Northern              | • Reduce 6 IFA placements.  
                        | • Develop intensive family support social services to aid those children on the edge of care for intervention, to escalate efforts at that point aiming to avoid admission to care.  
                        | • Increase foster care capacity.  
                        |                                                                                                          |
| Western               | • Reduced under 18 admissions to adult psychiatric care through intensive home treatment centre.  
                        | • Development of respite for children with learning disabilities.  
                        | • Development of short stay paediatric assessment units will prevent admissions.  
                        | • Further development of Family Support Hubs will include step up step down protocols to ensure signposting. This will reduce referrals to the gateway service.  
                        |                                                                                                          |
| **Year 3**            |                                                                                                          |
| Northern              | • Reduce reliance on residential care homes for children and young people and increase the number of foster carers - Close 1 children's home.  
                        | • Increase foster care capacity.  
                        |                                                                                                          |
| Western               | • Investment in the Strengthening Families programme will reduce childcare admissions through delivering preventative support.  
<p>| |
|                                                                                                          |</p>
<table>
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<tr>
<th>Belfast</th>
<th>South Eastern</th>
<th>Southern (including Children’s Services)</th>
</tr>
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</table>
| • Implement protocols for appropriate Gateway referrals.  
• Reduced referrals at UNOCINI Level 3.  
• Enable increase in foster carers.  
• Reduced need for residential care; reduction in length of time of permanency. | • Development of Family Support Initiatives (Family Support Hubs and Outcomes Board) to provide early intervention/prevention strategies to children and their families 1) Increase in the number of children attending school 2) Deliver more than 1300 packages of care and support to families.  
• To deliver a quality early years child care service in the area: To have no waiting list for the registration and inspection of provision.  
• To reform the Child Protection service: To reduce the number of children on the Child Protection Register (currently – 529). | • Family Support Hubs will be embedded across the southern area to ensure easy and early access to co-ordinated advice and support across a range of service providers.  
• Further develop the community infrastructure to support children & families access to early support services.  
• Centralise all referrals to CAMHS services to one location to facilitate closer working arrangements with Primary Care. | • Reduced need for referral at UNOCINI Level 2 and 3 services.  
• The Trust will support the development of Crisis Resolution & Home Treatment (CRHT) services and primary mental health services.  
• Reduced demand for step 3 provision, inpatient beds.  
• Cessation of use of adult beds for younger people under 18. | • Intensive and frontline fostering provision will increase and demand for mainstream children’s residential care will start to reduce.  
• The number of children missing paediatric and Child and Adolescent Mental Health (CAMHS) appointments will be reduced making best use of available resources.  
• Pathways will be agreed with primary care to enable more children and young people | • Review of Specialist Child Health & Disability Short Break Services across SHSCT.  
• Review mainstream statutory residential care services for Looked After Children with a view to reducing numbers of children resident in these facilities and also reducing the numbers of children being admitted to residential units.  
• Primary care will have enhanced access to specialist advice and support from |
<table>
<thead>
<tr>
<th>Implementation of central co-ordination function for all referrals to CAMHS: Target: 1827 referrals (2011/12 activity) centralised.</th>
<th>to be safely cared for at home.</th>
<th>Demand for core family intervention teams will reduce and support will be reinvested into community family support services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% reduction in referrals to the Gateway Services.</td>
<td>10% increase in FIT activity in high level family support casework to prevent family breakdown &amp; admissions to care.</td>
<td>paediatric and CAMHS staff.</td>
</tr>
</tbody>
</table>
### 4.5.7 People using mental health services

<table>
<thead>
<tr>
<th>People using mental health services</th>
<th>Regional Strategic Direction – Promote early intervention, independence and the personalisation of care, providing the right care in the right place at the right time and reducing institutional care</th>
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</thead>
<tbody>
<tr>
<td><strong>Year 1</strong></td>
<td><strong>Year 2</strong></td>
</tr>
<tr>
<td><strong>Northern</strong></td>
<td>• Continued development of a stepped care approach, with an emphasis on early intervention through the development of effective integrated care pathways – reducing acute LOS.</td>
</tr>
<tr>
<td></td>
<td>• Develop community based alternatives for services.</td>
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<tr>
<td></td>
<td>• Complete resettlement of service users currently in Inver 3. Reduce 8 beds.</td>
</tr>
<tr>
<td></td>
<td>• Develop more effective use of supported living and ensure tenants are facilitated to move on to more independent accommodation.</td>
</tr>
<tr>
<td><strong>Western</strong></td>
<td>• Re-design of inpatient addiction services with independent sector providers will enable re-provision of addiction beds.</td>
</tr>
<tr>
<td></td>
<td>• Reform of acute psychiatric services including alternatives to admission.</td>
</tr>
<tr>
<td></td>
<td>• Develop a network of inpatient provision to maximise economies of scale, subject to the completion of a Business Case, looking at a range of options on location of inpatient acute units.</td>
</tr>
<tr>
<td></td>
<td>• Development of acute day care in the southern sector will reduce admissions. The reduced LOS will enable a reduction in acute admission beds from 66 to 56.</td>
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<tr>
<td>Belfast</td>
<td>Belfast</td>
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</tr>
<tr>
<td>• Improved support for emotional resilience.</td>
<td>• Reduced use of level 2 and level 3 care.</td>
</tr>
<tr>
<td>• Improved access to support for recovery.</td>
<td>• Further development of home treatment and day support services.</td>
</tr>
<tr>
<td>• Urgent mental health services developed in support of emergency departments.</td>
<td>• Appropriate resettlement options provided.</td>
</tr>
<tr>
<td>• Implementation of single system of level 2 and 3 services.</td>
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</table>

<table>
<thead>
<tr>
<th>South Eastern</th>
<th>South Eastern</th>
<th>South Eastern</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community Mental Health Service Mapping and CAPA: 10% reduction in baseline LOS and a 10% reduction in admission rates.</td>
<td>• Resettlement of long stay patients leading to the closure of remaining Continuing Care Wards: The Trust will seek to reinvest £75k savings released from years 2 and 3 of the Resettlement Programme to enhance and support a Care Management Budget.</td>
<td>• Reform acute mental health inpatient services to create a single acute mental health inpatient unit with integrated PICU provision: upon the realisation of a single acute inpatient unit the Trust will seek to reduce admission rates by 8% and a reduction in the average LoS, commensurate with the regional average.</td>
</tr>
<tr>
<td></td>
<td>• Community Mental Health Service Mapping and CAPA: Reduce DNA rates to 5% for new appointment and 8% for review.</td>
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</tbody>
</table>

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| Southern (Mental Health & Disabilities) | · Work will continue with NI Housing Executive to secure development of supported living accommodation across the area.  
· The numbers of people with mental health and disabilities using personalised budgets will continue to increase alongside increased diversity of provision outside health and social care services.  
· Resettlement of 8-10 patients from St Luke’s Long stay Hospital to supported living accommodation by March 2013 (pending business case). | · Enhanced local addiction services will be developed within the community and the need for inpatient addiction beds will reduce.  
· New day opportunities and a wider range of non-building based respite support will be in place and the number of statutory day care centres will reduce.  
· Specialist local services for eating disorders will be in place to support local care and avoid the need for some people to receive their care outside NI.  
· Secure availability of placements for resettlement of remaining individuals from St Luke’s, Armagh: 10-16 people resettled from St Luke’s by March 2014. | · All long stay hospital based care at Longstone and St Luke’s Hospitals for people with mental health needs and learning disabilities will cease.  
· The Protect Life Action Plan will be implemented with the intent of reducing suicide rates in targeted areas of deprivation. |
### People with a learning disability

<table>
<thead>
<tr>
<th>People with a learning disability</th>
<th>Regional Strategic Direction – Promote early intervention, independence and the personalisation of care, providing the right care in the right place at the right time and reducing institutional care</th>
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<tbody>
<tr>
<td>Year 1</td>
<td>Year 2</td>
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<tr>
<td>Northern</td>
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</tr>
<tr>
<td>• Remaining 85 service users across the Trust (still at Adult Centres), to be Transferred completely to Day Opportunities.</td>
<td>• Review the provision of statutory daycare services for those whose needs cannot be met through day opportunities.</td>
</tr>
<tr>
<td>• 23 service users in transition from education to be absorbed within current provision.</td>
<td>• Develop specialist local services (to include short-term community based assessment and treatment interventions including crisis services) designed to reduce hospital admissions.</td>
</tr>
<tr>
<td>• Undertake resettlement of institutionalised service users through the development of supported living options and specialist day support to suit the individual needs of people.</td>
<td>• Undertake resettlement of an additional 10 service users.</td>
</tr>
<tr>
<td>• Resettle 22 service users.</td>
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<tr>
<td>Western</td>
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<tr>
<td>• Review respite services to offer greater flexibility and accessibility and capacity.</td>
<td>• Lakeview Hospital will be reconfigured; current 19 beds to provide 8 mental health and 4 challenging behaviour beds: Reduction in admissions and a refocus on treating people with mental health and challenging behaviours.</td>
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<tr>
<td>• Develop integrated pathways for LD including dementia and autism will increase productivity.</td>
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<tr>
<td>Belfast</td>
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</tr>
<tr>
<td>• Improve the physical and mental health of adults with LD in partnership with ICPs and other stakeholders, through the development of prevention strategies and with early intervention strategies.</td>
<td>• Develop supported housing services in line with the resettlement agenda and community accommodation pressures associated with ageing parents.</td>
</tr>
<tr>
<td>• Increase of percentage of people receiving mental health care in the community.</td>
<td>• The number of people accessing respite breaks increases.</td>
</tr>
</tbody>
</table>
### Transforming Your Care – Strategic Implementation Plan

- **Increase the number of people receiving their mental health treatment within the community.**

### South Eastern
- The resettlement of people with Learning Disabilities from long stay hospital beds into the community to be completed. Resettle 40% of long stay population by March 2013.
- All adults receive annual GP mental and physical health check to reduce referrals.
- Effective arrangements in place to enable access to secondary care services in line with GAIN Guidance.

### Southern (Mental Health & Disabilities)
- LD Resettlement of remaining people from Longstone to vacant residential, nursing home and supported living placements / return to parental home: Resettlement of 10 people from Longstone by March 2013.
- LD Resettlement of remaining people from Longstone to vacant residential, nursing home and supported living placements / return to parental home: Resettlement of 2 people from Longstone by March 2014.
- LD Remaining Longstone resettlements:
  - The Heathers – Phase 2: 4 people

### Generic
- Increase the number of people receiving mental health treatment within the community.
- There is an increase in the number of people receiving supported housing.
- Close long stay hospital wards.
- Provide for the resettlement of long stay patients from Muckamore Abbey Hospital: Close 7 wards by April 2015. 69 supported housing placements over a 3 year period.
- Close remaining long stay hospital beds: Yr. 2 and 3 targets will be determined regionally and will be dependent on progress of retraction model and which wards are to be closed. 100% resettlement by March 2015.
- Fewer admissions, outpatients and Primary Care interactions.
- Complete re-design of day care services in North Down and Ards.

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<th>resettled from Longstone.</th>
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<tr>
<td></td>
<td>– Granville: 24 Resettled from Longstone.</td>
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### 4.5.9 Acute care

**Regional Strategic Direction – Provide clear protocols for the point of contact for emergency care and deliver more planned care closer to home, using technology to facilitate this**

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<tr>
<th>Acute Care</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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</table>
| **Northern** | • Continue work in progress to secure staffing levels, and meet minimum service requirements.  
• Open redesigned ED and rehab ward at Antrim area hospital.  
• Complete programme of efficiency and quality improvement. | • Strengthen and develop specialty networks across site. Profiling services to make effective use of staff skills and rotas etc.  
• Ensure greater use of technology to support networks.  
• Continue to pursue improved efficiency, throughputs and adopt best practice.  
• Develop long term condition management in community settings (‘shift left’).  
• Establish, effective Integrated Care Partnerships and joint local working with GPs.  
• Continue to review the acute services profile on each site to maximise local access, achieve required standards and use of skilled staff. | |
| **Western** | • Develop end to end pathways for musculoskeletal indications, diabetic foot ulcers and varicose veins. This will reduce waiting times and allow shift from DC to OP.  
• Through ICPs extend GP minor surgery – retaining 500 patients. 350 day cases carried out in primary care.  
• Application of new/review ratios and clinical productivity planning assumptions.  
• Urgent care pathway will co-ordinate between GPs and OOH to reduce ED attendances and minor treatments.  
• Implementing rapid response nursing will | • Develop North West urology service across Western and Northern Trusts which will decrease FU appointments, elective and non-elective admissions.  
• Reduction in procedures of low clinical value will move 850 procedures to a lower cost setting of stop them altogether.  
• Implement a fracture liaison and falls prevention service delivering early intervention to reduce falls and improve patient outcomes.  
• Development of alternatives to hospital initiative. | • Implement NICE guidance on varicose veins which will reduce OP and DC referrals by 20%.  
• Services to be established with clear protocols and pathways for minor surgical cases.  
• Development of an elective surgical unit will reduce excess bed days as it will streamline the pathway and improve utilisation and pre-op assessment.  
• Reductions in DNAs, improved theatre utilisation and day case rates  
• Reduced admissions and length of stay |
### Belfast
- Establish ICPs.
- Pathways for unscheduled care developed and defined.
- Protocols for managing unscheduled episodes established.
- Single point of access established.
- Consult on ED configuration.
- LoS improvement initiatives in the hospitals.
- Develop patient focussed pathways for common conditions.
- Establish pathways for various specialities such as ENT, orthopaedics, pain management and dermatology.
- Increased proportion of patients treated as day cases.
- Improve theatre efficiency.
- Establish integrated primary care teams.

### Patients treated closer to home.
- Reduction in ED attendances.
- Reduction in unscheduled admissions.
- Provision of urgent/emergency outpatient slots.
- Provide clinics, diagnostics - where volumes/throughput and skill mix make it safe and sustainable to do so, and minor treatments in the community.
- Reduce referrals to the hospital clinics.
- Provide specialist clinics in community.

### Patients and carers fully involved in planning.
- Structures in place to support return to home.
- Reduction in beds in acute settings.
- Reduction in new and follow up appointments in the hospitals.
- Reduced waiting times in hospitals.

### South Eastern
- 40% shift in sexual health services from consultant to specialist nurse/ GP/ Practice Nurse.
- Reduce ED attendances and LoS and increase discharge rates.

### 10% reduction in admissions and LoS amongst patient with Diabetes.
- Through active disease management achieve a 10% reduction in outpatient activity.

### Over the 3 year period, achieve a 20% shift of review and memory clinic work into primary care.
- 10% reduction in admissions and LoS amongst patient with Diabetes.
| Southern | • Enhanced capacity will be in place to address recognised current capacity gaps and improve local access to services including trauma and orthopaedics, cardiology, general surgery, gynaecology and ENT.
  • Clinical escalation, and regional bypass and transfer protocols will be developed to enhance quality of care.
  • There will be a rebalancing of some elective services across CAH and DHH.
  • Ambulatory pathways will be in place for the most frequent diagnoses to reduce attendances at ED and avoid admissions. | • Provision of acute services will continue to be reviewed in the context of commissioner requirements and emerging standards of care to ensure they remain “fit for purpose”.
  • Clinical management pathways will be in place with GPs to support care for patients within primary care and reduce the need for them to attend hospital for outpatient consultation and greater use will be made of technology to support remote consultations.
  • The length of stay in hospital will be optimised with timely access to diagnostics, proactive clinical management of care plans, increased numbers of patients admitted on the day of their surgery and increased procedures delivered as day cases.
  • The number of patients needing to be reviewed in a hospital setting will reduce and the number of people missing hospital appointments will reduce.
  • The number of inpatient beds at both acute hospitals will reduce releasing capacity and resource to deliver required savings and support reinvestment in alternative services in primary and community settings. | • 10% reduction in outpatient activity.
  • Working with NIAS, reduce ED attendances and achieve a 10% reduction in number of ED attendances by ambulance.
  • Reduce ED attendances and LoS and increase discharge rates, e.g. 10% reduction in number of ED attendances by ambulance.
  • Over the 3 year period, achieve a 50% reduction in nursing home attendances to ED.
  • 20% reduction in respiratory admissions.
  • Reduce nursing home referrals by 20%. | • Redesign respiratory pathway.
  • Work with NIAS to refine ambulance protocols.
  • Target nursing home referrals by redesigning rapid response and district nursing support. | • By Year 2, the Trust will reduce the admission rate in UHD/Ards MIU/Bangor MIU to 20% in line with the regional benchmark.
  • 10% reduction in respiratory admissions.
  • Reduce ED ambulance attendances by 5%.
  • Reduce nursing home referrals by 10%. |
### 4.5.10 Palliative & end of life care

**Regional Strategic Direction** – Improve the overall quality of life in the last year of life and, by early identification and planning, reduce the level of inappropriate admissions to hospital for people in the dying phase of an illness

<table>
<thead>
<tr>
<th>Palliative and End of Life Care</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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<tbody>
<tr>
<td>Northern</td>
<td>• Increased numbers of staff competent in the core principles of palliative and end of life care.</td>
<td>• Reduce the number of people admitted to hospital during the end of life phase. To be achieved the development of palliative care tools and improved awareness raising.</td>
<td>• Develop palliative and end of life care register.</td>
</tr>
<tr>
<td></td>
<td>• Reduce the number of people admitted to hospital during the end of life phase. To be achieved the development of palliative care tools and improved awareness raising.</td>
<td>• Support Nursing Home sector for end of life care.</td>
<td>• Support Nursing Home sector for end of life care.</td>
</tr>
<tr>
<td></td>
<td>• Develop palliative and end of life care register.</td>
<td>• Reduce inappropriate hospital admissions for people in the dying phase of an illness.</td>
<td>• Reduce inappropriate hospital admissions for people in the dying phase of an illness.</td>
</tr>
<tr>
<td>Western</td>
<td>• Establish a specialist palliative care service with balance between primary and secondary care. Implement individualised care plans. Will reduce acute admissions and LOS.</td>
<td>• Implement advanced care planning to increase skills in palliative care in primary care to reduce acute admissions.</td>
<td>• Implement advanced care planning to increase skills in palliative care in primary care to reduce acute admissions.</td>
</tr>
<tr>
<td>Belfast</td>
<td>• Train existing staff within the community to deliver end of life care.</td>
<td>• Make available generalist and specialist palliative care in the community.</td>
<td>• Reduced admissions for patients at the end of life.</td>
</tr>
<tr>
<td></td>
<td>• Establish integrated pathways of care.</td>
<td>• Expand care to nursing homes.</td>
<td>• More patients on individualised care plans choose home as their preferred location.</td>
</tr>
<tr>
<td></td>
<td>• Develop information infrastructure to support palliative care in community.</td>
<td>• Reduced ED attendances.</td>
<td></td>
</tr>
<tr>
<td>South Eastern</td>
<td>• Implement regional communication strategy around death and dying reform of the patient pathway to prevent inappropriate ED attendance and provide alternatives in the</td>
<td>• Work across the interface of primary and secondary care to prevent inappropriate ED attendances having undertaken a case review of patients who have died within</td>
<td>• Reduce nursing home attendances to ED by 50%.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Further reduce ED attendances by 5%.</td>
</tr>
<tr>
<td>Community</td>
<td>48hrs of admission and established a baseline for taking this work forward: reduce inappropriate end of life attendances to ED by 5% in year 2.</td>
<td>Hub fully staffed and operational and robust evaluation plan in place.</td>
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<tr>
<td>• Establish project group, secure finance, work with LCG localities and stakeholders regarding the bid and business plan inc. workforce requirements and skills set.</td>
<td>• Reduce no. of patients receiving End Of Life Care in hospital by 10%: Based on 1353 deaths per year in hospital this will be a reduction in 135.</td>
<td>• Reduce no. of patients receiving End of Life Care in hospital by 10%. Based on 1353 deaths per year in hospital this will be a reduction in 135 and a further 10% Year 3.</td>
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<tr>
<td></td>
<td>• The Trust is developing a proposal for the Ards Hospital site which will be a community facing model which would enable assessment of palliative and end of life patients in a single centre. The Trust would see this “Hub” as contributing to reducing the number of hospital admissions and will provide an enhanced experience for patient and families at the end of life; Year 2, establish the “Hub”.</td>
<td>• The trust's intention would be to reduce end of life admissions to acute hospital by 20% by year 3.</td>
<td></td>
</tr>
<tr>
<td>Southern</td>
<td>• A Macmillan Palliative Care Service Improvement Lead in place to support the development of action.</td>
<td>• Access to specialist palliative support will be enhanced out of hours and there will be enhanced links between specialist and generalist services – March 2014.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community palliative care multi-disciplinary teams (e.g. consultant, AHP / specialist nursing etc.) will be in place – March 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A southern area Palliative &amp; EOL Service Improvement Plan will be fully implemented.</td>
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<tr>
<td></td>
<td></td>
<td>• The number of patients who are admitted to hospital from a nursing home and die within 48 hours will reduce.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reduce inappropriate hospital attendances and admissions at EOL. This includes training for staff and enhanced support – 5% targeted</td>
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</tbody>
</table>
- The number of staff in health and social care and in private nursing homes who have been awareness trained on palliative and EOL care will have increased.

<table>
<thead>
<tr>
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<th>reduction by March 2015.</th>
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</tbody>
</table>
### Appendix 1: Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHP</td>
<td>Allied Health Professionals</td>
</tr>
<tr>
<td>ALoS</td>
<td>Average Length of Stay</td>
</tr>
<tr>
<td>BHSCT</td>
<td>Belfast Health and Social Care Trust</td>
</tr>
<tr>
<td>V&amp;C</td>
<td>Voluntary and Community Sectors</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CATH Lab</td>
<td>Catheterisation Laboratory for diagnostic and interventional cardiac procedures</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing professional development</td>
</tr>
<tr>
<td>DHSSPS</td>
<td>Department of Health Social Services and Public Safety</td>
</tr>
<tr>
<td>DNA</td>
<td>Did not attend</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep Vein Thrombosis</td>
</tr>
<tr>
<td>ECR</td>
<td>Electronic Care Record</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>ELCOS</td>
<td>End of Life Care operation system</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
</tr>
<tr>
<td>EOL</td>
<td>End of Life</td>
</tr>
<tr>
<td>EPAU</td>
<td>Early Pregnancy Assessment Unit</td>
</tr>
<tr>
<td>Family Nurse Partnership Programme</td>
<td>Intensive home visiting from early pregnancy until the child is 2, designed to support young mums</td>
</tr>
<tr>
<td>Family Support Hubs</td>
<td>Network of agencies (voluntary/community and statutory) who work with families not meeting the threshold for statutory social work support.</td>
</tr>
<tr>
<td>HSC</td>
<td>Health and Social Care</td>
</tr>
<tr>
<td>HSCB</td>
<td>Health and Social Care Board</td>
</tr>
<tr>
<td>ICP</td>
<td>Integrated Care Partnerships</td>
</tr>
<tr>
<td>ICT</td>
<td>Information Communication Technology</td>
</tr>
<tr>
<td>IP</td>
<td>Inpatient</td>
</tr>
<tr>
<td>LCG</td>
<td>Local Commissioning Group- Responsible for the commissioning of health and social care by addressing the care needs of their local population</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disability</td>
</tr>
<tr>
<td>LGB&amp;T</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
</tr>
<tr>
<td>Long Term Condition (LTC)</td>
<td>Chronic ailment from which there is no cure but will require long term treatment or monitoring</td>
</tr>
<tr>
<td>LOS</td>
<td>Length of Stay</td>
</tr>
<tr>
<td>MLU</td>
<td>Midwife Led Unit</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>MSK</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>NDA</td>
<td>North Down &amp; Ards Locality</td>
</tr>
<tr>
<td>NHSCT</td>
<td>Northern Health and Social Care Trust</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>NISAT</td>
<td>Northern Ireland Single Assessment Tool - for use when planning home care for older people</td>
</tr>
<tr>
<td>NNU</td>
<td>Neo-Natal Unit</td>
</tr>
<tr>
<td>OOH</td>
<td>Out of Hours</td>
</tr>
<tr>
<td>PC</td>
<td>Primary Care</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Partnership</td>
</tr>
<tr>
<td>PD</td>
<td>Physical Disability</td>
</tr>
<tr>
<td>PHA</td>
<td>Public Health Agency</td>
</tr>
<tr>
<td>Population Plans</td>
<td>Document outlining key proposals for how TYC will be implemented, developed by each LCG in conjunction with respective HSC Trust.</td>
</tr>
<tr>
<td>QICR</td>
<td>Quality Improvement Cost Reduction</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality &amp; Outcomes Framework</td>
</tr>
<tr>
<td>Reablement</td>
<td>Programme of support to assist people in getting back to independent living</td>
</tr>
<tr>
<td>Resettlement</td>
<td>Shift from long term institutional care to living in the community</td>
</tr>
<tr>
<td>RQIA</td>
<td>Regulation and Quality Improvement Authority</td>
</tr>
<tr>
<td>SEHSCT</td>
<td>South Eastern Health and Social Care Trust</td>
</tr>
<tr>
<td>Shift Left</td>
<td>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.</td>
</tr>
<tr>
<td>SHSCT</td>
<td>Southern Health and Social Care Trust</td>
</tr>
<tr>
<td>SSPAU</td>
<td>Short Stay Paediatric Assessment Units</td>
</tr>
<tr>
<td>Strategic Implementation Plan</td>
<td>Framework for the delivery of the TYC programme over the next 3 to 5 years.</td>
</tr>
<tr>
<td>Telehealth, Telecare, Telemedicine</td>
<td>Use of telecommunications to facilitate an independent lifestyle, includes alarm systems and monitoring systems</td>
</tr>
<tr>
<td>Third sector</td>
<td>Voluntary sector</td>
</tr>
<tr>
<td>Trust</td>
<td>Provider of Health and Social Care Services to a particular population</td>
</tr>
<tr>
<td>TYC</td>
<td>Transforming Your Care</td>
</tr>
<tr>
<td>UNOCINI</td>
<td>Understanding the Needs of Children in Northern Ireland</td>
</tr>
<tr>
<td>WHSCT</td>
<td>Western Health and Social Care Trust</td>
</tr>
</tbody>
</table>
Appendix 2: Capability and engagement

1. Purpose and objectives of the capability and engagement workstream

The overall objective of the Capability and Engagement workstream of the TYC Programme is to help create an environment which is receptive to and supports the transformation required to deliver the vision set out in ‘Transforming Your Care’ and the benefits set out in this Strategic Implementation Plan (SIP).

In order to achieve this there is a need to ensure that key groups are receptive in terms of their willingness to adopt new behaviours and support the delivery projects (‘engagement’), and that they have the ability to do so (‘capability’). At the centre of both this willingness and ability is the need to work towards a common goal, and to have the right skills mix across the HSC system now, and into the future.

As with any complex transformation of this kind, the levels of engagement and capability will vary for different groups, as the changes will impact on them in a number of ways, at different times. Furthermore, the systemic wide-ranging nature of the transformation set out in TYC will mean that improvement activities will be taking place and embedded throughout the Health and Social Care system, rather than delivered in a ‘top down’ manner from a central Programme. It is vital therefore that the approach taken to capability and engagement for TYC is flexible and adaptable, and can operate at a number of levels.

The Capability and Engagement workstream, and the approach set out in this Appendix of the SIP, is closely aligned to the delivery strategy described in Section 3, and explicitly explores the activities which will be required at both regional / programme and local / project levels.

At the core of the approach is that each change project or initiative would be empowered to manage the specific engagement or capability impacts of their own project or initiative, facilitated and supported by the TYC Programme Team. Experience shows that this approach to change management is more successful and more likely to be sustainable in the long term as it is owned by those involved in implementation, rather than ‘done to them’.

It also explicitly recognises that capability and engagement activities are on-going throughout the system all the time – the approach set out herein is intended to complement and augment these on-going activities for the purposes for TYC, rather than duplicate, replace or conflict with them. It is important to align with workforce planning to ensure that the capability needs for TYC are supportive of, and feed into system-wide skills development plans.

In this section of the Strategic Implementation Plan, we set out the proposed approach for the Capability and Engagement Workstream, with the aim of informing debate and discussion before we finalise detailed plans based on the Population Plans and SIP.
2. Change principles

The change approach set out here adheres to some core change principles, which are based on experience from both large transformational programmes and small strategic changes that affect a specific workforce or team. These align to the overall programme delivery approach and include:

- **A focus on the individual** – understanding the impacts on specific people and how their day to day role may be affected in future by the TYC programme, supporting these individuals to understand and effectively operate, not only in the new model of care provision and also during the transition to make the change process as smooth as possible. The engagement and capability strategy enables this through the tailoring of programme messages based on “what does it mean for me?”, and a capability approach which aligns skill development to individual needs.

- **Leadership and commitment at all levels** – empowerment for leaders of change through a programme of support and learning, ensuring they have opportunities to develop skills and encouraging shared learning through specific and targeted approach.

- **Integrated approach** – between engagement and capability as pillars of support which will enable success for individuals and teams working on TYC. These 'workstreams' have been aligned deliberately to ensure this link is maintained through the life of the programme.

- **Alignment** – co-ordination between change occurring at programme and local levels, working collaboratively and at pace towards the same goals but with a different focus and purpose at the different levels. This alignment is supported by a robust cross-programme branding strategy which enables the programme to 'speak with one voice'.

3. The change impact of ‘Transforming Your Care’ on key groups

Before embarking on any change approach or developing a plan for capability or engagement, it is vital to understand the impact of the changes. This ensures that you are addressing the needs of those to whom engagement and capability activities are directed, and therefore has a greater chance of being meaningful, valuable and sustainable.

As we move into the implementation phase following consultation, and the change initiatives and projects are agreed and known, it is expected that a more detailed change impact analysis would be conducted for each project or initiative to support engagement and capability planning.

For the purposes of this statement of approach, a high level view can be developed based on the TYC vision, and what this will mean in implementation terms as set out in this Strategic Implementation Plan. The table below sets out this high level view with the key impacts and proposed key messages for some of the key groups/stakeholders. The detailed stakeholder and capability plans will build on these.
<table>
<thead>
<tr>
<th>Key Groups</th>
<th>Impact of TYC</th>
<th>Key Messages</th>
</tr>
</thead>
</table>
| Public including Patients and Carers | Each Programme of Care will bring specific impacts and there are many different types of patient and user. In general however, an impact may be felt due to the following:  
- More care closer to home in primary or community settings and a reconfigured hospital network – how you access or receive care services may be different.  
- More control over your own care budgets through Direct Payments.  
- Increased diversity and choice in terms of the types of health service provision.  
- More control and responsibility for self-management for some.  
- Clarity on and encouragement to take responsibility for our own health and wellbeing. |  
- Patients, clients, users and carers are at the heart of all that we do.  
- Providing the right care in the right place at the right time = better outcomes.  
- Safe, quality and resilient service based on assessment of our population’s needs and evidence on the best care pathways.  
- More choice and control – promoting independence and personalisation of care.  
- More care closer to home where it’s safe and appropriate to do, and so less hospital admissions.  
- Clarity on how you access HSC services – we all have a collective responsibility in how we use HSC services, and to manage our own health and wellbeing.  
- Reducing health inequality and having equitable access to services where it is most appropriate. |
| HSC Staff, including HSCB and Trusts |  
- A shift of activity from an acute to a community and enhanced primary care setting.  
- Delivery of care in a more integrated manner across primary, secondary and community care may mean a change in role and location for some staff.  
- Enhanced role for some of our independent health care provider partners may require enhanced training and regulatory frameworks.  
- Development of acute networks across an area may mean a change in working patterns or organisational structures. |  
- Patients, clients, users and carers are at the heart of all that we do.  
- Committed to supporting workforce through the transition.  
- Workforce planning is integral to planning and delivery of reforms: right people, right place.  
- We want to engage in a meaningful way with staff, unions, the voluntary, community and independent sectors to ensure an integrated approach to workforce planning.  
- Training, retraining and capability development is a key enabler for making TYC successful.  
- Get involved in the design of the new service models and care pathways |
| Healthcare Staff outside HSCB and Trusts, including GPs, Dentists and Pharmacists |  
- Enhanced role for some of our independent health care provider partners may require enhanced training and regulatory frameworks.  
- Development of acute networks across an area may mean a change in working patterns or organisational structures. |  
- Patients, clients, users and carers are at the heart of all that we do.  
- Committed to supporting workforce through the transition.  
- Workforce planning is integral to planning and delivery of reforms: right people, right place.  
- We want to engage in a meaningful way with staff, unions, the voluntary, community and independent sectors to ensure an integrated approach to workforce planning.  
- Training, retraining and capability development is a key enabler for making TYC successful.  
- Get involved in the design of the new service models and care pathways |
<table>
<thead>
<tr>
<th>Key Groups</th>
<th>Impact of TYC</th>
<th>Key Messages</th>
</tr>
</thead>
</table>
| Voluntary and Community Groups        | 1. More care in the community where safe and effective to do so.  
2. A focus on prevention, wellbeing and tackling inequalities will need greater partnership across all sectors  
3. Greater choice and a mixed economy for service provision, underpinned by the personalisation of care.  
4. An overhauled financial model for procuring services to support our new ways of working together.  
5. Different roles for residential care and nursing homes, and the promotion of reablement and independent ageing.  
6. Greater V&C involvement in joint planning service provision, such as disabled people, and mental health.  
7. Strong recognition of the role of carers, including practical support and respite.  
8. Population planning – providing a 3 year view of population health and social care needs enabling you to plan your own services better. | 1. Patients, clients, users and carers are at the heart of all that we do.  
2. You need to think about how your organisation can respond to the changing model of health and social care provision.  
3. We will support your ability to build longer term business and delivery plans.  
4. The need to build capacity and capability in the V&C sectors to support the shift to care closer to home.  
5. Get involved in the design of the new service models and care pathways – you have great insight into the needs and preferences of patients and their carers.  
6. Be innovative – seeking the best solution to respond to population needs. |
| Professional Groups and Staff Representative Bodies, including TUS | There are 2 types of impact of the programme on these bodies  
1. You may be directly involved in the Programme or one of the Projects / TYC Initiatives to input to  
a. The design of care pathways and service model from a clinical perspective – *what the future will look like.*  
b. The design of the implementation and rollout – *how we will* | 1. Patients, clients, users and carers are at the heart of all that we do.  
2. Committed to supporting workforce through the transition  
3. Workforce planning integral to planning and delivery of reforms: right people, right place  
4. We want to engage in a meaningful way with professional groups and |
transforming your care
strategic implementation plan

key groups

impact of tyc

got to the future.

2. as a body that represents your members’ interest, there will be an impact as it is likely some initiatives and projects will lead to changes to members’ working practices and skills mix due to the move of some care provision from hospitals into primary and community settings.

key messages

- representative bodies to ensure an integrated approach to workforce planning.
- training, retraining and capability development is a key enabler for making tyc successful.
- get involved in the design of the new service models and care pathways – you have clinical expertise and insights into areas for improvement.
- we want your support and advocacy to make implementation as smooth as possible for your members and ensure their voice is heard.

tyc leadership (including programme board, and key leaders in delivery of tyc programme)

- be able to develop, articulate and role-model the vision for transforming your care.
- leading the design, planning and delivery of the changes ‘on the ground’ whilst ensuring safe, high quality services continue to be delivered.
- empowered to make change happen in own organisation, but within an overall delivery and monitoring framework as an effective leadership team to avoid haphazard change and inconsistency.
- will be expected to work in different ways across the boundaries of their organisations and through a different level / type of engagement with internal and external groups.
- there will be an impact on the overall shape and nature of the organisations they lead, and this may require a different strategic approach / structure etc which would not necessarily be addressed through a single project.

clinical leaders from

- designing, planning, delivering and sustaining the changes ‘on the ground’.

patients, clients, users and carers are at the heart of all that we do.

- opportunity to shape healthcare services for the future, make real changes with real outcomes.
- this is challenging and complicated, and won’t be without its difficulties.
- complex systemic transformation requires a different set of behaviours and new mindsets to what we may have used in the past.
- a positive leadership influence will be critical to empowering and motivating the organisation to deliver tyc.
- detailed service modelling and evidence based approaches will be vital to ensure we meet our users’ expectations and can be resilient and sustainable.
- the tyc programme team is to support you in the delivery of changes on the ground, bring a consistency and alignment across the region and ensure benefits are realised.
### Key Groups

<table>
<thead>
<tr>
<th>Impact of TYC</th>
<th>Key Messages</th>
</tr>
</thead>
</table>
| across HSC and external organisations | - Opportunity to shape healthcare services for the future, make real changes with real outcomes.  
- This is challenging and complicated, and won’t be without its difficulties.  
- Opportunity to learn new skills and competencies, which will help your career development and build your networks. In some cases this may lead to accreditation or CPD recognition.  
- You will be provided with training and support along the way. |
| TYC delivery teams, including Regional and Local project teams | - Patients, clients, users and carers are at the heart of all that we do.  
- Opportunity to shape healthcare services for the future, make real changes with real outcomes.  
- Get involved in the design of the new service models and care pathways – you have great insight into the needs of patients and what is required to achieve the best outcomes.  
- Lead and show advocacy for the new models and ways of working, support younger members of your profession.  
- This is challenging and complicated, and won’t be without its difficulties.  
- Opportunity to learn new skills and competencies, which will help your career development and build your networks. In some cases this may lead to accreditation or CPD recognition.  
- You will be provided with training and support along the way. |

*Figure 4: Change Impact and Key Messages for key groups*
4. A model for transformational change

There are a number of change models that can be employed to support transformational change, and experience demonstrates that the most successful are those which have been designed or adapted by the system undergoing the change itself. This ensures there is ownership for the model, collective understanding of what it means for the HSC system in NI, and that it is appropriate to the unique nature of TYC.

Once there is a clear and agreed picture of the key changes and commitments over the next 3 to 5 years, through the consideration and quality assurance of the draft SIP and the Population Plans that support it, and wide-ranging consultation with the public, the TYC Programme will seek to work together with leaders at all levels to build our own model of change for TYC.

However in the meantime, there are a consistent set of behaviours and capabilities which are at the core of leading and delivering successful and sustainable change. Therefore as a starting point a proposed model, strongly based on the NHS Change Model is set out in Figure 5 below.

This model is based on a proven approach and evidence of what makes transformation successful. One of the underpinning principles of this model is the need to ensure there is alignment between the elements of change, and those responsible for defining and delivering the change. Without this alignment the overall transformation can be undermined by unintentional consequences, and significant effort wasted.

![Figure 5: The NHS Change Model (from NHS Institute for Innovation and Improvement)](image)

More information on each of the components above is available from the NHS Institute for Innovation and Improvement.
5. Proposed capability and engagement approach

Taking into account the objectives of this workstream, the delivery strategy of the Programme as a whole and the change principles, there are 4 key components of the Capability and Engagement Approach for the TYC Programme.

These are set out in Figure 6 below, and are described in more detail in the table in Figure 7 overleaf.

![Diagram of Capability and Engagement Approach](image)

*Figure 6: Key components of the Capability and Engagement Approach*

The future capability and engagement states need to be defined in order to not only develop a clear vision and direction, but also a clear plan towards these goals. A simple maturity model framework can provide aspirational, but realistic and achievable phasing by which the organisation will move towards the desired future state. From this, the development plan can be developed and socialised with relevant stakeholders across TYC.
## Figure 7: Summary of Proposed Capability and Engagement Approach

<table>
<thead>
<tr>
<th>Engagement</th>
<th>Capability</th>
</tr>
</thead>
</table>
| **Programme level** | **Building commitment across the region**  
**What:** Rigorous Programme level stakeholder engagement and communications to establish, build and sustain common awareness, understanding and support for the TYC vision as a whole, both internally within HSC and with external organisations and the public.  
**Why:** Transformation of this scale requires a sustaining and coherent vision and narrative, which is both compelling and clear. The activities in this quadrant set the context for, and mobilise commitment to, the projects to make the changes happen on the ground. Without wide-ranging programme level commitment, delivery challenges will easily de-rail the overall transformation.  
**Who leads:** The Programme Team, working with the HSCB and DHSSPS Teams, and interfacing closely with local leaders and communications teams, programme workstreams and individual projects as required. | **Building transformation capability & leadership**  
**What:** Support leaders of change at all levels to develop the skills and behaviours required to develop a vision and strategy to make the changes real, and see them through to implementation and delivery of the benefits, and mobilise and support others through the transformation. This includes 3 key target audiences:  
- The Senior Leaders responsible for TYC  
- Delivery teams (regional and local level) planning and delivering the changes  
- Clinical staff who will work alongside and within the Delivery Teams  
**Why:** TYC is a complicated whole system transformation which is unprecedented in our HSC system. We need to equip those who will be tasked with taking forward these changes to think and operate in different ways, to maximise learning available from outside our system, and to work together to manage the challenges which will arise as cohesive high performing teams.  
**Who leads:** The Programme Team, working alongside HSC Leadership Centre and local L&D teams. |
| **Local / Project level** | **Building commitment to local changes**  
**What:** Rigorous local level stakeholder engagement and communications to establish, build and sustain common awareness, understanding and support for how TYC will impact locally (either as a geographical area impacted by a range of initiatives within that Trust / LCG boundary, or as distinct stakeholder groups impacted by a specific project). This may target stakeholders both internally within HSC, and with external organisations and the public.  
**Why:** As planning for improvements should as ‘close to the point of delivery’ as possible, so too engagement and conversations about such improvements and changes should also be as ‘local’ as possible. Feedback and evidence to date has shown that people want to be engaged about what does it mean for me’. Therefore this quadrant of activity complements Programme level activity by providing this detail within the context of consistency in messaging for TYC.  
**Who leads:** Given the nature of these activities, each of the local areas and projects will take the lead, with support from the central Programme Team. | **Building capability to operate in the new model**  
**What:** Support local teams and staff to identify and develop change plans, and learning & development / training required to ensure that staff are supported and have the abilities to operate with the new processes, systems and ways of working put in place by a specific change to be implemented. This could include for example, the re-training of staff increasingly delivering care in a primary or community setting, or the re-training of nursing home staff in relation to Palliative Care.  
To work with each project to identify the long term skills mix required (and gaps) to promote transformation and ensure this is fed into workforce plans and training.  
**Why:** The activities in this quadrant will bring smooth and co-ordinated transition, reduced risk (including clinical risk), ensure we have a clear view of long term skill gaps, and maximise benefits by ensuring all staff are equipped and confident, and feel supported in the delivery of their roles.  
**Who leads:** The workstream / project (whether at local or regional level) responsible for implementing the change will take the lead for any training requirements arising from their project / workstream, supported by the L&D teams in their organisation and the central Programme Team, and working with DHSSPS. |
6. Engagement approach

Appropriate engagement and communications will play an extremely important role in ensuring that groups and individuals are fully informed of the direction of change; are involved and feel part of that change. It is essential that engagement builds confidence in the health service and that Transforming your Care (TYC) becomes synonymous with positive, powerful and innovative change. Failure to effectively engage and communicate could have a detrimental effect on ability of the HSC system to deliver meaningful change.

The TYC Programme requires a clear, targeted and considered stakeholder engagement approach at both regional and local levels to ensure:

- Impacted groups and individuals are appropriately identified and engaged through all phases of the programme.
- Communications are developed and delivered in a consistent and co-ordinated way through the life of the programme, and at different ‘points of delivery’.
- Stakeholder engagement covers a wide range of activities designed to build people’s willingness to support and be committed to delivering TYC. It goes beyond but is closely integrated with ‘communications’ in its traditional sense. Therefore this approach is closely aligned with the Regional Communications Strategy, which is one way in which engagement activities are delivered, but also encompasses activities such as one to one meetings, workshops and presentations by the Programme Team.

The TYC Programme Capability and Engagement Team will be responsible for:

- Developing the overall engagement plan.
- Developing content for communications materials in conjunction with the Regional Communications Team.
- Setting up and delivering a series of engagement events to promote buy-in to the vision of TYC both internally and externally.
- Supporting projects and initiatives in their stakeholder engagement processes.
- Measuring the effectiveness of engagement activities for TYC.

The Regional Communications Group (comprising of senior communications staff from all HSC organisations, led by the HSCB Communications Manager) will be responsible for:

- Developing the overall regional communications strategy and plan
- Design and delivery of major external and internal communications channels (such as e-Briefs, articles, interviews)
- All engagement with the media in relation to TYC
- Developing and maintaining electronic communications channels such as the website, twitter and social media
- Co-ordinating and building consistency across the HSC
6.1. **Principles and objectives for engagement**

The success of this engagement strategy relies on a number of key principles. These are aligned with the Regional Communications Strategy.

- Ensure clear, timely consistent and effective engagement and communications at a regional and local level to fully support the Minister’s vision of enhancing the quality of care for clients and patients, and improving outcomes and patient experience.
- Activities must be planned in harmony with the strategy that is adopted by the overall TYC programme.
- Speak with one voice but tailored for the stakeholder group
- Strong editorial direction and governance to provide swift and decisive sign off for approach and content
- Existing channels, media and standards will be leveraged where possible, utilising established formal and informal communication processes.
- Role-model and demonstrate new processes or behaviours to make it real to reinforce the message
- Rigorous measurement is essential to ensure the key messages are getting through to stakeholder groups and being correctly interpreted, and allow adjustment of messages to meet emerging needs

The approach for stakeholder assessment, engagement and communications is summarised in Figure 8 below:

**Figure 8: Key Steps in the Engagement Approach**

It is anticipated and expected that each organisation and project will have its own plan at varying levels of detail, however, this strategy aims to provide a strategic and co-ordinated approach for all HSC organisations.

Therefore this approach, together with tools and templates to support its use, will be made available to each change initiative or project (whether at local or regional level). The Programme Capability and Engagement Team will also provide support and guidance to
project teams in how they go about assessing development or training needs arising from their project, and how they can build this into their plans from the outset. This will promote consistency to the approach taken to capability development across the TYC Programme, and help to ensure the smooth implementation and sustainability of the change.

6.2. Stakeholder analysis

Stakeholder analysis and mapping provides any programme, particularly one of this size and complexity with some clarity around who the key stakeholders are (based on the Impacted Groups set out in Section 6.3) and how to engage them, thereby allowing prioritisation and focus.

The TYC programme manages stakeholders and engagement activity using a proven approach. Stakeholders are mapped against a simple matrix below which assesses both influence and interest of each stakeholder, and these can then be integrated at both programme and local / project levels.

![Stakeholder Analysis matrix](image)

**Figure 9: Stakeholder Analysis matrix**

6.3. Key messages

Once the stakeholder mapping analysis is undertaken, the key messages for each stakeholder can be developed. It is recognised that these will, and should, be revised on a regular basis, particularly at a local level. It is also recognised that the messages for different groups or individuals will be different at various points throughout implementation. This addresses one of the core principles of engagement: to focus on the needs of the individual and tailor our messages accordingly to support meaningful engagement based on “what does it mean for me?”
The TYC Programme, working with other HSC organisations and wider stakeholders groups have started to set out some of the key specific messages for defined groups in Figure 4 above. However, as set out in the Regional Communications Strategy, the key ‘generic’ messages, which can be tailored for the specific group or individual will broadly fall under 3 main categories:

**We are listening**

- It is vital that everyone joins the debate on what they want their health service to look like.
- There will be formal consultation processes in relation to any significant changes to services and key stakeholders and wider public will be able to have their say.
- It is essential that frontline professionals are involved at the core of decision making and service development; and there continues to be powerful local commissioning.

**We are changing**

- The proposals offer an unparalleled opportunity to provide Northern Ireland with safe, sustainable and accessible care services well into the future.
- There needs to be a shift in care currently carried out in hospitals, into the community with patients being treated in the right place, at the right time, and by the right people.
- It will be necessary to stop doing what does not work, become more assertive in challenging out of date practices, and acknowledge that some of today’s services and their current design are no longer sustainable.
- The proposals will offer a wider range of accessible and quality services closer to home.

**We are delivering**

- This is what has been achieved and what is on-going (including good news stories and examples of best practice).
- This is when and how you can keep updated on what we are delivering, and how it impacts you.

6.4. **Branding**

Branding is of critical importance for a programme such as TYC. Effective branding enables a programme (and the organisations and projects within the programme) to:

- Create awareness and common understanding of the programme and promote its impact and benefits in NI, speaking with ‘one voice’. This is achieved through a constant link back to vision or goal statement within the branding and strapline.
- Generate an emotional connection for those involved in leading and delivering TYC, and gaining recognition for the programme through its brand
- Transpose boundaries to promote the feeling of shared purpose, both within TYC across delivery teams and staff, and out across the organisation leading the delivery of TYC and the communities which TYC will impact.
- Reiterating the message from the Regional Communications Strategy, it is very important that there is consistent branding developed which becomes synonymous with positive and powerful change of the TYC Programme.

- Guidance on localising branding and support materials and templates will be provided to support the above, including, for example, briefing pack, documentation templates, pop up stands etc, as well as branding usage guidance. This is under development.

- All organisations involved in Health and Social Care are involved are bought into and have a role to play in delivering the TYC vision

- Future focussed and transformational in nature

- Covers all of Health and Social Care across Northern Ireland
7. Capability approach and plan

The purpose of the TYC Programme Capability Approach is to support those responsible for the delivery of the TYC Programme so that they have the opportunity to develop the transformation capability and leadership necessary for successful and sustainable implementation. It also aims to ensure that the capability and training needs arising from TYC projects and initiatives, and the workforce planning around the new service models are addressed in a managed way.

It sets out an approach for identifying, assessing and addressing development needs (both technical competencies as well as ‘softer’ skills such as core competencies and behaviours) for specific groups. The benefits of doing this are:

- Skills development increases the chances of programme being delivered on time and on budget
- Awareness of capability requirements at all levels and providing the most support to the areas where there are the biggest gaps, thereby making best use of our resources
- Motivating for staff, who are keen to develop their skills and opportunities
- We develop a clearer view of the skills development required in future which can feed into system-wide workforce plans

For all Capability Development interventions undertaken by the TYC Programme the following approach will be used to ensure it:

- Is focussed on the needs of the individual and organisation to whom it is directed.
- Is designed to promote leadership and commitment to the values of TYC through empowerment and shared learning.
- Is co-designed/produced with the team or organisation to which it is directed.
- Employs an integrated approach with TYC engagement activities.

Any capability development undertaken by the TYC Programme will take cognisance of, and so far as possible will be designed to explicitly complement existing leadership and management development activities already underway and delivered by Trusts and other organisations, including programmes relating to Clinical Leadership. It will also be aligned to the NHS Leadership Framework.

It is intended that the HSC Leadership Centre will work alongside the Programme Team to design and deliver these interventions, as well as close involvement and collaborative design with their client organisations from across HSC to ensure it meets their needs.
7.1. Building capability to operate in the new model

As further work is undertaken on the detailed service modelling and through the Population Plans in later years, greater understanding will be developed on the workforce skills mix needed to deliver new models of care. This will support the identification of the training and capability needs for staff groups, and where any gaps and risks exist which could impact on the resilience of the service in later years.

Whilst the development of an appropriate HSC workforce to meet the requirements for service delivery is led by the DHSSPS, for the purposes of defining the impact of TYC, it will be supported by the TYC Finance and Workforce enabler workstream. Therefore the Capability and Engagement Plans need to be closely aligned with this work to ensure that short and medium term training and capability needs arising from the TYC initiatives set out in this document are addressed and monitored through the TYC Programme. It is critical that the capability to operate in the new model is developed throughout the TYC implementation period, but also that future skills and professional development needs are identified to enable a strong and resilient flow through from our educational institutions in future years.

In relation to specific changes, the process approach set out above, together with tools and templates to support its use, will be made available to each change initiative or project (whether at local or regional level). The Capability and Engagement Team will also provide support and guidance to project teams in how they go about assessing development or training needs arising from their project, and how they can build this into their plans from the outset. This will promote consistency to the approach taken to capability development across the TYC Programme, and help to ensure the smooth implementation and sustainability of the change.

7.2. Strategic programme level capability plan

Although there are many groups and individuals that are involved in the TYC programme, the focus for Programme Capability can be categorised into 4 key areas, as these capability needs and interventions are unique and specific to TYC (rather than a general development need which would be addressed through ‘business as usual’ Learning & Development activities, or a specific training need arising from a single initiative or project).
Subject to further validation and collaborative design of the change model, and detailed development needs analyses and plans, these 4 key areas of activity are:

a) Leading Transformation
b) Building capability to deliver
c) Learning from others: Skills Transfer Programme
d) Learning from others: Intelligence Hub

Figure 11 overleaf describes the Approach, target group and the proposed content for these interventions.
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<thead>
<tr>
<th><strong>Target Audience</strong></th>
<th><strong>Objective</strong></th>
<th><strong>Approach</strong></th>
<th><strong>Key Milestone Plan</strong></th>
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| **Leading Transformation** | Those responsible as a team for leading the TYC Programme throughout implementation. This is likely to include the Programme Board, LCG Leads, Directors of Planning, and ADs in TYC Programme Team | Recognising that delivering transformation of this scale and complexity across a whole system requires different skills and behaviours than those which may have been required in the past. This intervention is to support key leaders individually and collectively to develop common goals, translate transformation visions into applied changes ‘on the ground’, and manage challenges as a high performing Programme Board and senior team. | Blended approach including:  
- Facilitated collective design workshops.  
- Themed knowledge workshops.  
- ‘Organisational raids’ from other areas undergoing large scale change.  
- Board effectiveness. | **July / August 2013:** Validation of proposals and model, scoping of needs and detailed OD plan  
**Dec 2013 – Mar 2016:** Programme Delivery with annual evaluation reports and updated plans to ensure alignment to objectives |
| **Building capability to deliver** | Anyone responsible for leading or managing a workstream, project or initiative as part of the TYC Programme Implementation. Participants would self-nominate or be put forward by their employing organisation. From both regional or local levels, this could include  
- Service Managers  
- Local PMO.  
- Clinical staff.  
- Core or non-core HSC orgs. | Evidence shows there are a number of skills and behaviours which are most likely to make change successful and sustainable.  
This programme is designed to provide a menu of products to allow flexible attainment of these skills and behaviours focussing on TYC requirements, and aligned to the TYC change model.  
These include:  
- Vision & Strategy.  
- Engaging Others.  
- Awareness & Comms. | Blended approach as appropriate to the topics including:  
- Online Resources.  
- Short Courses.  
- Workplace support / consultancy.  
- Coaching.  
- Themed knowledge workshops. | **July / August 2013:** Validation of proposals and model of delivery  
Scoping of needs and detailed OD plan; rollout of existing available products and launch of online resource library  
Design of ‘new’ products.  
Promotion and marketing of products to book courses etc  
**Sept 2013 – Mar 2016:** Rollout of support and training products, with annual evaluation reports and updated plans to ensure alignment to objectives |
### Learning from others: Skills Transfer Programme

It is hoped that members of project teams and clinical staff who undertake a change as part of TYC will be able to go and work with a project team in another Trust / LCG who are about to embark on a similar change to transfer their learning and skills.

This would be structured and managed brokering of the transfer of skills to spread learning.

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| primarily through the HSC Leadership Centre with TYC specific products aligned with their existing portfolio of courses and resources. Organisations would be responsible for part funding their own participants | - Innovation.  
- Teamworking.  
- Improving Performance.  
- Project Management.  
- Improvement Methodologies.  
- Benefits Realisation. | Blended approach including  
- Induction package for those embarking on the "Skills Transfer Programme"  
- Facilitated action learning sets  
- Regular evaluation of skills transfer application  
- CPD, Accreditation or qualification, as relevant  
- Coaching | **July / August 2013**  
- Validation of proposals and model of delivery  
- Scoping of needs and detailed OD plan  
- Design of materials and schedule of activities  

**Sept 2013 – Mar 2016:** Programme Delivery with annual evaluation reports and updated plans to ensure alignment to objectives |

### Learning from others: Intelligence Hub

Feedback from across the HSC organisation shows there is a need for having accessible and up to date knowledge and intelligence about recent developments.

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</table>
| Feedback from across the HSC organisation | To provide access to knowledge and expertise to plan and design of changes and improvement as part of TYC, with the purpose of  
- Maximising the spread of innovation from outside and | An ‘Intelligence Hub’ to include:  
- Online resources with latest research  
- Brokering workshops with | **July / August 2013:**  
- Validation of proposals and model, identify priorities and develop ‘quick wins’ initial delivery plan |

- Maximising the spread of innovation across our HSC system is critical to the effective, efficient and sustainable delivery of the TYC Programme.

We propose to support those involved in order to maximise the opportunities and learning for the following:

- the individual  
- the substantive organisation  
- the receiving organisation

An ‘Intelligence Hub’ to include:

- Online resources with latest research
- Brokering workshops with
Such an ‘Intelligence Hub’ will provide access to knowledge and expertise to support those responsible for planning and designing major change initiative from across the HSC system. It would be open to those involved in planning and design TYC change projects from across HSC system.

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| within HSC      | • Providing the open space and encouragement to ‘think differently’  
|                 | • Enabling teams to develop a clear and compelling vision and strategy for their change initiative  
|                 | • Supporting Population Planning for Years 2 & 3  
| recognised experts | • ‘Hot Housing’ events bringing together internal and external interests to learn and share  
|                 | • design of online ‘site’ and materials; agreement of event plan to Dec 2013; launch with rollout of initial delivery plan / events |

**Fig 11: Proposed Programme Level Capability Interventions**

**Sept 2013 – Mar 2016:** Programme Delivery with annual evaluation reports and updated plans to ensure alignment to objectives
8. Measurement and monitoring of capability and engagement activities

The overall effectiveness of activities will be monitored regularly during the implementation process to confirm that the capability and engagement activities are having the desired effect and that target stakeholder groups are achieving the planned levels of engagement and capability.

**Figure 12: Evaluation Approach**

We will apply proven techniques and models for measurements and evaluation of the effectiveness of the capability and engagement approaches, such as the Kirkpatrick model, which has four sequential levels which are increasingly more difficult to measure. These are:

1. **Reaction** – what participants thought and felt about the training (satisfaction; ‘smile/happy sheets’)

2. **Learning** – the resulting increase in knowledge and/or skills, and change in attitudes. This evaluation occurs during the training in the form of either a knowledge demonstration or test.

3. **Behaviour** – transfer of knowledge, skills, and/or attitudes from classroom to the job (change in job behaviour due to training programme). This evaluation occurs 3-6 months after the learning event.

4. **Results** – the final results that occurred as a result of the learning (can be performance based, financial, ROI, etc.)
A number of simple feedback and monitoring mechanisms will be used to measure progress against the specific objectives that have been identified for each different group in relation to both engagement and capability, either at Programme level or for a specific project implementation. Feedback mechanisms will include feedback from staff and clinicians, patients and carers, Project Teams, Professional Bodies and other external stakeholders. It will also include quantitative measures such as social media hits, positive media coverage, website uptake and hits. We will seek to include feedback gathering on TYC into other regular opinion testing mechanisms (such as PPI, user surveys).

We will also use focus groups and interviews to investigate where specific issues have been identified during monitoring. This includes understanding the scale of the issue, the underlying causes and how engagement and capability activities can be focussed to address the issue.

In addition, the effectiveness of each intervention will be assessed at the point of delivery using feedback forms on communications and evaluation forms for every training session to ensure that the objectives for that activity are met. Simple and focussed annual evaluation exercises using consistent criteria each year will be undertaken for each element of the capability plan to inform planning for the year ahead.

The information from this monitoring process on the effectiveness of both specific interventions and the overall effectiveness will be fed back into the Programme Team, and used by the Capability and Engagement Team to modify the plan for the forthcoming year, feeding into individual Project/ Workstream Plans, the Population Plans and the Strategic Implementation Plan as required.