Northern Ireland Audit Office

Management of the Transforming Your Care Reform Programme

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
11 April 2017

Northern Ireland Audit Office

Management of the Transforming Your Care Reform Programme

Published 11 April 2017

This report has been prepared under Section 29 of the Police (Northern Ireland) Act 2000 for presentation to the Northern Ireland Assembly in accordance with Section 30 of the Act.

K J Donnelly
Comptroller and Auditor General

Northern Ireland Audit Office
11 April 2017

The Comptroller and Auditor General is the head of the Northern Ireland Audit Office. He, and the Northern Ireland Audit Office are totally independent of Government. He certifies the accounts of all Government Departments and a wide range of other public sector bodies; and he has statutory authority to report to the Assembly on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

For further information about the Northern Ireland Audit Office please contact:

Northern Ireland Audit Office
106 University Street
BELFAST
BT7 1EU

Tel: 028 9025 1100
email: info@niauditoffice.gov.uk
website: **www.niauditoffice.gov.uk**

Contents

Contents

Abbreviations

AHP	Allied Health Professionals
CAMHS	Child and Adolescent Mental Health Services
CHIC	Connected Health Innovation Centre
CPN	Community Psychiatric Nursing
DCP	Delivering Choice Project
DEP	Developing Eyecare Partnerships
DHSSPS	Department of Health, Social Services and Public Safety
FTC	Financial Transactions Capital
GP	General Practitioner
HSC	Health and Social Care
HSCB	Health and Social Care Board
HIB	Health Infrastructure Board
ICP	Integrated Care Partnership
LCG	Local Commissioning Group
LTC	Long Term Condition
NI	Northern Ireland
NIAO	Northern Ireland Audit Office
NIAS	Northern Ireland Ambulance Service
OECD	Organisation for Economic Co-operation and Development
pPCI	Primary Percutaneous Coronary Intervention
PCID	Primary Care Infrastructure Development programme
PHA	Public Health Agency
ROI	Republic of Ireland
RQIA	Regulation and Quality Improvement Authority
3PD	Third Party Developer
SBC	Strategic Business Case
SIP	Strategic Implementation Plan
SPEARS	Southern Primary Eyecare Assessment and Referral Service
TYC	Transforming Your Care
UK	United Kingdom
VR/VER	Voluntary Redundancy/Voluntary Early Retirement

Executive Summary

Key Facts

TYC proposed a programme of **99** proposals for change to health social care

---

Estimated Gross Cost of TYC reforms of **£148 million**

£40 million actually spent on TYC reforms

£130 million expected benefits to be realised by reforms

£28 million benefits actually realised by TYC reforms

£83 million intended reallocation of resources from secondary care to primary/community by March 2016

£65.4 million reallocated at March 2016 – expected to reach **£80 million** by March 2018

£126 million of Departmental Capital Funding for new Health & Care Centres in Banbridge, Ballymena and Omagh

£80 million Third Party Development cost of new Health & Care Centres in Lisburn and Newry - Ministerial Directions were given for this expenditure

Executive Summary

Management of the Transforming Your Care Reform Programme

1. In common with countries across the developed world, the Department of Health (Department) has been striving to transform how it delivers and manages health and social care in Northern Ireland to meet population needs. The context within which it does so includes: increasing demands placed on these services by an ageing population (often living with a number of chronic conditions); constrained resources; technological advances; and rising patient expectations.

2. In 2011, a review of health and social care delivery[1] set out an ambitious vision for health and social care services under *Transforming Your Care* (TYC) which aimed to respond to the many challenges these services faced. As initially envisaged, a reform programme to deliver the model of care set out in TYC was to take place over a five year period. TYC was to act as a beacon, setting out a shared view on how services would need to change and what models of care would be required to meet the vision of everyone living longer, healthier lives, where home would become the "hub" of the health and social care services they receive.

3. Given the time taken to identify and consult on the range of service changes required, full implementation of the transformation programme did not commence until March 2013. Indeed, the scale and complexity of the task TYC set itself is not to be underestimated. As far back as 1993[2], Peter Drucker, often described as the founder of modern management, concluded that healthcare organisations are the most complex form of human organisation ever to be managed. According to Drucker, this complexity derives from, among other things, the confluence of professions (e.g. general practitioners, nurses, hospital consultants, pharmacists and administrators) and other stakeholders (e.g. patients and government) who may often have seemingly incompatible interests, perspectives and time horizons.

4. In addition to funding constraints and the need to satisfy a growing demand for health and social care, the challenges these relationships present to health and social care leaders have also been exacerbated by other initiatives in the sector: for example, the constant and immediate pressure Health and Social Care (HSC) Trusts face to meet waiting time targets and to manage their finances in the face of potential deficits - both of which can be barriers to the reallocation of resources across sectors or allocating resources in areas which are perceived to have major care deficits.

Key Messages

5. The evidence brought together in this report identifies a range of ways in which health and social care bodies have sought to improve outcomes and deliver better value services for patients under TYC. Making better use of available data on local health and

1 *Transforming Your Care: A Review of Health and Social Care in Northern Ireland,* Department of Health, Social Services and Public Safety, December 2011

2 The New Realities, Peter Drucker, 1993

Executive Summary

social care needs, these initiatives have involved changes in clinical practice so that care is provided more appropriately and in more co-ordinated ways: for example, the use of reablement services[3] has allowed £7 million to be redirected to support the management of demand for domiciliary care services; fewer hospital beds have been required as a result of changes in the rehabilitation of those suffering from strokes; and further inroads have been made in developing community based mental health services.

6. Despite the progress made in developing locally based services and revising how core elements of health and social care services are delivered, the impact of TYC overall has been more limited and the pace of change not as swift as originally envisaged. In January 2016, commenting on our *General Report on the Health and Social Care Sector 2012-13 and 2013-14*[4], the Public Accounts Committee (PAC) said: *"Transforming Your Care is heralded as the great transformational saviour for health and social care, but the pace of change has been at best mediocre."* This reflects the fact that, while each individual example of change may be impressive on its own (see **Appendix 2**), scaling up the new models of care has proved challenging in the face of rising demand. In addition, as referred to at paragraph 3, there was a delay in the full implementation of the TYC programme due to the work required to identify and consult on the service changes involved.

7. TYC's most substantial financial proposal – the reallocation of £83 million of resources from secondary care to the primary and community care sectors - was originally planned to take place between 2012-13 and 2015-16. However, as implementation of the transformation programme did not begin until March 2013 due to the work involved in defining and consulting on the specific service changes required, only £65 million had been reallocated between the sectors by 2015-16. The Department's current forecast is that this will rise to £80 million by March 2018.

8. Realisation of the benefits which TYC was designed to deliver and when they would be delivered has also posed a difficult challenge for the Department. While we found that the Department and its partners have demonstrated a clear commitment to managing the realisation of the benefits of TYC in terms of improved patient outcomes, a precise action plan had not been established at the outset of the programme setting out clear measurable aims and objectives together with an appropriate set of performance indicators for assessing its performance. The Department told us that the complexity of the relationships between the various health and social care stakeholders involved had impeded the development of a profile for the delivery of improved patient outcomes.

3 Reablement encourages independence, with the aim of helping to avoid unnecessary admissions of older people into hospital. It also provides a range of support services required to help older people return to their own homes following a stay in hospital, an accident or other care crisis.

4 Northern Ireland Assembly, Public Accounts Committee, General Report on Health and Social Care Sector 2012-13 and 2013-14, published 20th January 2016

9. The lack of progress towards meeting the aims of TYC was also highlighted in the Donaldson Report, set up by the Department in 2014 to take a fresh look at governance arrangements across the health and social care sector. In terms of TYC, the review called for a new, costed, timetabled implementation plan and a greater involvement of Community Pharmacists and NI Ambulance Service staff in the new service models.

Conclusion

10. In our view, the Department's focus on transformation is welcome and we recognise that TYC has provided a shared vision for the reform of health and social care services which patients, carers and health professionals can unite behind. Although not as large-scale as intended, many TYC initiatives have been successfully implemented. Given the scale of the challenge that the health and social care sector faced, this is not an inconsiderable achievement. Reforms could not have been accomplished without the commitment and effort of many health and social care staff, supported by the Department and the Health and Social Care (HSC) Board.

11. However, while progress towards better service provision has been made under TYC, in our view there is huge opportunity for further improvement. Following the lead given by the Donaldson Report, we consider there is a clear and compelling case for the Department to build on the foundations established by TYC by developing a clear strategy to guide the implementation of change. In this regard, the Department has recently established a series of initiatives which offer good grounds for optimism that more progress can be made and that the pace of implementing the vision set out in TYC can be accelerated.

12. Significantly, in January 2016, the Department appointed a clinically focused expert panel[5] to lead the debate on the best configuration of health and social care services for Northern Ireland. The panel's report[6] was published alongside the Department's vision[7] for future health and social care delivery in October 2016. The panel expressed its confidence that the capability exists within the integrated workforce to deliver on reform but has pointed out that it considers the health and social care system here faces a further eight-to-10-year period in which to build on and realise the aspirations originally set out in TYC. In our view, moreover, this optimism must be weighed against daunting objectives, set out in successive HSC Board annual Commissioning Plans, that Trusts will achieve financial balance, secure considerable efficiency savings and recover performance against key targets.

13. Transformational change of the kind set out in TYC will almost invariably require adaptability and flexibility as it is implemented. Leadership of the

5 The Panel was chaired by Professor Rafael Bengoa who has practiced as a doctor for seven years in both hospital and primary care. From 2009 to 2012, he was Minister for Health and Consumer Affairs in the Basque Government in Spain and during that time implemented a transformation of the region's health service during a period of even harsher austerity than we now face in Northern Ireland.

6 *Systems, Not Structures: Changing Health and Social Care*, Expert Panel Report, Department of Health, October 2016

7 *Health and Wellbeing 2026 – Delivering Together,* Department of Health, October 2016

Executive Summary

highest order is, therefore, needed to ensure that, as transformation moves into the post-expert panel phase, it avoids the pitfalls that have hampered progress under TYC in terms of creating and sustaining the implementation capabilities required to take forward the new strategy. In doing so, there are a number of key challenges to be faced.

Key challenges

14. ***Developing a clear action plan for transformation:*** Leaders within the health and social care services need to match resources to the vision established by TYC and to find more effective ways of turning the vision into practice. Designing a coherent short and longer-term strategy for implementing transformation, focussing on the objective of accelerating change through supporting front-line staff, is a daunting one for any industry, especially the health and social care system which is among the largest and most complex industries there is. However, this task has to be faced now, as the implications of not facing it are already well sign-posted.

15. ***Models of care which centre on patients will have implications for workforce planning:*** Self-care has the potential to reduce the burden on health and social care professionals and make the most appropriate use of their skills, as well as improving patient outcomes. With much of the health and social care budget spent on staff, exploring ways of using the workforce differently is likely to assume growing importance. From our review of transformation to date, it seems clear that the health and social care system of the future will require staff who are team players and who are able to adapt their skills to changing patient needs. This will enable care to be provided by staff who have the most appropriate skills, allowing the most senior and qualified staff to perform only those functions that cannot be better undertaken by others.

16. ***There is a clear need to build on experience and evidence:*** Even for the high-level analysis undertaken in this report, we found it difficult to find early evidence on the progress and impact of many of the recent initiatives under TYC. This is not surprising as the field of evaluating such interventions is beset by methodological issues, such as the attribution of impact to discrete interventions when there is almost always a range of policy and practice-oriented activities taking place simultaneously. We recognise that it is a massive undertaking to gather, sort and analyse the admittedly uneven evidence base, however, we consider that the sensitive use of available evidence can guide providers towards those interventions which show the greatest potential for success and help increase the pace of change.

17. ***Funding needs to be focused on new community-based models:*** TYC has faced considerable difficulty in releasing funding from the acute sector to increase

investment in primary and community care as a result of the growing demand on existing services. While there is considerable potential to release finance already in the health and social care system, some short-term, pump priming funding has also been seen as necessary, from the outset of TYC, to help achieve the scale of service reconfiguration required. To date, TYC has not received dedicated funding to support the change agenda and this has undoubtedly hampered the reform process. However, in March 2016, the Department announced the creation of a ring-fenced £30 million Transformation Fund to be invested in health and social care projects/initiatives focused on innovation, prevention and collaboration. It is hoped that this one-off investment will add further stimulus to the implementation of the vision set out in TYC.

Part One:
Health and Social Care reform is underway

Part One:
Health and Social Care reform is underway

Introduction

1.1 Across the developed world, governments are striving to transform how they deliver and manage health and social care in a way which is fit for a modern context. That context includes the increasing demands placed on these services by ageing populations (often living with a number of chronic conditions), constrained resources, technological advances and rising patient expectations. Northern Ireland has not been immune to these increased demands and to the realisation of the need for real strategic change.

1.2 In June 2011, the Minister for Health, Social Services and Public Safety announced that a review of the provision of Health and Social Care (HSC) services would be undertaken. The purpose of the review was to improve the quality of care, improve outcomes and enhance the patient experience. The key objectives were to:

- undertake a strategic assessment across all aspects of health and social care services;
- consult and engage on the way ahead;
- make recommendations on the future configuration and delivery of services; and
- provide an implementation plan for the required changes.

Transforming Your Care (TYC) outlined a blueprint for reform

1.3 Having engaged with stakeholders and carried out an assessment of local and international evidence, the review findings, "Transforming Your Care" (TYC), published in December 2011, identified 12 principles for change to underpin a new model of care (see **Figure 1**).

1.4 Using these principles, TYC proposed a programme of 99 proposals (**Appendix 1**) for change to health and social care, incorporating, a number of programmes which were already in existence across the sector. Of the overall 99 proposals, 39 related to the implementation of 14 existing regional programmes. As the Health and Social Care (HSC) Board implementation plan notes, it: *"... provides a coherent, controlled and managed framework (bringing) existing programmes together and (adding) new ones, in a well-integrated way....."*.

Figure 1: Twelve Principles of Transforming Your Care

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

1.5 The central tenet of the TYC proposals was to bring about a radical shift from a model of care based predominantly on acute hospitals towards a more preventative approach that promotes self-care and is much more personalised and co-ordinated around the needs of the individual. In practical terms, TYC called for the reallocation of services and associated resources, estimated at £83 million, from the acute sector to the primary and community sector.

1.6 While TYC represented a watershed in its analysis of how health and social care services should be organised, it reflected other policy directions issued at various points over the last decade and before. The Hayes report of 2001[8], for example, highlighted that health and social services should be more closely integrated to provide a seamless system, while a 20-year strategic framework for primary care in 2005,[9] noted the need for much wider development of community-based alternatives to hospital admission. More recently, a review[10] commissioned by the Department in 2010 had similarly highlighted that the supply of resources had become skewed towards secondary care and the acute sector, and pointed to the need for enhanced community and primary care services and stronger public engagement.

The Health and Social Care Board has been assigned the task of managing the TYC reform agenda

1.7 Given the scale of the proposed reforms and the number of inter-dependencies between different parts of the health and social care system, the Department faced a major challenge in trying to ensure coherence over the course of the transformation process. To ensure good governance and management of whole system transformation, the Department established a Strategic Planning Group, and allocated the lead responsibility for the implementation of the 99 proposals in TYC to the Department, the Public Health Agency (PHA) or the HSC Board.

8 *Acute Hospitals Review Group Report,* 2001, Belfast: TSO

9 *Caring for People Beyond Tomorrow, DHSSPS,* 2005

10 *Reshaping the System: Implications for Northern Ireland's Health and Social Care Services of the 2010 Spending Review,* McKinsey, 2010

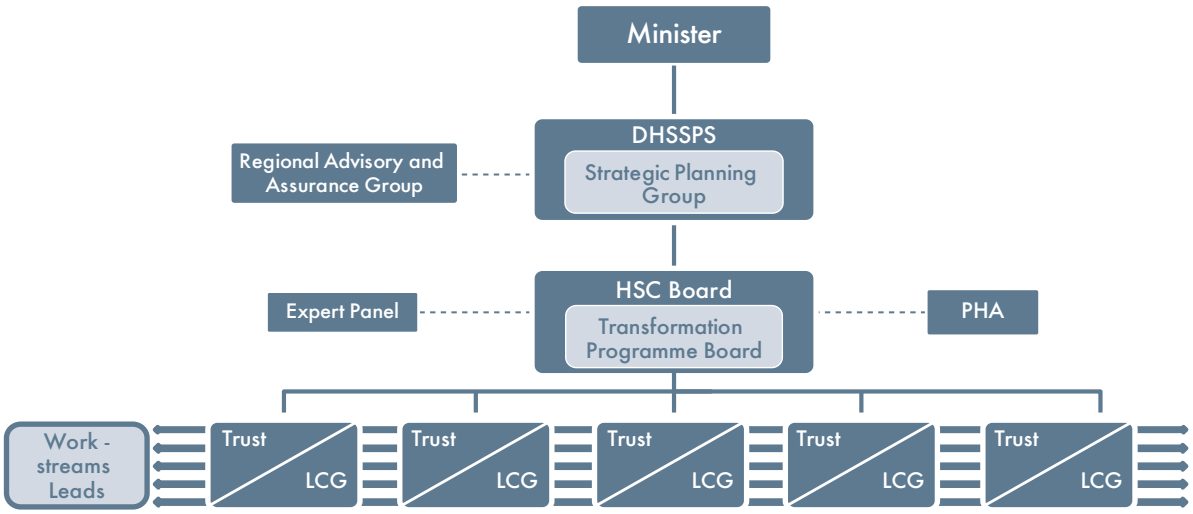
Part One:
Health and Social Care reform is underway

Around 70 of the 99 proposals flowing from the TYC review fell within the remit of the HSC Board (see **Appendix 1**). The HSC Board set up a Transformation Programme Board chaired by its Chief Executive, with representatives from its own ranks, Local Commissioning Groups and others from the HSC Trusts (**Figure 2**). The Transformation Programme Board managed and tracked the progress of reforms against the 70 proposals for which it had responsibility, along with the plans set out in the Strategic Implementation Plan and the TYC Vision to Action document[11].

1.8 The HSC Board's TYC Programme Management Team supported and monitored the progress of the transformation programme against approved plans for the Programme Board. In addition, this team worked with the Public Health Agency, the Trusts and other service providers involved in change projects and reported monthly to the Programme Board. The tools used to monitor progress included: a detailed project plan; project highlight reports; benefit realisation reports; finance reports; lessons learned registers; and risk registers.

1.9 The actual implementation of the numerous projects under the TYC banner were taken forward jointly by the five Local Commissioning Groups (LCGs)[12] working in conjunction with their respective HSC Trust, and colleagues in the primary care and voluntary and community sectors. HSC Board and

Figure 2: Governance Arrangements for HSC Board led TYC Transformation Programme



Source: The Department

11 *Transforming Your Care: Vision to Action – A Post Consultation Report,* HSC Board, March 2013

12 The Health and Social Care (Reform) Act (Northern Ireland) 2009 established five Local Commissioning Groups (LCGs) which function as committees of the Health and Social Care Board. Each LCG is co-terminus with its respective HSC Trust area and is responsible for assessing needs and commissioning health and social care for its local population.

HSC Trust officials provided regular updates to the Programme Board on the progress of implementation.

1.10 On the basis of population plans drawn up by LCGs, the Project Team drew up an overall Strategic Implementation Plan (SIP) to provide stakeholders with a clear understanding of the TYC proposals and how they would be delivered. The SIP listed the planned and existing programmes and enabling activities, at regional and local level, which were considered essential to maximise delivery of the TYC proposals. The projects could be aligned with one or multiple proposals.

Scope of NIAO review

1.11 This review provides an opportunity to describe the scale and urgency of the challenge set by TYC and the extent to which progress to date remains faithful to its original vision. The report draws together key insights from our examination of the implementation of TYC initiatives and also provides some commentary on the next steps in the transformation process. **Part 2** describes the resourcing arrangements put in place to support transformative change under TYC; **Part 3** draws together an update on the outcomes of the changes made under TYC up to 31 March 2016; and **Part 4** describes how transformation is to be taken forward from this juncture and provides some suggestions on what might be intelligent next steps in this process.

Part Two:
Funding the TYC reforms

Part Two:
Funding the TYC reforms

TYC funding helps to pump-prime reconfigured services

2.1 The Strategic Business Case (SBC) estimated that the gross cost of the reforms included in the TYC review between 2012-13 and 2015-16 would be £148 million. Transitional funding required to support the transformation was anticipated to be £70 million: £25 million in the first year (2012-13); £25 million in the second year (2013-14) and £20 million in the third year (2014-15). From 2015-16, it was anticipated that further transitional funding would not be required, with the release of cash savings from this and subsequent years re-invested to fund any future recurrent costs arising from the reform programme.

2.2 Much of the funding required for the initial implementation of TYC, therefore, was short-term -"pump priming"- rather than recurrent in nature. Once deployed, the argument was that enough resource should already exist within the system to bring about the improvement envisaged by the changes. Pump-priming funding would be needed, for example, to enable the transfer of care services from the acute sector and into a primary care/community setting to take place.

2.3 The SBC apportioned the estimated costs of implementation across four areas of spending:

- **Service Change** (£68 million): At the heart of TYC was the drive to shift resources and service provision away from hospitals and to increase care being provided in the community as close to home as possible. The new model of care placed the patient at the centre, with home as the "hub" of care as far as possible. The reforms under TYC also sought to build on the already integrated health and social care systems, with enhanced integration on the ground via the transition to local population-based service planning and a central role for GPs in the development of population-based primary care teams;

- **Integrated Care Partnerships (ICPs)** (£36 million): These were one of the key mechanisms through which service change was to take place for the clinical priority areas they were asked to address. ICPs are collaborative networks of care providers, bringing together doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals and the voluntary and community sectors, as well as service users and carers, to design and coordinate local health and social care services. ICPs are discussed in greater detail in Part 3;

- **Implementation Funding** (£8 million): For example, Trust backfill costs to free up staff to work on implementing TYC; and

- **Voluntary Redundancy/Voluntary Early Retirement Schemes** initiated under the Transforming Your Care programme and distinct from other

cost saving programmes (£35 million).[13]

These estimates, however, were subject to a significant degree of uncertainty as the Department had little reliable information on which to base its estimates and had to make broad assumptions.

Potential limitations of current funding arrangements for TYC reforms

2.4 Just under £40 million has been spent implementing the service changes required by the model of care set out in TYC, against a gross projected cost of £148 million: a shortfall between planned and actual spend of just over £108 million. In our view, a successful transition to the health and social care delivery systems envisaged in TYC requires an adequate and stable source of funding. By contrast, funding for TYC has been a discretionary choice for the Department and has depended on its ability to secure investment through In-year Monitoring[14] bids. As **Figure 3** demonstrates, however, many of the Department's bids have been unsuccessful: against bids of over £86 million, the Department received £28 million, with a further £11.6 million added from the HSC Board's own funds. The absence of a clear commitment to dedicated funding, therefore, has made the effective delivery and embedding of changes in patient care that TYC aspires to much more challenging.

Figure 3: Departmental bids for TYC revenue funding

Monitoring Round/ Invest To Save	Bid £m	Received £m
June 12-13	10.6	10.6
June 13-14	28.0	9.4
October 13-14	18.7	0.0
January 13-14	5.0	0.0
June 14-15	21.3	0.0
October 14-15	2.6	8.0
June 15-16	0.0	0.0
Bid Sub Total	86.2	28.0
HSC Board own funds (2014-15 & 2015-16)		11.6
TOTAL	**86.2**	**39.6**

Source: Department of Health

The financial benefits proposed in the TYC review have not been realised to date

2.5 The Strategic Business Case for the TYC reform programme anticipated that the reforms would realise financial benefits of £130 million by March 2016. At that date, however, as **Figure 4** shows, only £28 million had been realised – just over 20 per cent of that expected. Given the financial constraint surrounding the funding for TYC as outlined above, it is not surprising that opportunities for achieving improved efficiencies have not been fully realised.

13 Transforming Your Care, Strategic Business Case

14 In-year Monitoring allows the NI Executive to: adjust the allocation of resources set out in the multi-annual budget in relation to emerging expenditure pressures; and/or reprioritise the use of resources which are no longer required for the purpose originally allocated.

Part Two:
Funding the TYC reforms

Figure 4: Estimated and Actual Financial Benefits realised by TYC at 31 March 2016

Monetary Benefits	Estimated Total 2012-13 to 2015-16 £'000	Actual 2015-16 £'000
Integrated Care Partnerships	16,361	
Service Change – Stroke	4,085	16,800
Service Change – PCI/Cardiac Catherisation	12,814	
Service Change – Reablement	33,206	
TYC VR/VER	21,313	
TYC Implementation Benefits*	37,835	11,300
Telecare	1,333	
NIAS `See, Treat, Leave or Refer'	3,376	
TOTAL BENEFITS REALISED	**130,323**	**28,100**

* Incidental benefits occurring as a result of increased level of earlier diagnostic and preventative measures having been established.

Source: Department of Health

Primary Care Infrastructure Development programme (PCID)

2.6 The TYC programme also recognised the important need for capital investment in health and social care infrastructure, given that much of the primary care infrastructure was considered no longer fit for purpose and lacked the capacity to deal with the impact of service reforms TYC envisaged. This led to the establishment of the Health Infrastructure Board (HIB) comprising senior representatives from the Department, the HSC Board and the Strategic Investment Board. The remit of the HIB is to oversee the development and implementation of investment to reconfigure the primary care infrastructure under the Primary Care Infrastructure Development programme (PCID).

2.7 The PCID is based on a "hub and spoke" model, with hubs providing core services for their range of spokes. Each spoke would have a defined level of services, depending on economies of scale, and would draw on the services of the hub as required. The hubs would essentially encompass those services which do not require a hospital bed but which are too complex or specialised

to be provided in a local GP surgery (a spoke). In the main, hubs would include the capacity to deliver GP and Trust-led primary care services and those services which will "shift-left" from secondary care under TYC. The spokes will be local GP surgeries and health centres which include practitioners such as GPs, practice nurses and Trust services where there is localised demand.

2.8 This direction of travel pre-dates TYC as the 2005 strategic framework for primary care had already described such 'hubs'. The Portadown Health and Care Centre, for example, which opened in March 2010 includes eight GP practices along with diagnostic and treatment facilities. Belfast has seven similar centres: Arches Centre (East Belfast - completed 2005), Beech Hall Centre (West Belfast), Bradbury Centre (South Belfast), Carlisle Centre (North Belfast), Grove Wellbeing Centre (North Belfast – completed 2008), Knockbreda Centre (Castlereagh) and Shankill Centre (West Belfast). These are described by the Belfast Trust as 'Health and Wellbeing Centres' – 'one stop shops' for treatment, care and information which had previously been provided from a number of sites.

2.9 In launching a programme of new Health and Care Centres, however, the TYC Strategic Implementation Plan (paragraph 1.10) indicated that there would be a significant projected shortfall in available capital funding to enable their development. Conventional capital funding was used to complete Health and Care Centres in Banbridge (£16 million)[15], Ballymena (£25 million)[16] and Omagh[17] (£85 million). However, an alternative funding stream – Third Party Development (3PD)[18] – was established in order to enable the delivery of new Health and Care Centres in Lisburn (£40 million) and Newry (£40 million).

2.10 Ministerial Directions were required to commission procurement for these two sites[19]. While the business cases for these centres demonstrated that the lowest cost option was to build them through the Department's own capital programme, in the Department's view the capital costs associated with conventional procurement options were not affordable within the capital programme if the centres were to be progressed in the short to medium term. The Ministerial view was that delaying the projects would impact on the reform of the health and social care system.

15 Banbridge Health and Care Centre opened in January 2016. It employs around 220 staff delivering a range of community services including physiotherapy, occupational therapy and speech and language therapy, specialist nursing, a rehabilitation suite and two dental surgeries. There is also bookable space available for other visiting services.

16 Ballymena Health and Care Centre opened in February 2016. It includes six GP Practices as well as a mix of locally accessible acute, primary and community care services. In addition to a mental health consultation wing there is also a separate children's wing for all child associated assessments and clinics. Dental Services are also provided from the centre.

17 A new Health and Care Centre is also integral to the new hospital in Omagh, due to open early 2017.

18 The procuring authorities are the South-Eastern HSC Trust in the case of Lisburn and the Southern HSC Trust in the case of Newry. Under 3PD, the Trusts partner with private developers and take the head lease on the buildings. Broadly, a 3PD agreement provides for the developer to build new premises to a certain standard and design and, on practical completion of the development, the nominated HSC Trust partner will sign a lease. GPs then take a sub-lease from the HSC Trusts. While the GPs pay rent and rates to their respective HSC Trust, this is a "pass through" cost and is paid for by the HSC Board. The HSC Trusts, in turn, pay the developers an Annual Service Payment for the use of the building.

19 When a Minister wishes to proceed with a course of expenditure against the advice of his or her Accounting Officer, a Ministerial Direction is notified to the Public Accounts Committee, leaving the accountability line for this expenditure with the Minister rather than the Accounting Officer.

Part Two:
Funding the TYC reforms

2.11 The Strategic Implementation Plan for Primary Care Infrastructure Development was completed in 2014 and identified the next tranches of the roll out of the programme. Local Commissioning Groups are examining the current and future health needs for their local populations to ensure that the right care can be delivered in the right place. Once identified, these schemes will require business cases to be developed for further consideration.

2.12 GPs have had access to ring-fenced funding made available by the Department of Finance, known as Financial Transactions Capital (FTC)[20]. Under this scheme, GPs are given a loan to invest in the modernisation of their owned premises (spokes). During 2015-16, £1 million of funding was taken up by GPs. The FTC scheme remains open for GPs to invest in their own premises but the Department told us that funding is likely to decrease over the coming years.

2.13 3PD funding and Financial Transactions Capital can be viewed as helping to enable the delivery of the health and social care reforms set out in TYC. In particular, facilitating investment in premises is aimed at increasing the number and quality of facilities used to provide primary care and to create opportunities for greater integration between GPs and Trust services. Such investment will also help to create a modern environment where facilities are fit-for-purpose and allow GPs to provide a higher standard of care to their patients.

2.14 In our view, the process of implementing a new model of primary care through 3PD and FTC is an important addition to the long-running Departmental strategy of diverting patients away from inappropriate and more expensive secondary care and, also, to ensure the long-term sustainability of health and social care services. While the impact of the more recently opened health and care centres has yet to be evaluated, the experience of the Portadown Health and Care Centre demonstrates that the changes this approach seeks to make can be realised through the integration of health and care, and by reconfiguring services away from hospitals (see **Figure 5**).

2.15 While we acknowledge that the use of capital funding streams like 3PD and FTC can have significant benefits such as those described in the Portadown example, in our view they also need to dovetail closely with more concerted efforts to move resources away from secondary care in line with the aspirations of TYC. In particular, the change in capacity associated with an initiative like PCID will have specific workforce implications. The integrated care provided in these centres

20 FTC funds may only be deployed as a loan to, or equity investment in, a private sector entity. The investment must be consistent with, and supportive of, the Northern Ireland Executive's overall strategic aims and objectives. HM Treasury require FT capital to be repaid although they do not require full repayment. Different scheme allocations may have different repayment levels. Departments retain half the difference in the funding allocation and the repayment to HM Treasury. For example, when the private sector repays the department, if the repayment rate to Treasury is 60 per cent, the department will retain half the remainder i.e. 20 per cent of the original funding. Projects in receipt of FT capital are required to comply with European Union (EU) rules on "State Aid". FT capital that is not used for loan or equity investment must be surrendered back to HM Treasury.

Figure 5: Case Example - Portadown Health and Care Centre

Opened: March 2010 Cost: £16.5 million

Patients attending the Portadown hub are benefiting from the ability to access a wide range of primary and community care services all under one roof. Such services include: GP services; physiotherapy; orthopaedics; x-ray and ultrasound investigations; podiatry; and social care, as well as a wide range of specialist GP and consultant-led clinics.

The experience of the hub has been that this has taken significant pressure off outpatient referrals to the local acute hospital because people have been getting the service closer to home. By way of example, the x-ray facility in the hub has accommodated 80 per cent of referrals from GPs based within the hub and 20 per cent from GPs based in spoke practices surrounding the hub. A total of 6,553 x-ray attendances were undertaken in 2012-13 which would otherwise have required referral to an acute hospital.

Source: Martin Kelly, PCID Programme Director

requires professionals to work in new ways, for example, in multi-disciplinary settings where trusting colleagues and being able to work collaboratively is essential. In this regard, Proposal 97 of the TYC Review called for a "*more formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation, with regard to workforce planning*". Viewed in the context of a PCID programme which has funnelled resources into primary care infrastructure, it is essential that adequate attention is given to building capability in the operational and change management skills needed to make sustained improvements in patient care.

2.16 The Department is aware of the need to develop the required capability and meet the recurrent costs of the new facilities in the face of the many other pressures on resources including, but not limited to, funding new service developments, the perceived lack of growth in the general practice workforce to keep pace with the demand for services, and a reported decline in the community nursing workforce over recent years.

The importance of dedicated funding in the transformation of services

2.17 Providing ring-fenced financial support for the transformation of health and social care services is currently exceptionally challenging. However, funding transformation represents a significant investment in the future of health and social care services and the alternative is to risk a decline in the quality and safety of that care and a reduction in access to, or the breadth of, services that HSC Trusts provide. Without resources specifically dedicated to transformation, there is a risk that health and social care services will be unable to deliver the changes considered

Part Two:
Funding the TYC reforms

essential by TYC and that the costs of continuing to provide services along traditional lines will only get larger.

2.18 Towards this end, we acknowledge the creation of a ring-fenced £30 million Health and Social Care Transformation Fund for 2016-17. Its specific purpose was to fund innovative projects aimed at improving outcomes for patients and also saving money that could be redirected to other frontline services. Funding such as this can be a catalyst for change, however, we are aware too of the risk that the Fund may become subject to pressure to fix immediate crises, support pet projects or, potentially, be an easy target for expropriation when extra funding is needed elsewhere. It will be essential that some level of guarantee can be given to prevent funding being diverted away from the purposes intended.

2.19 We acknowledge that funding cannot do all of the work of the TYC programme, or solve all of the problems of the health and social care system, and some transformation tasks will require little additional funding. It will be important, therefore, that the focus on funding does not distract attention from the wider issues involved in a change programme of the magnitude of TYC, for example, leadership and overcoming embedded organisational silos. Alongside the intelligent distribution of funding for transformation, Parts 3 and 4 of the report outline a range of other factors which are also important in supporting and sustaining the successful implementation of a transformation programme.

Part Three:
What have been the outcomes of the TYC reform initiative to date?

Part Three:
What have been the outcomes of the TYC reform initiative to date?

The significant shift of resources from secondary to primary and community care planned under TYC has yet to be completed

3.1 Providing care closer to home has been a perennial feature of health and social care policy for many years and the TYC review reaffirmed and consolidated this direction of policy: a reallocation of at least £83 million from existing expenditure levels on secondary care and its reinvestment into primary, community and social care services. According to the TYC review, this level of resource re-allocation reflected the anticipated level of resource shifting required to meet the level of intended transformation of services. The redistribution of the £83 million was to be divided across the following service areas:

- increase spend in the Personal and Social Services by £21 million (a two per cent increase);
- increase spend in Family Health Services and Primary Care Services by £21 million (a three per cent increase); and
- increase spend in Community Services by £41 million (a nine per cent increase).

3.2 Shifting resources from the acute sector to the home or community, however, continues to present challenges in the face of rising demand and the Department has not made the progress towards achieving the proposal within the timeframe envisaged in the initial TYC vision. As noted at paragraph 3, the delay in the reallocation of resources reflects the fact that, as a result of the time taken to identify and consult on the range of service changes required, implementation of TYC did not commence until March 2013. **Figure 6** shows that against the original target to reallocate £83 million by 2015-16 just over £65 million was reallocated at that date. The current forecast is that £80 million will be 'shifted' by March 2018 – three per cent below what was expected to be in place by March 2016.

Despite the slow progress of transformation overall, TYC has led to some notable achievements in the development of locally based services

3.3 While the pace of change in terms of realising efficiencies and the shifting of resources from the acute sector has not been within the timeframe originally envisaged due to a number of external influences, TYC has brought about some notable changes that have the potential to make a difference to patients' services and outcomes. In particular, as **Figure 6** shows, the reallocation of resources due to service changes amounted to £25 million. The main service changes that have contributed have been:

- reablement (£4.8 million);

Figure 6: Actual reallocation of resources

	Actual 2012-13 £m	Actual 2013-14 £m	Actual 2014-15 £m	Actual 2015-16 £m	Actual Total £m
Integrated Care Partnerships	–	–	–	0.9	0.9
Service Change	6.0	8.3	2.4	8.3	25.0
Resettlement of Mental Health & Learning Disability Patients	11.4	13.7	2.4	12.0	39.5
Implementation	–	–	–	–	–
TOTAL	**17.4**	**22.0**	**4.8**	**21.2**	**65.4**

Source: Department of Health

- telecare and telemedicine (£2.9 million);
- elderly care (£1.7 million); and
- dementia strategy and memory services (£1.3 million).

Appendix 2 provides further detail on a range of case examples within these categories which demonstrate how services have been successfully re-designed to meet the objectives of TYC in a more efficient, effective and patient-centred manner.

3.4 The Department has undertaken regular monitoring of actions within the health and social care sectors to deliver the model of care set out in TYC. In November 2015, an update showed that around half of the 99 proposals had been completed, with good progress made on nearly all the rest.

3.5 The Benefits Management Framework of the TYC Programme was the subject of a review commissioned by the Health Committee in December 2014. That review highlighted deficiencies in the Benefits Realisation Plan, at that time. In particular, while performance metrics had been developed for tracking some of the reforms (see **Appendix 3)**, it was not clear how progress was to be measured in other areas. We acknowledge that the ambitious nature of the changes TYC proposes has raised complex issues, particularly where improvements in patient care are often to be achieved at some point in the future. However, given the scale of transformation underway, defining performance metrics for more complex care objectives will be crucial in the face of increasing demands for accountability.

3.6 The annual Commissioning Plan Direction issued by the Department to

Part Three:
What have been the outcomes of the TYC reform initiative to date?

the HSC Board is a key document in the commissioning of health and social care services with a view to delivering the patient-centred service model set out in TYC. The Direction sets out the Department's priorities for the health and social care services and the areas where it expects to see improvements. In response, the HSC Board then prepares a Commissioning Plan aimed at delivering the planned transformation of services. The Department identified three strategic themes, consistent with TYC, in its Direction for 2015-16:

- to improve and protect population health and wellbeing and reduce inequalities;
- to provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction; and
- to ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

3.7 The priorities and targets detailed in the Commissioning Plan Direction are complemented by a core set of indicators which can be used by the HSC Board, the Public Health Agency and the Trusts to monitor trends and take early and appropriate action to address any variations / deterioration in unit costs or performance against Ministerial targets (see **Appendix 4**).

3.8 In terms of performance against these indicators, demographic changes, an increase in the number of people with long-term complex conditions and the challenging budgetary climate, as noted previously, continue to highlight capacity gaps in the system, which in turn have led to increased waiting times across a number of specialties and services in 2015-16. These pressures have been identified within the 2016-17 HSC Financial Plan and will require careful financial management in order to deliver efficiencies.

Integrated Care Partnerships (ICPs) are key components in the successful implementation of TYC

3.9 At the heart of TYC was the establishment of 17 Integrated Care Partnerships (ICPs), each covering a population of around 100,000 people. ICPs are collaborative networks of care providers[21] whose priority is to make sure each person gets the care they need, in the right place, at the right time. To achieve this, the work of ICPs involves: identifying patients in 'at risk' groups and focusing on prevention or managing existing conditions to stop a problem becoming an emergency; sharing information and thinking ahead to plan care around the individual; helping people to stay out of hospital unless absolutely necessary; and coordinating care in the community.

21 By March 2016 all 17 ICPs had been fully populated, each comprising 13 members: one medical specialist; one nurse; one allied health professional; one social worker; one member of the ambulance service; one member from the voluntary sector; one from the community sector; two service users/carer representatives; two GPs; a council officer concerned with community planning and two community pharmacists.

3.10 ICPs obtain agreement for the revision of care pathways and (where required) obtain funding through Local Commissioning Groups. The commissioning relationship between LCGs and ICPs, therefore, is central to the delivery of integrated health and social care services under TYC. At the same time, this presents a formidable challenge for ICPs as they need to be rigorous in their determination of priorities, assessing competing needs and demands in order to reach agreement on the key priorities.

3.11 To date, ICPs have reviewed and improved local care pathways for diabetes, respiratory, stroke and services for the frail elderly. This crucially also involved full engagement with service users and carers, offering opportunities for integration and improvements to be identified, leading to a more joined up service for the user across sectors and professional groupings.

3.12 The principal currency of ICPs lies in their capacity to influence and lead across organisational and professional boundaries. Achieving change in this way requires exceptionally strong and skilful leadership, and places a high premium on these 'soft' skills – for example, taking account of the different cultures and ways of working within the health and social care sector. Effective leadership and management qualities, therefore, will be essential if ICPs are to grow into mature partnerships with the ability to engender willingness among the various interests to work together and agree local priorities.

3.13 The development of ICPs under TYC signals a more distributed approach to leadership within the health and social care sector by helping to ensure that all partners actively participate in the reform process and in facilitating cultural change. It is simply not always possible to push change through in a directive way. As such, devolved leadership, which relies on inspiring and facilitating people, is often more appropriate for bringing about change. **Figures 7 and 8** outline two cases which demonstrate how a more distributed form of leadership can underpin successful transformation initiatives in contrast to leadership which depends solely on a small number of key individuals in a hierarchy. The two cases show how effort and expertise has been pooled across a system or health community and describe a process of change which emphasises the building of relationships and connections with other leaders and the wider system.

Part Three:
What have been the outcomes of the TYC reform initiative to date?

Figure 7: Transforming Your Palliative and End of Life Care Programme

An alliance between Marie Curie, the Public Health Agency (PHA) and the HSC Board has developed a programme which aims to design and support the delivery of coordinated services to enable people with palliative and end of life care needs to have choice in their place of care, greater access to services and improved outcomes at the end of their lives.

The initial two-year Programme to August 2015 is based on the Delivering Choice methodology developed by Marie Curie which uses a whole systems approach to improve care and outcomes. The Delivering Choice methodology has been previously delivered in 19 sites across the UK. It includes:

- comprehensive needs assessment to understand local changes;
- a patient-centred approach;
- collaboration between all the relevant resources and stakeholders;
- a mechanism to deliver change and leverage expertise for new models of care; and
- reconfiguring or designing new sustainable services.

The Delivering Choice methodology has been shown to improve patient outcomes in palliative and end of life care, involving increased use of community and voluntary resources and a shift of resources from acute to community services. The evaluation of the Delivering Choice project (DCP) in Somerset evidenced reduced emergency admissions and A&E attendances in the last month of life for DCP users than for non-users. *(The University of Bristol, 2012)*

The Regulation and Quality Improvement Authority (RQIA) has reviewed the progress made in taking forward the Programme and concluded that very significant progress was made during the period 2010 to 2015 towards implementing the recommendations of the strategy. Many initiatives have been developed to raise awareness of palliative and end of life care. But there remains a significant lack of understanding about these services amongst service users and staff. There is a continuing need for a coordinated approach to raising public awareness about palliative and end of life care.

Figure 8: Dementia Care and Appropriate Medication

Another example where collective leadership will be important is around the use of anti-psychotic drugs for people with dementia. The Dementia Strategy, launched in 2011, emphasises the need to promote the use of appropriate medication and to avoid the inappropriate use of anti-psychotic drugs for the management of behavioural and psychological symptoms of dementia. The Strategy sets an ambitious goal that:

"The HSC Board and PHA will ensure that medication for the management of dementia is prescribed appropriately, that medication review is an integral part of the care management process and that a range of therapeutic interventions are available to people with dementia and their carers appropriate to their assessed needs."

This is a significant undertaking: a recent study which reviewed prescribing data for over 250,000 people, aged 65 years and over and living here from 2008 to 2010; found that 8.2 per cent were prescribed such drugs before entry to care homes, rising to 18.6 per cent after entering care. Many groups of people and many individuals will be needed to play a part in helping to achieve the goal set for the HSC Board and the PHA, including people with dementia and their carers, and the voluntary and advocacy groups that support them, leaders of care homes, the clinicians and clinical teams who prescribe, dispense and review the medications, as well as commissioners of health and social care.

Part Four:
Where now for transformation?

Part Four:
Where now for transformation?

Governance and commissioning

4.1 In April 2014, the Department commissioned a review of governance arrangements across the health and social care sector. The ten recommendations which flowed from the Donaldson Review[22], although focused on governance, included specific reference to TYC: in particular, there was a clear recognition that, while TYC contained many good ideas for developing alternatives to hospital care, belief among those within the health and social care services that it could be implemented or that necessary funding would be made available to assist with the reform process was at a low ebb.

4.2 The Review also commented on the apparent lack of a measurable action plan to guide the implementation of TYC. In responding to the Assembly's Health Committee[23] in 2016, the Department characterised TYC as a set of guiding principles and proposals for the development of patient-centred health and social care services whose role was to inform commissioning decisions, rather than a "plan" which was to be completed within a specific timeframe. As a result of these differing interpretations, the Committee took the view that the absence of a plan against which the achievement of TYC's aims could be measured raised concerns about the governance and funding of the programme.

4.3 The link between commissioning and the reshaping of services is picked up in more recent research carried out by the OECD[24]. This takes the view that the absence of a longer-term strategy which clearly establishes what the commissioning process is trying to achieve has led to decision-making being focussed more on immediate performance targets rather than longer-term impacts. As a result, this research considers that the strategic ambitions of several reform initiatives, including TYC, have had limited traction.

Expert Panel

4.4 In January 2016, the Department appointed an expert, clinically-led panel (based to some extent on a recommendation in the Donaldson Review) to consider, and lead the debate on, the best configuration of local health and social care services. Within a month of its formation, the panel held a cross-party health summit and developed a set of 13 working principles. These bear a striking resemblance to those guiding TYC, as summarised below (**Figure 9**).

22 *The Right Time, the Right Place: an expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland*, The Donaldson Report, December 2014

23 *Review of Workforce Planning in the context of TYC*, Committee for Health, Social Services and Public Safety, NIA 268/11-16

24 Organisation for Economic Co-operation and Development

Figure 9: Expert Panel Working Principles Summary

Ethos

1. **The system should be collaborative, not competitive** – (i) organisations must work together to provide high quality care, (ii) unwarranted variance in care across the system should be minimised, (iii) the HSC should continue to work in partnership across government, with industry, academia, the community and voluntary sector, staff and patients to deliver new models of care.
2. **The system should adopt a population health and well-being model with a focus on prediction and prevention rather than reaction** – this principle acknowledges that HSC resources and service developments are often *"locked into reactive disease care"* and there should be an increased emphasis on prevention and health promotion, particularly for those experiencing inequalities.
3. **Patients should be active participants in their own care, not passive recipients** – patients should be supported to take greater ownership of their own health outcomes.

Delivery Model

4. **Health and Social Care is already integrated in Northern Ireland. Remodelling must build on this strength and take a whole system perspective** – building on the integration that already exists to allow patients to be able to transition smoothly between social care, community care and hospital care.
5. **Only people who are acutely unwell need to be in a hospital** – the principle is backed by research showing that hospital use is affected by deprivation, with people in poorer areas more reliant on emergency services, and making insufficient use of planned elective services, and studies showing positive feedback from patients who were treated in community settings.
6. **Very specialist services can be based anywhere in Northern Ireland** – it is proposed that any acute hospital in NI has the potential to become a regional centre and that the HSC should: *"continue to explore and realise the mutual benefits of collaboration with other jurisdictions in ensuring patients have access to high quality, sustainable services"*.
7. **The location and composition of resources should be based on meeting patients' needs and achieving the best outcomes** – co-ordinated workforce and service planning should be carried out on the basis of the population's need rather than to maintain services which are not sustainable in the long term.
8. **The real value of Health and Social Care is in its people, not its buildings** - local initiatives should be encouraged and best practice should be shared across the region, with HSC staff given the freedom to innovate and deliver services in a way that best meets people's needs.

Part Four:
Where now for transformation?

Implementation

9. **Whole system remodelling is a medium to long term process:** *"Reform and remodelling on this scale will take time and must be supported by an evidenced, costed and resourced implementation plan. This will need policy and political commitment in the long term".*
10. **The system must be supported to implement change with pace and scale:** *"Service developments and investment from this point should be geared towards supporting and complementing a long term strategy for sustainable and quality care".*
11. **Technology should be developed and adopted where it can support and enable transformation** - it was acknowledged that NI has one of the most advanced electronic care record systems in Europe: *"Innovation and new technologies should be embraced in collaboration with industry where they offer the potential to deliver better or more efficient services".*

Leadership and Culture

12. **The panel will engage constructively with elected representatives when designing and communicating a remodelled HSC. The Panel will also engage openly with HSC staff and the public:** *"Without change, the Northern Ireland Health and Social Care system is not sustainable in the medium to long term. Elected officials will play a key role in analysing proposals and enabling the public to understand the need for change".*
13. **Northern Ireland can be a world leader in transforming health and social care** – this principle highlights that NI can be a pioneer in *"designing and delivering health and social care services fit for the 21st Century".*

4.5 The panel's report[25] was published alongside the Department's vision[26] for future health and social care delivery in October 2016. In its vision, the Department clearly demonstrates that the panel's report will be used to guide the development of plans for health and social care over the next eight-to-10 years. The changes to be introduced will involve shifting more health and social care from hospitals to settings closer to people's homes, enhancing support received in primary care, and reforming and reconfiguring hospital services. In turn, this may involve making difficult decisions about changing, reducing or cutting some services. Moreover, such moves would also require a significant shift in the behaviour of the local public about how they access, use and receive health and social care services.

4.6 Given the context outlined above, we have identified a series of factors which need to be addressed in order to increase the pace of transformation and the implementation of more effective models of care. The issues surrounding these are discussed below.

Developing a clear action plan for transformation

4.7 The key objective of shifting care from the acute hospital sector to community-based services requires a clear action plan and a compelling narrative that can drive and sustain the transformation process. As we have pointed out, the TYC programme of reforms was strategic in nature and stakeholders lacked a clear framework of how such a shift in resources was to be achieved in practice. In addition, there was a lack of clarity around measures of success, such as milestones and indicators for measuring progress.

Transforming models of care will have implications for workforce planning

4.8 In aiming to move care closer to home and tailor it to meet the needs of individual patients, TYC has increased the significance attached to the community-based workforce. If the vision for future services, set out in TYC, is to be realised, it will be important that equal weighting is afforded to both health and social care which will, in turn, require a workforce development plan to underpin it. Recruiting and retaining staff on permanent contracts remains a significant problem within the health and social care services – for example, among hospital consultants and GPs.

4.9 Another significant issue is that the social care workforce will require better access to relevant training and development opportunities, to ensure that individuals can be deployed in a range of roles. The registration, training and development needs of the social care workforce are issues previously addressed by PAC in 2011 following

25 *Systems, not Structures: Changing Health and Social Care,* Expert Panel Report, Department of Health, October 2016

26 *Health and Wellbeing 2026 – Delivering Together,* Department of Health, October 2016

Part Four:
Where now for transformation?

our report on the quality of care in homes for older people.[27] Recently, a review of domiciliary care[28] has identified the challenges faced by the social care sector in terms of recruiting and retaining care workers and the terms and conditions under which they are employed. The report points out, too, that these issues impact more severely on social care workers employed in the independent sector.

4.10 As the transformation programme develops, the health and social care services will face the ongoing challenge of trying to ensure that staff with the right skills are available to provide new community-based models of care. The Regional Workforce Planning Group, chaired by the Department, was established in August 2012 to consider the implications of TYC for the workforce and to ensure that this was reflected in the workforce planning programme. While it took the Group until April 2015 to finalise a Regional Workforce Planning Framework, the Department highlighted to the Health Committee that other streams of work had been progressed in parallel, including a programme of medical specialty reviews, additional uni-professional reviews, and a pilot workforce review for domiciliary care for older people - in the context of a programme of care rather than a particular profession.

4.11 The specific workforce planning elements within TYC include key proposals 79, 95 and 97A:

- 79: make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements;

- 95: development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is co-ordinated at home or close to home; and

- 97A: more formal integration of workforce planning into the commissioning process to drive the financial transformation.

4.12 The Commissioning Plan for 2015-16 (see paragraph 3.6) set out a number of workforce initiatives and services as follows:

- Integrated service - the regional workforce planning framework will drive the practical implementation and improvement of workforce planning across the HSC;

- Profession specific - there will continue to be workforce planning and development through profession specific activities, including: a workforce planning review for Nursing and Midwifery services in Northern Ireland - *Delivering Care: Nurse Staffing in Northern Ireland;* Trusts to increase working practices which support seven day services; a range of workforce plans across different specialties have been developed or are underway; the

27 *Arrangements for ensuring the quality of care in homes for older people,* NIAO, 8 December 2010; *Arrangements for ensuring the quality of care in homes for older people, Public Accounts Committee, NIA 39/10/11R, 3 February 2011*

28 *A Managed Change: Agenda for Creating a Sustainable Basis for Domiciliary Care in Northern Ireland,* HSC Board, November 2015

implementation of the Social Work Strategy, which includes workstreams such as workload, job rotation, extended hours and flexible working;

- Capability Development Initiatives to support the reform agenda – these include: change management and core skills programme for those involved in TYC or transformation projects; effective partnership working and skills programmes for those on ICP Committees or supporting their operation; development of an HSC Knowledge Exchange open to all those involved in the design, commissioning or provision of health and social care services across Northern Ireland; and investment in 'Organisation Workforce Development and Service Improvement' skills to support staff in their roles;

- The *Delivering Care: Nurse Staffing in NI* Project - a framework to determine staffing ranges for the nursing and midwifery workforce in a range of specialties: phase one set out the nursing workforce required for all general and specialist medical and surgical hospital services – the HSC Board has agreed an implementation plan; three further phases were at development stage: phase two focuses on nurse staffing within Emergency Departments; phase three focuses on District Nursing; and phase four focuses on Health Visiting.

Evidence-based planning and innovation will be key elements in moving transformation forward

4.13 TYC initiatives such as those we describe in **Appendix 2** will generate much needed evidence about what works and the best ways to spread successful interventions. It will be important that this evidence base is appropriately recorded, collated, synthesised and shared. Ongoing evaluation of "what works" and "how it works" should be a core activity of the Department's approach to transformation. If the evaluation of interventions is not undertaken, this could have negative impacts both locally, where it has been tried, but also regionally, through a failure to share learning.

4.14 The case examples we have used in the report demonstrate clearly that a core part of transformation and the allocation of funding has been an established evidence base. This is most notable in the case of the Bamford Review which examined the evidence for improvement across a number of key areas in order to develop a transformation plan. ICPs are responsible for drawing up proposals to implement an intervention and in doing so they must demonstrate the use of existing evidence on implementation and the extent to which it can be replicated; the proposals are evaluated by a Local Commissioning Group according to the evidence base, which includes projected activity, costs and outcomes.

Part Four:
Where now for transformation?

4.15 During our fieldwork we identified a number of ways in which HSC bodies have been attempting to encourage and develop innovative approaches to services by harnessing the creativity and skills of the people who provide the services. Radically different models of care are likely to depend on emulating the approaches taken by peers and by finding ways of learning from experience and adapting innovations that emerge from other health and social care communities. In this regard, we acknowledge a number of different ways in which innovative ideas can be encouraged to develop and flourish, for example:

- The Health and Social Care Knowledge Exchange, hosted by the HSC Leadership Centre on behalf of the health and social care sector, provides links to existing projects and activities being undertaken to ensure health and social care is delivered as effectively and efficiently as possible.

- The Quality Improvement Innovation Centre, based in the South Eastern Trust, aims to bring together innovative and creative thinking, forming a hub for staff.

- The Connected Health Innovation Centre (CHIC) focuses on business-led research in the area of connected health. CHIC seeks to lead transformational research which aligns care needs with technology providers, researchers and clinical experience. This alignment builds on partnerships with the local integrated Health and Social Care Trusts, universities, investment organisations and Government. CHIC targets research in areas such as e-Health, digital health, tele-health, tele-monitoring, disease management, and home-based care.

4.16 Our review of TYC initiatives demonstrated to us that, even where local reforms have been successfully implemented, it does not automatically follow that such projects can be replicated in other settings. However, we did conclude that the sensitive use of the available evidence can guide the Department and providers of health and social care services towards those interventions which are most likely to have more meaningful and widespread impacts and those which would allow resources to be employed more prudently.

Encouraging a distributed leadership approach

4.17 While a transformation programme like TYC may have a compelling narrative, interesting new models of care and a battery of aligned interventions, unless it is supported by an adequate leadership culture, progress is likely to be hampered. In view of the complexity of the reform process, our review of the work of ICPs indicates that the participation of health care

professionals and staff engagement has been crucial in facilitating reform through a more distributed type of leadership which promotes doctors' commitment to improvement initiatives. Paradoxically, therefore, gaining more control over transformation can mean giving up some control. Leading successful large-scale change will require the building of strong cultures based on common purpose and shared values. This will mean encouraging the development of a distributed leadership system which focuses less on the behaviours and actions of individual leaders and more on relationships, interventions and leadership practice across the whole health and social care system.

Dedicated funding to support transformation

4.18 One of the issues we identified which challenged the successful implementation of TYC was the fragmentation of the funding required during the transition period. The Department, therefore, needs to identify adequate and timely longer-term funding to support transformational change. It has provided a series of short-term funding through in-year monitoring to help local bodies implement change but this does not provide the level of funding or certainty to make large-scale sustainable changes. Towards this end, we welcome the Department's announcement in March 2016 of a £30 million Transformation Fund to support innovative change.

Appendices:

Appendix 1: (paragraphs 1.4 and 1.7)

Ownership of the 99 TYC proposals at July 2012

Proposal No.	Proposal	Lead Responsible Body
1	**Population health** – Renewed focus on health promotion and prevention to materially reduce demand for acute health services.	DHSSPS & PHA
2	**Population health** – Production by PHA of an annual report communicating progress on population health and wellbeing to the public.	PHA
3	**Population health** – Maintenance of existing, and implementation of new, screening and immunisation programmes where supported by clinical evidence.	PHA
4	**Population health** – Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: (i) in relation to pricing of alcohol; (ii) 'junk' food; and (iii) further controls on tobacco usage.	DHSSPS
5	**Population health** – Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.	DHSSPS
6	**Population health** – Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.	DHSSPS
7	**Population health** – An expanded role for community pharmacy in the arena of health promotion, both in pharmacies in the community.	DHSSPS & HSCB
8	**Population health** – Support for the health promotion and preventation role played by Allied Health Professionals, particularly with older people.	PHA
9	**Older People** – Home as the hub of care for older people, with more services provided at home and in the community.	DHSSPS
10	**Older People** – A major reduction in residential accommodation for older people, over the next five years.	HSCB
11	**Older People** – Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.	HSCB
12	**Older People** – A greater role for nursing home care in avoiding hospital admissions.	HSCB
13	**Older People** – More community-based step-up/step-down and respite care, provided largely by the independent sector.	HSCB
14	**Older People** – A focus on promoting healthy ageing, individual resilience and independence.	HSCB

Appendix 1 (continued)

Proposal No.	Proposal	Lead Responsible Body
15	**Older People** – More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.	DHSSPS & HSCB
16	**Older People** – a holistic and consistent approach to assessment of older people's needs across NI and an equitable range of services.	HSCB
17	**Older People** – A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.	HSCB
18	**Older People** – Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.	DHSSPS & HSCB
19	**Older People** – A policy review of carers' assessments and more practical support for carers, including improved access to respite provision.	HSCB
20	**Older People** – An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.	DHSSPS
21	**Long Term Condition (LTC)** – Partnership working with patients to enable greater self-care and prevention.	HSCB
22	**LTC** – Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.	HSCB
23	**LTC** – Patients to have named contacts for the multi-disciplinary team in each GP surgery, to enable more straightforward communication.	HSCB
24	**LTC** – Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.	DHSSPS & HSCB
25	**LTC**– A stronger role for community pharmacy in medication management for LTCs.	DHSSPS & HSCB
26	**LTC** – Development of admission protocols between Secondary Care specialist staff and those in community.	HSCB
27	**LTC** – Maximising the opportunities provided by telehealth in regard to LTC patients.	PHA

Appendix 1: (paragraphs 1.4 and 1.7)

Ownership of the 99 TYC proposals at July 2012

Proposal No.	Proposal	Lead Responsible Body
28	**Physical Disability** – Promoting independence and control for people with a disability, enabling balanced risk-taking.	HSCB & PHA
29	**Physical Disability** – A shift in the role of the health and social care organisations towards being an enabler and information provider.	HSCB & PHA
30	**Physical Disability** – Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.	HSCB & PHA
31	**Physical Disability** – Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.	HSCB & PHA
32	**Physical Disability** – More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.	DHSSPS
33	**Physical Disability** – More respite and short breaks provision.	HSCB
34	**Maternity** – Written and oral information for women to enable an informed choice about place of birth.	HSCB
35	**Maternity** – Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.	PHA
36	**Maternity** – Services in consultant-led obstetric and midwife-led units available, dependent on need.	HSCB
37	**Maternity** – Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions	HSCB
38	**Maternity** – Continuity of care for women throughout the maternity pathway.	HSCB
39	**Maternity** – A regional plan for supporting mothers with serious psychiatric conditions.	PHA & HSCB jointly
40	**Child Health** – Further development of childhood screening programmes as referenced in the Health and Wellbeing section.	PHA
41	**Child Health** – Child health included as a component of the Headstart programme, referenced in the Family and Childcare section.	HSCB & PHA
42	**Child Health** – Promotion of partnership working on children's health and wellbeing matters with other government sectors.	DHSSPS
43	**Child Health** – Close working between hospital and community paediatricians through Integrated Care Partnerships.	HSCB

Appendix 1 (continued)

Proposal No.	Proposal	Lead Responsible Body
44	**Child Health** – Completion of a review of inpatient paediatric care to include palliative and end of life care.	DHSSPS
45	**Child Health** – Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.	DHSSPS
46	**Family and Child Care** – Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.	DHSSPS
47	**Family and Child Care** – Exploration through pilot arrangements of budgetary integration for services to this group across departments, under the auspices of the Child and Young People's Strategic partnership.	DHSSPS & HSCB
48	**Family and Child Care** – Completion of a review of residential care to minimise its necessity.	HSCB
49	**Family and Child Care** – Promotion of foster care both within and outwith families.	HSCB
50	**Family and Child Care** – Development of a professional foster scheme for those hardest to place.	HSCB
51	**Family and Child Care** – Implementation of the RQIA recommendations in relation to Child and Adolescent Mental Health Services (CAMHS).	DHSSPS & HSCB
52	**Family and Child Care** – Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS.	HSCB
53	**Mental Health** – Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.	DHSSPS
54	**Mental Health** – Establishment of a programme of early intervention to promote mental health wellbeing.	DHSSPS
55	**Mental Health** – Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.	DHSSPS
56	**Mental Health** – A consistent, evidence-based pathway through the four step model provided across the region.	HSCB & PHA
57	**Mental Health** – A consistent pathway for urgent mental health care, including how people in crisis contact services, triage and facilities in emergency departments.	HSCB
58	**Mental Health** – Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.	HSCB

Appendix 1: (paragraphs 1.4 and 1.7)

Ownership of the 99 TYC proposals at July 2012

Proposal No.	Proposal	Lead Responsible Body
59	**Mental Health** – Further shift of the balance of spend between hospital and community, with re-investment of any hospital savings into community services.	DHSSPS & HSCB
60	**Mental Health** – Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.	HSCB
61	**Mental Health** – Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.	DHSSPS & HSCB
62	**Mental Health** – Close long stay institutions and complete resettlement by 2015.	HSCB
63	**Learning Disability** – Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds, as referenced in the Family and Childcare section (Section 12).	HSCB & PHA
64	**Learning Disability** – Further development of the current enhanced health services on a NI basis.	HSCB & PHA
65	**Learning Disability** – Support from integrated care partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.	DHSSPS
66	**Learning Disability** – Better planning for dental services should be undertaken.	HSCB
67	**Learning Disability** – Further development of a more diverse range of age-appropriate day support and respite and short-break services.	HSCB
68	**Learning Disability** – Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.	DHSSPS
69	**Learning Disability** – Development of information resources for people with a learning disability to support access to required services.	HSCB
70	**Learning Disability** – Advocacy and support for people with a learning disability, including peer and independent advocacy.	HSCB
71	**Learning Disability** – Commitment to closing long stay institutions and to completing the resettlement process by 2015.	HSCB

Appendix 1 (continued)

Proposal No.	Proposal	Lead Responsible Body
72	**Acute care** – Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document	DHSSPS (with HSCB/PHA to implement)
73	**Acute care** – Over time move to a likely position of five to seven major acute hospital networks in NI. [*The text of the Report recommends that LCGs develop proposals for acute hospital service configuration on the basis of an assessment that the service is sustainable and resilient in clinical terms, along with the potential to provide services to the ROI*].	HSCB
74	**Acute care** – Ensure urgent care provision is locally available to each population.	HSCB
75	**Acute care** – Set targets for the reduction of hospital admissions for long-term admissions and end of life care.	DHSSPS
76	**Acute care** – Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.	DHSSPS
77	**Acute care** – Ensure the transition takes full account of Service Frameworks and clinical pathways.	HSCB
78	**Acute care** – Expeditious implementation of a managed clinical network for pathology.	DHSSPS
79	**Acute care** – Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.	DHSSPS
80	**Palliative & End of Life Care** – Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.	HSCB
81	**Palliative & End of Life Care** – Enhanced support to the Nursing Home Sector for end of life care.	HSCB
82	**Palliative & End of Life Care** - Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.	HSCB
83	**Palliative & End of Life Care** – Electronic patient records in place for the patient, their family and staff.	HSCB
84	**Palliative & End of Life Care** – Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.	DHSSPS
85	**Palliative & End of Life Care** – Palliative and end of life care for children considered as part of the proposed review of paediatric services as referenced in the Maternity and Child Health section.	DHSSPS

Appendix 1: (paragraphs 1.4 and 1.7)

Ownership of the 99 TYC proposals at July 2012

Proposal No.	Proposal	Lead Responsible Body
86	**Service Implications** – Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.	DHSSPS to lead on policy; HSCB & PHA on implementation
87	**Service Implications** – Development of population plans for each of the five LCG populations by June 2012.	HSCB
88	**Service Implications** – Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/allied health professions, and social care.	HSCB
89	**Service Implications** – Development of clear pathways for networked and regional services.	HSCB
90	**Service Implications** – Establishment of a forum to take forward how technology will support the new model of care linking the services to industry and academia.	DHSSPS
91	**Service Implications** – Full rollout of the Electronic Care Record Programme.	HSCB
92	**Service Implications** – Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.	HSCB
93	**Service Implications** – Introduction of a single telephone number for urgent care.	HSCB
94	**Service Implications** – Introduction of a single robust community information system.	HSCB
95	**Service Implications** – Development of new workforce skills and roles to support the shift towards prevention, self care and integrated care that is well co-ordinated, integrated and at home or close to home.	DHSSPS
96	**Service Implications** - Development of GPs to assume a critical leadership role in the new integrated care teams.	DHSSPS & HSCB
97	**Service Implications** – More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.	DHSSPS
98	**Service Implications** – Re-allocation of resources estimated to equate to a 4 per cent shift of funds from hospitals into the community.	DHSSPS
99	**Service Implications** – Initiation of a sensible debate about growing income within the spirit of NHS principles.	DHSSPS

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

Case Example 1: Service Change: Reablement

TYC Proposal 11

Objectives: Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.

Deliverables: To provide people with the support required to return to their own homes following a stay in hospital, an accident or other care crisis.

Achievements to date: Between April 2013 and March 2014, 5,517 people started reablement. Of these 77 per cent were discharged within three weeks of admission to hospital and 43 per cent required no on-going statutory services.

An audit of the reablement service confirmed that c. £7m (gross) in the calendar year 2013 was associated with cost avoidance/cash releasing for domiciliary care as a result of reablement.

Based on actual Trust performance in the period April 2014 - October 2014, the potential for further savings was estimated to be in the region of £5m for 2014-15 (subject to Trusts taking forward specific audit recommendations). The opportunities for further savings/cost avoidance are greatest in Southern and Western Trusts (representing 78 per cent of the opportunity) through full roll-out of the service. This is an objective to which both Trusts are committed; however, it should be acknowledged the phasing/pace of roll-out will be influenced by other competing service demands.

Of 248 successfully reabled service users, 40 per cent were 85+ years of age and of these 38 per cent had two or more ill-health conditions. Of these, 83 per cent were discharged without any on-going care package and 77 per cent have remained out of the service, leading to net savings of £1.3 million.

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

Case Example 2: Service Change: Telecare and Telemedicine

TYC Proposal 27

Objectives: Investment aimed at avoiding hospital care through the provision of health monitoring technology for a range of long term chronic conditions, which allows early intervention in the management of care for these patients before their conditions exacerbate to the stage where a hospital admission is necessary.

Deliverables: To deliver a major procurement of remote monitoring of chronic disease, in line with policy directions, to develop early intervention strategies; promoting and securing community alternatives to hospital referrals and admission; and the better use of ICT combined with reform of the care delivery system.

Achievements to date: Telemonitoring NI service has been made available to over 5,500 users by end March 2016 with 3,000 clients receiving telecare under the terms of the contract at the end of March 2016. Improved access to patient education/self management programmes and remote telemonitoring has allowed increasing numbers of people to effectively and more confidently manage their condition at home, reducing the risk of exacerbation of their condition which could lead to unnecessary admission to hospital.

Case Example 3: Service Change: Hospital at Home Service for Older People

TYC Proposals 13 & 16

Objectives: A service designed to enable health and social care providers to work more closely together to keep people well in local communities and to better share information to plan safe, high quality care around each individual's needs.

Deliverables: Patients referred to the service have, within their own home environment, the same access to specialist tests as hospital inpatients and will receive assessment and treatment from a team of specialist professionals, including a hospital consultant.

Between 2014-15 and 2015-16, £961,000 of funding was provided by the Belfast Local Commissioning Group and the initiative has been established by the Belfast Integrated Care Partnership which brought together the healthcare professionals, voluntary and community representatives and service users and carers who have been involved in designing the new service.

Appendix 2: (continued)

Case Example 4: Service Change: Dementia/Memory Services

TYC Proposal 58

Objectives: In November 2011, the Department released the Northern Ireland Dementia Strategy. It made recommendations aimed at improving the current services and support arrangements for people living with dementia, their families and their carers.

Deliverables/Achievements to date:

- **Belfast Trust - *Dementia Inpatient and Outreach Service*:** The inpatient service provides specialist assessment, treatment and care of people with dementia to enable them to return to the community. The outreach service then provides assistance to enable better care in the community and to prevent unnecessary admission or readmission to hospital.

- **Northern Trust - *Dementia Home Support Team and Inver Model of Care*:** The team is made up of social workers, behavioural science nurses and support workers, with sessional input from a consultant clinical psychologist. Its aims are to provide comprehensive assessment, providing a better understanding of a person's needs, and then to determine how best these needs can be met. The Inver Model of Care was used to guide the refurbishment of the ward so that it is more dementia friendly.

- **South Eastern Trust - *Liaison Psychiatry, Mental Health Services for Older People*:** The community psychiatric nursing (CPN) service came up with the simple solution of aligning itself with each of our care homes in order to provide the first response to the home in cases of delirium, rather than the GP. The service developed a systematic checklist that standardised the approach of the CPN on examination of the patient.

  There has been a marked reduction in waiting times for patients with dementia who exhibit challenging behaviour, from a four-month wait for an acute psychiatric referral or appointment to one week; and a marked reduction in the number of straight referrals to the department of acute psychiatry by 26 per cent. Care home staff have reported that they now feel more confident and supported in dealing with delirium and challenging behaviours, the CPNs have consolidated their knowledge and there is less chance of the symptoms of delirium being missed in the treatment of our patients. CPNs now organise post-diagnostic support clinics where they are involved in anxiety management groups and participate in a new and innovative well-being hub in the Dunmurry and Stewartstown area.

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

- **Southern Trust - *Knowledge is Power, Memory Clinic Information Packs*:** Best practice guidance was consulted to identify information requirements and gaps in the provision of information on dementia. Packs produced containing information on types of dementia, what happens after diagnosis, practitioners within the dementia care services, and health matters specific to dementia. All people living with dementia and their carers are provided with a pack, the intention being that people living with dementia and their carers are better informed and empowered to make decisions about their care.

- **Western Trust - *The Memory Assessment Clinic*:** The clinic is staffed by a nurse, social worker, psychiatrist, geriatrician and psychologists, who meet weekly to discuss and assess patients referred to the service. This facilitates a more focused and streamlined approach, with less overlap between professional roles. There is joint decision making in relation to diagnosis, which delivers prompt decisions, which are unified and more accurate. The result of this teamwork is that people living with dementia have to attend fewer appointments. The team won the 'Team of the Year' in the 2012 Northern Ireland Dementia Excellence Awards, and ranked the Western Trust fifth in the UK, in an Alzheimer's study mapping dementia prevalence and diagnosis rates.

Case Example 5: Service Change: Primary Percutaneous Coronary Intervention

Objectives: Primary Percutaneous Coronary Intervention (pPCI) is a state-of-the-art medical technology that clears blockages in the arteries which can stop blood from flowing to the heart. The objective was to roll out 24/7 coverage across all Trust areas.

Deliverables: A 24/7 primary PCI service at Altnagelvin started on 15 September 2014 and is available to all patients in the Western Trust and a proportion of patients within the Northern Trust. The launch completed full roll-out of the pPCI service across Northern Ireland. £10.6 million was spent on the initiative against a TYC estimate of £9.3 million.

Achievements: State of the art cardiac catheterisation facilities have been of enormous benefit to patients having a heart attack, allowing them to bypass the emergency department and go straight to the laboratory for treatment. Primary PCI is a good example of a modern, responsive, 24-hour, seven day a week service that provides the right care in the right place at the right time.

Appendix 2: (continued)

Case Example 6: Resettlement of Mental Health & Learning Disability Patients

Objectives: Closing long stay institutions and completing the resettlement of adults with mental health and learning difficulties by 2015.

Deliverables: Establishment of a range of community based services.

Achievements: An initial target was to resettle all learning disability patients from long-stay hospitals by 2002. However, this target was not met and by 2002 only half of the patients had been resettled. The Bamford Review of Mental Health and Learning Disability recommended that "by June 2011, all people living in a learning disability hospital should be relocated to the community". TYC's objective was to complete the process by 2015 but as outlined below, this was not fully achieved.

At 31 March 2015, 35 long stay patients remained in learning disability hospitals. Twenty of these patients were planned to commence resettlement during summer 2015 with the longest four planned to be resettled into a new build which will not be completed until the 2016-17 financial year.

At 31 March 2015, 23 long stay patients remained in psychiatric hospitals. Resettlement plans are in place for 16 patients which had not commenced by 31 March 2015. This is due to some schemes being delayed due to procurement, planning permission issues and being new builds. Five of these patients are planned to be resettled into new builds which will not be completed until the 2016-17 financial year.

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

Case Example 7: Western HSC Trust - Respiratory care service

Objectives: Service was changed to encourage a consultant-led focus on the community.

Deliverables: The multidisciplinary model comprised a consultant, an oxygen specialist nurse, a respiratory pharmacist and a respiratory physiotherapist. The change in approach involved the introduction of outreach clinics; the use of phone or virtual clinics; phone and email consultations; home oxygen assessment; drugs reviews; and physiotherapy being available at home.

Achievements: The outcome in one year has been a 38 per cent reduction in the length of stay in the South West Acute Hospital for respiratory inpatients; there were 152 new referrals contacted, and 48 of those patients were discharged; using phone and email consultations, 33 admissions and 89 review clinic appointments were averted; the waiting time for oxygen assessment reduced by 10 months.

Five of the top six drugs prescribed in the Western Trust are respiratory drugs. In four months, there was a saving of approximately £70,000, and almost 100 admissions were prevented through physiotherapy interventions. Patients have reduced side effects from drugs, have interventions to avoid admission, are supported in a more timely fashion and, if admitted, have shorter hospital stays. The Haematology Service in the Western Trust has also transformed outpatient services using similar approaches.

The transformation in services achieved in respiratory care can be replicated in other service areas: work is underway in diabetes, cardiology, ENT and renal services.

Appendix 2: (continued)

Case Example 8: Developing Eye Care

Objectives: In 2012, the Department of Health Social Services and Public Safety (now the Department of Health) launched a five year strategy for eyecare services *(Developing Eyecare Partnerships (DEPs): Improving the Commissioning and Provision of Eyecare Services in Northern Ireland)*. DEP aims to facilitate an integrated approach to the development of eyecare services in Northern Ireland.

Deliverables: DEP adopts a pathway approach to this integration across all sub-specialties where appropriate, from primary care through to specialised secondary care utilising the expertise of a varied skill mix. Supporting these pathways will be the use of new and emerging technologies with seamless communication between those providing the care. The result will be a patient-centred service with emphasis on clinical leadership, training and development giving improved patient experience and outcomes. Information technology is a major enabler for the delivery of DEP

Achievements: There have been several developments over the last 12 months: for example, a local enhanced service for suspect Ocular Hypertension (OHT) referrals has been launched and is working well. Initial data shows that cases which would have been originally referred to secondary care for suspect OHT in line with NICE CG85: Glaucoma: Diagnosis and Management are being successfully deflected by the repeat measurement of Intra Ocular Pressures, reducing false positive referrals and associated patient anxiety. In addition the Health and Social Care Board has registered a number of Independent Prescribing (IP) Optometrists and who have now been issued with NHS prescription pads.

In September 2014, a pilot project was launched in 13 community optometry practices in one locality of the Southern Local Commissioning Group area. The Southern Primary Eyecare Assessment and Referral Service (SPEARS) will enable accredited optometrists to investigate and manage, or triage for onward referral, patients presenting with acute, sudden onset, mainly anterior, non-sight threatening eye problems who would otherwise visit their GP, the Emergency Hospital Eye Service or, an Ophthalmology out-patient clinic.

Appendix 2: (paragraphs 6, 3.3 and 4.13)

Case Examples of Service Change

Case Example 9: Service Change: Stroke Services

There are 2,700 new stroke cases each year, and 35,000 stroke survivors currently living in the community. The TYC strategic business case envisaged stroke service change costs of £10.6m for a range of areas, including provision of stroke service improvement leads in each Trust, a regional stroke co-ordinator, enhanced community infrastructure teams and funding to enable early supported discharge of stroke patients from hospital.

The development of the actual service changes have been impacted by the need to formally request, consider and approve specific provider initiatives as well as the process delays brought about by the need to bid annually to the Department of Health (Department) for TYC in-year funding and the timing, and value, of the funds received from the Department.

All Trusts have in place a stroke service improvement lead (although this has not always required transitional funding as outlined in the business case). The regional stroke co-ordinator was recruited later than expected.

A number of Trusts/ICPs have initially been slow to develop and implement proposals for reforming secondary care stroke services: however that is now changing with the appointment of the regional stroke co-ordinator.

The actual spend of £0.96m by 2015-16 includes TYC funding made available to the Northern Trust who have reformed their secondary care stroke services. This has complemented reform the Trust has taken forward in relation to intermediate stroke rehabilitation, which overall has resulted in 1,714 fewer beds being required in 2014-15 compared to 2013-14. This has been achieved whilst the number of emergency admissions relating to stroke has remained constant.

It is estimated that stroke costs the health and social care services almost £240 million every year. Currently, around a third of stroke patients suffer a decline in health and wellbeing post-stroke and it is recognised that many require additional support to achieve their optimum level of recovery.

In January 2016, the Department announced a Northern Ireland-led international consortium had been awarded €3.6 million (£2.7 million) from the EU's Horizon programme to improve care for stroke patients.

The new research aims through a co-creation process to re-engineer the current approach to stroke patient rehabilitation and discover novel, highly effective rehabilitation technologies and techniques which will have a tangible impact on patient health.

Appendix 3: (paragraph 3.5)

List of all TYC Programme Benefit Measures as at March 2016

Ref	Benefit Measure Description
1a	Increase number of **specialist foster carers** registered
1b	Maintain the number of 'Blueprints' best practice **family early intervention programmes** that are operating in NI
1c	By March 2017 reduce the number of New Emergency Department Attendances, with a Primary Diagnosis of Acute Paediatric Asthma, by 2% compared to 2015-16 volumes (Care Pathways)
1d	By March 2017, maintain at 2015-16 volumes the number of non-elective patient admissions with a primary diagnosis of heart failure (Care Pathways)
1e	90% of complex discharges from acute hospitals to take place within 48 hours for Unplanned Admissions for those with a specified Long Term Condition (LTC) and Frail Elderly patients **(ICP Measure)**
1f	Increase the number of community pharmacies accredited in the **Health Plus Pharmacy Scheme**
1g	Increase the number of adults who have completed a Long Term Condition (physical or mental health related) **patient education** or self-management course
2a	Increase the number of Frail Elderly people treated via an ICP Acute/Enhanced Care at Home Service **(ICP Measure)**
2b	Measure relating to Outpatient Reform to be identified
2c	Increase the number of adults in **supported living accommodation**
2d	Increase the number of adults availing of **Day Opportunity** Placements
2e	Increase the % of the NI population aged 65+ who do not need any **care package** in a given year
2f	Reduce the % of the over 85 population who are treated in acute General Hospitals, who subsequently die in hospital **(ICP Measure)**
2g	Increase the number of clients in receipt of **Direct Payments** for Self Directed Support
2h	Monitor the rate of **normal births**
3a	Reduce the Average Length of Stay resulting from unplanned admissions for all patients with specified long term conditions or defined as Frail Elderly **(ICP Measure)**
3b	Reduce the number of new and unplanned review attendances for the Frail Elderly at Emergency Departments **(ICP Measure)**
3c	Maintain the overall number of **Emergency Department Attendances** at 2014-15 year end volumes
3d	Increase the number of adults in receipt of **short breaks**
3e	The proportion of adults receiving **short breaks** via residential home and nursing home breaks to be 22.6 % or less

Appendix 3: (paragraph 3.5)

List of all TYC Programme Benefit Measures as at March 2016

Ref	Benefit Measure Description
3f	**Shift Left** £83m from hospital/institutional based care into primary, community and social care services
3g	Measure relating to Outpatient Reform to be identified
4a	Increase the number of indicative patients who receive **Telehealth** monitoring
4b	Increased use of **Telecare** services (Monitored Patient Days)
4c	Reduce the rate of emergency readmissions within 30 days of the original discharge date for those with specified LTCs or the Frail Elderly **(ICP Measure)**
4d	Increase the % of people Discharged from **Reablement** who require no further care package
4e	Nursing measure to be identified
4f	Increase the number of active users of **Electronic Care Records**
Qual	**Service User Feedback** on their experience receiving targeted care, treatment and support, perception of joined-up nature of treatment/support

Appendix 4: (paragraph 3.7)

2015-16 Commissioning Plan Direction - Ministerial Priorities and Targets

Ministerial Theme 1: *To improve and protect population health and wellbeing and reduce health inequalities*

Standards and Targets

1	**Bowel cancer screening**	By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited.
2.	**Tackling obesity**	From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.
3.	**Substance misuse**	During 2015-16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes
4.	**Family Nurse Partnership**	By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme

Ministerial Theme 2: *To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.*

Standards and Targets

5.	**Unplanned admissions**	By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas
6.		During 2015-16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting do not exceed 2013-14 levels.
7.	**Carers' assessments**	By March 2016, secure a 10% increase in the number of carers' assessments offered.
8.	**Direct payments**	By March 2016, secure a 10% increase in the number of direct payments across all programmes of care.

Appendix 4: (paragraph 3.7)

2015-16 Commissioning Plan Direction - Ministerial Priorities and Targets

9.	**Allied Health Professionals (AHP)**	From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment
10.	**Hip fractures**	From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.
11.	**Cancer services**	From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.
12.	**Unscheduled care**	From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.
13.		By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.
14.	**Emergency readmissions**	By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.
15.	**Elective care – outpatients / diagnostics/ inpatients**	From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks.
16.		From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken
17.		From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.
18.	**Organ transplants**	By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD (donation after circulatory death) and DBD (donation after brain death) donors.
19.	**Stroke patients**	From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.
20.	**Healthcare acquired infections**	By March 2016 secure a reduction of 20% in MRSA and *Clostridium difficile* infections compared to 2014-15.

Appendix 4: (continued)

21.	**Patient discharge**	From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.
22.	**Mental health services**	From April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).
23.	**Children in care**	From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.
24.		By March 2016, ensure a three year time frame for 90% of children who are adopted from care.
25.	**Patient safety**	From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.
26.	**Normative staffing**	By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.

Ministerial Theme 3: *To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.*

Standards and Targets

27.	**Excess bed days**	By March 2016, reduce the number of excess bed days for the acute programme of care by 10%.
28.	**Cancelled appointments**	By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment.

Appendix 4: (paragraph 3.7)

2015-16 Commissioning Plan Direction - Ministerial Priorities and Targets

29.	**Delivering transformation**	By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model.
30.	**Pharmaceutical Clinical Effectiveness Programme**	By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

NIAO Reports 2016 and 2017

Title	Date Published
2016	
Governance of Land and Property in the NI Housing Executive	07 January 2016
Continuous Improvement Arrangements in Policing	08 March 2016
Local Government Code of Audit Practice	31 March 2016
Managing Legal Aid	21 June 2016
Contracted Training Programmes	28 June 2016
Renewable Heat Incentive Scheme	05 July 2016
The National Fraud Initiative: Northern Ireland	07 July 2016
Department for the Economy - Access to finance for small and medium sized enterprises	19 July 2016
The Rivers Agency: Flood Prevention and Management	13 September 2016
Local Government Auditor's Report 2016	20 September 2016
Northern Ireland Public Sector Voluntary Exit Schemes	11 October 2016
Managing Emergency Hospital Admissions	08 November 2016
Financial Auditing and Reporting: General Report by the Comptroller and Auditor General for Northern Ireland – 2016	06 December 2016
Special Educational Needs	12 December 2016
2017	
Continuous improvement arrangements in policing	04 April 2017

Published and printed by CDS

CDS 169007

ISBN 978-1-911003-68-7