2013 No. 13

The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by sections 6 and 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(a):

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014 and shall come into operation on 13 November 2013.

(2) In this Direction—

“the Act” means the Health and Social Care (Reform) Act (Northern Ireland) 2009;
“LCG” means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;
“Commissioning Plan” means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission for the period 1st April 2014 to 31st March 2015, for consideration and approval by the Minister. In doing so, it shall include the underpinning financial plan, and detail how commissioning will serve to deliver the planned transformation of services, including Transforming Your Care (TYC), and meet the standards and targets set out in the Schedule.

(2) The Commissioning Plan shall provide details of indicative commissioning intentions and associated indicative financial commitments for the period 1st April 2015 to 31st March 2016.

(3) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board and the underpinning financial plan align with and support the delivery of the Executive’s Programme for Government (PFG) commitments and associated milestones, its Economic Strategy and its Investment Strategy; the Minister’s vision and priorities for health and social care; extant statutory obligations, including Equality duties under the Northern Ireland Act 1998(b), the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); the standards, policies and strategies set by the Department; the agreed transformation of health and social care services including TYC; and Departmental guidance and guidelines.

(4) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board will deliver safe, effective and high quality care in the most appropriate

(a) 2009 c.1 (N.I.)
(b) 1998 c.47
setting, represent an equitable use of the resources made available for health and social care to the Northern Ireland population, based on relative need, and support the implementation of the agreed service delivery changes arising from planned transformation. In doing so the Commissioning Plan must:

(a) include the Strategic Context – the environmental factors and drivers for change influencing commissioning intentions and future service development and design, taking account of the strategic policies and priorities set by the Department;

(b) include the five LCG Commissioning Plans as part of the Commissioning Plan. These should reflect the use of an evidence-based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCG's target fair share, and the actual resources deployed for the respective populations;

(c) for all regional services and for each of the five Local Commissioning Groups, set out fully the services to be commissioned with details of specific commissioning intentions designed to deliver on the targets, standards and strategic priorities in this Direction for the year 1st April 2014 to 31st March 2015. This should include the values and volumes of services to be commissioned at LCG level and how they relate directly to meeting the assessed needs of the population and the delivery of standards and targets. The Plan should also provide indicative commissioning intentions for the year 1st April 2015 to 31st March 2016, to include a high level assessment of values and volumes of services to be commissioned;

(d) set out clear timescales and milestones for the delivery of the commissioning plan and underpinning financial plan as appropriate, and for the implementation of agreed service delivery changes arising from TYC;

(e) demonstrate how commissioning intentions take account of existing performance, and detail how performance management of HSC Trusts and other providers is used to ensure that assessed needs are met and targets and standards are being delivered through the effective and efficient use of the available resources. The Plan should explain how the Regional Board, in consultation with the Regional Agency as appropriate, will address significant under-performance against requirements by providers; and

(f) include specific commissioning intentions designed to support the six PFG commitments led by DHSSPS and the achievement of PFG milestones.

3.—(1) The Commissioning Plan shall demonstrate how the commissioning proposals deliver on the following key strategic priorities and statutory obligations:

(a) To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion, anticipation and earlier intervention;

The Commissioning Plan must demonstrate how the services to be commissioned support the aims and outcomes of the Public Health Strategic Framework 2013-23 and related population health strategies, and are conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland to fulfill the requirements of Section 2(3) (g) of the Act. There should be a strong focus in the Plan on how the services to be commissioned will prevent ill-health, anticipate the needs of local populations, and promote health and well-being. The Plan should also detail the early intervention measures being taken by the Regional Board and Regional Agency, where appropriate working in partnership with other organisations, and should demonstrate a commitment to address the wider determinants of health through, for example, the use of social clauses in procurement and service contracts where appropriate, and to maintaining and developing grassroots community and voluntary organisations.
(b) *To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting;*

The Commissioning Plan must demonstrate how the services to be commissioned will fulfil the statutory duty on the Regional Board under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(a); reflect the principles, values and standards set out in the Quality 2020 Strategy; improve the safety and effectiveness of services to deliver safe, high quality care that meets recognised standards, including those set out in Service Frameworks; and improve the patient and client experience, including implementation of the regional priorities identified in the PHA annual report (2013/14) on the Patient Experience Standards. The Plan must explain the outcomes which will be delivered for patients, clients and carers and outline how the Regional Board will take account of the views of patients, clients and carers in the commissioning of services. The Plan should also demonstrate that the design and delivery of services to be commissioned is based on the best available robust, research-informed evidence, in accordance with the objectives of the Department’s strategy for Health and Social Care Research and Development.

(c) *To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions;*

The Commissioning Plan must demonstrate how the services commissioned will improve access to treatment, care and support closer to home, and facilitate people to live as independently as possible in their own community. This should include preventing people unnecessarily entering hospital and enabling them to return home safely as soon as they are fit to do so. The Plan should set out how services being commissioned will meet the requirement for more effective long-term condition management. The Plan should demonstrate how innovation in the delivery of services has been adopted, working with a range of providers to improve patient and client care, including through the use of innovative technologies to support people to manage their conditions at home.

(d) *To promote social inclusion, choice, control, support and independence for people living in the community, especially older people, and those individuals and their families living with disabilities;*

The Commissioning Plan must detail how the services to be commissioned will promote social inclusion and support people with health and care needs living in the community, particularly older people, and people with disabilities and their families. The Commissioning Plan should demonstrate an emphasis on home as the hub of care, including through the use of personal budgets, access to reablement services, age-appropriate day opportunities, enhanced provision of short breaks and the timely delivery of carers’ assessments.

(e) *To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the community, voluntary and independent sector;*

The Commissioning Plan must detail how the Regional Board proposes to take forward the design and delivery of services developed around the local needs of patients, clients and carers through strengthened local commissioning and performance management systems, and working in partnership with other organisations as appropriate.

(f) *To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities;*
The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations, and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act. It must also demonstrate how the Regional Board and Regional Agency will adopt and implement learning from relevant benchmarking studies; the experience of other organisations and how they intend to promulgate and share best practice.

(g) To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services;

The Commissioning Plan must demonstrate that the services being commissioned are sufficient to ensure that statutory responsibilities to assess needs, safeguard, protect and support vulnerable groups, including through the discharge of delegated statutory functions, will be met. There should be an emphasis on prevention and early intervention, in particular in connection with those families whose children are on the edge of care. The Plan will demonstrate how all HSC Trusts, as corporate parents, will be expected to meet the specific needs of looked-after children by providing high quality, enduring placements for them and supporting their transition out of care and into adult life.

Commissioning and the use of financial allocations

4.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1st April 2014 to 31st March 2015, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources. The Plan shall also provide details of indicative commitments for the financial year from 1st April 2015 to 31st March 2016.

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

(3) This information shall be provided separately for each of the five LCGs, for provider organisations and for services commissioned regionally by the Regional Board in the manner specified by the Department in its budget allocation letters.

(4) This information shall include an analysis of how the Regional Board plans to shift the proportion of spend from hospital services to primary and community services in accordance with the planned transformation of health and social care services.


[Signature]

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety
# SCHEDULE

## Standards and Targets for 2014/15

<table>
<thead>
<tr>
<th>Priority</th>
<th>Standard/ Target</th>
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<tbody>
<tr>
<td>To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention</td>
<td><strong>Bowel cancer screening</strong></td>
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<td>1. The HSC will extend the bowel cancer screening programme from April 2014 to invite, by March 2015, 50% of all eligible men and women aged 60-74, with an uptake of at least 55% of those invited.</td>
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<td><strong>Family Nurse Partnership</strong></td>
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<td>2. By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust.</td>
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<td><strong>Substance misuse</strong></td>
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<td>3. By March 2015, services should be commissioned and in place that provide seven day integrated and coordinated substance misuse liaison services within all appropriate HSC acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention programmes.</td>
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<td><strong>Tackling obesity</strong></td>
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<td>4. By March 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.</td>
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<td>To improve the quality of services and outcomes for patients, clients and carers, through the provision of timely, safe, resilient and sustainable services in the most appropriate setting.</td>
<td><strong>Hip fractures</strong></td>
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<td>5. From April 2014, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.</td>
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<td><strong>Cancer care services</strong></td>
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<td>6. From April 2014, 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</td>
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cancer should begin their first definitive treatment within 62 days.

Unscheduled care

7. From April 2014, 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.

8. By March 2015, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.

Hospital readmissions

9. By March 2015, secure a 5% reduction in the number of emergency readmissions within 30 days (using 2012/13 data as the baseline).

Elective care – outpatients / diagnostics/ inpatients

10. From April 2014, at least 80% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 15 weeks.

11. From April 2014, 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.

12. From April 2014, at least 80% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks

Healthcare acquired infections

13. By March 2015, secure a further reduction of x% in MRSA and Clostridium difficile infections compared to 2013/14. [x to be available in March 2014]

Organ transplants

14. By March 2015, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.

Specialist drugs
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<tr>
<th>15. From April 2014, no patient should wait longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.</th>
<th><strong>Stroke patients</strong></th>
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<tr>
<td>16. From April 2014, ensure that at least 12% of patients with confirmed ischaemic stroke receive thrombolysis.</td>
<td><strong>Pressure ulcers</strong></td>
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<td>17. By March 2015, secure a 10% reduction in pressure ulcers in all adult inpatient wards.</td>
<td><strong>Medicines Formulary</strong></td>
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<td>18. From April 2014, ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area.</td>
<td><strong>Allied Health Professionals (AHP)</strong></td>
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<td>To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions</td>
<td>19. From April 2014, no patient waits longer than nine weeks from referral to commencement of AHP treatment.</td>
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<td><strong>Telehealth</strong></td>
<td><strong>Unplanned admissions</strong></td>
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<td>20. By March 2015, deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.</td>
<td>21. By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions (using 2012/13 data as the baseline).</td>
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<td><strong>To promote social inclusion, choice, control, support and independence for people living in the community, especially older people and those individuals and their families living with disabilities</strong></td>
<td><strong>Carers’ assessments</strong></td>
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<td>22. By March 2015, secure a 10% increase in the number of carers’ assessments offered.</td>
<td><strong>Direct payments</strong></td>
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<td>23. By March 2015, secure a 5% increase in the number of direct payments across all programmes of care.</td>
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<td><strong>Telecare</strong></td>
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<td>24. By March 2015, deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.</td>
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<td><strong>To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the community, voluntary and independent sector</strong></td>
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<td><strong>Patient experience</strong></td>
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<td>25. The Regional Agency, in liaison with the Regional Board and HSC Trusts, to assist the Department to deliver a regional survey of inpatient and A&amp;E patient experience during 2014/15, in order to baseline the position regarding patient experience and put in place a programme of work to secure improvements.</td>
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<td><strong>Integrated Care Partnerships</strong></td>
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<td>26. By March 2015, 95% of patients within the four ICP priority areas [frail elderly, diabetes, stroke, respiratory] will have been identified and will be actively managed on the agreed Care Pathway.</td>
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<td><strong>To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities</strong></td>
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<td><strong>Delivering transformation</strong></td>
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<td>27. By March 2015, transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services.</td>
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<td><strong>Normative staffing</strong></td>
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<td>28. The Regional Agency should continue to lead and monitor the programme of work to develop and implement Normative Nurse Staffing which should be used to commission and deliver services as follows:</td>
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<td>i. From April 2014, the Normative Nurse Staffing Tool should be applied to all inpatient general and specialist adult hospital medical and surgical care settings;</td>
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<td>ii. By March 2015 normative staffing</td>
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ranges will be developed and introduced for Health Visiting within a range which secures the delivery of the service model detailed within the Departmental Strategy ‘Healthy Futures’.

Unnecessary hospital stays

29. By March 2015, reduce the number of excess bed days for the acute programme of care by 10% (using 2012/13 data as the baseline).

Cancelled clinics

30. By March 2015, reduce the number of hospital cancelled consultant-led outpatient appointments by 17%.

Patient discharge

31. From April 2014, 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.

Learning disability and mental health

32. By March 2015, resettle the remaining long-stay patients in learning disability and psychiatric hospitals to appropriate places in the community.

Mental health services

33. From April 2014, 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).

Children in care

34. From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%.

To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across all our services
35. By March 2015, ensure a three year time frame for 90% of children who are to be adopted from care.

36. From April 2014, ensure that all school-age children who have been in care for 12 months or longer have a Personal Educational Plan (PEP).
EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2013

1. The Minister’s vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister’s vision and priorities during the year 1st April 2014 to 31st March 2015.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2014/15 financial year are resourced through the underpinning financial plan and will serve to deliver on the agreed planned transformation of services, including TYC. The Commissioning Plan shall provide details of indicative commissioning intentions and associated indicative commitments in 2015/16 to reflect the integrated nature of the Plan and the need to plan over the longer term timescale for effective implementation of agreed transformation.

4. The targets and standards included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year and are complemented by identified indicators of performance included in a separate Indicators of Performance Direction to the Regional Board.

5. Effective performance management of the health and social care system requires availability of a range of indicators to help track trends. An Indicators of Performance Direction will be produced alongside the Commissioning Plan Direction to ensure that the HSC has a core set of indicators in place, on common definitions across the sector. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.
PROGRAMME FOR GOVERNMENT (PFG) COMMITMENTS AND MILESTONES

The Department leads on six PFG Commitments each of which has three annual milestones. The Commissioning intentions within the Commissioning Plan must support the continued delivery of milestones set for 2012/13 and 2013/14, and the achievement of milestones for 2014/15.

**PFG Commitment 22:** Allocate an increasing percentage of the overall health budget to public health

2012/13 – Strengthen the cross-sectoral, cross-Departmental drive on improving health and mental wellbeing and reducing health inequalities by setting new policy direction and associated outcomes based on the most recent bodies of evidence available.

2013/14 – The HSC will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from 1st April 2014

2014/15 – Invest an additional £10m in public health (increase based on 2011/12 spend)

**PFG Commitment 44:** Enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic management programme

2012/13 – Identify and evaluate the current baseline of patient education and self management support programmes that are currently in place in each Trust area.

2013/14 – Health and Social Care Board and Public Health Agency should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long-term conditions effectively, alongside full application of the Remote Telemonitoring contract

2014/15 – People with a long-term condition will be offered access to appropriate education, information and support programmes relevant to their needs, including innovative application of connected health

**PFG Commitment 45:** Invest £7.2 million in programmes to tackle obesity

2012/13 – Invest £2 million in tackling obesity through support of Obesity Prevention Framework

2013/14 – Invest £2.4m in tackling obesity through support of Obesity Prevention Framework

2014/15 – Invest £2.8m in tackling obesity through support of Obesity Prevention Framework
**PFG Commitment 61:** Introduce a package of measures aimed at improving safeguarding outcomes for children and vulnerable adults across Northern Ireland

2012/13 - **Develop a Strategic Plan for Adult Safeguarding in Northern Ireland and produce a joint Domestic and Sexual Violence and Abuse Strategy**

2013/14 - **Open new Sexual Assault Referral Centre at Antrim Area Hospital**

2014/15 – **Develop an updated inter-departmental Child Safeguarding Policy Framework**

**PFG Commitment 79:** Improve Patient and Client outcomes and access to new treatments and services

2012/13 – **Enhance access to life-enhancing drugs for conditions such as rheumatoid arthritis, cancer, inflammatory bowel disease and psoriasis and increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis**

2013/14 – **Improve long-term outcomes relating to health, well-being, education and employment for the children of teenage mothers from disadvantaged backgrounds by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site**

2014/15 – **Expand cardiac catheterisation capacity to improve access to diagnostic intervention and treatment and further develop the primary percutaneous coronary intervention (PPCI) service to reduce mortality and morbidity arising from myocardial infarction (heart attack)**

**PFG Commitment 80:** Reconfigure, reform and modernise the delivery of Health and Social Care services to improve the quality of patient care

2012/13 – **Development of a clear implementation and Population plan to ensure delivery of the new model of care as set out in the Transforming Your Care report**

2013/14 – **As part of a shift in the delivery of services to primary and community settings reduce by 2013/14, the number of days patients stay in acute hospitals unnecessarily (excess bed days) by 10% compared with 2011/12**

2014/15 – **Secure a shift from hospital-based services to community-based services together with an appropriate shift in the share of funding in line with the recommendations of Transforming Your Care**