HEALTH AND WELLBEING 2026

DELIVERING TOGETHER

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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FOREWORD

The World Health Organisation defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". That is the health outcome I want to deliver for all our people.

But without new approaches and in the face of ever growing demand - often driven by successful interventions and improving life expectancy - we will increasingly struggle.

Change is quite simply essential to deliver the world class service - free at the point of delivery and based on need - that is our collective commitment.

We must move beyond simply managing illness and instead ensure that our health service supports people to stay well; physically, mentally and emotionally.

In other words, we need to rethink how we deliver our health and social care service.

My predecessor, Simon Hamilton, asked a panel led by the internationally recognised expert, Professor Rafael Bengoa, to help us identify how to tackle the challenges in our Health and Social Care system.

Their report tells us clearly that we need to re-organise how we do things - and that we need to do this in partnership with the people who use the service and those who work in it. Critically, we must prioritise prevention and early intervention to ensure that people stay well. This approach will produce better health and wellbeing outcomes and it will reduce demand on our over stretched acute services. It will also help us tackle what the Expert Panel Report calls "striking health inequalities" in our society.

This document, Health and Wellbeing 2026: Delivering Together, is the outworking of the Expert Panel's recommendations. It sets out a commitment to tackle the issues we face in our Health and Social Care system through decisive political leadership. We are determined to move beyond short-term approaches and crisis management.

This Executive is united as never before in its commitment to take the right, perhaps difficult, decisions. But we know this is the only way to deliver better outcomes for our people.

We are facing into a time of change for our health system but it is change that must happen. This document sets out a direction of travel that I hope all of our society can embrace and support in the challenging but exciting time ahead.

Michelle O'Neill, MLA
Minister of Health

1 THE CHALLENGE

My desire for world class health and social care is based on firm foundations - we have a health and social care system staffed with many talented and dedicated people working extremely hard to deliver high quality services to those in need. But increasingly those efforts are frustrated by a system which is clearly under mounting pressure. This is impacting on both those within the system and those it serves. Without radical change there is no doubt the situation will further deteriorate. That is why I am convinced that change is needed now.

Before I set out the case for change, it is important to acknowledge and celebrate where Health and Social Care, in collaboration with wider government, is making a real difference to our health and wellbeing.

Standardised
CIRCULATORY DEATH RATE
in under 75s
decreased by a fifth over the last 5 years

ENGAGEMENT WITH EDUCATION TRAINING OR EMPLOYMENT FOR THOSE AGED 16-21 WHO ARE IN CARE OR HAVE LEFT CARE HAS RISEN 5.7% IN THE PAST YEAR

SMOKING PREVALANCE FELL
from 26% in 2004/05
to 22% in 2014/15

7677
CARERS RECEIVED SUPPORT FROM TRUSTS IN 2015 COMPARED TO 1414 IN 2011

Over **1 in 3** adults (36%) reported that they ate the recommended
5 PORTIONS
of fruit & veg a day (2014/15)
increased by a third over the last 10 years

FAMILY SUPPORT HUBS
In 2015/16, **4522 families with children** were referred to Family Support Hubs, a **72% increase** on the previous year. Of the 5346 children referred to Hubs in 2015/16, **around 18% were children with a disability**

BOWEL CANCER DECREASE
Since **bowel cancer screening** was introduced, the percentage of people diagnosed with early stage disease has increased from **14% to 22%** thereby **improving their life chances**

LOOKED AFTER CHILDREN
achieving Key Stage 1: Level 2 or above

in English
7.5% INCREASE

in Maths
7% INCREASE

INCREASE IN ADOPTIONS
Between 2014/15 and 2015/16, there has been a **24% INCREASE** in the adoptions of Looked After Children

LIFE EXPECTANCY
over the last 5 years life expectancy has increased

1.3 YEARS
for males
(78 years)

1 YEAR
for females
(82.3 years)

Standardised
RESPIRATORY DISEASE DEATH RATE
in under 75s
decreased by a fifth
over the last 5 years

MMR VACCINE
over 95% of children received the MMR Vaccine which means we have not seen the outbreaks of measles that have occurred elsewhere

At the heart of the many successes of the Health and Social Care (HSC) system is the hard work and dedication of all staff, in every grade and role, who are delivering care at higher levels than ever before.

However, while there is much to celebrate, we must recognise the challenges in the current system. The reality is that we increasingly cannot properly meet people's needs with our current structures. In the past, and for a range of reasons, it has not been possible to achieve the whole system transformation at the scale and with the pace we need to meet the evolving health needs of our people. More and more the impact of this is felt on a daily basis and takes its toll on both those who use services and those working in the sector.

Our Health and Social Care System faces a number of significant challenges:

Organisational

In many past reviews, professionals and staff have expressed their frustration at the limitations of our current arrangements and their desire for change, most recently in the Expert Panel report. The 20th century configuration of our services is simply not optimised to meet the needs of 21st century care.

The point has now been reached where maintaining the current delivery models is having increasingly negative impacts on the quality and experience of care for many service users, while constraining the ability of the system itself to transform to meet today's health needs.

While staff work increasingly hard to mitigate these structural issues, the overall impact is experienced by service users and their families every day in every part of the system. Regrettably, delays in accessing services and unacceptable waiting times for treatment are commonplace. The quality of our service, and the experience of those providing and receiving it, is not as good as it should be.

Modern research shows that outcomes for patients requiring complex or specialist treatment improves where high levels of specialist expertise is available and these teams are able to keep pace with innovation. The current spread of such HSC resources, too often committed to buildings rather than outcomes for patients, is a central challenge we must address.

If we persist with our current models of care, even with the best efforts of all staff and more investment year on year, waiting lists will continue to grow, our expertise will continue to be diluted, and the best possible outcomes for patients will not be realised. This is both unsustainable and unacceptable.

In addition, the way we are organised means that opportunities are being missed to create sustainable employment, drive economic investment, and maximise the contribution of the HSC to the economic goals of the Executive. For example, the life and health sciences sector provides 10% of all of the North's exports. Closer working between the HSC, our world class universities and life and health science organisations and maximising the potential for growth in this high value sector, is fundamentally dependent on centres of clinical excellence with the right level of expertise and the necessary capacity.

Workforce

A further challenge relates to the workforce itself. People who work in health and social care are its greatest strength, working ever harder to provide the care needed by patients and service users. Year on year, investment has been directed to front line services in an effort to meet the ever growing need for treatment and care.

However, if we accept, as a whole range of reviews have, that our services are not best configured for our needs, then it follows that recruiting additional staff alone to prop up outdated service models, is not the answer. We must be able to provide safe and high quality care which keeps up with the fast pace of innovation and health and social care developments. I recognise that staff need the opportunity to develop their skills and expertise in an environment which allows for a greater degree of specialisation, whilst maintaining personalised compassionate care.

It has also become clear that even when resources are made available to recruit additional staff, it has simply not been possible to fill all vacant posts. This in turn puts additional pressure on already hardworking staff and has seen our service become increasingly reliant on short term solutions such as locums and agency staff. This creates additional expense with negative implications for the quality of care. It has become a vicious circle which we must stop.

We must invest in our staff and provide the environment to allow them to do what they do best - provide excellent high quality care. This means providing opportunities to develop their skills and find suitable career paths at all levels. Where necessary, we will increase the numbers we train and consider ways of delivering care more effectively through the development of new roles and skills.

I am determined that we will make the health and social care system an employer of choice in the north of Ireland.

The Needs of a Rapidly Changing and Ageing Population

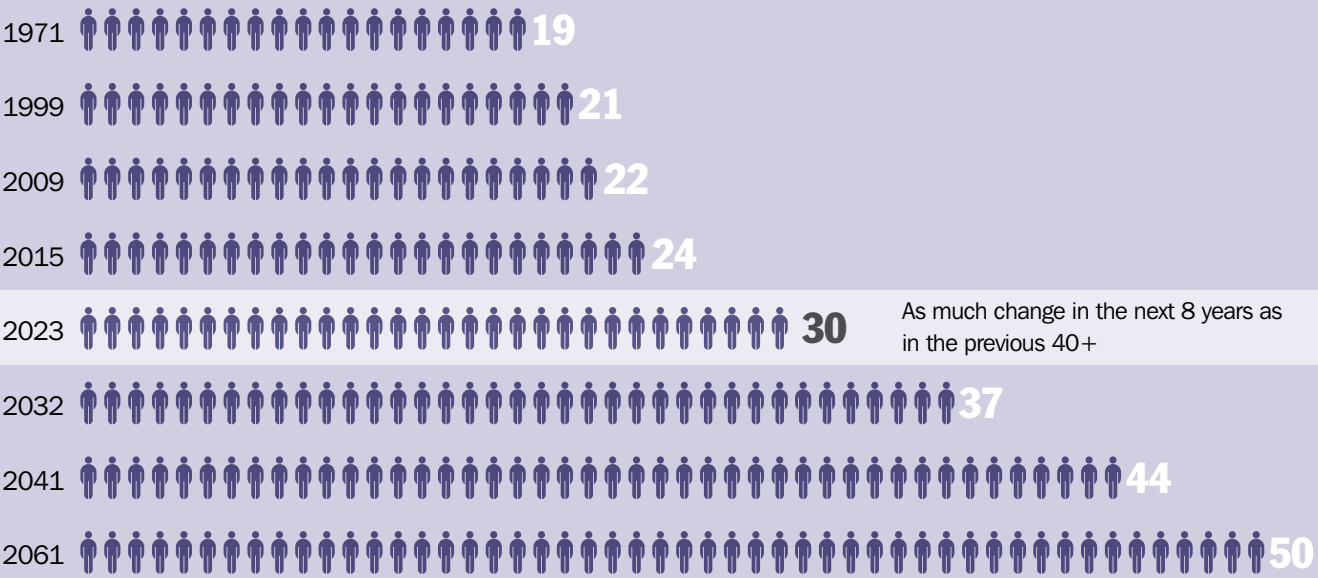
Our society is getting older: people are living longer, often with long-term health conditions, and we are having fewer children. Estimates indicate that by 2026, for the first time, there will be more over 65s than under 16s.

By 2039, the population aged 65 and over will have increased by 74% compared to the position in 2014. This will mean that one in four people will be aged 65 and over.

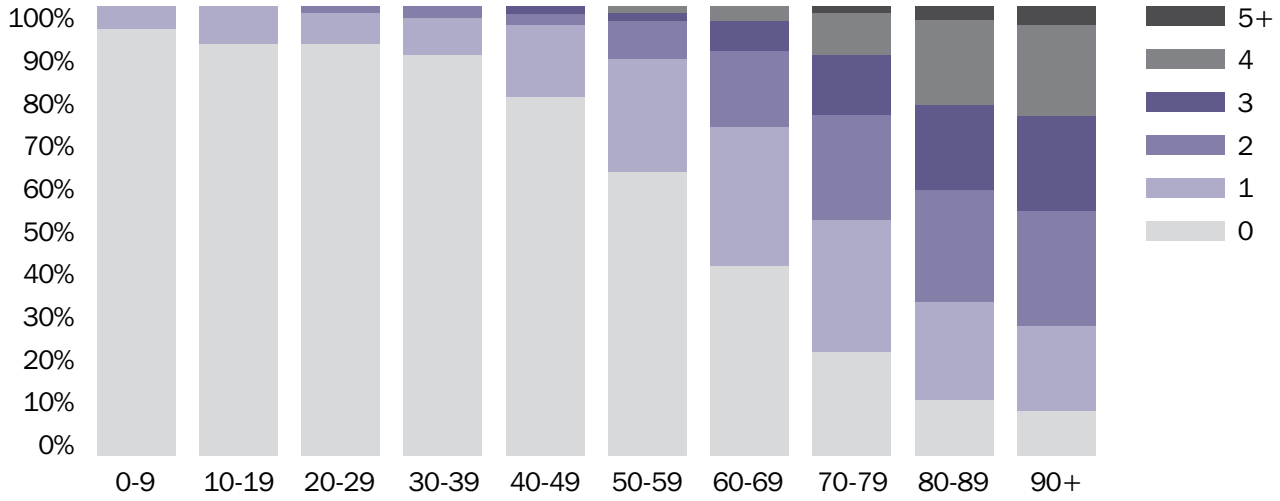
Similarly, the population aged 85 and over will increase by 157% over the same period, which will see their share of the population increase from 1.9 % to 4.4%.

By any analysis, this is a massive success to which our health and social care service has made a significant contribution. That said, it does present a huge and growing challenge in terms of the demands and pressures on health and social care services.

An ageing population - number of older people (65+) per 100 aged 16-64



Percentage of patients in each age band with the indicated number of morbidities



Developments in how conditions can be treated and managed mean that as we get older we are much more likely to develop and live with one or more long term conditions. The table above demonstrates that as we get older, the likelihood of having more than one condition at the same time increases dramatically, and with that the care and treatment that we require becomes much more complex.

Furthermore, people's health and social care needs have changed, and their expectations are rightly higher than at any other time before. In the past, for many conditions, where there was an effective treatment available, it often required hospital attendance or an in-patient stay. Increasingly, such treatments are available in the community, or can be provided on a day care basis; which in many instances is more appropriate to the needs of people with longer-term chronic conditions.

People today want to lead full and productive lives, staying independent for longer. In line with wider societal changes, we all expect improved access, choices and control when it comes to public services.

Health Inequalities

Despite people living longer, health inequalities continue to divide our society. The differences in health and wellbeing outcomes between the most and least deprived areas are still very stark, and completely unacceptable.

For example, men in the least deprived areas live 7.5 years longer than men in the most deprived areas. For women, the difference is over four years. In the most deprived areas, 30% of people report a mental health problem - double the rate in least deprived areas. Rates of suicide are also higher, and leave a devastating impact on people, families and those communities.

Birth weight is an important indicator of foetal and neonatal health, and a low birth weight has a strong association with poor health outcomes in infancy, childhood and throughout someone's life. Between 2010 and 2014, the proportion of babies born at a low birth weight was 44% higher in the most deprived areas than in the least deprived areas.

In 2013/14, the rate of obesity among children in Primary 1 was 71% higher in the most deprived areas than those in the least deprived areas. 42% of Looked After Children (LAC) come from the most deprived areas in the North. Being looked after is associated with poorer socio-economic outcomes in adulthood.

It is clear that economic, social and environmental factors, and experiences early in life, play a major role in determining not just the health outcomes at an individual and community level, but also their social, educational, economic and other outcomes. There is also growing evidence that children who experience adversity in childhood are far more likely to experience health issues in adult life. Specifically, these children are more likely

to adopt health harming behaviours during adolescence which can lead to mental health illness and diseases such as cancer, heart disease and diabetes later in life. Adversity in childhood also means that children are more likely to perform poorly in school, more likely to be involved in crime and more likely to experience poverty and disadvantage in adult life.

Our future health and social care system needs to not only treat people who become sick or need support now, but also needs to do much more to ensure that the next generation is more healthy with more equitable life opportunities for all.

Our Opportunity

The problem and the compelling case for change is not in itself new, and has been made repeatedly by experts, staff and patients over many years. The Expert Panel's Report "Systems, not Structures: Changing Health and Social Care" once again reaffirms this. But despite the overwhelming evidence, the opportunity has thus far not been grasped. However, both as Minister and as an Executive we believe there is now no alternative but to transform how we design and deliver health and social care services.

The political summit hosted by the Expert Panel in February 2016 secured a political mandate for the need for change and the principles to underpin it, and I look forward to all parties engaging with and supporting the HSC to make the difficult decisions required to improve our population's health, and build a sustainable health and social care system. This is the time for political leadership.

The advent of a new outcomes based approach in the draft Programme for Government puts an onus on us all to work together, across traditional silos and boundaries to deliver the best outcomes for the people of the North. Now is the time for us to work collectively to deliver a world class health service.

Across this island, the health and social care fabric of both jurisdictions face the same challenges. We have the opportunity to work more collaboratively with colleagues to address those challenges, and deliver services in a way that improves care for our population as a whole. There are many good examples of where this is already working well, such as cancer and cardiac services in the north west or the partnership with Dublin for children's heart surgery. There are many more such opportunities, including the transplantation of organs and rare diseases, and we have developed a programme of work with the Department of Health in the South to identify areas of mutual benefit.

Staff, clinicians and professionals from right across our health and social care system are telling us loud and clear that change is now necessary. If we do not grasp this opportunity change will happen anyway but in a reactive and unplanned way, with more potential for detrimental impacts on those who use and deliver our services.

In addition, the HSC itself is a huge contributor to the economy in many ways, through skills development, spending power and employment practices.

As the single biggest employer in the North, we have a real opportunity and responsibility to make a tangible and positive contribution to the health and wellbeing of our staff, and society as a whole. We will be an employer of choice, leading by example and investing in the wellbeing of our staff. Despite the demand, resource and service pressures being experienced, I am committed to ensuring the wellness dimensions of being an employer of this scale will be better achieved across the HSC.

In the way we operate, we have the opportunity to promote a new way of working with the community and voluntary sectors through the innovative use of social procurement clauses, and commissioning services based on social value rather than simply on the basis of lowest cost.

Working with our world class universities, skilled graduates and world leading companies, we can grow our life and health sciences sector, creating new jobs. This will mean access to cutting edge technology and therapies, and the dual benefit of improving care and economic growth. To do so requires further collaboration between HSC, academia and industry. The HSC can only play its part if it can provide the centres of expertise and excellence that will continue to attract partners, and support the recruitment and retention of experts in their fields.

2 THE AMBITION

Health is a human right. I am deeply committed to the principle of universal health care, free at the point of delivery to those in need.

Aligned with the aspirations the Executive set out in the draft Programme for Government, my overarching ambition is for every one of us to **lead long, healthy and active lives**.

Therefore, we want to see a future in which:

- people are supported to keep well in the first place with the information, education and support to make informed choices and take control of their own health and wellbeing;
- when they need care, people have access to safe, high quality care and are treated with dignity, respect and compassion;
- staff are empowered and supported to do what they do best; and
- our services are efficient and sustainable for the future.

All of these aims are of great importance and must be addressed if we are to meet the future needs for our population.

They will underpin a new model of **person-centred care** focussed on prevention, early intervention, supporting independence and wellbeing. This will enable the focus to move from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

We will create the circumstances for people to stay healthy, well, safe and independent in the first place. We will anticipate the needs of individuals for support and care and this new model of person-centre care will intervene early to avoid deterioration.

This model will be designed for and with people and communities rather than by organisations and services. Instead of thinking about buildings and hospitals as the only place to deliver services, we will deliver care and support in the most appropriate setting, ideally in people's homes and communities. In most instances people should only have to go to hospital when they need treatment that can't be provided in their community.

The way we design and deliver services will be focussed on providing continuity of care in an organised way. To do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration.

3 THE CHANGE NEEDED

If we are to support everyone to lead long, healthy, and active lives, we need to change the focus of our services, and how and where those services are delivered. The Expert Panel has clearly said that 'something very different has to happen at the delivery of care level'.

We must:

- **Build capacity in communities and in prevention** to reduce inequalities and ensure the next generation is healthy and well;
- **Provide more support in primary care** to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems;
- **Reform our community and hospital services** so that they are organised to provide care when and where it is needed;
- **Organise ourselves to deliver** by ensuring that the administrative and management structures make it easier for staff to look after the public, patients and clients.

Build capacity in communities and in prevention

We will work with communities to support them to develop their strengths and use their assets to tackle the determinants of health and social wellbeing.

We will support the development of thriving and inclusive communities, through the work of the HSC working closely with Executive colleagues and other providers such as councils, schools, police, housing and transport.

In particular, the HSC will become better at tapping into the innovative ideas and energies in communities themselves, and in the community and voluntary sectors. In all communities, every child and young person should have the best start in life, people should have a decent standard of living, and all citizens should be supported to make healthier and better informed life choices.

We will invest in HSC community development resources to work alongside all communities to enable social inclusion and tackle health inequalities and the underlying contributory factors including poverty, housing, education and crime.

It will take time to realign and grow the community development resource, and as a first step we will review existing capacity and then invest to meet any gaps, including a programme of training.

Alongside this, we will link social care more strongly with improving and safeguarding the wellbeing of individuals, families and communities. We will strengthen the social work profession by fully implementing my Department's Improving and Safeguarding Social Wellbeing Strategy.

To give every child and young person the best start in life, we will further increase the support we provide to children, young people and families from before birth to adulthood. The universal Health Visiting and School Nursing service will enable and support children and young adults to be successful healthy adults through the promotion of health and wellbeing; this will include the full delivery of the Healthy Child, Healthy Future programme. This will support the implementation of the Executive's Public Health Framework "Making Life Better" and its ambition to give every child the best start.

I will work with other Ministers to build on the success of the Early Intervention Transformation Programme and enhance early intervention services and the Family Support Hub network by exploring ways to build on the capacity of the hub model. This would include both better coordination of existing early intervention services and increasing the assessment capacity of the Hubs. This will enable us to respond quickly and flexibly to meet the needs of families early on before the problems they face become more intractable and severe. By increasing our early support to families we will reduce the need for later intervention, such as the need for children to come into care.

For children who are in the care system we will work to improve their life chances. Looked After Children experience much worse health, social, educational, and employment outcomes than other children. We will honour our corporate parenting responsibilities to the fullest extent and will be as ambitious for children in care as we are for our own children.

The range of placement options available to Looked After Children will be expanded. Through service redesign and, if necessary, new legislation we will better meet the individual needs of each child and put in place more effective supports for their caregivers, including kinship carers and families who adopt children from care. By working with the courts we will secure permanence for them more quickly helping their mental and emotional wellbeing, educational attainment and health in particular. Support will also be extended so that they are better prepared for independent living in adult life.

FAMILY SUPPORT HUBS

Family Support Hubs provide an accessible, flexible and responsive point of contact for families in need of support.

As of June 2016, 29 family support hubs were operational, providing full regional coverage across the North.

The engagement of local communities in the planning and commissioning of local services has been a key component to the successful delivery of Family Support Hubs.

In 2015/16 there were 4522 families referred through family support hubs, an increase of 1887 compared with 2014/15.

In 2015/16 a total of 5346 children were referred, 953 of which were children with a disability.

PRACTICE BASED PHARMACISTS

This initiative will see pharmacists working as an integral part of the GP surgery practice team. This means we can use their skills and experience to improve patient outcomes through reviewing their medication and reducing errors.

Practice Based Pharmacists (PBP) can help to alleviate some of the pressures faced by general practice through triaging patients to appropriate services and in some instances undertaking the diagnosis and initiation of treatment and follow-up appointments in patients with long term conditions.This will enable GPs to spend more time with patients with complex needs.

By December 2016, it is anticipated that 54 PBPs will have been placed in GP practices across the North with further PBPs appointed and in place over the period January-May 2017.

Enhancing support in primary care

Primary care is the bedrock of our health and social care system and provides around 95% of the care people need throughout their life. General Practitioners (GPs) and multidisciplinary primary care teams have a key role to play in improving population health and wellbeing, as well as developing care pathways and services to meet the population needs.

Our primary care service is still largely based on GPs working independently with some input from other disciplines. In future, the focus of our system will be increasingly on keeping people healthy and well in the first place. The World Health Organisation defines good health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. In the future we need a model that provides fully integrated multidisciplinary care, not just medical or nursing care.

Our future model of primary care is to be based on multidisciplinary teams embedded around general practice. The teams will work together to keep people well by supporting self management and independence, providing proactive management of high risk patients. They will identify and respond earlier to problems that emerge whether related to health or social circumstances or the conditions in which people live, providing high quality support treatment and care throughout life.

These teams will include GPs, Pharmacists, District Nurses, Health Visitors, Allied Health Professionals and Social Workers, and new roles as they develop, such as Advanced Nurse Practitioners and Physician Associates. There will be capacity and skills to proactively support individuals to address the lifestyle choices that impact upon their health and wellbeing. They will have the right tools and skills to diagnose, treat and coordinate the majority of care for their practice. They know the people they serve, and understand their needs better than anyone.

These teams will work in a more integrated way with all other community services and development work in their area, including Community Pharmacy. Community Pharmacy is an important part of primary care and can help to reduce pressure on other parts of the HSC. We must use them better, especially to support improved public health and engaging in with the public to ensure medicines are being used appropriately.

This model is radically different from what we have at present. It will require significant change in the way staff across the HSC are organised and deployed, and in the way GPs and other members of the new teams work together. This new model will therefore be rolled out incrementally over the next 5 years, learning and addressing gaps in staffing as we proceed. The roll-out of Practice Based Pharmacists will be completed by March 2021. GP surgeries will have named health visitors and named district nurses to work with by the end of March 2017. In addition, the way that core district nursing is delivered will be transformed, and a District Nursing Framework will be published by the end of this year.

We will maximise the potential for developing social prescribing models in the multidisciplinary primary care teams, through the embedding of social workers and building linkages to the range of early support services available to service users, such as Mental Health Hubs and other early help initiatives.

Additional funding for primary care will be focussed on developing these teams, with more funding for mental health interventions in primary care and funding to test the impact that specialist allied health professionals, such as physiotherapists, can have when working alongside the primary care team. Training for the first Advanced Nurse Practitioners for primary care and a new Physician Associate post-graduate degree programme have been developed and will start in early 2017. We will work closely with GPs and other professionals on the roll-out and evaluation of this model.

Together, the enhanced community capacity, the focus on prevention based approaches and the multidisciplinary teams in primary care will provide much greater capability to keep individuals and communities well.

Reforming our community and hospital services

Sometimes, the primary care or community care teams cannot fully meet a patient's needs but it isn't appropriate for them to be admitted to a hospital.

With developments in treatments and technology, we are able to do so much more without the need to admit people to hospital. Therefore in future we want to build on new services and models which are already emerging, and ensure that these are implemented across our health and social care system, working in partnership with those who deliver and use these services.

Acute Care at Home is an example of this type of service. Patients, often frail and elderly, are treated in their own homes by doctors, nurses and other staff. Conditions such as chest infections, urinary tract infections and dehydration can all be safely treated without the need to go to hospital, which can be a worrying and anxious experience for many. Patients have, within their own home environment, the same access to specialist tests as hospital inpatients and receive consultant led assessment and treatment.

We will make Acute Care at Home available to the whole population. We will better integrate it with social care and ensure it is supported by other services, including short stay hospital services, GPs and palliative care. This new model of care will be rolled out to all areas within the next three years.

We are committed to the further development of **Ambulatory Assessment and Treatment Centres**, to provide a more joined up, 1-stop service. Evidence from here and elsewhere shows there are significant benefits to be gained from this approach. Our current model is based on the traditional outpatient model of care where a GP refers a patient to the specialty the GP believes most closely relates to the possible cause of the person's symptoms. But as people live longer and develop more problems, diagnosis and treatment becomes more complex. So the traditional model is no longer fit for purpose.

Over the next 12 months, we will start to design these centres in partnership with clinicians and patients. They will provide simpler and easier access to the healthcare professionals and diagnostic equipment (such as X-Rays, CT scanners) needed to assess and diagnose conditions. Importantly, if a treatment or procedure is needed this will be possible on site with the aim of getting patients safely home the same day.

This avoids multiple outpatient visits and enables earlier diagnosis and appropriate treatment, and is therefore much better for those who use our services, and makes better use of our resources. Staff will have all the facilities they need to make the right diagnosis there and then, and to provide high quality care.

Elective Care Centres will be established to provide a dedicated resource for less complex planned surgery and other procedures. Evidence from elsewhere shows that such centres can reduce waiting times for planned care, and provide a better experience for both patients and staff. The current approach of delivering both planned and unplanned care using the same facilities and the same resources, means that waiting times can be adversely affected when the demand for urgent and emergency care is very high.

By making better use of our existing resources, and organising these in a different way, we will be able to provide larger volumes of activity, to a higher quality and in a more timely manner. The centres will be a resource for the region and the way they operate will be designed around the needs of patients. The number and location of these centres will be developed in partnership with clinicians and patients, and I expect proposals to be brought forward in the next 12 months.

Acute inpatient care will change. By changing the way preventive care, primary, community and less complex elective care is provided, and by looking after people in settings that are more appropriate to their needs, the nature of acute inpatient care will change.

Acute inpatient care will therefore focus on complex planned surgery and emergency care of patients who need an acute inpatient setting, for example, patients who have had a stroke, heart attack, or trauma, and those needing obstetric, neonatal or paediatric services or those with a significant worsening of a long term health condition. Multidisciplinary working will be a key feature of good quality inpatient care.

Across many different services there is very strong evidence that concentrating specialist procedures and services in a smaller number of sites produces significantly better outcomes for patients, as well as a much better and more supportive environment for staff

The role of our hospitals will therefore fundamentally change as they will focus on delivering the highest quality of specialist and acute care. However, not every service will be available in every hospital.

In the past few years we have seen the successful development of region-wide and cross-border **networks for highly specialist services** such as cancer, neonatology or cardiology as well as the development of the first truly all-island service in children's congenital cardiology. These are delivering innovative, world class services and we will seek to maximise opportunities to expand this approach and deliver more services on an all-island basis, where clinically appropriate to do so.

This is about changing the way that services are delivered, improving safety and quality, and making the best use of the resources we have. The Expert Panel, working with clinicians, has developed criteria which will help us to assess the sustainability and future of how services are provided, and this provides us with a route-map to work in partnership with those who use and deliver our services.

Mental Health

The North has a particular challenge with mental health, having the highest rates of mental illness in these islands. There are many talented and hardworking professionals in the system and the voluntary and community sector, who do excellent work in the services they provide. It is clear that our services need to continue to evolve and improve, building on the Bamford reforms from the last decade.

Mental health is one of my priorities as Minister of Health, and it is an issue that I will champion at every opportunity. I want better specialist mental health services. This would include further support for perinatal mental health and inpatient services for mothers, with potential to address the need that exists across the island. We will expand services in the community and services to deal with the trauma of the past. Underpinning all of this, I am committed to achieving a parity of esteem between mental and physical health to ensure that we are tackling the true impact of mental health on our communities.

Carers

Families and friends take on most of the caring responsibilities for their loved ones and this makes an enormous contribution both to the HSC and to society as a whole. I fully recognise that carers are an equal partner in providing care, and they need our support to be carers. They also need support to enable them to do the things that those without caring responsibilities take for granted such as working, going out socially, having a break or going on holidays. In the case of young carers, they need help and support just to do the things that young people do. I am committed, along with other government departments and their agencies, to providing that support.

We know that the needs of carers are changing, this means the type of support we need to give them is also changing. We need to encourage greater take up of carer's assessments and expand the options for short breaks, as well as enabling the greater use of personalisation and personal budgets where appropriate. We need to ensure carers can access up to date information and crucially consider how we can support carers to live their own lives. The role of carers and how we can better support them will be central to the Review of Adult Care and Support and I encourage everyone to make their views known when we bring proposals forward for consultation in spring 2017.

DELIVERING ACUTE CARE AT HOME

This service enables this vulnerable patient group to retain their independence and dignity and prevents unnecessary and stressful hospital admissions.

It was designed and implemented by East Belfast Integrated Care Partnership (ICP) and subsequently rolled out across Belfast. Similar services are available in some other Trust areas.

In the Belfast area, the average length of stay for Acute Care at Home patients is 6 days compared to 11 days in hospital. Over 1084 referrals have been received for the extended service in the Southern area.

Organising ourselves to deliver

To deliver care in a different way, it is clear that the way we plan and manage health and social care will also need to change. Therefore, in line with the recommendations of the Expert Panel's Report, we need to empower local providers and communities to work in partnership, including health and social care trusts, independent practitioners such as GPs and voluntary providers.

Embracing new models of care has the potential to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and beyond what is traditionally considered to be the health and social care sector.

Working together, they will be expected to plan integrated and continuous local care for the populations they serve. I will set the outcomes we expect them to deliver, and the frameworks within which they need to operate, and hold them to account accordingly. For the first time, they will have the autonomy to make rapid and sustainable changes to improve services and address health inequalities in their area.

Where services are highly specialised, they will be planned and delivered on a region-wide basis. Building on the programme of work currently underway with Department of Health counterparts in Dublin, we will continue to explore opportunities to plan and deliver services on an all-island basis.

The recent consultation on HSC structures supported the need to reduce bureaucracy and put in place a more effective streamlined mechanism for how we plan health and social care services.

Starting now, we will work with the wider HSC system to design the new partnership approaches to the planning and management of HSC services, which moves away from competition towards collaboration, integration and improvement.

PRIMARY PERCUTANEOUS CORONARY INTERVENTION (pPCI)

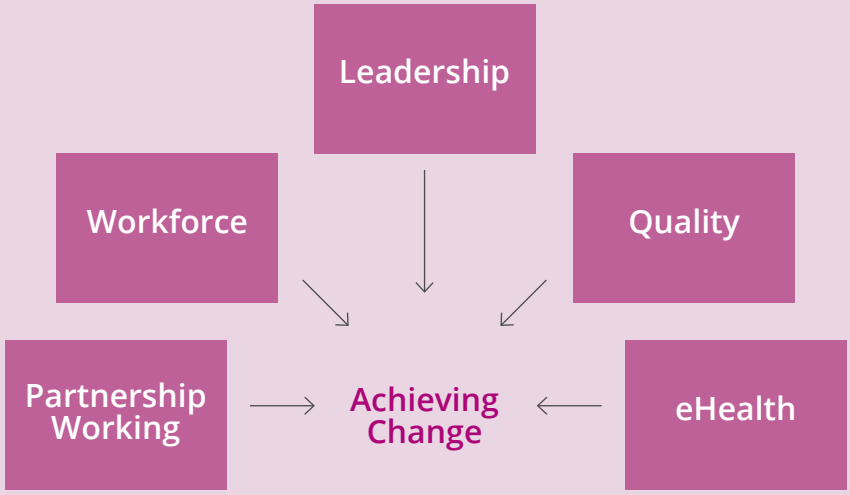
This service, based in Belfast and in Derry, means that patients having a particular type of heart attack are taken from anywhere across the North straight to a specialised centre which can undertake this life saving procedure on a 24/7 basis.

On average a total of 66 pPCI procedures are being carried out per month and from May 2016, Donegal patients have access to the Derry based service.

4 THE APPROACH

How we plan, design, support and implement service transformation is as important as the changes we wish to make.

Only by taking the right approach will these changes be the best ones for our population as a whole, and be sustainable in the long run.



Partnership Working

With people who use and deliver services

Our Health and Social Care system belongs to all of us and we all bring valuable insights to how it can improve. We must work in partnership - patients, service users, families, staff and politicians - in doing so we can co-produce lasting change which benefits us all. Everyone who uses and delivers our health and social care services must be treated with respect, listened to and supported to work as real partners within the HSC system.

Building on the good practice which already exists in the HSC, such as the Mental Health Recovery Colleges, we will work collaboratively in the spirit of openness and trust to deliver agreed outcomes.

When we embark on a change to our system or services, all relevant individuals or groups will be brought together, including those who use and those who deliver our services. A clear terms of reference will be developed collaboratively, ensuring all parties are clear about the task at hand, and how we will work together.

We will adopt creative and innovative ways to maximise involvement. All views and opinions will be received with equal merit. In the past the system has been criticised for delays in bringing forward change, we will support teams to work at pace.

Co-production will empower patients, service users and staff to:

- **design the system** as whole to ensure there is a focus on keeping our population well in the first place and ensuring that when people need support and help they receive safe and high quality care;
- work together to **develop and expand specific pathways of care and HSC services** which are designed around people and their needs, including setting outcomes to measure impact;
- be partners in **the care they receive** with a focus on increased self-management and choice, especially for those with long-term conditions.

A move to this model will not happen overnight. However, I am fully committed to this approach and will support this new way of working across the HSC. In order to start this process in November I will embark on a period of engagement about my proposals for the model of health and care for the future.

I am making a commitment that the design of new and reconfigured services will be taken forward on the basis of co-production and co-design.

We will strengthen the capacity of both those who use our services and those who deliver them to bring about positive change for and by themselves. This includes continued investment in initiatives such as Expert-by-Experience programmes, which provides training and development for users who work with the HSC to improve our services. We will also train staff to support the continued roll-out of the Quality 2020 Attributes Framework.

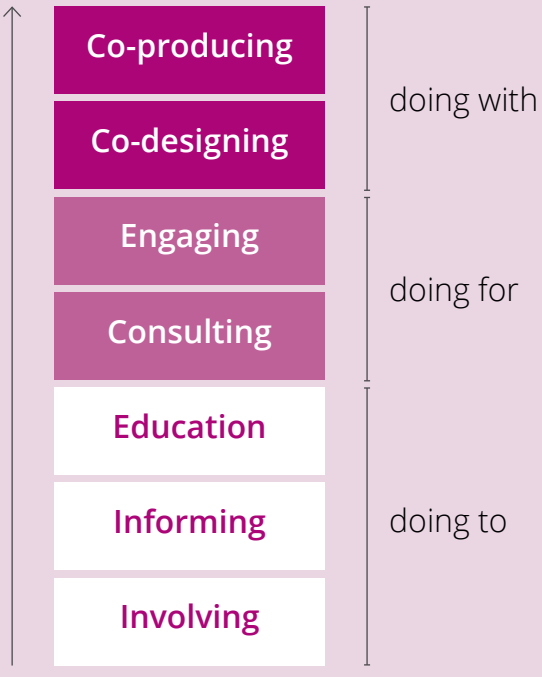
In addition, I intend to maximise the patient voice across our system, and align it much more closely to the quality improvement, and inspection and regulation. I also want to hear the voice of staff particularly those on the ground closest to those who use our services. In early 2017, I will consult and design a new feedback platform open to all those who both use and deliver our services. This will enable users and staff to tell us what matters to them in terms of their health and social care and to raise issues in as timely a manner as possible, so that they can be addressed early before they escalate to a complaint.

Co-production - a new approach to the design and development of mental health services

An example of how co-production can make a big impact on our services is the design and delivery of Mental Health Recovery Colleges. This is an innovative model that assists individuals in their personal and collective journey of recovery. This recovery focussed approach creates opportunities for those with lived experience to contribute as volunteers and in paid roles. These peer educators assist those with mental health problems to discover personal talents and develop life skills which can help them enter the labour market.

A number of people with lived experience have and continue to be developed to become peer educators and are now making a contribution to care delivery. Over 236 sessions of peer education have been delivered.

An alternative ladder of participation



With other providers

Partnership with other providers of care and other service providers is key to improving and safeguarding social, emotional and physical wellbeing. Health and social care has a strong tradition of working with other professions and sectors including the voluntary, community, criminal justice, education, housing and private sectors. These partnerships will be maintained and strengthened to maximise the impact we can make on improving people's health, social wellbeing and quality of life, as well as making the best use of resources.

Improving Quality and Safety

In the design and delivery of health and social care, quality and safety will always be a fundamental priority. The Expert Panel said "any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this".

It is clear to me that, in order to achieve our ambition for health and social care, we need to establish an infrastructure capable of supporting, enabling and driving the improvements we seek, with people at its heart. There needs to be a greater alignment between quality improvement, partnership with those who use our services, and how we regulate those services.

Like many healthcare systems, there has been a gradual increase in improvement capability across our health and social care service. One example is the Regional Mortality and Morbidity Review System, which supports the review of all hospital deaths by multidisciplinary 'frontline' teams to identify learning to improve the quality and safety of care. The system is well embedded in two Trusts at present and will be fully embedded across all Trusts by April 2017. Another example is the Medicines Optimisation Quality Framework which is supporting improvement by scaling up good practices for the appropriate, safe and effective use of medicines across health and social care.

We now need to fully integrate quality improvement into the work of every HSC organisation and provide real support for local and regional improvement work. That will mean improving our capacity to foster local innovation and to implement what works at scale. It also requires us to be able to proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs. Developing the science of improvement can be done at the same time as making improvements.

To deliver a sustainable and world class service into the future will require of all of us to work together very differently. We need an infrastructure that makes this possible.

For that reason, I intend to establish an Improvement Institute that will better align existing resources to enable improvement in our system of care. These include resources currently devoted to patient safety, regulation, evidence gathering, data analytics, information and, critically, those with experience of using our services. My aim is to establish a strong and integrated infrastructure to support improvement wherever it needs to happen across our system of care. This aim will only be achieved with the support and engagement of all leaders across the HSC system.

I have asked my Department to convene a group of local clinicians, professionals and service users with experience in improvement to advise on the design of that infrastructure. This will not be a new HSC organisation but will align existing resources and functions. The design work will be complete by February 2017 and I expect the Institute to begin to test how it will operate by May 2017.

Investing in our Workforce

The Expert Panel has re-affirmed that effective workforce engagement and planning are key enablers to HSC transformation. I believe the far-reaching transformation journey we are about to embark on needs the commitment and engagement of workers across the HSC at every grade if it is to succeed. I am confident that working together we can succeed.

The increasing pressure on services has contributed to difficulties in attracting and retaining experienced staff and the vacancy rate in a range of disciplines continues to grow. These factors have led to an escalation in the costs of maintaining safe service provision through the use of expensive agency and locum staff, as well as longer hospital stays than necessary.

Clearly, this is unsustainable and workforce planning cannot continue to be used simply as an exercise to ensure that existing rotas are filled. It has to be a vehicle for supporting the implementation of a new and sustainable model of care. It has to take account of increasing demand as a result of demographic trends, be informed by robust and accurate workforce information and analysis, and map to the new configuration of services in secondary care and the increased focus on primary care. It also has to address the factors that enhance the attractiveness of key jobs, such as domiciliary care.

However, effective workforce planning is only one aspect of what is needed. We want to ensure that we are harnessing the skills and experience of the 72,000 individuals working in the wider HSC family.

As stated earlier, I want the HSC to be an employer of choice, leading by example and investing in the health and wellbeing of its staff. We will explore ways to build on and consolidate the health and wellbeing services we provide for our staff.

I recognise the fears and anxieties about job security, role and job location that any change process will create. Based on their lived experience, HSC staff at all grades are all too well aware of the unintended day to day impact on their own teams of previous change initiatives. Too many of these experiences to date have not been positive.

I am determined that the unique store of knowledge, commitment and public service ethos that the HSC workforce represents will be listened to, engaged and nurtured at all levels. It is the single most important resource we have to achieve lasting change.

In collaboration with stakeholders, we are committed to ensuring a Workforce Strategy is developed by spring 2017 which will cover all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles and of reskilling and upskilling initiatives. This will require investment but we are convinced that investment in every area of our workforce is critical in delivering this new model of sustainable care.

But it is clear that some action needs to be taken now to address current workforce challenges. Therefore, we will continue to invest in training by expanding GP and nurse training places. I have asked for a number of areas to be looked at in detail, including the appointment of a Nursing and Midwifery Task group which will report within 12 months with recommendations for how we can maximise the contribution nursing and midwifery can make to improved outcomes for the population.

The forthcoming Reform of Adult Social Care and Support will consider the nature, size and skills of the social care workforce needed to deliver social care in the future. I will consider carefully the findings of the Domiciliary Care Workforce Review, which is due to be completed by the end of 2016. I am committed to taking steps to improve the recruitment and retention of this critically important group of staff.

Leadership and Culture

If we are to develop a culture of quality improvement and partnership working, this must be underpinned by a new approach to collective and system leadership. We are fortunate to have some of the most capable, committed and enthusiastic people making up our health and social care workforce. Many leading edge research and reports provide evidence that having continuous learning cultures and team working in health and social care organisations is crucial to ensuring safe high quality care.

Rather than concentrating power at the top, I want all those working in health and social care to feel able to effect change and improvement in care. This means developing leadership at all levels, a truly collective leadership model. I will flatten and remove unnecessary hierarchy, eliminating those policies which inhibit innovation and improvement. If we are to move towards a model of care powered by multidisciplinary teams, we need to empower all teams to deliver care, not micro-manage them. Working in partnership with our staff, I believe this is achievable.

This will require a major programme of cultural change and it will not happen overnight. But we need to start now.

As part of this we need to enhance our clinical leadership. The Expert Panel said that change *"will be more successful if… implemented in a setting which encourages clinical and professional engagement"*. I want to see our structures have more professionals directly engaged in the management and leadership of our services, effecting the change supported by skilled and able managers.

I have recently re-established the Strategic Health Partnership Forum and see this as an important contribution to the development of a new culture of partnership, involvement and listening.

Over the next 6 months, an HSC-wide Leadership Strategy will be developed to support this aim. Resources will be directed over the next 3 years and beyond to develop the right staff and leaders, with the skills, behaviours and values that will be so crucial in developing the compassionate, collaborative and high performing culture we seek.

eHealth and Care

Making better use of technology and data is essential if we are to move to a model focussed on service users, on improving the health and wellbeing of the population and on getting beyond organisational and professional silos. I am determined to realise the potential and opportunities presented by modern information technology to improve outcomes for service users and free up time for front line staff. To do so, co-production must underpin our approach, and we must learn the lessons and build on the experience of current and past HSC IT initiatives.

We will expand the range of information and interaction available to citizens, service users and those providing services both online and through apps. This will include building a new patient portal which will allow secure online access to their own health and care information where service users want this. This new patient portal will be in place for dementia patients next year and rolled out across the North by 2021.

To ensure our staff can focus on supporting individuals, the right information must be available to the right professionals, at the time they need it. Our award-winning approach to sharing information across different IT systems (the Electronic Care Record) has significantly changed the way care is delivered and improved safety. However, we still have too many different systems across the HSC making it difficult to join up data and focus on the service user.

We are currently assessing the best way to achieve a much more consolidated and common patient and user record, with fewer separate IT systems. This will be a major undertaking. We will aim to liberate time for care by equipping our community based workforce with new technology that will increase the time that doctors, nurses, therapists and social workers have to spend with patients. If we can realise a 15-minute increase in care time by reducing bureaucracy this equates to over 1,000 additional care professionals working with service users. These initiatives will also allow more staff in the HSC to work remotely, saving travel to and from hospitals, care centres and offices.

Moving to a more consolidated health record across the North will allow us to make better use of information about our population - designing new ways to intervene early and support people in managing their conditions. A programme of work to improve our use of health analytics, focussed on dementia patients, will start in 2017.

5 THE ACTIONS

In this document I have set out my commitment to change but I recognise that much work is needed to develop, design and deliver the building blocks that will enable sustained improvement. I am committed to achieving the change required using a process of co-production.

The task is challenging and will take sustained and incremental effort over the next ten years to achieve real transformation.

But we start now. In the next section I have set out my actions for the next 12 months. These will be taken forward to make a positive and ambitious start towards stabilisation, reconfiguration and transformation.

As I have said, to deliver real and meaningful change will require an extension of the political goodwill and cooperation given to the Expert Panel. Moreover significant investment will be required. I believe this shared investment will not only improve people's health and wellbeing but have a positive impact on every aspect of their lives.

I fully believe that it is only by working together we can deliver a world class health and social care system.

Stabilisation

1	Develop a comprehensive approach for **addressing waiting lists** which takes account of the ongoing work of the Health and Social Care Board, as well as the recommendations from the Expert Panel.	*January 2017*
2	To improve access and resilience, and support the development of new models of care, make **significant investment in primary care** to ensure there is a multidisciplinary team focussed on the patient and with the right mix of skills. This will be supported by: - increased GP training places; - continued investment in Practice Based Pharmacists; - ensuring every GP practice has a named District Nurse, Health Visitor and Social Worker to work with; - supporting the development of new roles such as Physician Associates and Advanced Nurse Practitioners; and - further roll-out of the AskMyGP system. Bring forward a public consultation on the role of GP Federation and whether they should become HSC bodies.	*March 2017*
3	Bring forward proposals relating to the extension of placement options for **Looked After Children**.	*October 2017*
4	Following the completion and evaluation of a pilot project, roll-out access to the electronic care record (NIECR) to **community pharmacists** and establish a pilot to test access to the record for **independent optometrists.**	*October 2017*
5	Begin development of a new framework to fully realise the potential of **community pharmacy services** to support better health outcomes from medicines and prevent illness.	*November 2016*

Reconfiguration and service change

6	Embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of **service configuration reviews**. These will be clinically led, working in partnership with those that use the services.	*November 2016*
7	As part of this process, my immediate priorities are: • following extensive review and engagement, launch a public consultation on proposals to modernise and transform **Pathology** services designed to improve service and workforce sustainability ensuring a high quality pathology service for the future; — *November 2016* • move forward with the implementation of the new **Diabetes** Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups; — *November 2016* • launch and commence implementation of the **Paediatric Strategies** (2016-2026) designed to modernise and further improve the standard of treatment and care provided in hospital and community settings, and palliative and end of life care for children and their families; and — *November 2016* • launch a public consultation on proposals to develop sustainable **Stroke** services and further improve the standard of treatment and care provided to stroke patients. — *February 2017* • following a recent review, launch a public consultation on the configuration of **Imaging** services, taking account of advances in technology, demographics and demands, and looking to both national and international best practice; — *February 2017*	
8	Bring forward proposals for the location and service specification for **Elective Care Centres**, and **Assessment and Treatment Centres.**	*October 2017*
9	Develop design for new structures and approaches to support the **reform of planning and administration** of the HSC	*March 2017*
10	Identify current **innovative HSC projects** at the local level and develop a rolling programme and implementation plan to scale up these projects across the region.	*April 2017*

Transformation

11	Embark on a **period of engagement** with staff and service users to build a collective view of how our health and social care services should be configured in the future, and encourage a much wider public debate.	*November 2016*
12	Establish and seek members for a **transformation oversight structure** with membership drawn from within and outwith the HSC.	*November 2016*
13	Consult on proposals for the reform of **adult social care and support**, to consider different approaches to ensuring the long-term sustainability of the adult social care system.	*April 2017*
14	Consult on proposals for and complete design of a **new user feedback platform** open to all those who both use and deliver our services.	*October 2017*
15	Complete the initial design work for the **Improvement Institute.**	*February 2017*
16	Develop a **Workforce Strategy** covering all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles; and upskilling initiatives.	*May 2017*
17	Develop a **HSC-wide Leadership Strategy** to consider a 5 year approach and plan for development of collective leadership behaviours across our system.	*May 2017*
18	Expand the range of information and interaction available to citizens online and development **patient portal** for dementia patients.	*October 2017*