

**Report on the Public Engagement
on
*“Priorities for Action”***

7 December 2009

Public Engagement Project on Priorities for Action

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Dear Friend,

This report presents the outcome of some thirty meetings between staff from the Patient and Client Council and people across Northern Ireland. The purpose of these meetings was to discuss priorities for health and social care and to advise the Department of Health, Social Services and Public Safety on public attitudes towards the setting of targets.

This report links together the opinion of individual patients, service users and carers with policy making within the Department. Making sure the voice of the individual is heard by those who plan and deliver health and social care in Northern Ireland is one of the statutory duties of the Patient and Client Council.

There are important messages from the public in this report. That these messages are heard now, at a time of major financial and other challenges for health and social care is, in my view, particularly important.

The report makes clear that people have welcomed improvements in services resulting from target setting; for example, reduced waiting times for hospital treatment and care. It also makes clear that people place a high value on good care in their own homes and communities.

In times of financial hardship it is tempting to focus on highly visible services, such as those in hospitals. However, for many people, it is in their own home and community that they need professional care and support from the service.

Finally, the report also makes clear the value service users and the public place on their relationship with health and social care services. Much is said in what follows about the extent to which public trust and confidence in services depends on continuity in caring relationships.

My sincere thanks to the many individuals who took part in these meetings; and for the generosity with which they gave their time and shared their experience.

John Keanie
Chair of the Patient and Client Council

1.0 INTRODUCTION & PURPOSE OF THIS REPORT

The Patient and Client Council is a new organisation, which has been set up to provide a powerful independent voice for patients, service users, carers and communities on health and social care issues.

The main functions of the Patient and Client Council are to;

- Engage with the public to obtain their views on any part of health and social care;
- To promote the involvement of patients, clients, carers and the public in the design, planning, commissioning and delivery of health and social care;
- To provide assistance to people making a complaint relating to health and social care; and,
- Provide advice and information to the public about health and social care services.

In the period August to November 2009 staff from the Patient and Client Council met with people across Northern Ireland. These meetings took place in small groups, to maximise opportunity for discussion. What follows are their responses to questions asked about priorities, target setting and what the future should look like for Health and Social Care.

The purpose of this series of meetings was to help ensure that the process of setting future targets for health and social care sufficiently reflects the opinions of people accessing the services.

2.0 BACKGROUND

“Priorities for Action” (PFA) is one of the most important documents produced by the Department of Health, Social Services and Public Safety (the Department) each year. PFA sets out the key targets for the Health and Social Care Board and the Public Health Agency which plan services; and for the Health and Social Care Trusts which deliver services. PFA priorities decide how services will change and develop in the coming years.

The Patient and Client Council was set up by the Minister for Health in April 2009 and given the job of making sure that the voice of service users and the public was heard at all levels of Health and Social Care. Therefore, the Patient and Client Council made it a priority to establish a project aimed at understanding the key areas of concern for the public. This project will start to deliver on this job.

The aims of this project were:

- To make people aware of the targets and their content;
- To ask whether people had experienced changes in services received in recent years;
- To ask people what their priorities would be for the health and social care services;
- To produce a report based on what people said;
- To use the findings in the report to inform PFA for next year; and,
- To raise awareness of the work of the Patient and Client Council.

3.0 THE PROCESS OF ENGAGEMENT

Patient and Client Council staff met people in small groups across Northern Ireland. A full list of the groups who took part is attached at **Appendix A**.

A short letter explaining the reason for the meeting was sent out (attached at **Appendix B**). The meetings followed the same general format with a short introduction by a member of Patient and Client Council staff followed by an open discussion for around an hour at which the following three questions were asked:

1. Were you aware of the targets before we met?
2. Have you noticed any differences in health and social care recently?
3. If you were the Minister, what would be your top three priorities?

Five meetings were organised in each Health and Social Care Trust area and five meetings were organised with groups with a special interest and remit across Northern Ireland.

In organising the meetings care was taken to ensure that each Section 75* group was represented either locally or regionally.

(*Section 75 of the Northern Ireland Act 1998 states:

“ A public authority shall in carrying out its functions relating to Northern Ireland have due regard to the need to promote equality of opportunity—

(a) Between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;

(b) Between men and women generally;

(c) Between persons with a disability and persons without; and

(d) Between persons with dependants and persons without”)

After the meeting, the Patient and Client Council staff member who attended the meeting wrote a short report and sent it to the group to confirm that it reflected the discussion and for them to add comments. Patient and Client Council Officers informed each group that they would receive a copy of the full report and information on the Department's response in due course.

Between August 2009 and November 2009, 27 meetings were held with 303 individual members of the public taking part. One of the benefits of meeting with small groups was that almost everyone who attended the meetings made a contribution.

4.0 THE LEVEL OF AWARENESS OF EXISTING TARGETS

This section summarises answers given in response to the question “Were you aware of the targets before we met?”

One group was aware of the actual document entitled “Priorities for Action”. There was some awareness of the use of targets in health and social care. This awareness was largely attributed to media coverage. People were, however, widely aware of improvements in waiting times for hospital treatment and care and appreciated this.

People were also aware of the targets for access to General Practitioner (GP) services. It was well understood that an appointment could be made to see a GP in the practice within 48 hours. It was also well understood that an appointment with a named doctor would take longer.

In one group, the targets for discharge planning were well known. This group felt the service was writing discharge plans only to move people on from hospital; but, that once the person was out of hospital the care plan was not delivered.

A number of people expressed scepticism about targets. They felt that targets could be manipulated and that there was a risk that the service would focus on getting around the targets in order to meet them at the expense of service quality.

“It’s about a sympathetic approach from staff and not just being part of a target”

Many people made comments about wanting public information on targets and how well the service was performing. They could not see the point of setting targets if service users and the public did not know what they were.

Similar comments were made about monitoring targets and holding people to account for their delivery. The public had no insight into how this was done and no assurance that if the targets were not met that there was any way of reporting this and having it put right.

5.0 OPINION ON THE IMPACT OF TARGETS

This section summarises answers given in response to the question “Have you noticed any changes in Health and Social Care recently?”

Many groups were anxious to share their positive experience of services. They did not wish their comments to be seen as only complaining about a service which they valued highly. There was wide experience of improvements in waiting times for hospital treatment and people noted this as a positive change.

There was also a wide understanding of recent changes in General Practitioner services particularly of the Out of Hours service and of the access times to see a GP. These were less positively experienced by people. There was frustration at the length of time it took to see a named GP. People felt it was difficult as a result to establish a continuous caring relationship with the GP. This perceived loss of the “family doctor” was reported as having a major impact on the trust and confidence people feel in the doctor’s ability to understand their needs.

With regard to targets which focus on patient experience, people reported a feeling that health and social care as a whole was fragmented. There was a widely held opinion that one part of the service did not seem to communicate with another and that professionals also did not seem to communicate with each other. They reported lost notes and diagnostic reports but most often frustration that they did not see the same person twice; whether in the GP surgery, the hospital outpatients departments or in community services. People reported having to give their full history every time they met someone.

Not only was this repeated telling of their story distressing for some people it created a sense that the service was not joined up enough to plan and deliver a coherent programme of care based on a sound knowledge of the patient.

6.0 CONSENSUS OF OPINION ON PRIORITIES FOR 2010 AND BEYOND

This section summarises answers given in response to the question “If you were the Minister, what would be your top three priorities?”

During the discussions seven general priorities emerged and these were:

1. Patients, clients and carers wanted to be fully involved in decisions regarding the planning and delivery of community based health and social care.
2. Patients, clients and carers wanted an individual care plan which they could hold in their own home.
3. Greater recognition of the value and needs of carers; including young carers was seen as a priority.
4. Making sure that standards and targets set are applied equally to all; regardless of location.
5. Communication with health and social care staff at all levels
6. Visible accountability – people wanted to know that standards and targets existed, what they were and how they were monitored.
7. Continuity in Care – people wanted to see services organised so there was a sense of continuity of relationship with health and social care services; whether in primary, community or hospital care, people reported rarely seeing the same person twice and having to explain their needs on each occasion – something they saw as, at best, time-wasting and at worst, distressing.

On the whole, people were particularly concerned about the quality of home and community based services. Comments in these areas made up the majority of concerns expressed in the meetings and are outlined in the paragraphs which follow.

6.1 Patients, clients and carers wanted to be fully involved in decisions regarding the planning and delivery of community based health and social care.

The need for greater involvement of patients and their carers in discharge planning and community based care planning was the most often mentioned concern. People reported feeling being kept out of the process and this resulted in a care plan that was not as good as it could be, as it hadn't taken into account the contribution that could be made by a carer. Some arrangements were unworkable or unnecessarily difficult; others were unnecessary – carrying out tasks the patient or carer could carry out for themselves.

“This one man asked if he could have a bath and was told – ‘you’re on fortnightly baths’”

People spoke of a desire for community care plans to be much more sensitive to the needs of individuals and their circumstances and to be able to respond more effectively as a result. Fast tracking of patients was deemed necessary in some cases for patients with a rapidly progressing disease, or for children. People reported care plans being changed without consultation or notice and with no regard for how the patient or their family might be affected. Others stated that they could not see how the allocation of resources for community care was fair – they shared experiences of higher levels of care for people with apparently less need than others. Others expressed frustration at the way in which older people were required to pay for their care if they had any resources.

6.2 Patients, clients and carers wanted an individual care plan which they could hold in their own home.

Patients, clients and carers expressed a strongly held desire to have a personalised care plan which they could hold in their own home. They felt that this was a fundamental communication tool to enable them to understand the level of health and social care that was agreed. They also stressed the importance of this to help them contribute to the management and monitoring of their individual service provision. The need for clear contact information within the plan was seen as vital to the plan; also details of where and whom to seek support should the plan fail in any way.

6.3 Greater recognition of the value and needs of carers; including young carers was seen as a priority.

In general carers felt isolated in the process and that their contribution was not recognised or supported by the services. Young carers felt particularly vulnerable and unrecognised. Most carers reported that they had never had a carer's assessment; and many of those that did reported no action resulting from the assessment. Carers across the region expressed a desire for improved respite provision to enable them to cope with the demands of caring.

“Why are they like that?” (Child carer speaking about the attitude of care workers to her)

One Example:

Children who are carers stated that they felt totally ignored by health and social care services and they put this down to a lack of awareness of children

as carers. While they expressed the same frustrations with the service as many carers, the fact that they were children made communication and involvement even less likely and their specific needs were overlooked

6.4 Making sure that standards and targets set are applied equally to all; regardless of location.

In general people expressed the perception that the same standard of service was not available across the region and indeed across localities. They felt that it was important that there should be equal access to services for everyone regardless of where they lived.

There was concern – particularly in rural areas – about changes to the Ambulance Service. The increased use of Rapid Response Vehicles and the reduction in numbers of fully crewed ambulance hours was seen as a cut in service, causing anxiety that emergency services may not be there for them when they needed them.

One example:

A group of travellers stated that there was need for more directed support for their community – particularly when it came to health and wellbeing. They stated that they needed the service to be more active – to go out to provide services within that community

6.5 Communication

Without doubt communication between patients, service users and carers; and service providers was a major concern. They expressed concern that staff had neither the time to explain what was happening nor to listen to issues which they raised

6.6 Visible accountability – people wanted to know that standards and targets existed, what they were and how they were monitored.

In general people wanted information about targets in health and social care and how they were monitored.

Specifically, people also stated that there needed to be much more visible monitoring of how care was being delivered in care homes and communities. There should be clear accountability for the failure to deliver care according to agreed plans. People felt that independent care providers were not monitored and held to account and that the standards that applied to health and social care staff should also apply to them if they were being paid to provide a service.

6.7 Continuity in Care

Aside from improved communication, people wanted to see services organised so there was a sense of continuity of relationship with health and social care services. Whether in primary, community or hospital care, people reported rarely seeing the same person twice and having to explain their needs on each occasion. This was something they saw as, at best, time-wasting and at worst, distressing.

Service users and carers expressed concern regarding continuity in care during significant transitions such as: discharge from hospital; admission to residential care; young people leaving children's homes; and, children and young people with a learning disability between schools and further education institutions.

The need to maintain the community infrastructure to care for people at home and to support their families and carers was emphasised in some groups. These community facilities were the only option for respite, peer support and self-care for many. Some groups were very anxious that health and social

care services should recognise that this was the case and give such services a priority in future planning.

Home visits by GPs outside of normal working hours were a cause of concern because people felt that the decision to make a home visit was made purely on the basis of the symptoms that were being reported. The decisions took no account of the circumstances of the people calling. This worried people who were carers or parents of young children in particular. This often meant that they could not attend the Out of Hours service. People reported, as a result of this, they:

- would end up waiting until the morning surgery; or,
- would be taken to accident and emergency by ambulance. Once treated they would have no means of getting home.

One example: Support for new mothers – particularly younger mothers – was raised by some groups. They felt that the need to give a new mother time to start breastfeeding and begin to care for their baby in hospital and immediately after the birth was not properly recognised by the service. People said there was no continuity in the midwives with whom they worked and reported variations in the skills of those midwives – particularly when it came to working with teenage and young mothers – who felt dismissed by midwives in some cases.

“Who’s going to look after them?” (Carer talking about patient discharge from hospital)

7.0 KEY MESSAGES & RECOMMENDATIONS

7.1 Key Messages

The report summarises the views of over 300 people across Northern Ireland on Health and Social Care priorities and highlights the following key messages:

- Recent reductions in waiting times for hospital treatment, and care were appreciated by the public.
- There is widespread concern about community care – how it is planned and how it is delivered.
- Patients, clients and carers wanted to be fully involved in decisions regarding the planning and delivery of community based health and social care.
- Patients, clients and carers wanted an individual care plan which they could hold in their own home.
- Greater recognition of the value and needs of carers; including young carers was seen as a priority.
- Making sure that standards and targets set are applied equally to all; regardless of location.
- Communication with health and social care staff at all levels.
- Visible accountability – people wanted to know that standards and targets existed, what they were and how they were monitored.

- Continuity in Care – people wanted to see services organised so there was a sense of continuity of relationship with health and social care services; whether in primary, community or hospital care, people reported rarely seeing the same person twice and having to explain their needs on each occasion – something they saw as, at best, time-wasting and at worst, distressing.

7.2 Recommendations

There is common ground between the sorts of targets this group of people have said they wish to see and those within “Priorities for Action” for 2010 and beyond. The current “Priorities for Action” sets targets for communication, for increased individual care planning and respite packages and sets a strategic direction aimed at improving and developing community and home based services.

Taking this into account, but recognising also what people have said about their actual experience we recommend the following:

1. Patients, clients and carers should be fully involved in decisions regarding the planning and delivery of community based health and social care.
2. Everyone receiving care at home should have an individual care plan that they hold personally.
3. Every carer should have an assessment of their needs carried out. This assessment and the views of carers should be used to agree individual care plans as well as to provide for the needs of carers themselves.
4. The Department should ensure that standards and targets are equally applied to all regardless of location.
5. The Department should set further standards for communication and pay particular attention to patient concerns around fragmented services and the reported lack of continuity in care.

6. The Department should report on an ongoing basis to the general public about targets, how they are monitored and the performance achieved by health and social care organisations.
7. The Department should consider standards regarding continuity of care, including giving attention to significant transitions such as: discharge from hospital; admission to residential care; young people leaving children's homes; and, children and young people with a learning disability during transitional between schools and further education.
8. The process of engaging with the public in the setting of priorities should be further developed by the Patient and Client Council in 2010 and beyond.

List of Participating groups by Area

Region

Carers NI
Progressive Supranuclear Palsy Association
VOYPIC (Voice of Young People in Care)
Na Cushan Munair
Northern Ireland Regional Young Carers Forum (Barnardos)

Belfast

Stroke Patients and Carers Reference Group
Clan Mor Surestart
East Belfast Seniors Forum
East Belfast Healthy Living Network
Queens University LGBT Group

South Eastern

Footprints Women Centre, Belfast
The Wednesday Club (Older Peoples Group), Newcastle
Downpatrick Surestart
Age Concern, Bangor

Western

Senior Citizens Consortium, Omagh
Action Mental Health, Enniskillen
Hands that Talk, Dungiven
Strabane Surestart

Northern

Rehability, Rathenraw
North Antrim Community Network, Cushendall
The Relatives Association, Rathcoole, Newtownabbey
Representatives of the Muslim Community, Ballymena
Dalriada Rural Surestart, Ballycastle

Southern

Surestart Clogher Valley, Augher
Willowbank Community Centre, Dungannon
Prospects Citizens Group, Newry
Works Department, Armagh City Council, Armagh

Dear Colleague,

PRIORITIES FOR ACTION – HEALTH AND SOCIAL CARE

Thank you for agreeing in principle to meet with us. I have attached for your information a short paper – intended for people who will participate in the meetings – which explains why we would like to meet and what we hope will come out of meeting.

I have attached also – for your information – a short paper on how we hope each meeting will go. We will be very flexible with this, however, what is important is that we hear from the people themselves at the meeting what is most important to them in Health and Social Care.

As regards expenses, we are able only to reimburse travel expenses and the cost of tea and coffee. We are not able to pay for the hire of rooms or for any other matter. Our aim is to meet with people where they are already meeting – not to put groups and communities to the trouble of making special arrangements for us other than to give us an hour of your time. If this presents any problem to your group, please let me know.

I will call you again before the end of the month to confirm times and dates and to give you any further information. If you have any questions or comments on any of this please contact me at any time.

Thank you again for your help with this.

Yours sincerely

Richard Dixon
Area Manager – Belfast

Project: Stakeholder Engagement on Priorities for Action

Subject: Meeting Format

The format of each of the stakeholder meetings will be as follows:

- a. Each meeting will be attended by two people – both from the Patient Client Council.
- b. Each meeting will open with a short (5-10) minute presentation on Priorities for Action.
- c. The Patient Client Council representatives will be responsible for facilitating the meeting, for maintaining a short, but accurate, record of the discussion and for guiding the discussion through the following four questions:
 1. Were you aware of the targets before we contacted you?
 2. Do you think the targets have made a difference?
 3. If you were the Minister, what would be your top three targets?

Each discussion should last around an hour.

- d. Following each meeting, the representative of the Patient Client Council will write a short report and arrange to share this, wherever possible, with one or to members of the group before submitting it.

Project: Stakeholder Engagement on Priorities for Action

Subject: User Group Briefing Note on Targets

Every year, the Minister for Health sets targets for health and social care. These targets decide what the most important things are for health and social care to be doing in each year and the standards the Minister expects – how long you should wait, especially.

These targets are published each year in a document called “Priorities for Action”. There are over 50 targets and they cover all the different part of health and social services. They have been used in the last four years particularly to make sure patients do not have to wait too long for treatments like hip replacement. A couple of examples:

- *From April 2009, no patient should wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 13 weeks for inpatient or day case treatment.*
- *from April 2009, 95% of patients attending any A&E department should be either treated and discharged home, or admitted within four hours of their arrival in the department*

The Patient Client Council wants to talk to members of the public about these targets. To ask you what is most important to you, what your experience has been and what you would most like to change.

A meeting has been arranged with your group to talk about these things. At each meeting, there will be someone from the Patient Client Council to listen to what you have to say. What we learn from these meetings will be used by the Patient Client Council to help to advise the Minister on the kind of targets he should be setting

The whole “Priorities for Action” document can be found in the internet at:

http://www.dhsspsni.gov.uk/priorities_for_action

We look forward to meeting you.

Appendix C

PATIENT CLIENT COUNCIL - PUBLIC MEETING ON PRIORITIES IN HEALTH AND SOCIAL CARE

THE PROJECT – WHY ARE WE MEETING?

Every year, the Health Minister decides on priorities for Health and Social Care services. These are published in a document called “Priorities for Action”. This is sent to Health and Social Care organisations across Northern Ireland who act on these priorities to meet the standards set and to improve services.

The Patient and Client Council is meeting with small groups of people across Northern Ireland to ask what they think are the most important issues that need to be tackled in Health and Social Care in the coming year.

We will talk to up to 500 people, from all walks of life, with different experiences of health and care services and from communities throughout the country.

The Patient Client Council will take all of these views and put them into a report which it will send to the Department of Health. The report will be part of the process of setting priorities for Health and Social Care next year.

WHAT IS THE PATIENT CLIENT COUNCIL?

The Patient and Client Council is a brand new organisation, which has been set up to provide a powerful independent voice for patients clients carers and communities on health and social care issues.

The main functions of the PCC are to

- Engage with the public to obtain their views on any part of health and social care.
- To promote the involvement of patients, clients, carers and the public in the design, planning, commissioning and delivery of health and social care.
- To provide assistance to people making a complaint relating to health and social care.
- Provide advice and information to the public about health and social care services.

WHAT'S IN PRIORITIES FOR ACTION?

The current Priorities for Action document runs from April 2009 to April 2010.

This year is the first year that all the new organisations that will plan and provide Health and Social Care in Northern Ireland are in place. These are:

- **The Health and Social Care Board** – this is a new organisation that, with the Public Health Agency, is responsible for planning the best use of health funds to achieve the Minister's Priorities for Action targets. The Board is also responsible for managing and supporting the Trusts to ensure the achievement of these targets.
- **The Public Health Agency** – this is a new organisation set up to promote public health and to prevent illness and disease. Public health is something that affects all government departments and local government so the Public Health Agency has a particular role in working closely with the rest of government and with the voluntary and community sector. The Agency is jointly responsible with the Board for planning the use of health funds.
- **The Health and Social Care Trusts** – these are the organisations that provide hospital, community and ambulance services.

As a result of Priorities for Action in the past few years, patients should have noticed a change. There are no more long waiting times, in particular for surgeries like hip replacement. There are much fewer stories in the papers about patients left to wait on trolleys in casualty departments for hours on end.

However, Priorities for Action this year states that there is still plenty to be done:

- More services are to be provided at home and in communities
- More money needs to be put into services that have not relatively less well funded in the past in comparison with others – mental health and learning disability services, for example.
- People need to become more involved in looking after their own health.

There are seven priority areas for action in the document:

PRIORITY AREA 1: IMPROVING HEALTH AND WELL-BEING

It is under this heading that targets around obesity, smoking, alcohol use, underage pregnancy and new screening programmes appear. For example:

Bowel cancer screening: by December 2009, Commissioners and Trusts should establish a comprehensive bowel screening programme for those aged 60-69 (to include appropriate arrangements for follow-up treatment).

PRIORITY AREA 2: ENSURING SAFER, BETTER QUALITY SERVICES

This heading is concerned with things like reducing hospital infection rates and with service frameworks – plans that set out standards to be achieved for major services – like heart and cancer services. There are standards here, too, for patient experience:

Patient Experience: by September 2009, Trusts should adopt Patient and Client Experience Standards in relation to Respect, Attitude, Behaviour, Communication, and Privacy and Dignity, and have put in place arrangements to monitor and report performance against these standards on quarterly basis.

PRIORITY AREA 3: IMPROVING ACUTE SERVICES

This is the area concerned with hospital waiting times. There are targets for waiting times for all inpatient and outpatient, urgent and emergency services. An example is:

A&E: from April 2009, 95% of patients attending any A&E department should be either treated and discharged home, or admitted within four hours of their arrival in the department.

PRIORITY 4: ENSURING FULLY INTEGRATED CARE AND SUPPORT IN THE COMMUNITY

Under this heading are targets for the services people receive at home. They are also about avoiding admitting people to hospital wherever possible and – when people are in hospital - about discharging them as soon as they are fit to go home. An example is:

Hospital discharges: from April 2009, 90% of complex discharges should take place within 48 hours, with no discharge taking longer than seven days. All other patients should be discharged within six hours of being declared medically fit.

PRIORITY 5: IMPROVING CHILDREN'S SERVICES

Targets in this area are mainly to do with social services support to children and families. An example is:

Care leavers in education, training or employment: by March 2010, ensure that at least 70% of all care leavers aged 19 are in education, training or employment.

PRIORITY 6: IMPROVING MENTAL HEALTH SERVICES

Mental Health and Learning Disability services are an area where the Department of Health sees a need to invest more in services because they have not been given the same priority as some other services until recently. It is also an area in which much more care and treatment will take place outside the hospital. An example of a target in this area is:

Assessment and treatment: from April 2009, implement a stepped care model and ensure no patient waits longer than 13 weeks from referral to assessment and commencement of treatment for mental health issues including psychological therapies, reducing to nine weeks by March 2010, other than psychological therapies.

PRIORITY 7: IMPROVING SERVICES FOR PEOPLE WITH A DISABILITY

Disability under this heading means learning, physical and sensory disability. The targets as in the other areas reflect a general drive to reduce waiting times, to make less use of hospitals if a service could be provided in the community and to improve community based services.

An example is:

Housing adaptations: by March 2010, all lifts and ceiling track hoists are to be installed within 22 weeks of the occupational therapy assessment and options appraisal as appropriate, and all urgent minor housing adaptations are to be completed within 10 working days.

These are all the headings that deal mainly with direct patient care but there are three other areas relevant more to the service but which have an impact on patient care. These are:

ENSURING EFFECTIVE FINANCIAL CONTROL AND IMPROVED

EFFICIENCY - These are about making sure that money is spent wisely and that the Health and Social Care organisations live within their budgets.

IMPROVING PRODUCTIVITY - These are about doing more work for less money and are about reducing staff absenteeism, cancelled operations and so on.

MODERNISING THE INFRASTRUCTURE - These are about making sure that the planners stay on target in their preparation for maintaining existing and building new healthcare facilities.

QUESTIONS FOR DISCUSSION

- Were you aware of the targets before we contacted you?
- Do you think the targets have made a difference?
- If you were the Minister, what would be your top three targets

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Public Engagement Project on Priorities for Action